USFHP Prior Authorization Request Form for
berdazimer (Zelsuvmi)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007
https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization expires after 3 months. Initial USFHP/TRICARE PA approval is required for renewal. Coverage will be approved for 3 months for continuation of therapy.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication being prescribed by a dermatologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Zelsuvmi.*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **5**
3. Has documentation been provided to confirm that the patient has had a positive clinical response defined as clearance or reduction in number of lesions with Zelsuvmi treatment? *NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.*	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient require ongoing treatment of molluscum contagiosum lesions which must be symptomatic (for example, painful, itchy)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is the patient 2 years of age or older?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. What is the indication or diagnosis?	☐ Molluscum contagiosum – Proceed to question **7** ☐ Other - **STOP** **Coverage not approved**	

7. Is this treatment solely due to cosmetic concern?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. Are the lesions symptomatic (for example, painful, itchy)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the prescriber confirm that a single lesion will be treated with Zelsuvmi for NO MORE THAN 12 weeks?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Please explain why this agent is required and cannot be treated with ALL the following: cryotherapy, AND curettage, AND two additional topical agents (for example, salicylic acid, cantharidin).	_____ **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date