

## DRAFTING A PRIOR AUTHORIZATION REQUEST\*

Most health plans require a prior authorization request and supporting documentation to process a claim for biologic treatments. A prior authorization allows the payer to review the reason for the requested treatment and determine its medical appropriateness.

This resource provides information to healthcare professionals (HCPs) for their consideration in drafting a prior authorization request, including guidance and recommendations, a checklist, and a sample letter with information health plans often require.

Use of the information in this letter does not guarantee that the health plan will provide reimbursement for BIMZELX and is not intended to be a substitute for, or an influence on, the physician's independent medical judgment.

### Prior authorization requests: Guidance and recommendations

- **Your BIMZELX Patient Experience Specialist** may be able to provide you with prior authorization requirements for specific plans and pharmacy benefit managers. BIMZELX Navigate™ and/or specialty pharmacies can assist with identifying prior authorizations, form requirements, and step edit therapies.
- **You may submit a request for the patient to bypass a required plan-specified step edit therapy if you think it won't be well tolerated or another therapy is more appropriate. For more information, refer to [Composing a Letter of Medical Necessity](#) or visit [StepTherapy.com/step-therapy-legislation-by-state/](#).**
- **All completed BIMZELX prior authorization forms** should be submitted by your office to BIMZELX Navigate or your specialty pharmacy.
- **Plans will often allow up to 3 levels of appeal for prior authorization denials.** The third appeal may include a review by an external review board or hearing.

### Prior authorization considerations

- ✔ **Verify and record that all of the prior authorization requirements** for the plan have been met
- ✔ **If applicable, provide evidence that all step edit therapy prerequisites have been met.** For step edit therapy exception requests, explain why BIMZELX is medically appropriate for the patient in place of a prerequisite/step edit therapy
- ✔ **If required, use the Prior Authorization Request Form** that can be found on the health plan's website

\*The information in this guide is presented for informational purposes only and is not intended to provide reimbursement or legal advice. HCPs are encouraged to contact third-party payers for specific information on their current coverage policies. For other questions, please call BIMZELX Navigate at **1-866-4-BIMZELX (1-866-424-6935)**.



## SAMPLE PRIOR AUTHORIZATION REQUEST

Most health plans require a prior authorization request and supporting documentation to process a claim for BIMZELX.

**You may choose to use this template to assist in completing your request. Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.**

### SAMPLE PRIOR AUTHORIZATION REQUEST

**You may choose to use this template to assist in completing your request. Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.** Use of the information in this letter does not guarantee that the health plan will provide reimbursement for BIMZELX and is not intended to be a substitute for, or an influence on, the physician's independent medical judgment.

[Date] Re: [Patient's name]  
 [Prior authorization department] [Plan identification number]  
 [Name of health plan] [Date of birth]  
 [Mailing address]

To whom it may concern:

This letter serves as a prior authorization request for BIMZELX<sup>®</sup> (bimekizumab-bkzx) for [patient's name, plan identification, and group number] for the treatment of [diagnosis and ICD code]

- [Patient's gender and age]
- [Patient's relevant history, findings, and diagnosis; previous treatment of BIMZELX]
- [Past treatment start/stop date and patient's response to these therapies]
- [Brief description of the patient's recent symptoms or conditions]

\_\_\_\_\_ Indicate here, by adding a checkmark, that the patient does not have active tuberculosis or other serious infections (required by some health plans). If the patient has any serious infections, please list them below:

Infection name and affected part(s) of body	Treatment type(s)	Treatment start/stop dates	Anticipated resolution date

**Summary of your professional opinion:**

[Insert rationale for prescribing BIMZELX here, including your professional opinion of the patient's likely prognosis or disease progression without BIMZELX treatment.]

**Provide supporting references for your recommendation:**

[Provide clinical rationale for treatment; this information may be found in the BIMZELX Prescribing Information and/or clinical peer-reviewed literature.]

**Physician contact information:**

The ordering physician is [physician name, NPI #]. The prior authorization decision may be faxed to [fax #]. Please send a copy of the coverage determination decision to [patient's name, street address, city, state, ZIP].

Sincerely,  
 [Physician's name and signature] [Patient's name and signature]

[Physician's medical specialty]  
 [Physician's NPI #]  
 [Physician's practice name]  
 [Phone #]  
 [Fax #]

Consider including patient's medical records and supporting documentation:

- Clinical evaluation
- Scoring forms
- Photos of affected areas, where relevant
- Identify drug name and strength, dosage form, and therapeutic outcome

If this prior authorization request letter is intended to appeal a plan's step edit requirement, consider adding text as follows:

*This plan currently lists required step edit therapies to be attempted prior to treatment with BIMZELX. These step edit therapies are not viable for this patient. We are requesting that the step edit therapy requirement be bypassed. Provide statement(s) indicating why these step edit therapy requirements are inappropriate for this patient.*

# HELP CLEAR THE WAY WITH BIMZELX Navigate™\*



BIMZELX Navigate helps make the treatment journey smooth from the start for your patients.

Start your patients on BIMZELX Navigate today

*Here Is How!*

- 1** Enroll your patients at [BIMZELXhcp.com](https://BIMZELXhcp.com).
  - 2** Then, log in to the BIMZELX Navigate HCP Portal, click the **"Add a Patient"** button in the top right, and fill out the patient information.
- or
- Fax a completed BIMZELX Navigate enrollment form to **844-628-3299**.

*Patients Get Support*

- Easy enrollment and onboarding support for **streamlined product access—with no prior authorization (PA) needed** for eligible, commercially insured patients if there is a delay or denial in insurance coverage<sup>††</sup>
- Eligible, commercially insured patients may **pay only \$5 per dose once insurance coverage is approved or just \$15 per dose** for up to 2 years while insurance coverage is pending<sup>‡</sup>
- Innovative tracking tools and resources available online at [My Navigate Portal](#)
- Nurse Navigators for **assistance throughout the patient journey**<sup>§</sup>

\*The BIMZELX Navigate program is provided as a service of UCB and is intended to support the appropriate use of BIMZELX. The BIMZELX Navigate program may be amended or cancelled at any time without notice. Some program and eligibility restrictions may apply.

†Prior to second dose, a PA will be needed.

‡For eligible, commercially insured patients only. Eligible patients who have a delay or denial of coverage may pay as little as \$15 per dose of BIMZELX for up to two years or until the patient's commercial insurance plan approves coverage, whichever comes first. Eligible, commercially insured patients may pay \$5 per dose. Please see full eligibility requirements and terms at [BIMZELXhcp.com](https://BIMZELXhcp.com).

§Nurse Navigators do not provide medical advice and will refer patients to their healthcare professional for any treatment-related questions.

 Inspired by patients.  
Driven by science.

Please see Important Safety Information on next page. Please click to access the full [Prescribing Information](#), or visit [BIMZELXhcp.com](https://BIMZELXhcp.com).



## INDICATION

BIMZELX is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

## IMPORTANT SAFETY INFORMATION

### Suicidal Ideation and Behavior

BIMZELX<sup>®</sup> (bimekizumab-bkzx) may increase the risk of suicidal ideation and behavior (SI/B). A causal association between treatment with BIMZELX and increased risk of SI/B has not been established. Prescribers should weigh the potential risks and benefits before using BIMZELX in patients with a history of severe depression or SI/B. Advise monitoring for the emergence or worsening of depression, suicidal ideation, or other mood changes. If such changes occur, advise to promptly seek medical attention, refer to a mental health professional as appropriate, and re-evaluate the risks and benefits of continuing treatment.

### Infections

BIMZELX may increase the risk of infections. Do not initiate treatment with BIMZELX in patients with any clinically important active infection until the infection resolves or is adequately treated. In patients with a chronic infection or a history of recurrent infection, consider the risks and benefits prior to prescribing BIMZELX. Instruct patients to seek medical advice if signs or symptoms suggestive of clinically important infection occur. If a patient develops such an infection or is not responding to standard therapy, monitor the patient closely and do not administer BIMZELX until the infection resolves.

### Tuberculosis

Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with BIMZELX. Avoid the use of BIMZELX in patients with active TB infection. Initiate treatment of latent TB prior to administering BIMZELX. Consider anti-TB therapy prior to initiation of BIMZELX in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Closely monitor patients for signs and symptoms of active TB during and after treatment.

### Liver Biochemical Abnormalities

Elevated serum transaminases were reported in clinical trials with BIMZELX. Test liver enzymes, alkaline phosphatase and bilirubin at baseline, periodically during treatment with BIMZELX and according to routine patient management. If treatment-related increases in liver enzymes occur and drug-induced liver injury is suspected, interrupt BIMZELX until a diagnosis of liver injury is excluded. Permanently discontinue use of BIMZELX in patients with causally associated combined elevations of transaminases and bilirubin. Avoid use of BIMZELX in patients with acute liver disease or cirrhosis.

### Inflammatory Bowel Disease

Cases of inflammatory bowel disease (IBD) have been reported in patients treated with IL-17 inhibitors, including BIMZELX. Avoid use of BIMZELX in patients with active IBD. During BIMZELX treatment, monitor patients for signs and symptoms of IBD and discontinue treatment if new onset or worsening of signs and symptoms occurs.

### Immunizations

Prior to initiating therapy with BIMZELX, complete all age-appropriate vaccinations according to current immunization guidelines. Avoid the use of live vaccines in patients treated with BIMZELX.

## MOST COMMON ADVERSE REACTIONS

Most common adverse reactions ( $\geq 1\%$ ) are upper respiratory infections, oral candidiasis, headache, injection site reactions, tinea infections, gastroenteritis, Herpes Simplex Infections, acne, folliculitis, other Candida infections, and fatigue.

Please click to access the full [Prescribing Information](#), or visit [BIMZELXhcp.com](https://www.bimzelxhcp.com).



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\_\_\_\_\_

Infection name and  
affected part(s) of body

\_\_\_\_\_

Treatment type(s)

\_\_\_\_\_

Treatment start/stop dates

\_\_\_\_\_

Anticipated resolution date

### Summary of your professional opinion:

[Insert rationale for prescribing BIMZELX here, including your professional opinion of the patient's likely prognosis or disease progression without BIMZELX treatment.]

### Provide supporting references for your recommendation:

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### Physician contact information:

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Sincerely,

\_\_\_\_\_  
[Physician's name and signature]

\_\_\_\_\_  
[Patient's name and signature]

[Physician's medical specialty]

[Physician's NPI #]

[Physician's practice name]

[Phone #]

[Fax #]