*REQUIRED

ENROLLMENT AND BENEFITS VERIFICATION FORM

FAX COMPLETED FORM TO 1-844-628-3299 • FOR ASSISTANCE, CALL 1-866-424-6935
ENROLL ONLINE AT UCBNAVIGATE.COM OR E-PRESCRIBE TO CAREFORM PHARMACY (NPI #1043762750)

Bimzelx® (bimekizumab-bkzx) Navigate

PATIENT INFORMATION

*Name (First, Middle Initial, Last)		*Gender assigned at birth ☐ Male ☐ Female	*DOB / /
*Street Address			Weight
*City	*State	*ZIP	*Patient Email Address
*Primary Phone #	Alternate Phone #		Preferred Language ☐ English ☐ Spanish ☐ Other_____
Authorized Representative Contact Name		Authorized Representative Contact Phone #	

*INSURANCE INFORMATION

☐ Front and back copies of the patient's medical and pharmacy insurance card(s) attached ☐ No Insurance

Primary Prescription Insurance			Prescription Insurance Phone #
Rx Member ID#	*Rx BIN #	*Rx PCN #	*Rx Group #
Primary Medical Insurance	Phone #	Medical Insurance ID #	Medical Insurance Group #

PRESCRIBER INFORMATION

*Prescriber Name (First, Middle Initial, Last)		*NPI#	*Tax ID #
Office Contact	*Phone #		*Fax #
*Practice/Clinic Name	Prescriber Email		
Street Address	City	State	Zip Code
Supervising Physician		NPI #	

CLINICAL INFORMATION

*Primary Diagnosis Code (Check one)	PSO ☐ L40.0 ☐ Other:_____	PsA ☐ L40.5 ☐ Other:_____	AS ☐ M45 ☐ Other:_____	nr-axSpA ☐ M45.A ☐ Other:_____	HS ☐ L73.2 ☐ Other:_____	Secondary Diagnosis:_____
Prior Treatment Failures, Contraindications, or Intolerances (Select all that apply)	☐ HUMIRA®	☐ ENBREL®	☐ REMICADE®	☐ SIMPONI ARIA®	☐ STELARA®	☐ TALTZ®	☐ XELJANZ®
	☐ OTEZLA®	☐ COSENTYX®	☐ SKYRIZI®	☐ SILIQ®	☐ DMARD	☐ None	Other:_____

Please Provide: ☐ PA/Appeal support ☐ Bridge/Savings support[1] (for eligible patients only)

I have sent this prescription to: ☐ I have only sent this to BIMZELX Navigate®

PRESCRIPTION INFORMATION

☐ Sample provided on (Date) _____

INDICATION	INITIAL	REFILLS	MAINTENANCE	REFILLS	DISPENSE
PSO	☐ Inject 320 mg subcutaneously every 4 weeks at weeks 0, 4, 8, and 12	4	Inject 320 mg subcutaneously at week 16 and then every: ☐ 8 weeks **OR** ☐ 4 weeks may be considered if weight ≥ 120 kg		☐ **BIMZELX 160 mg/mL x 2 Autoinjector** NDC 50474-781-85 ☐ **BIMZELX 160 mg/mL x 2 Prefilled Syringes** NDC 50474-780-79
HS	☐ Inject 320 mg subcutaneously every 2 weeks at weeks 0, 2, 4, 6, 8, 10, 12, and 14	7	☐ Inject 320 mg/mL subcutaneously at week 16 and then every 4 weeks		☐ **BIMZELX 160 mg/mL x 2 Autoinjector** NDC 50474-781-85 ☐ **BIMZELX 160 mg/mL x 2 Prefilled Syringes** NDC 50474-780-79
PsA			☐ Inject 160 mg/mL subcutaneously every 4 weeks		☐ **BIMZELX 160 mg/mL x 1 Autoinjector** NDC 50474-781-84 ☐ **BIMZELX 160 mg/mL x 1 Prefilled Syringe** NDC 50474-780-78
PsA with PSO	☐ Inject 320 mg subcutaneously every 4 weeks at weeks 0, 4, 8, and 12	4	Inject 320 mg subcutaneously at week 16 and then every: ☐ 8 weeks **OR** ☐ 4 weeks may be considered if weight ≥ 120 kg		☐ **BIMZELX 160 mg/mL x 2 Autoinjector** NDC 50474-781-85 ☐ **BIMZELX 160 mg/mL x 2 Prefilled Syringes** NDC 50474-780-79
nr-axSpA or AS			☐ Inject 160 mg/mL subcutaneously every 4 weeks		☐ **BIMZELX 160 mg/mL x 1 Autoinjector** NDC 50474-781-84 ☐ **BIMZELX 160 mg/mL x 1 Prefilled Syringe** NDC 50474-780-78

By signing below, I certify: 1) The therapy is medically necessary and that 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; 6) the prescription complies with my state-specific prescribing requirements, and I appoint UCB as my agent for the limited purpose of conveying this prescription by any means under applicable law only to the dispensing pharmacy; and 7) I hereby authorize UCB's patient support program vendor to submit this Enrollment Form to the dispensing pharmacy as my signature. I understand that by signing this form, I am requesting support from UCB for the above-referenced patient who has been prescribed BIMZELX.

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.

PRESCRIBER SIGNATURE REQUIRED

☐ Patient unable to provide consent. Please send digital request to obtain Patient Authorization to Use/Disclose Health Information.

DISPENSE AS WRITTEN **OR** SUBSTITUTION PERMITTED *Date Signed

Please follow your state's prescribing guidelines for electronic prescriptions (if applicable). Please see accompanying Important Safety Information, refer to the full Prescribing Information provided by the UCB representative, and visit BIMZELXhcp.com.

CA, MA, NC, & PR: Interchange is mandated unless prescriber writes "No Substitution." ATTN: NY and IA, please submit electronic prescription.

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

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, and date of birth (together, "Health Information"), to UCB, Inc. and its agents, service providers, contractors, and representatives (together, "UCB"). My Health Information will be shared with UCB so that UCB may: (i) enroll me in, and contact me about, patient support programs and/or related market research for UCB medications; (ii) provide me with educational materials and information related to UCB medications; (iii) verify, investigate, assist with, and coordinate my coverage for a UCB medication with my Insurers and Providers; (iv) determine my eligibility for and help me access savings, interim care and/or free drug programs for UCB medications; (v) conduct market research and/or analyses or other commercial activity, including aggregating my Health Information with other data for such analyses; (vi) assist with analysis related to quality, efficacy, and safety for UCB medications; (vii) de-identify my Health Information for use for any purpose under applicable law.

I understand that I do not have to sign this Authorization and choosing not to sign will not affect my ability to receive treatment from my Providers or payment from my Insurers. However, if I do not sign this form, UCB may not be able to provide me with certain patient support. Once my Health Information has been disclosed to UCB, I understand that federal privacy laws may no longer protect this 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 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. I may revoke this Authorization at any time (1) by mailing a letter, including my First Name, Last Name, Date of Birth, Gender, and ZIP Code, requesting such cancellation to UCBCares® at 1950 Lake Park Drive, Smyrna, GA 30080; or (2) 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 Health Information, but it will not affect previous disclosures made 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 Health Information to UCB as permitted by this Authorization.

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

Patient Signature (Patient or Patient Representative) _____ **Patient/Patient Representative Name** _____ **Date** ___/___/___

☐ Court Appointed ☐ Guardian ☐ Power of Attorney (including for healthcare decisions) ☐ Other

☐ **I agree** to receive text messages from BIMZELX Navigate®. Message and data rates may apply. You will receive two messages per month. Text STOP to cancel. Text HELP for help. If you have questions, contact the BIMZELX Nurse Navigator at 1-833-931-6877. View the complete Terms of Use at BIMZELX.com.

☐ **I agree** that I am a U.S. resident and give UCB permission to send me information or contact me and/or my healthcare provider regarding my disease as well as information on other related treatments, products, and services, and for marketing and informational purposes by phone, email, or mail. I understand that UCB will not sell my name, address, email address, or any other information to any other third party (other than UCB's agents, service providers, contractors, and representatives) for their own marketing use.

☐ **I agree** to receive communications from UCB (as defined above), including but not limited to calls made with an autodialer or prerecorded voice at the phone number(s) provided to provide me with insurance coverage and financial assistance resources and information, injection support, and for other non-marketing purposes. If I have designated a patient representative, he or she also agrees hereby to receive such communications from UCB for the purposes described above at the phone number(s) provided. I understand that I (and, if applicable, my patient representative) can opt out of these communications at any time by mailing a letter, including my First Name, Last Name, Date of Birth, Gender, and ZIP Code, requesting such cancellation to UCBCares at 1950 Lake Park Drive, Smyrna, GA 30080.

Patient Signature (Patient or Patient Representative) _____ **Patient/Patient Representative Name** _____ **Date** ___/___/___

☐ Court Appointed ☐ Guardian ☐ Power of Attorney (including for healthcare decisions) ☐ Other

For more information on how UCB will use your information, please view our privacy policy at BIMZELX.com.

†For eligible, commercially insured patients only. With BIMZELX Navigate® Bridge, eligible patients whose insurance coverage is delayed or denied may receive BIMZELX for $15 per dose for up to two (2) years or until the patient's coverage is approved, whichever comes first. Once coverage is approved, eligible patients will transfer to the BIMZELX Navigate® Savings program and receive BIMZELX for as little as $5 per dose. View complete eligibility requirements and terms at BIMZELX.com/Patient-Support/Navigate-Benefits.

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)