



2018 REGRANEX[®] (becaplermin) Prior Authorization Request
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(You must complete both pages.)

Fax completed form to: 1-800-408-2386

For urgent requests, please call: 1-800-414-2386

Patient information		Prescriber information		
Patient name		Today's date	Physician specialty	
Patient insurance ID number		Physician name		NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP		
Patient home telephone number		M.D. office telephone number		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	M.D. office fax number		
Diagnosis and medical information				
Medication requested			Frequency	
New prescription OR date therapy initiated		Quantity	Day supply	Expected length of therapy
Diagnosis (Please check all boxes that apply and include all office notes supporting diagnosis.)				
<input type="checkbox"/> Treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply				
<input type="checkbox"/> Other diagnosis/(ICD 10): _____				
Please check all boxes that apply:				
1. <input type="checkbox"/> Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in adverse clinical outcomes.				
2. <input type="checkbox"/> All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/ or would likely have adverse effects for the enrollee.				
3. <input type="checkbox"/> Yes <input type="checkbox"/> No Will good ulcer care practices including initial sharp debridement, pressure relief and infection control be performed?				
4. <input type="checkbox"/> Yes <input type="checkbox"/> No Regranex gel will not be covered if the patient has a neoplasm at any site of the medication's application. Does the patient have any neoplasms where Regranex is being applied?				

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Please check all boxes that apply (continued):

5. Please list all medications the patient has tried specific to the diagnosis and specify below.

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

6. Other supporting information

*NOTE: All exception requests require prescriber supporting statements. Also, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature

Date