Prior Authorization Request Form for Regranex (becaplermin)

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Criteria for Approval:

1. Has the patient been diagnosed with diabetic neuropathic ulcer of the lower extremeties? Yes☐ No ☐
2. Does the ulcer extend into the subcutaneous tissue or beyond? Yes☐ No ☐
3. Has adequate blood supply to the ulcer been demonstrated by: *Check one:*
   Transcutaneous oxygen pressure of TCPO2>30mm Doppler
4. Is the patient hypersensitive to parabens or other components of Regranex gel? Yes☐ No ☐
5. Does the patient have a neoplasm at the site of application? Yes☐ No ☐
6. Will Regranex gel be applied in a wound that closes by primary intention? Yes☐ No ☐
7. Are good ulcer care being practiced with any of the following: *Check all that apply:*
   Establishment of adequate blood supply as indicated above ☐
   Determination of adequate nutritional status with serum albumin levels of > 2 g/dL ☐
   Appropriate debridement to remove dead tissue with ongoing debridement as necessary ☐
   No weight on affected area to relieve pressure points ☐
   Systemic treatment of wound infections if present ☐
   Maintenance of a moist wound environment (i.e., dressing changes including alginates, foams, hydrocolloids, hydro gels, and transparent films) ☐
8. Has the ulcer been treated with Regranex for 3 months? Yes☐ No ☐
9. Has the ulcer decreased in size by at least 30% in the initial 10 weeks of therapy? Yes☐ No ☐

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received_____

Reference Number_____

Approved / Denied (Circle One) by _____ Date_____

Date/Time Returned to Provider_____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
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