



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Zelsuvmi (berdazimer topical gel) Page: 1 of 2

Effective Date: 12/5/2025 Last Review Date: 11/18/2025

Applies to:  Illinois  New Jersey  Maryland  
 Florida Kids  Pennsylvania Kids  Virginia

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Zelsuvmi under the patient's prescription drug benefit.

### Description:

#### FDA-Approved Indication

Zelsuvmi is indicated for the topical treatment of molluscum contagiosum (MC) in adults and pediatric patients 1 year of age and older.

### Applicable Drug List:

Zelsuvmi

### Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of molluscum contagiosum (MC)

**AND**

- The patient is 1 year of age or older

**AND**

- The requested drug will not be used on the same lesions for more than 12 weeks

**AND**

- The request is NOT for continuation of therapy

**OR**

- The request is for continuation of therapy

**AND**

- The patient has achieved or maintained a positive clinical response to the requested drug (e.g., clearance of or reduction in the number of lesions with prior treatment)

**AND**

- If additional quantities are being requested, then the requested drug is being prescribed to treat a number of lesions that requires more than 1 carton per 28 days.

### Approval Duration and Quantity Restrictions:

**Initial Approval:** 3 Months

**Renewal Approval:** 12 Months

**Quantity Level Limit:** 1 carton per 28 days;

For a number of lesions requiring more than 1 carton per 28 days: 2 cartons per 28 days



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### References:

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