

## Colchicine Agents Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.**

**1. Patient information**

**2. Physician information**

Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

**3. Medication**

**4. Strength**

**5. Directions**

**6. Quantity per 30 days**

	_____	_____	Specify: _____
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**7. Diagnosis** \_\_\_\_\_

**8. Approval criteria:** Item (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a documented allergy or contraindication to preferred medications in this class?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of renal or hepatic impairment in the last 365 Days?

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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of the following medications in the last 30 days: atazanavir, clarithromycin, darunavir, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, tipranavir, cyclosporine, or ranolazine?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the quantity requested less than or equal to 1.8mg (3 tablets) per day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the quantity requested less than or equal to 2.4mg (4 tablets) per day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a documented allergy or contraindication to preferred agents in this class.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.
<p>For the <i>Texas Medicaid Preferred Drug List</i>, please refer to the Texas Medicaid Vendor Drug Program website at <a href="https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs">https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs</a>.</p>	

**9. Physician signature**

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Prescriber or authorized signature	Date

PA of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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