



Updated: 11/2025

DMMA Approved: 11/2025

Request for Prior Authorization for Papzimeos (zopapogene imadenovec-drba)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

Papzimeos (zopapogene imadenovec-drba) 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.



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**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: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: (844) 325-6251 Mon – Fri 8:00 am to 7:00 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? Yes 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? Yes 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