SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Bimzelx® (bimekizumab) **Injection (Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Plaque Psoriasis**
Dosing SubQ: 320 mg (two 160mg injections) subcutaneous at Weeks 0,4,8,12 and 16, then every 8 weeks thereafter. For patients weighing ≥ 120kg, consider a dose of 320mg every 4 weeks after Week 16

Initial Authorization: 12 months

- ❑ Member is 18 years of age and older and has a diagnosis of plaque psoriasis
- ❑ Member has a previous failure on a topical psoriasis agent and be a candidate for phototherapy or systemic therapy

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❑ Member has tried and failed **TWO (2)** of the **PREFERRED** therapies below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis: Psoriatic Arthritis**
Dosing: SubQ: 160mg every 4 weeks (if coexisting PsA and PSO, use dosage for PSO)

Initial Authorization: 12 months

❑ Member is 18 years of age and older and has a diagnosis of psoriatic arthritis

❑ Member has tried and failed **TWO (2)** of the **PREFERRED** therapies below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis: Ankylosing Spondylitis**
Dosing: SubQ: 160mg every 4 weeks

Initial Authorization: 12 months

❑ Member is 18 years of age and older and has a diagnosis of ankylosing spondylitis

❑ Member has tried and failed **TWO (2)** of the **PREFERRED** therapies below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis: Non-Radiographic Axial Spondyloarthritis**
Dosing: SubQ: 160mg every 4 weeks

Initial Authorization: 12 months

❑ Member is 18 years of age and older and has a diagnosis of Axial Spondyloarthritis

❑ Member has tried and failed **TWO (2)** of the **PREFERRED** therapies below:

❑ Humira®	❑ Infliximab

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❑ **Diagnosis: Moderate-to Severe Hidradenitis Suppurativa (HS)**
Dosing: SubQ: 320mg every 2 weeks for the first 16 weeks (9 doses), then 320mg every 4 weeks thereafter

Initial Authorization: 12 months

- ❑ Member is 18 years of age and older
- ❑ Member has a diagnosis of moderate-to-severe hidradenitis suppurativa
- ❑ Member has trial and failure of Humira®

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*