Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

ZELSUVMI™ (berdazimer) PA CRITERIA:

ZELSUVMI™ (berdazimer) is a nitric oxide-releasing agent indicated for the topical treatment of molluscum contagiosum in patients 1 year of age and older.

Prior authorization is required for ZELSUVMI™ (berdazimer). Prior authorization approval will be considered when the following criteria are met. Along with the Universal PA Form, please submit any supporting clinical documentation.

Initial Authorization: 12 Weeks

1. The patient has a diagnosis of molluscum contagiosum (ICD-10 B08.1); **AND**

2. Age of the patient is within the age range as recommended by the FDA label; **AND**

3. The patient has at least one of the following conditions:
    a. A chronic skin condition, such as eczema
    b. Molluscum contagiosum in the genital area
    c. A weakened immune system and numerous bumps
    d. Severe, symptomatic molluscum contagiosum causing significant discomfort; **AND**

4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis; **AND**

5. The patient has tried and had an inadequate response to a conventional therapy (such as cryotherapy, laser therapy, curettage).

ZELSUVMI™ (berdazimer) Dosing:

- Apply a thin layer of mixed gel to each lesion once daily for up to 12 weeks.

Formulation:

- ZELSUVMI ™ (berdazimer) 10.3% topical gel is supplied in a carton containing:
    - Tube A (14 g) with blue label containing berdazimer sodium in an opaque white to off-white gel
    - Tube B (17 g) with yellow label containing translucent to opaque white to off-white hydrogel