

Clinical Policy: Bimekizumab-bkzx (Bimzelx)

Reference Number: CP.PHAR.660

Effective Date: 03.01.24

Last Review Date: 11.24

Line of Business: Medicaid

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Bimekizumab-bkzx (Bimzelx[®]) is a humanized interleukin-17A and F antagonist.

FDA Approved Indication(s)

Bimzelx is indicated for the treatment of:

- Moderate to severe plaque psoriasis (PsO) in adults 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).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Bimzelx is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Plaque Psoriasis (must meet all):

1. Diagnosis of moderate-to-severe PsO as evidenced by involvement of one of the following (a or b):
 - a. $\geq 3\%$ of total body surface area;
 - b. Hands, feet, scalp, face, or genital area;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a, b, or c):
 - a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses;
 - b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
 - c. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;

5. Member meets ONE of the following, unless contraindicated or clinically significant adverse effects are experienced (a or b, *see Appendix D*):
 - a. Failure of a ≥ 3 consecutive month trial of one* adalimumab product (e.g., *Hadlima[™]*, *Simlandi[®]*, *Yusimry[™]*, *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred);
 - b. History of failure of two TNF blockers;
**Prior authorization may be required for adalimumab product*
6. Failure of a ≥ 3 consecutive month trial of Taltz^{®*}, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for Taltz*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed one of the following (a or b):
 - a. 320 mg at weeks 0, 4, 8, 12, and 16, then every 8 weeks;
 - b. Weight ≥ 120 kg: 320 mg at weeks 0, 4, 8, 12, and 16, then every 4 weeks.

Approval duration: 6 months

B. Psoriatic Arthritis (must meet all):

1. Diagnosis of PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. Failure of ALL* of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, c, and d, *see Appendix D*):
 - a. One adalimumab product (e.g., *Hadlima*, *Simlandi*, *Yusimry*, *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred), unless the member has had a history of failure of two TNF blockers;
 - b. Otezla[®];
 - c. Taltz;
 - d. If member has not responded or is intolerant to one or more TNF blockers, *Xeljanz[®]/Xeljanz XR[®]*, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
**Prior authorization may be required for adalimumab products, Otezla, Taltz, and Xeljanz/Xeljanz XR*
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. Dose does not exceed one of the following (a or b):
 - a. PsA alone: 160 mg every 4 weeks;
 - b. PsA with coexistent PsO (i or ii):
 - i. 320 mg at weeks 0, 4, 8, 12, and 16, then every 8 weeks;
 - ii. Weight ≥ 120 kg: 320 mg at weeks 0, 4, 8, 12, and 16, then every 4 weeks.

Approval duration: 6 months

C. Axial Spondylitis (must meet all):

1. Diagnosis of AS or nr-axSpA;
2. Prescribed by or in consultation with a rheumatologist;

3. Age \geq 18 years;
4. Failure of at least TWO non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for \geq 4 weeks unless clinically significant adverse effects are experienced or all are contraindicated;
5. For AS, member meets ALL* of the following, each used for \geq 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c, *see Appendix D*):
 - a. Failure of one adalimumab product (e.g., *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
 - b. Failure of Taltz[®];
 - c. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz[®]/Xeljanz XR[®], unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

**Prior authorization may be required for adalimumab products, Xeljanz/Xeljanz XR, and Taltz*
6. For nr-axSpA: Failure of Taltz*, used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for Taltz*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed 160 mg every 4 weeks.

Approval duration: 6 months

D. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

- b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
 - a. PsA, AS, nr-axSpA: 160 mg every 4 weeks;
 - b. PsO (with or without coexistent PsA) (i or ii):
 - i. 320 mg every 8 weeks;
 - ii. Weight \geq 120 kg: 320 mg every 4 weeks.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.
- B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia[®], Enbrel[®], Humira[®] and its biosimilars, Remicade[®] and its biosimilars (Avsola[™], Inflectra[™], Renflexis[™], Zymfentra[®]), Simponi[®]], interleukin agents [e.g., Actemra[®] (IL-6RA), Arcalyst[®] (IL-1 blocker), Bimzelx[®] (IL-17A and F antagonist), Cosentyx[®] (IL-17A inhibitor), Ilaris[®] (IL-1 blocker), Ilumya[™] (IL-23 inhibitor), Kevzara[®] (IL-6RA), Kineret[®] (IL-1RA), Omvoh[™] (IL-23 antagonist), Siliq[™] (IL-17RA), Skyrizi[™] (IL-23 inhibitor), Stelara[®] (IL-12/23 inhibitor), Taltz[®] (IL-17A inhibitor), Tofidence[™] (IL-6), Tremfya[®] (IL-23 inhibitor), Wezlana[™] (IL-12/23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo[™], Olumiant[™], Rinvoq[™], Xeljanz[®]/Xeljanz[®] XR,], anti-CD20 monoclonal antibodies [Rituxan[®] and its biosimilars (Riabni[™], Ruxience[™], Truxima[®]), Rituxan Hycela[®]], selective co-stimulation modulators

[Orencia[®]], integrin receptor antagonists [Entyvio[®]], tyrosine kinase 2 inhibitors [Sotyktu[™]], and sphingosine 1-phosphate receptor modulator [Velsipity[™]] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AS: ankylosing spondylitis	nr-axSpA: non-radiographic axial spondyloarthritis
BSA: body surface area	PsA: psoriatic arthritis
FDA: Food and Drug Administration	PsO: plaque psoriasis
MTX: methotrexate	

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane [®])	PsO 25 or 50 mg	50 mg/day
cyclosporine (Sandimmune [®] , Neoral [®])	PsO 2.5 mg/kg/day PO divided BID	4 mg/kg/day
methotrexate (Rheumatrex [®])	PsO 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Hadlima (adalimumab-bwwd), Simlandi (adalimumab-ryvk), Yusimry (adalimumab-aqv), adalimumab-aaty (Yuflyma [®]), adalimumab-adaz (Hyrimoz [®]), adalimumab-fkjp (Hulio [®]), adalimumab-adbm (Cyltezo [®])	AS, PsA 40 mg SC every other week PsO <u>Initial dose:</u> 80 mg SC <u>Maintenance dose:</u> 40 mg SC every other week starting one week after initial dose	40 mg every other week
Otezla [®] (apremilast)	PsA <u>Initial dose:</u> Day 1: 10 mg PO QAM Day 2: 10 mg PO QAM and 10 mg PO QPM Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 30 mg PO QPM	60 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	<u>Maintenance dose:</u> Day 6 and thereafter: 30 mg PO BID	
Taltz [®] (ixekizumab)	AS, nr-axSpA, PsA <u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0 <u>Maintenance dose:</u> 80 mg SC every 4 weeks PsO <u>Initial dose:</u> 160 mg (two 80 mg injections) SC at Week 0, then 80 mg SC at Weeks 2, 4, 6, 8, 10, and 12 <u>Maintenance dose:</u> 80 mg SC every 4 weeks	80 mg every 4 weeks
Xeljanz [®] (tofacitinib)	AS, PsA 5 mg PO BID	10 mg/day
Xeljanz XR [®] (tofacitinib extended-release)	AS, PsA 11 mg PO QD	11 mg/day

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Definition of failure of MTX or DMARDs
 - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
 - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- TNF blockers:
 - Etanercept (Enbrel[®]), adalimumab (Humira[®]) and its biosimilars, infliximab (Remicade[®]) and its biosimilars (Avsola[™], Renflexis[™], Inflectra[®], Zymfentra[®]), certolizumab pegol (Cimzia[®]), and golimumab (Simponi[®], Simponi Aria[®]).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PsO (with or without coexistent PsA)	320 mg (given as 2 SC injections of 160 mg each) at Weeks 0, 4, 8, 12, and 16, then every 8 weeks thereafter For patients weighing \geq 120 kg, consider a dosage of 320 mg every 4 weeks after Week 16.	320 mg/8 weeks (after loading doses) Weight \geq 120 kg: 320 mg/4 weeks (after loading doses)
PsA	160 mg SC every 4 weeks	160 mg/4 weeks
AS	160 mg SC every 4 weeks	160 mg/4 weeks
nr-axSpA	160 mg SC every 4 weeks	160 mg/4 weeks

VI. Product Availability

- Single-dose prefilled syringe: 160 mg/mL, 320 mg/2 mL
- Single-dose prefilled autoinjector: 160 mg/mL, 320 mg/2 mL

VII. References

1. Bimzelx Prescriber Information. Smyrna, GA: UCB, Inc; October 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761151s0091bl.pdf. Accessed October 22, 2024.
2. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. *J Am Acad Dermatol*. 2021 Feb;84(2):432-470. doi: 10.1016/j.jaad.2020.07.087.
3. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019 Apr;80(4):1029-1072. doi: 10.1016/j.jaad.2018.11.057.
4. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020 Jun;82(6):1445-1486. doi: 10.1016/j.jaad.2020.02.044.
5. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. *American College of Rheumatology*. 2019; 71(1):5-32. Doi: 10.1002/art.40726.
6. Gossec L, Kerschbaumer A, Ferreira RJO, et al. EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2023 update. *Ann Rheum Dis*. 2024 May 15;83(6):706-719. doi: 10.1136/ard-2024-225531. PMID: 38499325; PMCID: PMC11103320.
7. Ward MM, Deodhar A, Gensler LS, et al. 2019 update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis & Rheumatology*. 2019. Doi: 10.1002/art.41042.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3590	Unclassified biologics
C9399	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	12.06.23	02.24
2Q 2024 annual review: added Wezlana, Sotyktu, and Velsipity to section III.B; references reviewed and updated.	01.30.24	05.24
Per June SDC, added Simlandi to listed examples of preferred adalimumab products. Per SDC, added unbranded adalimumab-aaty to listed examples of preferred adalimumab products.	07.23.24	08.24
RT4: added criteria for newly approved indications for PsA, AS, and nr-axSpA; for PsO and continued therapy section, added criteria “Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors” per competitor analysis.	09.26.24	11.24
RT4: added new strength [320 mg/2 mL] for single-dose prefilled syringe and single-dose prefilled autoinjector.	10.22.24	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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