

COLCHICINE (single-ingredient) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antihyperuricemics** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	<input type="checkbox"/> colchicine 0.6 mg capsule (<i>preferred, clinical PA req'd</i>)	<input type="checkbox"/> Colcris tablet (<i>non-preferred</i>)	<input type="checkbox"/> _____
	<input type="checkbox"/> colchicine 0.6 mg tablet (<i>preferred, clinical PA req'd</i>)	<input type="checkbox"/> Mitigare capsule (<i>non-preferred</i>)	<input type="checkbox"/> _____
Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (required):	

SINGLE-INGREDIENT COLCHICINE (COLCRYS, MITIGARE, COLCHICINE TABLET/CAPSULE) REQUESTS

Does the beneficiary have a history of any of the following? <i>Check all that apply.</i>	<input type="checkbox"/> Yes – <i>Submit results of recent kidney and liver function tests.</i>
<input type="checkbox"/> liver impairment or failure <input type="checkbox"/> ascites <input type="checkbox"/> hepatitis <input type="checkbox"/> renal/kidney impairment <input type="checkbox"/> cirrhosis <input type="checkbox"/> encephalopathy	<input type="checkbox"/> No
Is the beneficiary currently taking, or taken within the past 14 days, a medication that is an inhibitor of P-glycoprotein (P-gp) or a strong inhibitor of cytochrome P450 3A4 (CYP3A4) (ex., amiodarone, diltiazem, certain HIV medications, quinidine, Ranexa, verapamil)?	<input type="checkbox"/> Yes <i>Submit beneficiary's current complete medication list.</i> <input type="checkbox"/> No
For NON-PREFERRED Colcris or Mitigare: Does the beneficiary have a history of trial and failure of or contraindication/intolerance to the preferred agents, colchicine capsule & colchicine tablet?	<input type="checkbox"/> Yes <i>Submit all supporting documentation.</i> <input type="checkbox"/> No

COLCHICINE (COLCRYS, MITIGARE, COLCHICINE TABLET/CAPSULE) FOR ACUTE GOUT ATTACKS

Did the beneficiary try and fail, or have a contraindication or intolerance to, the following standard therapies for the <u>CURRENT</u> gout attack? <i>Check all that apply.</i>	<input type="checkbox"/> Yes – <i>Submit all supporting documentation of drug regimen (drug name, strength, directions, and dates tried) and treatment outcome.</i>
<input type="checkbox"/> Intra-articular (joint injection) or oral corticosteroids (ex., Depo-Medrol, Kenalog, Aristospan, etc.) <input type="checkbox"/> NSAIDs (ex., ibuprofen, indomethacin, naproxen, piroxicam, etc.) or COX-2 inhibitor (ex., Celebrex)	<input type="checkbox"/> No

COLCHICINE (COLCRYS, MITIGARE, COLCHICINE TABLET/CAPSULE) FOR CHRONIC GOUT PROPHYLAXIS

Does the beneficiary have a recent uric acid level above goal based on American College of Rheumatology guidelines?	<input type="checkbox"/> Yes – <i>Submit recent lab results.</i>
Did the beneficiary recently start taking a uric acid-lowering medication for gout prophylaxis, such as allopurinol, probenecid, or Uloric?	<input type="checkbox"/> No

For a beneficiary who has been taking a uric acid lowering medication for more than 6 months, submit documentation of the following:

- a recent uric acid level therapeutic outcomes of uric acid lowering medication(s)
 uric acid lowering medication(s) currently using or previously tried (including name, strength, daily dosage, dates taken)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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