

Sterling Retiree Rx Prior Authorization Form

REGTRANEX (Becaplermin)

Coverage Criteria / Required Medical Information

- A. Must be used for treatment of lower-extremity diabetic ulcers **and**
- B. Ulcer must extend into subcutaneous tissue **and**
- C. Tissue must have an adequate blood supply **and**
- D. Patient must have concurrent good ulcer treatment practices including **ALL** of the following:
debridement; pressure relief; infection relief, and ulcer must be < 10 cm² in size.

Coverage Duration: 10 weeks

Exclusion Criteria

Neoplasm at intended site of application

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

REGTRANEX	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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