AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION ZELSUVMI™ (berdazimer)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: ______________________ **First Name:** ______________________

Medicaid ID Number: ______________________ **Date of Birth:** ______________________

Weight in Kilograms: ____________________________

PRESCRIBER INFORMATION

Last Name: ______________________ **First Name:** ______________________

NPI Number: ______________________

Phone Number: ______________________ **Fax Number:** ______________________

DRUG INFORMATION

Drug Name/Form: ____

Strength: ____

Dosing Frequency: ____

Length of Therapy: ____

Quantity per Day: ____

(Form continued on next page.)

Member's Last Name: ______________________ **Member's First Name:** ______________________

DIAGNOSIS AND MEDICAL INFORMATION

ZELSUVMI™ – to receive a twelve (12) weeks approval for this drug, complete the following questions.

1. Does the member have a diagnosis of molluscum contagiosum (MC)?

   ☐ Yes ☐ No

2. Is the member 1 year of age or older?

   ☐ Yes ☐ No

3. Will the member be using Zelsuvmi in combination with another conventional therapy (e.g., cantharidin, cryotherapy, curettage, podofilox)?

   ☐ Yes ☐ No

______________________________ ______________

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.