



**Becaplermin (Regranex®) Initial
Prior Authorization Request Form**

Beneficiary Name: _____
Beneficiary Medicaid ID #: _____ Date Of Birth: ____/____/_____

Pharmacy Name: _____
Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____
Phone Number: (____) _____ Fax Number: (____) _____
NDC _____

Ordering Physician Name (*please print*): _____
Ordering Physician Medicaid Provider ID#: _____ Physician NPI#: _____
Phone Number: (____) _____ Fax Number: (____) _____

Wound Information: (If more than one wound, this information must be provided for each wound.)
Type and location: _____

Wound Size: _____ Date: ____/____/_____

Stage: _____ Is there adequate blood flow to the area? _____

Is wound infected? ____ If yes, is infection under control with antibiotics? _____

Has off-loading of pressure on the wound area been accomplished? _____

Has initial sharp debridement been done? _____

Concurrent use of other topical products is contraindicated.

WARNING

An increased rate of mortality secondary to malignancy was observed in patients treated with 3 or more tubes of REGRANEX Gel in a post-marketing retrospective cohort study. REGRANEX Gel should only be used when the benefits can be expected to outweigh the risks. REGRANEX Gel should be used with caution in patients with known malignancy. (See **CONTRAINDICATIONS** and **WARNINGS**)

By signing this form, the physician certifies that caregivers have been educated regarding the proper application, storage and cost of this medication, and that all responses provided are correct. A thin layer (1/16th") of Regranex®) should be applied **once daily** and the wound covered with a saline moist dressing, which should be changed again in 12 hours. Regranex®) must be refrigerated (do not freeze).

Provider Signature: _____ Date: ____/____/_____

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**