

May 8, 2026

PRIOR AUTHORIZATION FOR PAPZIMEOS EFFECTIVE APRIL 1, 2026

BACKGROUND

HHSC has added Papzimeos (procedure code J3404) as a benefit for Medicaid and CHIP, effective April 1, 2026, and will require prior authorization for those programs, effective May 1, 2026.

KEY DETAILS

Papzimeos (zopapogene imadenovec-drba) is a non-replicating adenoviral vector-based immunotherapy indicated for the treatment of adults with recurrent respiratory papillomatosis.

ACTION

Authorization requirements

- Prior authorization is required for Papzimeos (zopapogene imadenovec-drba).
- The prior authorization request for Papzimeos (zopapogene imadenovec-drba) may be approved for 6 months for patients meeting the following requirements:
 - a. Patient is 18 years of age or older.
 - b. Patient has a confirmed diagnosis of recurrent respiratory papillomatosis (diagnosis code: D14.1).
 - c. Patient has documented human papillomavirus (HPV) serotype 6 or 11.
 - d. Prescriber must perform a surgical debulking of visible papilloma prior to the initiation of Papzimeos treatment (Day 1) to establish minimal residual disease.
 - e. Prescriber attests to remove visible papilloma prior to the third and fourth Papzimeos administration to maintain minimal residual disease during treatment.
 - f. Authorization will be approved for no more than one treatment course (i.e., four doses).
- Monitoring parameters:
 - a. Monitor for signs and symptoms of thrombotic events (e.g., shortness of breath, chest pain, leg swelling, persistent abdominal pain, neurological symptoms, including severe or persistent headaches or blurred vision).

ADDITIONAL INFORMATION

HHSC approved this updated clinical prior authorization for use. Community Health Choice will implement the clinical coverage criteria on May 1, 2026.

QUESTIONS

For any questions regarding this notice, please contact your Community Provider Performance Manager (provider representative). E-mail: ProviderRelationsInquiries@CommunityHealthChoice.org