

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 extremities? 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
 3375-I Capital Circle NE
 Tallahassee, FL 32308

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