ambetter. FROM peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Zopapogene Imadenovec (Papzimeos)
PDAC Drug Review Form

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:

Physician Information

*Name:	*Specialty:	*Phone #:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Recurrent respiratory papillomatosis (RRP) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Papzimeos (Zopapogene Imadenovec)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with an otolaryngologist? ☐Yes ☐No
2. Is RRP confirmed by tissue biopsy? ☐Yes ☐No
3. Has patient had ≥ 3 interventions (surgical resection or laser ablation) aimed at reducing voice and airway symptoms caused by the papilloma in the previous 12 months? ☐Yes ☐No
4. Is patient scheduled to undergo an endoscopic surgical debulking procedure to remove laryngotracheal papilloma prior to PRGN-2012 treatment? ☐Yes ☐No
5. **If age ≤ 45**, has patient previously received human papillomavirus (HPV) vaccination? ☐Yes ☐No ☐Contraindicated/intolerant

Complete this section ONLY for indications <u>other</u> than RRP:

6. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Information

*Number:	*Date of Request:
*HCPCS Code:	*Decision Due Date:
* Line of Business: ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	* Benefit: ☐ Medical ☐ Pharmacy

*** Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region

<u>Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.</u>

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Please continue to page 2.

Patient Name: _____ **DOB:** _____

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.XX Zopapogene Imadenovec (PRGN-2012)**]

Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):

_____

OR

☐ State or Health Plan Specific (please include policy)