



Prescription Drug Coverage Determination Form
Wound care agent-Topical Ulcers
Regranex® (becaplermin)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Is there a neoplasm at the site of application?
3. Does the ulcer extend into the subcutaneous tissues or beyond?
4. Does the ulcer have adequate blood supply?
5. Are good ulcer care practices being performed...
6. Does the ulcer being treated have an active wound infection not under control by way of active treatment?
7. Has the ulcer been treated previously with Regranex® for 3 months?
If yes:
- Did the ulcer size decrease by 30% within the first 10 weeks of therapy?

Please provide any additional history or medical information that may support coverage (attach office notes as necessary):

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.