Mountain Pacific
INNOVATING BETTER HEALTH
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Montana Healthcare Programs Prior Authorization Request Form for Use of Bimzelx® (bimekizumab-bkzx)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member has a diagnosis of refractory moderate to severe plaque psoriasis: ☐ Yes ☐ No
2. Member is 18 years of age or greater: ☐ Yes ☐ No
3. Medication is prescribed by, or in consultation with, a dermatology specialist: ☐ Yes ☐ No

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ **Contact date:** _____
4. Member has trialed and has had an inadequate treatment response, intolerance or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (mt.gov) (unless preferred product(s) do not have the appropriate indication): ☐ Yes ☐ No

   Name: _____ **Dates:** _____
5. Provider attests to all the following:
   - Member has been informed of the possible increased risk of infection while using Bimzelx®: ☐ Yes ☐ No
   - Member has been advised of increased suicidal ideation and behavior risk reported with Bimzelx® and need to monitor: ☐ Yes ☐ No
   - All age-appropriate vaccines and lab work have been completed prior to Bimzelx® initiation: ☐ Yes ☐ No
6. Provider attests the member will not use Bimzelx® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose for initial authorization: 320mg every 4 weeks (week 0, 4, 8, 12 and 16)

Initial authorization will be issued for 16 weeks (5 doses).

☐ CONTINUATION OF THERAPY

1. Member has documentation of positive clinical response to Bimzelx® therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations)? ☐ Yes ☐ No
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – Prescriber is specialist.
3. Provider attests the member will not use Bimzelx® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose for renewal authorization: 320mg every 8 weeks

Reauthorization will be issued for 12 months.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.

02/2024