PUBLISHED 01/2026

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 UCB NAVIGATE™ (NPI #1891487138)

***INDICATES REQUIRED FIELDS**

Bimzelx® (bimekizumab-bkzx) Navigate

1. SERVICES

☐ **Full Service Support** (includes: Benefits Verification, Copay/Bridge Enrollment, Specialty Pharmacy Triage, and Prior Authorization/Appeal Follow-Up) ☐ **Benefits Investigation Only**

2. PATIENT INFORMATION

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

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

3. 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 #

4. PRESCRIBER INFORMATION

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

5. BIMZELX PRESCRIPTION INFORMATION

☐ **Sample provided on** (Date):_____ ☐ Pharmacy to proceed with week:_____ ☐ **I have only sent this to BIMZELX Navigate®** ☐ I have also sent this prescription to: _____

Please select at least 1 option in each column/row, if applicable.

DISPENSE BIMZELX	INDICATION	PRIMARY DIAGNOSIS CODE	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ 320 mg/2mL Autoinjector Carton ☐ 320 mg/2mL Prefilled Syringe Carton ☐ 160 mg/mL Autoinjector Carton ☐ 160 mg/mL Prefilled Syringe Carton	PSO (+/- PsA)	☐ L40.0 ☐ Other: ____	Initial Dose	☐ Inject 320 mg subcutaneously every 4 weeks at weeks 0, 4, 8, and 12	QS 28 days' supply	3
			Maintenance Dose	Inject 320 mg subcutaneously at week 16 and then every:		
				☐ 8 weeks	QS 56 days' supply	8 or ____
				☐ 4 weeks may be considered if ≥ 120 kg	QS 28 days' supply	12 or ____
	HS	☐ L73.2	Initial Dose	☐ Inject 320 mg subcutaneously every 2 weeks at weeks 0, 2, 4, 6, 8, 10, 12, 14	QS 28 days' supply	3
			Maintenance Dose	☐ Inject 320 mg subcutaneously at week 16 and then every 4 weeks	QS 28 days' supply	12 or ____
	PsA	☐ L40.5	Maintenance Dose	☐ Inject 160 mg subcutaneously every 4 weeks	QS 28 days' supply	12 or ____
	nr-axSpA	☐ M45.A				
	AS	☐ M45				
	Other:____	☐ Other:____				

SECONDARY DIAGNOSIS: _____

Prior Treatment Failures, Contraindications, or Intolerances (select all that apply)								
	☐ HUMIRA®	☐ STELARA®	☐ SKYRIZI®	☐ COSENTYX®	☐ ENBREL®	☐ REMICADE®	☐ TALTZ®	☐ XELJANZ®
	☐ OTEZLA®	☐ SIMPONI ARIA®	☐ SILIQ®	☐ DMARD	☐ None	Other: _____		

***Healthcare Provider Certification (Required):** By my signature below, I certify that (a) I am the healthcare professional who has prescribed the medication identified in this form; (b) I have made an independent judgment that the above medication is medically necessary; and (c) the information provided in this form is accurate to the best of my knowledge. I hereby authorize UCB, Inc., and its affiliates, agents, representatives, and service providers (together, "UCB") as my agent to transfer this prescription to the appropriate dispensing pharmacy.

I further certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under federal and applicable state privacy laws to release the patient's health information, including that contained on this form, to UCB solely for purposes relating to UCB's patient support programs, including but not limited to: (i) enrolling the patient in support programs for UCB medications; (ii) verifying, investigating, assisting with, and coordinating the patient's access and coverage for a prescribed UCB medication with the patient's health insurers; (iii) providing the patient with educational materials and resources related to UCB medications; (iv) determining the patient's eligibility for and helping the patient access savings, bridge and/or free drug programs for prescribed UCB medications; (v) triaging the patient's prescription for a UCB medication to a dispensing pharmacy; and (vi) providing other eligible patient support for prescribed UCB medications. I also certify that I have obtained consent from the patient or the patient's authorized personal representative to be contacted by UCB using autodialed, prerecorded, and/or artificial voice calls and autodialed text messages at the phone number(s) provided above for the above purposes. Finally, I give permission for UCB to contact me using autodialed, prerecorded, and/or artificial voice calls and autodialed text messages at the phone number(s) I provided for the above purposes.

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

_____ 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.

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PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION AND PATIENT CONSENT TO RECEIVE COMMUNICATIONS

FOR BIMZELX® (bimekizumab-bkzx)

Bimzelx® (bimekizumab-bkzx) Navigate

By signing this **Patient Authorization to Use/Disclose Health Information** ("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 affiliates, agents, service providers, contractors and representatives (together, "UCB"). My Health Information will be shared with UCB so that UCB may: (1) enroll me in, and contact me about, patient support programs and/or related market research for UCB medications; (2) provide me with educational materials and information related to UCB medications; (3) verify, investigate, assist with, and coordinate my access and coverage for a UCB medication with my Insurers and Providers; (4) determine my eligibility for and help me access savings, bridge, and/or free drug programs for UCB medications; (5) triage my prescription for a UCB medication to a dispensing pharmacy; (6) conduct market research and/or analyses or other commercial activity, including aggregating my Health Information with other data for such analyses; (7) assist with analysis related to quality, efficacy, and safety for UCB medications; and (8) de-identify my Health Information for use for any purpose as permitted 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 and/or state 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 I (and my personal representative, if applicable) may revoke this Authorization at any time by (1) sending an email to PrivacyOptOut@ucb.com or (2) mailing a letter to UCBCares® at 1950 Lake Park Drive, Smyrna, GA 30080, stating that I wish to revoke my Patient Authorization to Use/Disclose Health Information for **BIMZELX Navigate®** and including my First Name, Last Name, Date of Birth, ZIP Code, and gender (as assigned at birth) for reference. I understand that by revoking my Authorization, UCB will no longer use or disclose my Health Information in connection with BIMZELX Navigate and may not be able to provide me with certain patient support and, further, my revocation will not affect previous disclosures made pursuant to this Authorization.

This Authorization expires 2 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.

SIGNATURE REQUIRED

Signature of Patient or Patient Personal Representative	Name of Patient or Patient Personal Representative **(please print)**	Date ___ / ___ / ___

If signed by Patient Personal Representative, please provide your phone number and indicate your authority to act on behalf of the Patient: _____ Phone Number

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

Patient Consent to Receive Communications (Optional)

☐ I agree to receive communications from UCB's **BIMZELX Navigate®** Program (the "Program"), including but not limited to autodialed, prerecorded, and/or artificial voice calls and autodialed text messages, at the phone number(s) I provided to offer enrollment support, insurance coverage and financial assistance resources and support, injection resources and support, treatment reminders, resources and support, and for other non-marketing, patient support purposes. If I have designated a personal representative, I certify that he or she also agrees hereby to receive such voice and text communications, including through an autodialer or prerecorded voice, from the Program for the purposes described above at the phone number(s) provided.

For text messages, message and data rates may apply. I understand that I will receive up to two (2) text messages per month. For questions, contact the BIMZELX Navigate Nurse Navigator at 1-833-931-6877. View the complete Terms of Use at www.bimzelx.com/terms-of-use.

I understand that I (and my personal representative, if applicable) may opt out of receiving text messages from the Program at any time by replying "STOP"; and for voice and text message communications by (1) sending an email to PrivacyOptOut@ucb.com, or (2) mailing a letter to UCBCares at 1950 Lake Park Drive, Smyrna, GA 30080, stating that I wish to opt out of receiving communications from UCB in connection with BIMZELX Navigate and including my First Name, Last Name, Date of Birth, ZIP Code, and gender (as assigned at birth) for reference.

[1]For eligible, commercially insured patients only. With BIMZELX Navigate Bridge, eligible patients whose insurance coverage is delayed or denied may receive BIMZELX® (bimekizumab-bkzx) 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/Terms-and-Conditions.

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)

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

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US-BK-2500703

Find additional resources, like the Patient Enrollment Form, at **UCBImmunologySupport.com**.