Prior Authorization Request Form for Colchicine

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Is the member 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)?	☐ Yes ☐ No	*Submit current complete medication list.*
Does the member have a history of a contraindication to Colchicine? Ex: Hepatic or Renal impairment	☐ Yes ☐ No	*Submit recent kidney and liver function tests.*
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred colchicine capsule or tablet? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

TREATMENT OF ACUTE GOUT ATTACK:

☐ Documented history of therapeutic failure, contraindication or intolerance to one of the following: (medication, start date and end date)
- ☐ NSAIDs or COX-2 inhibitors: _____
- ☐ Intra-articular or systemic corticosteroids: _____

TREATMENT OF CHRONIC GOUT:

☐ Recent uric acid level above goal based on American College of Rheumatology guidelines:_____(submit labs)

☐ Documented history of therapeutic failure, contraindication or intolerance to one of the following: (medication, start date and end date)
- ☐ Failure to achieve a positive clinical response using maximum tolerated doses of standard uric acid lowering medication (allopurinol, probenecid or febuxostat): _____
- ☐ Colchicine will be used in combination with a uric acid lowering medication: _____

FOR USE OF A URIC ACID LOWERING MEDICATION FOR MORE THAN 6 MONTHS:

☐ Recent uric acid level

☐ Therapeutic outcomes
☐ Uric acid lowering medication using medication(s) using or previously tried (medication, start date and end date)
_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)