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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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 DMARDs include but not limited to Olumiant, Otezla, Rinvoq, or Xeljanz/XR.]	Yes	No

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	[If yes, no further questions.]		
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 15) [] Axial spondyloarthritis, nonradiographic (If checked, go to 20) [] Psoriatic arthritis (If checked, go to 26) [] Hidradenitis suppurativa (If checked, go to 34) [] 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 patient tried AT LEAST TWO traditional systemic agents for psoriasis for AT LEAST 3 months or was intolerant traditional systemic agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include methotrexate (MTX), cyclosporine, acitretin (Soriatane, generics)] [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with an	Yes	No

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	adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
11	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with Interleukin 17 (IL-17) inhibitor, Cosentyx? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dosing: 320 mg once every 4 weeks for the first 16 weeks (5 doses), and then every 8 weeks thereafter.] [If yes, no further questions.]	Yes	No
14	Is the requested medication being prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
15	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
16	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	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
18	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dosing: 160 mg once every 4 weeks.) [If yes, no further questions.]	Yes	No
19	Is the requested medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No

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20	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
21	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 23.]	Yes	No
22	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
23	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dosing: 160 mg once every 4 weeks.) [If yes, no further questions.]	Yes	No
25	Is the requested medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
26	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
27	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for AT LEAST 3 months or was intolerant to conventional synthetic DMARDs? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] 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 an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
29	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma)? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If no, no further questions.]		
30	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
31	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with IL-17 inhibitor, Cosentyx? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dosing: 160 mg once every 4 weeks.) [If yes, no further questions.]	Yes	No
33	Is the requested medication being prescribed by or in consultation with a rheumatologist or dermatologist? [No further questions.]	Yes	No
34	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
35	Has the patient tried AT LEAST ONE other therapy for AT LEAST 3 months? [Note: Examples include but not limited to intralesional or oral corticosteroids (such as triamcinolone, prednisone), systemic antibiotics (for example, clindamycin, dicloxacillin, erythromycin), or isotretinoin.] [If no, no further questions.]	Yes	No
36	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
37	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with IL-17 inhibitor, Cosentyx? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
38	Is the requested medication prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
39	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dosing: 320 mg once every 2 weeks for the first 16 weeks (9 doses), and then every 4 weeks thereafter.]	Yes	No

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

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

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