UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

COLCRYS (colchicine)

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

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO 855-828-4992 note the new fax number

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

8/26/10

http://health.utah.gov/medicaid/pharmacy