Updated: 02/2021
DMMA Approved: 02/2021

Request for Prior Authorization for Regranex (becaplermin)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Regranex (becaplermin) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Regranex (becaplermin) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **lower extremity diabetic neuropathic ulcer** and the following criteria is met:

- The ulcer extends into the subcutaneous tissue or beyond and has an adequate blood supply
- Must have tried and failed standard good ulcer care therapy for at least two (2) months consisting of all of the following:
    - Initial complete sharp debridement followed by additional debridement as necessary
    - Non-weight bearing regimen
    - Systemic treatment for wound-related infection (if present)
    - Moist saline dressing changed twice a day
- Must be used as adjunct treatment to, not a replacement for, good ulcer care practices including sharp debridement, pressure relief, and infection control
- The wound must be free of infection
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member has no contraindications to the medication including known neoplasms at the site of application
- **Duration of Approval:** 6 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. Delaware HEALTH OPTIONS

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REGRANEX (BECAPLERMIN) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ **Lower Extremity Diabetic Neuropathic Ulcer**, ICD-10: _____

- Does the ulcer extend into the subcutaneous tissue or beyond? ☐ Yes ☐ No
- Does the ulcer have an adequate blood supply? ☐ Yes ☐ No
- Has the member failed two (2) months of standard good ulcer care therapy? ☐ Yes ☐ No
- Will good ulcer care practices (debridement, pressure relief, infection control) be used concurrently? ☐ Yes ☐ No
- Is the wound free of infection? ☐ Yes ☐ No
- Are there any contraindications or a known neoplasm(s) at the intended site of application? ☐ Yes ☐ No

☐ **Other:** _____ ICD-10: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date