[Date]
[Prior authorization department]
[Name of health plan]

[Mailing address]

Re: [Patient's name]
[Plan identification number]
[Date of birth]

To whom it may concern:

This letter serves as a prior authorization request for BIMZELX® (bimekizumab-bkzx) for [Patient's name] [Plan identification, and group number] for the treatment of [diagnosis and ICD code].

[Provide relevant dosing information here, including length of treatment, prior medications and dosing, diagnosis, and dosing for the medication being requested.]

[Provide patient information, including gender, age, relevant history, joint involvement, BSA (body surface area), difficult-to-treat areas, mobility limitations (e.g. inability to use hands during a flare) and a brief description of the patient's recent symptoms and conditions.]

___ Indicate here, by adding a checkmark, that the patient does not have active tuberculosis or other serious infections (required by some health plans). If the patient has any serious infections, please list them below:

Infection name and affected part(s) of body	Treatment type(s)	Treatment start/ stop dates	Anticipated resolution date

Summary of your professional opinion:

[Insert rationale for prescribing BIMZELX here, including your professional opinion of the patient's likely prognosis or disease progression without BIMZELX treatment.]

Provide supporting references for your recommendation:

[Provide clinical rationale for treatment; this information may be found in the BIMZELX Prescribing Information and/or clinical peer-reviewed literature.]

Physician contact information:

The ordering physician is [Physician name, NPI #, Fax#]

The prior authorization decision may be faxed to: [Fax#]

Please send a copy of coverage determination decision to [patient's name, street address, city, state, ZIP.]

Sincerely,

[Physician's name and signature]
[Physician's medical specialty]
[Physician's NPI #]
[Physician's practice name]

[Patient's name and signature]

[Date]
[Prior authorization department]
[Name of health plan]

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