UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1437-1
Program	Prior Authorization/Notification
Medication	Bimzelx® (bimekizumab-bkzx)* *Bimzelx is excluded from coverage for the majority of our benefits
P&T Approval Date	4/2024
Effective Date	7/1/2024

1. Background:
Bimzelx (bimekizumab-bkzx) is a humanized interleukin-17A and F antagonist indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Bimzelx** will be approved based on **both** of the following criteria:

   a. Diagnosis of moderate to severe plaque psoriasis

   -AND-

   b. Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

B. Reauthorization

1. **Bimzelx** will be approved based on **both** of the following criteria:

   a. Documentation of positive clinical response to Bimzelx therapy

   -AND-

   b. Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Exclusion: Bimzelx is excluded from coverage for the majority of our benefits
- Supply limits and/or step therapy may be in place.

4. Reference:

1. Bimzelx [package insert]. Smyrna, GA: UCB, Inc.; October 2023

Program	Prior Authorization/Notification - Bimzelx (bimekizumab-bkzx)
Change Control	
4/2024	New program