Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Bimzelx (bimekizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Bimzelx (bimekizumab) .** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

□ Initial therapy □ Continuing therapy, State date: _____

2. Member is ≥ 18 years

□ No □ Yes

3. Does the member have a diagnosis of one of the following?

□ Plaque psoriasis, and is a candidate for systemic therapy or phototherapy

□ Adult active psoriatic arthritis
□ Adult active ankylosing spondylitis
□ Adults with non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation

4. If the member has a diagnosis of plaque psoriasis, has there been a trail and failure of a topical psoriasis agent?

□ No □ Yes
If Yes, provide name of drug tried and outcome:_____

5. Was there therapeutic failure to one of the preferred agents? (e.g., Enbrel, Humira, etc)

□ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**