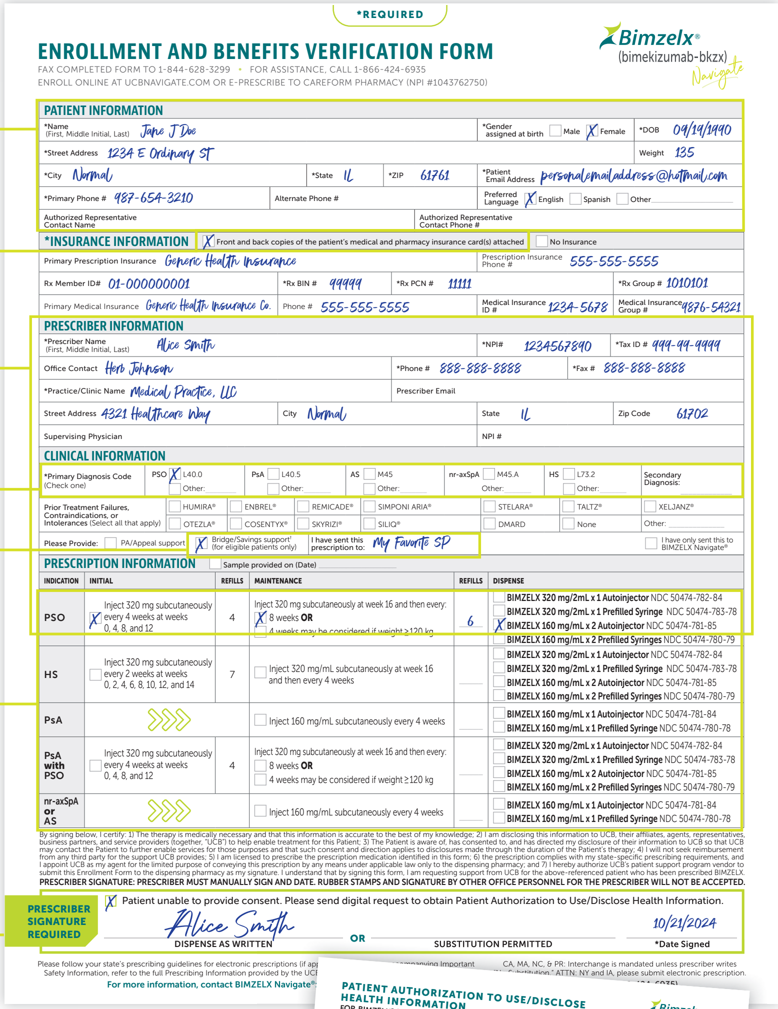
PATIENT ENROLLMENT FORM GUIDE

Bimzelx® (bimekizumab-bkzx) Navigate

Enrolling your patient in BIMZELX Navigate® is easy. Start your patient's treatment by following these important steps.

- Small errors in things like name, address, or date of birth (DOB), or missing required information can lead to delays or complications in the process. **Verify that all personal information is correct** and up-to-date ***before*** submitting the form.
- Fax a copy (front and back) of your **patient's insurance** and pharmacy benefit cards along with the Patient Enrollment Form. If you are unable to fax your patient's insurance cards, please fill out your patient's insurance information under Insurance Information.
- Complete all fields for **Clinical and Prescriber Information**. This will help to communicate with the patient's insurance company during the verification process and to schedule shipments of BIMZELX®.
- The patient's **Primary Diagnosis Code** will be used to identify medical diagnosis and verify benefits. It is required to initiate processing.
- To properly enroll eligible patients into BIMZELX Navigate Bridge, it is important that **BOTH** the **Bridge/Savings support** checkbox is checked and the **Prescription Information section** is filled out.
- Proper and accurate **dosing information** is important for both the patient's Specialty Pharmacy and BIMZELX Navigate to verify the patient's benefits and streamline prescription fulfillment.
- A completed **prescriber signature** gives permission to send a patient's prescription to the appropriate pharmacy. Without this signature, the patient cannot start on BIMZELX.
- Confirm that the form is **filled out in full**.
- Once all sections are complete, **fax to 1-844-NAVFAXX**.



*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)

PATIENT INFORMATION

*Name (First, Middle Initial, Last): Jane J Doe | *Gender assigned at birth: Male / X Female | *DOB: 04/14/1990
*Street Address: 1234 E Ordinary ST | Weight: 135
*City: Normal | *State: IL | *ZIP: 61761 | *Patient Email Address: personalemailaddress@hotmail.com
*Primary Phone #: 987-654-3210 | Alternate Phone # | Preferred Language: X English / Spanish / Other
Authorized Representative Contact Name | Authorized Representative Contact Phone #

*INSURANCE INFORMATION — X Front and back copies of the patient's medical and pharmacy insurance card(s) attached | No Insurance

Primary Prescription Insurance: Generic Health Insurance | Prescription Insurance Phone #: 555-555-5555
Rx Member ID#: 01-000000001 | *Rx BIN #: 99999 | *Rx PCN #: 11111 | *Rx Group #: 1010101
Primary Medical Insurance: Generic Health Insurance Co. | Phone #: 555-555-5555 | Medical Insurance ID #: 1234-5678 | Medical Insurance Group #: 9876-54321

PRESCRIBER INFORMATION

*Prescriber Name (First, Middle Initial, Last): Alice Smith | *NPI#: 1234567890 | *Tax ID #: 999-99-9999
Office Contact: Herb Johnson | *Phone #: 888-888-8888 | *Fax #: 888-888-8888
*Practice/Clinic Name: Medical Practice, LLC | Prescriber Email
Street Address: 4321 Healthcare Way | City: Normal | State: IL | Zip Code: 61702
Supervising Physician | NPI #

CLINICAL INFORMATION

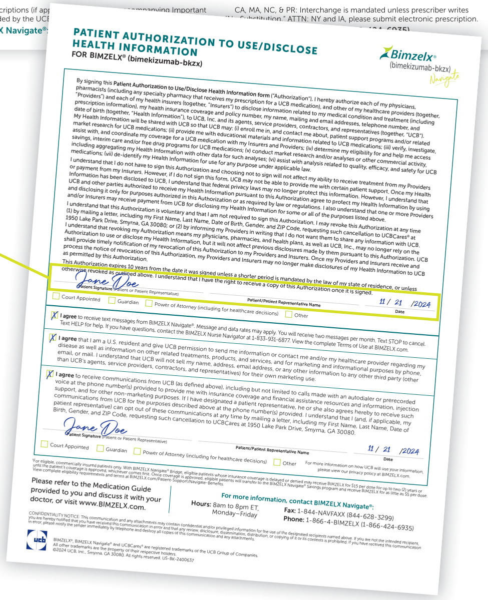
*Primary Diagnosis Code (Check one): PSO X L40.0 Other: | PsA L40.5 Other: | AS M45 Other: | nr-axSpA M45.A Other: | HS L73.2 Other: | Secondary Diagnosis:
Prior Treatment Failures, Contraindications, or Intolerances (Select all that apply): HUMIRA® | ENBREL® | REMICADE® | SIMPONI ARIA® | STELARA® | TALTZ® | XELJANZ® | OTEZLA® | COSENTYX® | SKYRIZI® | SILIQ® | DMARD | None | Other:
Please Provide: PA/Appeal support | X Bridge/Savings support* (for eligible patients only) | I have sent this prescription to: My Favorite SP | I have only sent this to BIMZELX Navigate®

PRESCRIPTION INFORMATION — Sample provided on (Date)

INDICATION	INITIAL	REFILLS	MAINTENANCE	REFILLS	DISPENSE
PSO	X 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: X 8 weeks OR 4 weeks may be considered if weight ≥120 kg	6	BIMZELX 320 mg/2mL x 1 Autoinjector NDC 50474-782-84; BIMZELX 320 mg/2mL x 1 Prefilled Syringe NDC 50474-783-78; X 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 320 mg/2mL x 1 Autoinjector NDC 50474-782-84; BIMZELX 320 mg/2mL x 1 Prefilled Syringe NDC 50474-783-78; 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 320 mg/2mL x 1 Autoinjector NDC 50474-782-84; BIMZELX 320 mg/2mL x 1 Prefilled Syringe NDC 50474-783-78; 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

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 — X Patient unable to provide consent. Please send digital request to obtain Patient Authorization to Use/Disclose Health Information.
Alice Smith — DISPENSE AS WRITTEN — OR — SUBSTITUTION PERMITTED — 10/21/2024 *Date Signed



PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION FOR BIMZELX® (bimekizumab-bkzx)

Jane Doe — 11/21/2024

IT IS VERY IMPORTANT THAT YOUR PATIENT SIGNS THE SECOND PAGE OF THE ENROLLMENT FORM.

It is one of UCB's fundamental priorities to protect your patient's information and privacy. To ensure patients have access to all the support BIMZELX Navigate has to offer, it is critical we first obtain the Patient Authorization to Use/Disclose Health Information form.

Is your office new to BIMZELX Navigate?

Speak with your BIMZELX representative or call 1-866-4-BIMZELX (1-866-424-6935) to start.

Please see full **Prescribing Information** included in this toolkit, or visit **BIMZELXHCP.com**.

Inspired by **patients.** Driven by **science.**