

**Louisiana Medicaid
Zopapogene Imadenovec-drba (Papzimeos™)**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for zopapogene imadenovec-drba (Papzimeos™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available [HERE](#).

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of recurrent respiratory papillomatosis confirmed by biopsy; **AND**
- The recipient has or will undergo debulking procedure prior to administration (must be **stated on the request**).

Duration of approval: 12 weeks (Not to exceed 4 doses)

Reauthorization is not permitted.

Reference

Papzimeos (zopapogene imadenovec-drba) [package insert]. Germantown, MD: Precigen, Inc; August 2025. <https://precigen.com/papzimeos-prescribing-information.pdf>

Revision / Date	Implementation Date
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