TRICARE Prior Authorization Request Form for
berdazimer (Zelsuvmi)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
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Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 3 months. No renewal allowed. When the PA expires, the next fill/refill will require submission of a new PA.

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. Is the patient 2 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Molluscum contagiosum – Proceed to question **4** ☐ Other - **STOP Coverage not approved**	
4. Is this treatment solely due to cosmetic concern?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **5**
5. Are the lesions symptomatic (for example, painful, itchy)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the prescriber confirm that a single lesion will be treated with Zelsuvmi for NO MORE THAN 12 weeks?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. 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

[15 July 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: