

# PATIENT ENROLLMENT FORM GUIDE



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-NAVFAAX**.

**\*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 #1045762750)

(bimekizumab-bkxz)  
Navigate

PATIENT INFORMATION			
*Name (First, Middle Initial, Last)	Jane J Doe		*Gender assigned at birth <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
*DOB	09/19/1990		Weight 135
*Street Address	1234 E Oakway ST		
*City	Normal	*State	IL
*ZIP	61761	*Patient Email Address	personalmailaddress@hotmail.com
*Primary Phone #	987-654-3210	Alternate Phone #	
Authorized Representative Contact Name		Authorized Representative Contact Phone #	
<input checked="" type="checkbox"/> Insurance Information <input type="checkbox"/> Front and back copies of the patient's medical and pharmacy insurance cards(s) attached <input type="checkbox"/> No Insurance			
Primary Prescription Insurance	Copico 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	Copico Health Insurance Co.
Phone #	555-555-5555	Medical Insurance ID #	1234-5678
Medical Insurance Group #	4876-54321		
PRESCRIBER INFORMATION			
*Prescriber Name (First, Middle Initial, Last)	Alice Smith		*NPI# 1234567890
*Office Contact	Hrs Johnson		*Phone # 888-888-8888
*Practice/Clinic Name	Medical Practice, LLC		*Fax # 888-888-8888
Street Address	4321 Healthcare Way		State IL
City	Normal	Zip Code	61702
Supervising Physician			
<input type="checkbox"/> PA/Apple support <input checked="" type="checkbox"/> Bridge/Savings support (for eligible patients only)			
I have sent this prescription to: <u>My Favorite SP</u> <input type="checkbox"/> I have only sent this to BIMZELX Navigate®			
PRESCRIPTION INFORMATION			
INDICATION	INITIAL	REFILLS	MAINTENANCE
PSO	<input checked="" type="checkbox"/> 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 4 weeks OR 4 weeks may be considered if weight ≥ 120 kg
PSa	<input type="checkbox"/> Inject 320 mg subcutaneously every 4 weeks at weeks 0, 4, 8, and 12	4	Inject 160 mg/mL subcutaneously every 4 weeks OR 4 weeks may be considered if weight ≥ 120 kg
n-aspa or AS	<input type="checkbox"/> Inject 320 mg subcutaneously every 4 weeks at weeks 0, 4, 8, and 12	4	Inject 160 mg/mL subcutaneously every 4 weeks OR 4 weeks may be considered if weight ≥ 120 kg
<input checked="" type="checkbox"/> BIMZELX 160 mg/mL x 2 Autoinjector <input type="checkbox"/> BIMZELX 160 mg/mL x 2 Prefilled Syringes <input type="checkbox"/> BIMZELX 160 mg/mL x 1 Autoinjector <input type="checkbox"/> BIMZELX 160 mg/mL x 1 Prefilled Syringe <input type="checkbox"/> BIMZELX 160 mg/mL x 2 Autoinjector <input type="checkbox"/> BIMZELX 160 mg/mL x 2 Prefilled Syringes <input type="checkbox"/> BIMZELX 160 mg/mL x 1 Autoinjector <input type="checkbox"/> BIMZELX 160 mg/mL x 1 Prefilled Syringe			

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 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 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 I am requesting support from UCB for the above-referenced patient who has been prescribed BIMZELX, BIMZELX Navigate, or BIMZELX Navigate Bridge. UCB's support is provided on a non-exclusive basis. UCB's support is provided on a non-exclusive basis. UCB's support is provided on a non-exclusive basis.

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.

*Alice Smith* 10/24/2024

DISPENSE AS WRITTEN OR SUBSTITUTION PERMITTED \*Date Signed

Please follow your state's prescribing guidelines for electronic prescriptions (if applicable). For more information, refer to the full Prescribing Information provided by the manufacturer.

## 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 patient authorization to use/disclose health information.

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

By signing this Patient Authorization to Use/Disclose Health Information Form ("Authorization"), I hereby authorize each of my physicians, prescribers, and health care providers ("Health Care Providers") to disclose information to UCB and its affiliates, agents, representatives, business partners, and service providers ("UCB") to help enable treatment for my condition. I understand that UCB may use this information for the purposes of providing patient support, including but not limited to, identifying my condition, providing patient support, and providing patient support. I understand that UCB may use this information for the purposes of providing patient support, including but not limited to, identifying my condition, providing patient support, and providing patient support. I understand that UCB may use this information for the purposes of providing patient support, including but not limited to, identifying my condition, providing patient support, and providing patient support.

*Jane Doe* 10/21/2024

DATE

## 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](http://BIMZELXHCP.com).



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