

Clinical Pharmacy Program Guidelines for Regranex

Program	Prior Authorization
Medication	Regranex® (becaplermin gel)
Issue Date	3/2013
Pharmacy and Therapeutics Approval Date	7/2017
Effective Date	9/2017

1. Background:

Regranex is indicated for the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue, or beyond, and have an adequate blood supply. Regranex should be used as an adjunct to, and not a substitute for, good ulcer care practices including initial sharp debridement, pressure relief and infection control. The efficacy of Regranex gel has not been established for the treatment of pressure ulcers or venous stasis ulcers.

2. Coverage Criteria:

<p>A. Authorization</p> <p style="margin-left: 40px;">1. Regranex will be approved based on both of the following criteria:</p> <p style="margin-left: 80px;">a. Patient has a lower extremity diabetic neuropathic ulcer</p> <p style="text-align: center; margin-left: 40px;">-AND-</p> <p style="margin-left: 80px;">b. Treatment will be given in combination with ulcer wound care (e.g., debridement, infection control and/or pressure relief)</p> <p style="margin-left: 40px;">Authorization will be issued for 6 months</p>
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3. References:

1. Regranex® prescribing information. Fort Worth, TX: Smith & Nephew, Inc. March 2017.

Program	Prior Authorization/Notification - Regranex
Change Control	
Date	Change
3/2013	New policy applicable to the Michigan line of business

6/2015	Updated policy to include Rhode Island and Ohio as an in-scope plan
6/2016	Updated policy template. Policy now applies to all lines of business.
7/2017	Annual review. Removed automated step language from background. Updated reference.