*REQUIRED FIELDS FOR PROCESSING

ENROLLMENT AND BENEFITS VERIFICATION FORM

FAX COMPLETED FORM TO 1-844-NAVFAXX • FOR ASSISTANCE, CALL 1-866-4-BIMZELX
ENROLL ONLINE AT UCBNAVIGATE.COM, E-PRESCRIBE TO CAREFORM PHARMACY (NPI #1043762750)

Bimzelx® (bimekizumab-bkzx) Navigate

PATIENT INFORMATION

*Name (First, Middle Initial, Last) _____ *Gender ☐ M ☐ F ☐ Other _____ *Date of Birth (mm/dd/yyyy)

*Address _____ *City _____ *State _____ *ZIP Code _____

*Primary Phone # ☐ Mobile ☐ Landline _____ Alternate Phone # ☐ Mobile ☐ Landline _____ Preferred Language ☐ English ☐ Spanish

Email Address _____ Authorized Representative Contact Name _____ Authorized Representative Contact Phone # _____

INSURANCE INFORMATION

*Prescription Insurer _____ *Prescription Insurance Phone # _____

Please fax front and back of patient's medical and prescription insurance cards

*Rx Member ID # _____ *Rx BIN # _____ *Rx PCN # _____ *Rx Group # _____

*Primary Medical Insurance _____ *Phone # _____ *Medical Insurance ID # _____ *Medical Insurance Group # _____

PRESCRIBER INFORMATION

*Prescriber Name (First, Last) _____ *NPI # _____ *Tax ID # _____

Office Contact _____ *Phone # _____

*Practice/Clinic Name _____ *Fax # _____

*Street Address _____ *City _____ *State _____ *ZIP Code _____

Supervising Physician _____ NPI # _____

CLINICAL INFORMATION

*Diagnosis
(check box next to primary)

☐ Psoriasis L40.0

OR

☐ Other ICD-10 Code _____

Patient Height (ft, in) _____ Patient Weight (lb) _____

Prior Treatment Failures, Contraindications, or Intolerances (select all that apply)

☐ OTEZLA® ☐ COSENTYX® ☐ TALTZ® ☐ HUMIRA®
☐ CIMZIA® ☐ ENBREL® ☐ TREMFYA® ☐ SKYRIZI®
☐ STELARA® ☐ ILUMYA® ☐ Infliximab ☐ Methotrexate
☐ Phototherapy ☐ No previous biologic or systemic agent
☐ Other: _____

Please refer to the full Prescribing Information for recommended evaluations prior to treatment.

Lab Work Completed ☐ Yes ☐ No

Plaque Psoriasis BSA % _____

Preferred Specialty Pharmacy _____

Pharmacy Phone # _____

☐ The patient prescription has been sent to the specialty pharmacy noted above

☐ Patient has been given a sample
QTY ____ Pack(s) of 2 autoinjectors/ prefilled syringes

PHARMACY PRESCRIPTION

*Dispense Device Type ☐ BIMZELX 160 mg/ML autoinjector (NDC-50474-781-85) ☐ BIMZELX 160 mg/ML prefilled syringe (NDC-50474-780-79)

BIMZELX Prescribing Information Adult Dosing	Quantity	Refills
☐ *Initial Dose: Inject 320 mg (2 x 160 mg/ML injections) subcutaneously every 4 weeks at weeks 0, 4, 8, 12, and 16	1 Pack of 2 autoinjectors/ prefilled syringes	4
*Maintenance Dose: (Please indicate) ☐ Inject 320 mg (2 x 160 mg/ML) subcutaneously every 4 weeks ☐ Inject 320 mg (2 x 160 mg/ML) subcutaneously every 8 weeks	1 Pack of 2 autoinjectors/ prefilled syringes	____

BRIDGE PROGRAM†

*Dispense Device Type ☐ BIMZELX 160 mg/ML autoinjector (NDC-50474-781-85) ☐ BIMZELX 160 mg/ML prefilled syringe (NDC-50474-780-79)

BIMZELX Prescribing Information Adult Dosing	Quantity	Refills
☐ *Initial Dose: Inject 320 mg (2 x 160 mg/ML injections) subcutaneously every 4 weeks at weeks 0, 4, 8, 12, and 16	1 Pack of 2 autoinjectors/ prefilled syringes	4
*Maintenance Dose: (Please indicate) ☐ Inject 320 mg (2 x 160 mg/ML) subcutaneously every 4 weeks ☐ Inject 320 mg (2 x 160 mg/ML) subcutaneously every 8 weeks	1 Pack of 2 autoinjectors/ prefilled syringes	____

By signing below, I certify: 1) The therapy is medically necessary and this information is accurate to the best of my knowledge; 2) I am disclosing this information to UCB, their affiliates, agents, representatives, business partners, and service providers (together "UCB") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to UCB so that UCB may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support UCB provides; 5) I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements and I appoint UCB as my agent for the limited purposes of conveying this prescription by any means under applicable law to the dispensing pharmacy; and 6) I hereby authorize UCB HUB to initiate and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. **PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.**

☐ *Send electronic authorization form to listed patient

Prescriber Signature Required _____ OR _____ Date Signed _____

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).
Please refer to the full Prescribing Information provided by the UCB representative.

For more information, contact BIMZELX Navigate™.
Phone: 1-866-4-BIMZELX (1-866-424-6935) Hours: 8am to 8pm ET, Monday–Friday.

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

FOR BIMZELX (bimekizumab-bkzx)

Bimzelx® (bimekizumab-bkzx) Navigate

By signing this **Patient Authorization to Use/Disclose Health Information** form ("Authorization"), I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy that receives my prescription for a UCB medication), and other of my healthcare providers (together, "Providers") and each of my health insurers (together, "Insurers") to disclose information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and email addresses, telephone number, date of birth and Social Security Number (together, "Protected Health Information"), to UCB, Inc. and its agents, service providers, contractors and representatives (together, "UCB"), so that UCB may: (i) enroll me in, and contact me about, UCB medication support programs and/or related market research; (ii) provide me with educational materials, information, and services related to UCB medications; (iii) verify, investigate, assist with, and coordinate my coverage for a UCB medication with my Insurers and Providers; (iv) conduct market analyses or other commercial activity, including aggregating my Protected Health Information with other data for such analyses; (v) assist with analysis related to quality, efficacy, and safety for UCB medication; (vi) de-identify my Protected Health Information for use for any purpose under applicable law; and (vii) send marketing communications to me, which may be delivered under the communication terms described below if I additionally agree to those terms.

Once my health information has been disclosed to UCB, I understand that federal privacy laws may no longer protect the information. However, I understand that UCB and other parties authorized to receive my health information pursuant to this Authorization agree to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I also understand that one or more Providers and/or Insurers may receive payment from UCB for disclosing my Protected Health Information for some or all of the purposes listed above.

I understand that this Authorization is voluntary and that I am not required to sign this Authorization. My treatment, payment, eligibility for benefits, and enrollment is not conditional upon signing this Authorization. I may also revoke this Authorization at any time by (1) logging in to my My Navigate account at https://www.bimzelx.com/navigate and following the instructions in communication preferences; (2) by mailing a letter, including my First Name, Last Name, Date of Birth, Gender, and ZIP Code, requesting such cancellation to UCBCares® 1950 Lake Park Drive, Smyrna, GA 30080; or (3) by informing my Providers in writing that I do not want them to share any information with UCB. I understand that revoking my authorization means my physicians, pharmacies, and health plans, as well as UCB, Inc., may no longer rely on the authorization to use or disclose my PHI, but it will not affect previous disclosures by them pursuant to this authorization.

UCB shall provide timely notification of my revocation of this Authorization to my Providers and Insurers. Once my Providers and Insurers receive and process the notice of revocation of this Authorization, my Providers and Insurers may no longer make disclosures of my Protected Health Information to UCB as permitted by this Authorization.

This Authorization expires 10 years from the date it was signed, or earlier by state law, unless otherwise revoked as outlined above, or unless a shorter period is mandated by the law of my state of residence. I understand that I have the right to receive a copy of this Authorization when it is signed.

☐ *I agree to be contacted by UCB by mail, email, and telephone, at the number(s) and address(es) provided in the Patient Information section of this Enrollment & Benefits Verification Form, to communicate with me for all of the purposes described in this Authorization.

I agree to this Patient Authorization Form — Patient/Authorized Surrogate Signature Required _____ **Date** _____

Relationship to Patient _____

☐ *I agree to receive text messages from My Navigate. Message and data rates may apply. Message frequency will vary based on need. Text STOP to cancel. Text HELP for help. If you have questions, contact the BIMZELX (bimekizumab-bkzx) Nurse Navigator at 1-833-931-6877. View the complete Terms of Use at BIMZELX.com. For more information on how UCB will use your information, please view our privacy policy at BIMZELX.com.

†For eligible commercially insured patients only. Eligible patients who have a delay or denial of coverage may pay as little as $15 per dose of BIMZELX® for up to two years or until the patient's commercial insurance plan approves coverage, whichever comes first. Please see full eligibility and terms at BIMZELX.com.

Please refer to the Medication Guide provided to you and discuss it with your doctor, or visit www.BIMZELX.com.

For more information, contact BIMZELX Navigate™:

Hours: 8am to 8pm ET, Monday–Friday

Fax: 1-844-NAVFAXX (844-628-3299) • **Phone:** 1-866-4-BIMZELX (1-866-424-6935)

Address: 6000 Park Lane Drive, Pittsburgh, PA 15275