Mass General Brigham Health Plan

Bimzelx (bimekizumab-bkzx)
Effective 04/01/2024

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions			

Overview
Bimzelx is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

Coverage Guidelines
Authorization may be granted for members new to the plan who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted when the following criteria is met:

1. Submission of medication records (e.g., chart notes) documenting diagnosis of moderate to severe plaque psoriasis
2. Member has at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected
3. Member meets ONE of the following criteria:
    a. Minimum duration of 4-week trial and failure, contraindication, or intolerance to ONE of the following topical therapies
        i. Corticosteroids (e.g., betamethasone, clobetasol)
        ii. Vitamin D analogs (e.g., calcitriol, calcipotriene)
        iii. Tazarotene
        iv. Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
        v. Anthralin
        vi. Coal tar
    b. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.
4. Paid claims or medical records documenting trial and failure, intolerance, or contraindication to TWO of the following:
    a. Cimzia
    b. Enbrel

c. Humira, Hadlima, Adalimumab-adaz, Adalimumab-fkjp
d. Skyrizi
e. Stelara
f. Tremfya

5. Paid claims or medical records documenting trial and failure, intolerance, or contraindication to Cosentyx

Continuation of Therapy

Authorization may be granted for continued treatment in members who demonstrate a positive clinical response when ONE the following criteria are met:

1. Reduction in body surface area (BSA) involvement from baseline
2. Improvement in symptoms (e.g., pruritis, inflammation) from baseline

Limitations

1. Initial approvals will be granted for: 6 months.
2. Reauthorizations will be granted for 12 months.

References

1. Bimzelx Prescribing Information. UCB, Inc. Smyrna, GA. October 2023.
2. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol 2019;80:1029-72.
3. Elmets CA, Korman NJ, Farley Prater E, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol 2021;84:432-70.

Review History

3/10/2023: Created and Reviewed at March P&T, Effective 4/1/2024