GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

COLCHICINE (single-ingredient) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Antihyperuricemics and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plans website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐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:
☐ colchicine 0.6 mg capsule *(preferred, clinical PA req'd)*
☐ colchicine 0.6 mg tablet *(preferred, clinical PA req'd)*
☐ Colcrys tablet *(non-preferred)*
☐ Mitigare capsule *(non-preferred)*
☐ _____

Strength:	Directions:	Quantity:	Refills:

Diagnosis *(submit documentation)*:

Dx code (required):

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

Does the beneficiary have a history of any of the following? *Check all that apply.* ☐ liver impairment or failure ☐ ascites ☐ hepatitis ☐ renal/kidney impairment ☐ cirrhosis ☐ encephalopathy	☐ Yes – *Submit results of recent kidney and liver function tests.* ☐ 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)?	☐ Yes ☐ No *Submit beneficiary's current complete medication list.*
For NON-PREFERRED Colcrys or Mitigare: Does the beneficiary have a history of trial and failure of or contraindication/intolerance to the preferred agents, colchicine capsule & colchicine tablet?	☐ Yes ☐ No *Submit all supporting documentation.*

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

Does the beneficiary have a documented history of therapeutic failure, intolerance, or contraindication to one of the following at doses and frequencies consistent with medically accepted standards for the treatment of gout? *Check all that apply.* ☐ Intra-articular (joint injection) or oral corticosteroids (ex., Depo-Medrol, Kenalog, Aristospan, etc.) ☐ NSAIDs (ex., ibuprofen, indomethacin, naproxen, piroxicam, etc.) or COX-2 inhibitor (ex., Celebrex)	☐ Yes – *Submit all supporting documentation of drug regimen (drug name, strength, directions, and dates tried) and treatment outcome.* ☐ 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?	☐ Yes – *Submit recent lab results.* ☐ No
Has the beneficiary failed to achieve a positive clinical response (e.g. reduction in flare rate, resolution of tophi, decrease in pain, and decreased functional impairment) using the maximum tolerated doses of standard uric acid lowering medication for the prophylaxis of gout attacks (such as xanthine oxidase inhibitors or probenecid)?	☐ Yes – *Submit documentation* ☐ No
Is colchicine being prescribed in combination with a uric acid lowering medication (such as allopurinol, probenecid, or febuxostat) for the prophylaxis of gout attacks?	☐ Yes – *Submit documentation* ☐ 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 submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: