PRIOR AUTHORIZATION REQUEST

Bimzelx

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with a biologic disease modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [NOTE: Examples of biologics include but not limited to Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include but not limited to Olumiant, Otezla, Rinvoq or Xeljanz/XR.] [If yes, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Plaque Psoriasis, moderate to severe (If checked, go to 8) [] Ankylosing spondylitis (If checked, go to 13) [] Axial spondyloarthritis, nonradiographic (If checked, go to 17) [] Psoriatic arthritis (If checked, go to 24) [] All other indications or diagnoses (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months or was intolerant to traditional systemic agents? [NOTE: Examples include but not limited to methotrexate (MTX), cyclosporine, acitretin (Soriatane, generics), or psoralen plus ultraviolet A light (PUVA).] [If no, no further questions.]	Yes	No
10	Does the patient have a documented intolerance, contraindication to, or failed treatment for at least 3 months with preferred Tumor Necrosis Factor (TNF) inhibitors, Enbrel (etanercept) and adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? [If no, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

11	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [If yes, no further questions.]	Yes	No
12	Is the requested medication being prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
13	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred Tumor Necrosis Factor (TNF) inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred Janus kinase (JAK) inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [If yes, no further questions.]	Yes	No
17	Is the requested medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
18	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
19	Does the patient have an objective sign of inflammation defined as a C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory? [If yes, skip to question 21.]	Yes	No
20	Does the patient have an objective sign of inflammation defined as a sacroiliitis reported on magnetic resonance imaging? [If no, no further questions.]	Yes	No
21	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred Tumor Necrosis Factor (TNF) inhibitors, Enbrel (etanercept), an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
22	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [If yes, no further questions.]	Yes	No
23	Is the requested medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
24	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
25	Has the patient tried AT LEAST TWO conventional synthetic disease-modifying antirheumatic drug (DMARD) for AT LEAST 3 months? [NOTE: Examples of conventional synthetic DMARDs are methotrexate (oral or injectable), leflunomide, sulfasalazine, and hydroxychloroquine.] [If yes, skip to question 27.]	Yes	No
26	Has documentation been provided to confirm that the patient has an intolerance to AT LEAST TWO conventional synthetic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred Tumor Necrosis Factor (TNF) inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
29	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [If yes, no further questions.]	Yes	No
30	Is the requested medication being prescribed by or in consultation with a rheumatologist or dermatologist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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