

Sterling Retiree Rx Prior Authorization Form

REGRANEX (Becaplermin)

Coverage Criteria

Diabetic neuropathic ulcer of the lower extremity

Required Medical Information

 Does ulcer have adequate blood supply? Does ulcer extend into subcutaneous tissue or beyond?
 For **renewal**, documentation of ulcer size reduction after 10 weeks of therapy required.

Exclusion Criteria

Neoplasm at intended site of application; active wound infection not under control by way of active treatment

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

REGRANEX	Reason for Request		
Condition/Diagnosis Related			

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage		
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			

Comments	
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Physician Signature: _____

Fax Form to 1-877-847-9904