

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

Colchicine (Cholcrys, Mitigare)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992**

CRITERIA FOR GOUT:

- Minimum age requirement: 18 years old.
- Documented failure on allopurinol.
- Documented failure on or a contraindication to corticosteroids and NSAIDS.
- Maximum approved dose is 1.8mg every 3 days.

CRITERIA FOR FAMILIAL MEDITERRANEAN FEVER:

- Minimum age requirement: 4 years old.
- Documented diagnosis of Familial Mediterranean Fever.
- Maximum approved dose is 2.4mg per day.

AUTHORIZATION:

The initial prior authorization will be approved for one year.

RE-AUTHORIZATION:

Updated letter of medical necessity

10/17/2014

<https://medicaid.utah.gov/pharmacy/>