AETNA BETTER HEALTH® Coverage Policy/Guideline			
Name:	Bimzelx (bimekizumab-bkzx)	Page:	1 of 8
Effective Date:	6/20/2025	Last Review Date:	5/2025
Applies to:	☐Illinois ☐Maryland ☐Michigan	☐Florida ☐Florida Kids ☐ Virginia	☒New Jersey ☐Pennsylvania Kids ☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Bimzelx under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications[1]

- Moderate to severe plaque psoriasis (PsO) in adult patients who are candidates for systemic therapy or phototherapy
- Adult patients with active psoriatic arthritis (PsA)
- Adult patients with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation
- Adult patients with active ankylosing spondylitis (AS)
- Adult patients with moderate to severe hidradenitis suppurativa (HS)

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Bimzelx

Policy/Guideline:

The patient is unable to take TWO preferred products (a preferred adalimumab product, Enbrel, a preferred ustekinumab product, Otezla or Rinvoq), where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Plaque psoriasis (PsO)

Initial requests

- Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).
- Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests

Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

Psoriatic arthritis (PsA), ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), and hidradenitis suppurativa (HS)

Initial requests

Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests

Chart notes or medical record documentation supporting positive clinical response.

Prescriber Specialties

This medication must be prescribed by or in consultation with one of the following:

- Plaque psoriasis: dermatologist
- Psoriatic arthritis and hidradenitis suppurativa: rheumatologist or dermatologist
- Ankylosing spondylitis and non-radiographic axial spondyloarthritis: rheumatologist

Coverage Criteria

Plaque psoriasis (PsO)[1-5,7-9]

Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for treatment of moderate to severe plaque psoriasis.

Authorization of 12 months may be granted for adult members for treatment of moderate to severe plaque psoriasis when any of the following criteria is met:

- Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
- At least 10% of body surface area (BSA) is affected.
- At least 3% of body surface area (BSA) is affected and the member meets either of the following criteria:
    - Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
    - Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin (see Appendix).

Psoriatic arthritis (PsA)[1,10,13-16]

Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis.

Authorization of 12 months may be granted for adult members for treatment of active psoriatic arthritis when either of the following criteria is met:

- Member has mild to moderate disease and meets one of the following criteria:
    - Member has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.
    - Member has an intolerance or contraindication to methotrexate or leflunomide (see Appendix), or another conventional synthetic drug (e.g., sulfasalazine).
    - Member has enthesitis or predominantly axial disease.
- Member has severe disease.

Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)[1,11,12,17,18]

Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis.

Authorization of 12 months may be granted for adult members for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis when either of the following criteria is met:

- Member has had an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs).
- Member has an intolerance or contraindication to two or more NSAIDs.

Hidradenitis suppurativa (HS)[1,19,20]

Authorization of 12 months may be granted for adult members who have previously received a biologic indicated for treatment of moderate to severe hidradenitis suppurativa.

Authorization of 12 months may be granted for adult members for treatment of moderate to severe hidradenitis suppurativa when either of the following is met:

- Member has had an inadequate response to an oral antibiotic used for the treatment of hidradenitis suppurativa for at least 90 days (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines).
- Member has an intolerance or contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa.

Continuation of Therapy

Plaque psoriasis (PsO)[1]

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when either of the following is met:

- Reduction in body surface area (BSA) affected from baseline
- Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

Psoriatic arthritis (PsA)[1,13,14]

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Number of swollen joints
- Number of tender joints
- Dactylitis
- Enthesitis

- Axial disease
- Skin and/or nail involvement
- Functional status
- C-reactive protein (CRP)

Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)[1,11,12,17]

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for ankylosing spondylitis or non-radiographic axial spondyloarthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Functional status
- Total spinal pain
- Inflammation (e.g., morning stiffness)
- Swollen joints
- Tender joints
- C-reactive protein (CRP)

Hidradenitis suppurativa (HS)[1,19,20]

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderate to severe hidradenitis suppurativa and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when any of the following is met:

- Reduction in abscess and inflammatory nodule count from baseline
- Reduced formation of new sinus tracts and scarring
- Decrease in frequency of inflammatory lesions from baseline
- Reduction in pain from baseline
- Reduction in suppuration from baseline
- Improvement in frequency of relapses from baseline
- Improvement in quality of life from baseline
- Improvement on a disease severity assessment tool from baseline

Other[1,6]

Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA]) within 12 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Appendix

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, Acitretin, or Leflunomide[8]

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
- Drug interaction
- Risk of treatment-related toxicity
- Pregnancy or currently planning pregnancy
- Breastfeeding
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
- Hypersensitivity
- History of intolerance or adverse event

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 Months

Quantity Level Limit:

- Bimzelx (bimekizumab-bkzx) 160 mg/mL auto-injector/prefilled syringe:
  - 2 auto-injectors/syringes per 28 days

- Exception limit: 18 auto-injectors/syringes per 112 days
- Bimzelx (bimekizumab-bkzx) 320 mg/2 mL autoinjector/prefilled syringe
  - 1 auto-injector/syringe per 28 days
  - Exception limit: 9 auto-injectors/syringes per 112 days

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