Bimzelx (bimekizumab-bkzx)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA. ☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Moderate to severe plaque psoriasis ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the prescriber a Dermatologist?

Will the patient use drug with another biologic response modifier or immunomodulatory agent? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Humira-adalimumab-aacf? ☐ Yes ☐ No Please submit documentation.

Is patient greater than or equal to 120kg? ☐ Yes ☐ No

If patient is greater than or equal to 120kg, will the patient be dosed every 8 weeks? ☐ Yes ☐ No

If patient is greater than or equal to 120kg, will the patient be dosed every 4 weeks? ☐ Yes ☐ No

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Does the patient have plaques covering ≥ 10% of their body surface area (BSA)? ☐ Yes ☐ No Please submit documentation.

Does patient have ≤ 10% of BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? ☐ Yes ☐ No Please submit documentation.

Is topical therapy no longer tolerated or effective with agents such as corticosteroids, anthralin, calcipotriene, or Tazarotene for thepatient? ☐ Yes ☐ No Please submit documentation.

Select if the patient has had previous treatment failure with the following Please submit documentation.

☐ Phototherapy

☐ Psoralens with UVA light (PUVA)

☐ UVB with coal tar

Has the patient had previous treatment failure with an oral systemic therapy (e.g., acitretin, methotrexate or cyclosporine)? ☐ Yes ☐ No

If "no" to the above question, does the patient have a contraindication to ALL oral systemic treatments?*

☐ Yes ☐ No

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***Documentation of a contraindication to ALL oral systemic treatments must be submitted*.**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is the patient continuing to have a positive clinical response and remission of disease is maintained with continued use?* □ **Yes** □ **No *Must be confirmed by provided chart notes.**

Will the patient use drug with another biologic response modifier or immunomodulatory agent? □ **Yes** □ **No**

Is prescriber a dermatologist? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811