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2019 REGRANEX® (becaplermin) Prior Authorization Request

(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 ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information			
Medication requested ☐ Regranex 0.01% topical gel		**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.)*

☐ Treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply

☐ Other diagnosis/(ICD 10): ____

Please check all boxes that apply:

1. ☐ **Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in adverse clinical outcomes.**

2. ☐ **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. ☐ Yes ☐ No **The quantity limit for Regranex gel is 30 grams per 30 days. Does patient require higher dosage (quantity limit exception)?**

   ►If yes, indicate quantity requested: ______________ per 30 days OR quantity ____________ per day

   ☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

   ☐ The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

(continued on page 2)

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Please check all boxes that apply *(continued)*:

4. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

5. ☐ **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.

____
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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**

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