PriorityHealth

Pharmacy
Prior Authorization Form

Last Reviewed: May 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: ☐ **Commercial Plan** ☒ **Medicaid Plan** ☒ **Medicare Plan**

Regranex Topical Gel 0.1% (becaplermin)

☐ Urgent ☐ Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

FDA approved indication:

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

Priority Health precertification requirement:
Authorization of Regranex requires:

- Patient has diabetes
- Intent to treat lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have adequate blood supply
- Patient does not have known neoplasm(s) at the site(s) of application
- The gel is not going to be used in a wound that closes by primary intention

Please complete the following:

☐ Patient has diabetes
☐ Intent to treat lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have adequate blood supply
☐ Patient does not have known neoplasm(s) at the site(s) of application
☐ The gel is not going to be used in a wound that closes by primary intention

Re-Certification Requirement After Initial Therapy: (Check if applicable)

☐ Ulcer has decreased in size by 30%

- If ulcer has decreased in size by a minimum of 30% after ten weeks of therapy, another ten weeks of therapy will be authorized.
- If ulcer is not completely healed after twenty weeks of treatment, no further authorization will be granted.

Note: Approval, when granted, will be for three months on initial request.

For Medicare only: If none of the above is applicable to this member, please check which, if any, of the following apply:

☐ All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects

☐ The number of doses available under a dose restriction for the prescription drug:
- ☐ Has been ineffective in the treatment of the enrollee's disease or medical condition or,
- ☐ Based on both sound clinical evidence and 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

☐ The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
- ☐ Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and 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; or
- ☐ Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

☐ None of the above apply

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX