



**CONTAINS CONFIDENTIAL PATIENT INFORMATION**  
**Regranex (becaplermin)**  
**Prior Authorization of Benefits (PAB) Form**  
**Complete form in its entirety and fax to:**  
**Prior Authorization of Benefits Center at 1-844-512-9004**  
**Provider Help Desk 1-800-454-3730**

**1. PATIENT INFORMATION    2. PHYSICIAN INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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<b>3. MEDICATION</b>	<b>4. STRENGTH</b>	<b>5. DIRECTIONS</b>	<b>6. QUANTITY PER 30 DAYS</b>
Regranex (becaplermin)	_____	_____	Specify: _____

**7. DIAGNOSIS:** \_\_\_\_\_

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has had an inadequate response to 2 weeks of wound debridement and topical moist wound dressing
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Request is for continuation of therapy
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wound has decreased in size by 30% after 10 weeks

**9. PHYSICIAN SIGNATURE**

Prescriber or Authorized Signature _____	Date _____
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Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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