

Family of health care plans



**Prior Authorization Form** 

CareFirst

Regranex

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**. Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Regranex.

Drug Name (select from list of drugs shown)					
Regranex (becaplermin)					
Quantity	Frequency		Strength		
Route of Administration	Expected Length of Therapy				
Patient Information					
Patient Name:					
Patient ID:					
Patient Group No.:					
Patient DOB:					
Patient Phone:					
Prescribing Physician					
Physician Name:					
Physician Phone:					
Physician Fax:					
Physician Address:					
City, State, Zip:					
Diagnosis:		ICD Code:			

Comments:

Please circle the appropriate answer for each question.					
1.	Is there a neoplasm(s) at the site(s) of application?	Y N			
2.	Is becaplermin (Regranex) being prescribed for the treatment of lower extremity diabetic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply?	Y N			
3.	Will good ulcer care practices including initial sharp debridement, pressure relief and infection control be performed?	Y N			

I affirm that the information given on this form is true and accurate as of this date.

## Prescriber (Or Authorized) Signature and Date

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