

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049



**SELECTCARE of TEXAS, L.L.C.**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Regranex® (becaplermin): Prior Authorization Request Form: Please respond.

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- Please complete the attached Regranex® (becaplermin) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

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You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

# Prior Authorization Request Form

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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Regranex® (becaplermin) Criteria

- 1 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed  
 Diabetes mellitus (ICD-9: 250) with skin ulcer (ICD-9: 686,707,728.86,730,731.8,785.4)  
 Other (diagnosis and ICD-9) \_\_\_\_\_
  - 2 Does the patient have a chronic pressure ulcer that has not responded to appropriate wound care?  
 Yes  No
  - 3 How is the pressure ulcer classified according to the Wagner Classification System (check appropriate box)?  
 5 = Ulcer that has caused gangrene of the entire foot or enough of the foot that it cannot be salvaged  
 4 = Ulcer that has led to gangrene of the toes and/or forefoot  
 3 = Deep ulcer that contains an abscess and/or osteomyelitis  
 2 = Deep ulcer that goes to the tendon, bone, or joint capsule  
 1 = Superficial ulcer that does not extend into the deeper tissues  
 0 = Intact skin
  - 4 Has patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance from topical and/or systemic antibiotics used for treating pressure ulcers?  
 Yes  No
  - 5 For refill Regranex® therapy, has the wound decreased in size?  
 Yes  No
- For optimal results please ensure the patient has an adequate blood supply to the affected area (demonstrated via Doppler or transcutaneous oxygen pressure), has adequate nutritional status with a serum albumin level > 2g/dl, is receiving appropriate debridement when necessary, and is avoiding weight bearing activities on the affected area.

Medical Justification: (Attach additional page if necessary): \_\_\_\_\_  
\_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_