**HUSKY Health Program PAPZIMEOS™ (zopapogene imadenovec-drba)**
**Prior Authorization Request Form**
**Phone: 1.800.440.5071**

**THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.**

| **Member Information** | | |
|---|---|---|
| Member ID Number: | Member Name (Last, First): | |
| Address: | City, State, Zip: | |
| DOB: | Sex: | |
| Primary Diagnosis Code: | HCPCS Code: | |
| Units Requested: | Dose: | Dates of Service: |

| **Please fill out completely for all requests:** | | |
|---|---|---|
| 1. Is the individual 18 years of age or older? | ○ Yes | ○ No |
| 2. Does the individual have a clinical diagnosis of Recurrent Respiratory Papillomatosis (RRP) defined by BOTH of the following? ***Please attach medical record documentation.***<br>a. Histological diagnosis of papilloma confirmed by pathology report<br>b. Documented human papillomavirus (HPV) serotype 6 or 11 | ○ Yes | ○ No |
| 3. Is Papzimeos™ prescribed by or in consultation with a provider who specializes in the treatment of RRP (e.g., otolaryngologist, pulmonologist, oncologist)? ***If yes, please specify:***<br><br>Provider Name: _____ Phone Number: _____ | ○ Yes | ○ No |
| 4. Does the individual have a history of three or more surgical debulking procedures in the last 12 months for control of RRP? ***Please attach signed provider attestation.*** | ○ Yes | ○ No |
| 5. Has the individual previously received Papzimeos™? ***Please attach signed provider attestation.*** | ○ Yes | ○ No |
| 6. Will the treating provider follow all FDA-approved labeling for dosing, administration, and additional monitoring for Papzimeos™, including surgical debulking guidelines before and during treatment? ***Please attach signed provider attestation.*** | ○ Yes | ○ No |

| **Billing Provider Information** | |
|---|---|
| Medicaid Billing Number: | Billing Provider Name: |
| Street Address: | City, State, Zip: |
| Contact Name: | Contact Telephone Number: |
| Contact Fax Number: | |

| **Ordering Provider Information** | |
|---|---|
| Medicaid Billing Number: | Ordering Provider Name: |
| Street Address: | City, State, Zip: |
| Contact Name: | Contact Telephone Number: |
| Contact Fax Number: | Provider Specialty: |

**Certification Statement:** This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner signed order is on file. This form, and any statement on my letterhead attached hereto, has been completed by me or by my employee, and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

| Provider Signature: | Date: |
|---|---|
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