BlueCross BlueShield of Arizona
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PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 1/18/18
LAST REVIEW DATE: 1/18/18
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

REGRANEX® (becaplermin) gel

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

REGRANEX® (becaplermin) gel (cont.)

Description:

Growth Factors:
Growth factors are proteins that signal cells to divide and grow. Types include platelet-derived growth factor (PDGF), basic fibroblast growth factor (BFGF), epidermal growth factor (EGF), insulin-like growth factor (IGF), transforming growth factor (TFGF) and recombinant PDGF.

Regranex is a recombinant human platelet-derived growth factor. It contains becaplermin and is topically applied. Regranex is FDA approved for treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond that have an adequate blood supply.

Autologous Wound Healing Factors:
Blood is drawn from an individual and centrifuged at high speeds to create an autologous concentrated platelet rich plasma (PRP) that contains a biologically active mixture of growth factors without the potential for an immune response. Autologous wound healing factors have been investigated for the treatment of wounds and non-orthopedic conditions.

There are numerous PRP preparation systems that have been cleared for marketing by the FDA through the 510(k) process. The use of different devices and procedures can lead to variable concentrations of active platelets and associated proteins, increasing variability between studies of clinical efficacy.

Wound Definitions:

Stage I:	Nonblanchable erythema of intact skin
Stage II:	Partial thickness skin loss involving epidermis and/or dermis
Stage III:	Full thickness skin loss involving damage or necrosis of subcutaneous tissues that may extend down to, but not through, underlying fascia
Stage IV:	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures
Chronic:	A wound or condition present for at least 30 days despite standard medical and surgical management

Regranex (becaplermin)

Medication class:
Dermatologicals - Wound Care, Growth Factor Agents

FDA-approved indication(s):
- Regranex contains becaplermin, a human platelet-derived growth factor that 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 is indicated as an adjunct to, and not a substitute for, good ulcer care practices.

Recommended Dose:
- Apply appropriate amount of gel once daily with a cotton swab, tongue depressor, or similar tool, as a coating over the ulcer. The amount to be applied will vary depending on the size of the ulcer area.
- To calculate the length of gel applied to the ulcer, measure the greatest length of the ulcer by the greatest width of the ulcer. Tube size and unit of measure will determine the formula used in the calculation. Recalculate amount of gel needed every 1 to 2 weeks, depending on the rate of change in ulcer area.

  Centimeters
  15 g tube
  [ulcer length (cm) × width (cm)] divided by 4 = length of gel (cm)

  Inches
  15 g tube
  [length (in) × width (in)] x 0.6 = length of gel (in)

Available Dosage Forms:
- Gel: 0.01%

Limitations of use:
- Efficacy has not been established for the treatment of pressure ulcers and venous stasis ulcers.
- The effects on exposed joints, tendons, ligaments, and bone have not been established in humans.
- Regranex Gel is a non-sterile, low bioburden preserved product. Therefore, it should not be used in wounds that close by primary intention.

Warnings and Precautions:
- Malignancies distant from the site of application have been reported in both a clinical study and in post marketing use.
- Regranex Gel should be used with caution in patients with a known malignancy.

REGRANEX® (becaplermin) gel (cont.)

Criteria:

- **Criteria for initial therapy:** Regranex is considered ***medically necessary*** as an adjunct to standard wound care management and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a Podiatrist or wound care specialist

  2. Individual is 16 years of age or older

  3. A confirmed diagnosis of **ONE** of the following:
     - Chronic neuropathic diabetic ulcers of the lower extremity extending into the subcutaneous tissue (full thickness, e.g., Stage III or IV)
     - Pressure ulcers extending into the subcutaneous tissue (full thickness, e.g., Stage III or IV)

  4. Adequate blood/tissue oxygenation supply

  5. Participation in a wound care program, which includes **ALL** of the following:
     - Initial sharp debridement
     - Pressure relief
     - Infection control

  6. Nutrition status has been evaluated.

  7. There are **NO** contraindications.
     - Contraindications include:
       - Known neoplasm(s) at the site(s) of application

  Initial approval duration: 2 months, not to exceed 45 g for the treatment period

- **Criteria for continuation of coverage (renewal request):** Regranex is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by a Podiatrist or wound care specialist

  2. Individual's condition has been reassessed for reduction in ulcer size

  3. Individual has not exceeded 45 g or will not exceed 45 g by the end of the treatment period

  Renewal duration: 3 months, not to exceed 45 g for the treatment period

Resources:

Regranex. Package Insert. Revised by manufacturer 3/2017. Accessed 10/16/17.

REGRANEX® (becaplermin) gel (cont.)

2.01.16 BCBS Association Medical Policy Reference Manual. Recombinant and Autologous Platelet-Derived Growth Factors as a Treatment of Wound Healing and Other Conditions. Re-issue date 01/12/2017, issue date 03/31/96.

BCBS Association Technology Assessment Program. Growth Factors for Wound Healing. 11-12/1992 1992.

BCBS Association Technology Assessment Program. Becaplermin for Wound Healing. 06/1999 1999;14(5).

Bello YM, Phillips TJ. Recent advances in wound healing. *JAMA.* 2000 Feb 9 2000;283(6):716-718.

California Technology Assessment Forum. Platelet-rich Plasma Injection for Achilles Tendinopathy. 10/13/2010.

Glover JL, Weingarten MS, Buchbinder DS, Poucher RL, Deitrick GAr, Fylling CP. A 4-year outcome-based retrospective study of wound healing and limb salvage in patients with chronic wounds. *Adv Wound Care.* 1997 Jan-Feb 1997;10(1):33-38.

Koob TJ, Lim JJ, Massee M, et al. Angiogenic properties of dehydrated human amnion/chorion allografts: therapeutic potential for soft tissue repair and regeneration. *Vasc Cell.* 2014;6:10.

Leitner GC, Gruber R, Neumuller J, et al. Platelet content and growth factor release in platelet-rich plasma: a comparison of four different systems. *Vox Sang.* 2006 Aug 2006;91(2):135-139.

Rees RS, Robson MC, Smiell JM, Perry BH. Becaplermin gel in the treatment of pressure ulcers: a phase II randomized, double-blind, placebo-controlled study. *Wound Repair Regen.* 1999 May-Jun 1999;7(3):141-147.

Roukis TS, Zgonis T, Tiernan B. Autologous platelet-rich plasma for wound and osseous healing: a review of the literature and commercially available products. *Adv Ther.* 2006 Mar-Apr 2006;23(2):218-237.

Zavadil DP, Satterlee CC, Costigan JM, Holt DW, Shostrom VK. Autologous platelet gel and platelet-poor plasma reduce pain with total shoulder arthroplasty. *J Extra Corpor Technol.* 2007 Sep 2007;39(3):177-182.

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:	Dosage Form:
Directions for Use:	Quantity: / Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

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Office notes, labs, and medical testing relevant to the request that show medical justification are required.