

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

REGGRANEX (becaplermin)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL
NECESSITY TO 855-828-4992**

CRITERIA:

- **Rule out venous ulcers and / or arterial ulcers.**
- Patient must be diabetic, either Type I or Type II.
- Not covered for diabetic ulcers above the ankle.
- Patient must have stage III or IV diabetic foot or ankle ulcer as defined in the International Association of Enterostomal therapy guide to chronic wound staging, 1989.
- Not a benefit for patients in long term care facilities, unless that patient is admitted from home or hospital with a pre-existing diabetic ulcer of the lower extremity. LTCF must submit copy of total skin assessment report made within 24hrs of admission.
- The client must have had a documented failure on a 60 day regimen of good ulcer care that includes but is not limited to :
 - Initial complete sharp debridement.
 - A non-weight bearing regimen.
 - Systemic treatment for wound related infections.
 - Moist saline dressing changes twice daily.
 - Additional debridement if necessary.
- The subcutaneous diabetic foot ulcer may not exceed 3cm in diameter or total surface of 9.42cm². (Size and shape must be documented).
- Total contact casting is an available method of treatment and must be considered and rejected before Regranex is to be considered.

AUTHORIZATION:

8 weeks(15-30 Grams)

RE-AUTHORIZATION:

Documentation of 30% reduction in ulcer size must be achieved before a second prior is given.
Treatment is limited to a maximum of 60 grams of Regranex.

9/20/10

<https://medicaid.utah.gov/pharmacy/>