PA Request Criteria

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**CAREFIRST - MD EXCHANGE 5T**
**Regranex (HMF)**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Regranex (HMF).

**Patient Name:** _____ **Date:** 11/29/2023
**Patient ID:** _____ **Patient Date Of Birth:** _____
**Patient Group No:** _____ **Patient Phone:** _____ **Physician Name:**
**NPI#:** **Specialty:**
**Physician Office Address:** _____ **Physician Office Telephone:**

**Drug Name (select from list of drugs shown)**
Regranex (becaplermin)

**Quantity:** _____ **Frequency:** _____ **Strength:** _____
**Route of Administration:** _____ **Expected Length of Therapy:** _____
**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____

**Please check the appropriate answer for each applicable question.**

1. Is the requested drug being prescribed for the treatment of a lower extremity diabetic neuropathic ulcer that extends into the subcutaneous tissue or beyond and has an adequate blood supply? **Y** ☐ **N** ☐
2. Will good ulcer care practices including initial sharp debridement, pressure relief, and infection control be performed? **Y** ☐ **N** ☐
3. Coverage is provided for up to 30 grams per month. If higher quantities are needed, additional questions are required. Is MORE than this quantity needed to manage the patient's ulcer(s)? **Y** ☐ **N** ☐
4. Is the requested drug being prescribed to treat an ulcer greater than 2.5 square inches in size OR multiple ulcers? **Y** ☐ **N** ☐
5. Does the patient require MORE than the plan allowance of 60 grams per month? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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**Prescriber (Or Authorized) Signature and Date**

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark