

TRICARE Prior Authorization Request Form for  
bimekizumab-bkzx (Bimzelx, Bimzelx autoinjector)



**JOHNS HOPKINS**  
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and  
Applicable Progress Notes to:  
(410) 424-4037**

## USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name: _____	Strength: _____
Dosage/Frequency (SIG): _____	Duration of Therapy: _____

**Questions?** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Does the patient have moderate to severe plaque psoriasis?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 6
4. Has the patient had an inadequate response to Humira?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 5
5. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
6. Does the patient have a contraindication to Humira (adalimumab)?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
7. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<b>8. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?</b>	<input type="checkbox"/> Yes Proceed to question <b>9</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>9. Is the patient a candidate for systemic therapy or phototherapy?</b>	<input type="checkbox"/> Yes Proceed to question <b>10</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example., azathioprine], etc.)</b>	<input type="checkbox"/> Yes Proceed to question <b>11</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>11. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?</b>	<input type="checkbox"/> Yes Proceed to question <b>12</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>12. Will the patient be receiving any other targeted immunomodulatory biologics with bimekizumab, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq ER, Rituxan, Siliq, Simponi, Skyrizi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?</b>	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No <b>Sign and date below</b>

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date

[30 November 2023]

<b>For Internal Use Only</b>	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: