Provider Help Desk
1.866.399.0928

FAX Completed Form To
1.877.386.4695

REQUEST FOR PRIOR AUTHORIZATION
BECAPLERMIN (REGRANEX®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for Regranex®. Payment for new prescriptions will be authorized for ten weeks for patients who meet have a diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and inadequate response to 2 weeks of wound debridement and topical moist wound dressing. Payment for Regranex® for longer than 10 weeks will be authorized for patients when the wound has decreased in size by 30% after 10 weeks of Regranex® therapy.

Non-Preferred

Regranex ☐

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

- ❑ **Lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond**
- ❑ **Other (specify):** _____

Current Wound measurements: Diameter _____ OR Height: _____ and Width _____

Is this a request to extend a prior authorization? ❑ No ❑ Yes If yes

Previous wound measurements: Diameter _____ OR Height: _____ and Width _____

Pertinent Lab data:_____

Additional relevant information: _____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.