



Updated: 10/2025
Approved: 10/2025

Request for Prior Authorization for Papzimeos (zopapogene imadenovec-ddrba)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Papzimeos (zopapogene imadenovec-ddrba) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Papzimeos (zopapogene imadenovec-ddrba) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **recurrent respiratory papillomatosis** and the following criteria is met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- The member has documented HPV serotypes 6 or 11
- Documentation the member has received 3 or more surgical debulking of laryngotracheal papillomas in the past 12 months
- The request must be for or part of the member's first treatment course

- **Duration of Approval:** one treatment course (12 weeks)

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

**PAPZIMEOS (ZOPAPOGENE IMADENOVEC-DRBA)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: 1-844-325-6251 Mon – Fri 8 am to 7 pm**

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Member weight: Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:
Directions:	Quantity: Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: at a pharmacy **OR** medically, JCODE:
Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
Does the member have HPV serotype 6 or 11? (please provide documentation) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the member received 3 or more surgical debulking of laryngeal papillomas in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this the member's first treatment course? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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