

Becaplermin (Regranex) Prior Authorization Form

START HERE

**Member &
Prescriber
Information**

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

Criteria

A. Must meet all of the following criteria, please check if this applies to approve:

- Patient with diabetes (type I or type II).
- Chronic ulcer present > than eight weeks, not responding to current wound care.
- Devoid of infection or necrosis of ulcer.
- Chronic lower extremity neuropathic ulcer (below ankle) extending into the subcutaneous tissue or beyond and with adequate tissue blood supply.
- Adequate blood supply must be demonstrated.
- Ulcer area > 1 cm² and < 40 cm².
- Adequate nutritional status (recommend serum albumin > 2g/dL).

B. Additional information

1. Wound Care - *The following wound care activities must be demonstrated to approve becaplermin:*

- a. Debridement to remove dead tissue with continued debridement as necessary.
- b. Weight bearing activities are to be avoided on area affected by ulcer.
- c. Becaplermin is not a replacement for proper wound maintenance including initial sharp debridement, pressure relief, infection control, frequent dressing changes and moist wound environment (i.e. dressing changes including alginates, foams, hydrocolloids, hydro gels and transparent films).

2. Duration of Therapy

- a. Debridement to remove dead tissue with continued debridement as necessary.
- b. Weight bearing activities are to be avoided on area affected by ulcer.

3. Quantity Limits

- a. One 15 gm tube per approval per copay unless otherwise demonstrated and requested.

**Sign/Date &
Mail or Fax**

Prescriber Signature: _____ Date: _____

Prescriber NPI: _____

Mailing Address

Physicians Plus Insurance Corporation
Attn: Pharmacy Services
P.O. Box 2078
Madison WI 53701-2078

Physicians Plus Pharmacy Services Fax:

(608) 258-1905

Prior Authorization Questions?

(608) 260-7803 or (800) 545-5015 (ext. 7803)

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