

Papzimeos™ (zopapogene imadenovec-drba) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)

Dose: _____ Regimen: _____ Start Date (or date of next dose): _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria**For Authorization:** (approvals will be for no more than 4 doses per member per lifetime)

1. Clinical documentation (i.e. recent chart notes) to support your request must be submitted. Is this information attached? Yes No
2. Please indicate the diagnosis and information:
 - Recurrent Respiratory Papillomatosis**
 - a. Does member have a history of 3 or more clinically indicated surgical resections or laser ablations for respiratory papillomatosis during the 12 months prior? Yes No
 - b. Will initial administration follow surgical debulking of visible papilloma to maintain minimal residual disease? Yes No
 - c. Will visible papilloma be removed, if present, prior to the third and fourth administration? Yes No
 - Other:** _____

Additional Information: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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