BlueCross BlueShield Federal Employee Program

BIMZELX
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

For claims adjudicated through the pharmacy benefit
For Standard and Basic Option patients Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara (SC), Taltz, Tremfya, and Xeljanz/Xeljanz XR are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Bimzelx (bimekizumab-bkzx)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Bimzelx continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
4. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   ****If YES***, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   ****If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
5. Will this medication be given in combination with any other biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   ****If YES,*** please specify the medication: _____
   ****DMARDs: Actemra, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***
6. What is the patient's diagnosis? ***Please select answer below:***
   ❑Ankylosing spondylitis (AS)
   a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Taltz? ❑Yes* ❑No
      ****If YES,*** please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz
   b. Does the patient have active ankylosing spondylitis (AS)? ❑Yes ❑No
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No
   d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 160 mg every 4 weeks? ❑Yes ❑No

   ❑ Hidradenitis suppurativa (HS)
   a. Does the patient have moderate to severe hidradenitis suppurativa (HS)? ❑Yes ❑No
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 320 mg every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Non-radiographic axial spondyloarthritis (nr-axSpA)

a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Cimzia, Rinvoq, or Taltz? ❑Yes* ❑No ***If YES,*** please select the preferred product: ❑Cimzia ❑Rinvoq ❑Taltz

b. Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA)? ❑Yes ❑No

c. Does the patient have objective signs of inflammation? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

e. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 160 mg every 4 weeks? ❑Yes ❑No

❑Plaque psoriasis (PsO)

a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Otezla, Skyrizi, Stelara (SC), Taltz, or Tremfya? ❑Yes* ❑No

If YES, please select one of the following: ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya

b. Does the patient have a diagnosis of moderate to severe active plaque psoriasis (PsO)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy

e. What is the patient's weight? ***Please select answer below:***

❑ **Less than 120 kg (264 lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 320 mg every 8 weeks? ❑Yes ❑No

❑ **Greater than or equal to 120 kg (264 lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 320 mg every 4 weeks? ❑Yes ❑No

❑Psoriatic arthritis (PsA)

a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR?

❑Yes* ***(*If YES, please select the medication below)*** ❑No

❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

b. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional DMARD? ❑Yes ❑No

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 160 mg every 4 weeks? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS WITH A DIAGNOSIS OF PLAQUE PSORIASIS, PSORIATIC ARTHRITIS, NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS, OR ANKLYOSING SPONDYLITIS REQUIRES PAGE 5 TO BE COMPLETED

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

For claims adjudicated through the pharmacy benefit
For Standard and Basic Option patients Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara (SC), Taltz, Tremfya, and Xeljanz/Xeljanz XR are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)

Bimzelx (bimekizumab-bkzx)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Bimzelx continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will this medication be given in combination with any other biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
7. What is the patient's diagnosis? ***Please select answer below:***

   ❑Ankylosing spondylitis (AS)
   a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Taltz? ❑Yes* ❑No
      If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 160 mg every 4 weeks? ❑Yes ❑No

   ❑ Hidradenitis suppurativa (HS)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 320 mg every 4 weeks? ❑Yes ❑No

   ❑Non-radiographic axial spondyloarthritis (nr-axSpA)
   a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Cimzia, Rinvoq, or Taltz? ❑Yes* ❑No ***If YES,*** please select the preferred product: ❑Cimzia ❑Rinvoq ❑Taltz
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 160 mg every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Plaque psoriasis (PsO)

a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Otezla, Skyrizi, Stelara (SC), Taltz, or Tremfya? ❑Yes***** ❑No

If YES, please select one of the following: ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya

b. What is the patient's weight? ***Please select answer below:***

❑ **Less than 120 kg (264 lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 320 mg every 8 weeks? ❑Yes ❑No

❑ **Greater than or equal to 120 kg (264 lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 320 mg every 4 weeks? ❑Yes ❑No

❑Psoriatic arthritis (PsA)

a. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR?

❑Yes***** ***(*If YES, please select the medication below)*** ❑No

❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 160 mg every 4 weeks? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS WITH A DIAGNOSIS OF PLAQUE PSORIASIS, PSORIATIC ARTHRITIS, NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS, OR ANKLYOSING SPONDYLITIS REQUIRES PAGE 5 TO BE COMPLETED

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 5 TO BE COMPLETED

1. Please select diagnosis and answer the following questions:

❑**Ankylosing spondylitis (AS)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Taltz?

Please select answer: ❑Yes ❑No**

****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Non-radiographic axial spondyloarthritis (nr-axSpA)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Cimzia, Rinvoq, or Taltz?

Please select answer: ❑Yes ❑No**

****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Plaque psoriasis (PsO)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Skyrizi, Stelara SC, Taltz, or Tremfya?

Please select answer: ❑Yes ❑No**

****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Psoriatic arthritis (PsA)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR?

Please select answer: ❑Yes ❑No**

****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.