



Bimzelx[®] Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Moderate to severe chronic plaque psoriasis					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information:					
Select if the requested medication is prescribed by or in consultation with one of the following specialists:					
<input type="checkbox"/> Dermatologist <input type="checkbox"/> Other _____					
Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For moderate to severe chronic plaque psoriasis (PsO), also answer the following:					
Has the patient had an inadequate response to, intolerance to, or contraindication to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine, calcipotriene, tazarotene, corticosteroid)? <input type="checkbox"/> Yes <input type="checkbox"/> No List _____					
Quantity limit requests:					
What is the quantity requested per TREATMENT? _____ syringe every _____ weeks					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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