

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Becaplermin Recombinant (Regranex) – Medical Necessity Request

****Complete pages 1 and 2 for New/Initial Requests****

General Information:

1. Is the member 16 years of age or older? **Yes or No**
2. Is Regranex being used with other ulcer care practices (such as good wound care management)? **Yes or No**

Contraindication Information:

Does the member have neoplasm at the site of application? **Yes or No**

Diagnosis Information (please indicate diagnosis and answer related questions):

Diabetic Neuropathic Ulcer

- a. Is the ulcer on a lower extremity? **Yes or No**
- b. Where is the location of the ulcer? _____
- c. What is the greatest width (in centimeters or inches) of the ulcer?

- d. What is the greatest length (in centimeters or inches) of the ulcer?

- e. What date were the measurements taken?

- f. Is the ulcer a full thickness ulcer (Stage III or IV), extending through the dermis, into the subcutaneous tissues or beyond? **Yes or No**
- g. Is there adequate tissue oxygenation or blood supply to the lower extremity site or at the margin of the ulcer? **Yes or No**

Pressure Ulcer/Decubitus Ulcer

- a. Is the ulcer acute or chronic? **Acute or Chronic**
- b. Is the ulcer a , full thickness ulcer (Stage III or IV), extending through the dermis, into the subcutaneous tissues or beyond? **Yes or No**
- c. Where is the location of the ulcer? _____
- d. What is the greatest width (in centimeters or inches) of the ulcer?

- e. What is the greatest length (in centimeters or inches) of the ulcer?

- f. What date were the measurements taken?

- g. Has the member received 16 weeks of therapy or more for the same affected area? **Yes or No**

Physician office's signature* _____ Print Name _____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Other

a. What is the diagnosis? _____

b. What is the affected area? _____

c. What is the greatest width (in centimeters or inches) of the affected area?

d. What is the greatest length (in centimeters or inches) of the affected area?

e. What date were the measurements taken?

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Becaplermin Recombinant (Regranex) – Medical Necessity Request

****Complete this page for Subsequent Request****

Diagnosis Information (please indicate diagnosis and answer related questions):

Diabetic Neuropathic Ulcer

- a. Is the ulcer on a lower extremity? **Yes or No**
- b. Where is the location of the ulcer? _____
- c. What is the greatest width (in centimeters or inches) of the ulcer?

- d. What is the greatest length (in centimeters or inches) of the ulcer?

- e. What date were the measurements taken?

Other

- a. What is the diagnosis? _____
- b. What is the affected area? _____
- c. What is the greatest width (in centimeters or inches) of the affected area?

- d. What is the greatest length (in centimeters or inches) of the affected area?

- e. What date were the measurements taken?

Physician office's signature* _____ Print Name _____

***Form must be completed and signed by physician or licensed representative from the physician's office**