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**