

Market Applicability/Effective Date														
Market	FL & FHK	FL MMA	FL LTC	GA	KS	KY	LA	MD	NJ	NV	NY	TN	TX	WA
Applicable	X	NA	NA	X	NA	X	X	X	X	X	X	NA	NA	X

\*FHK- Florida Healthy Kids

## Colcrys (colchicine tablets)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 Year

Medications	Quantity Limit
Colcrys (colchicine)	69 tablets* per 30 days.  *Note: Additional tablets allow for treatment of up to 3 gout flares per month
Requests for additional tablets of Colcrys may be approved if the following criteria are met:	
<p>I. May approve a quantity of 120 tablets per 30 days for diagnosis of Familial Mediterranean Fever (FMF).</p>	
If an increase in quantity of the drug is requested and the criterion is not met, then request will be reviewed on a case by case basis.	

### APPROVAL CRITERIA

Requests for Colcrys (colchicine) tablets may be approved if the following criteria are met:

- I. Individual has been on Colcrys (colchicine) tablets in the past 180 days (medication samples/ coupons/ discount cards are excluded from consideration as a trial);

**OR**

- II. Individual is using for the treatment of acute gout flares; **AND**
- III. Individual has history of a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of, intolerance to, or contraindication to one of the following for an acute gout flare:
  - A. Non-steroidal Anti-inflammatory Drug (NSAID); **OR**
  - B. Systemic corticosteroid;

**OR**

- IV. Individual is using for the prophylaxis of gout flares; and one of the following:
  - A. Individual will be initiating or has initiated urate-lowering therapy (ULT); **OR**
  - B. Individual has a contraindication or intolerance to urate-lowering therapy;

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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**OR**

- V. Individual is 4 years of age or older; **AND**
- VI. Individual has a diagnosis of Familial Mediterranean Fever (FMF);

**OR**

- VII. Individual is using for prevention of recurrent Pseudogout;

**OR**

- VIII. Individual is using for pericarditis with two or more recurrences (DrugPoints BIIa).

Colcrys (colchicine) may **NOT** be approved for the following:

- I. Treating pain from other causes;

**OR**

- II. Individual is currently on a medication that is known to inhibit CYP3A4\* and/or P-glycoprotein\*\* (P-gp); **AND**
- III. Individual has concomitant renal or hepatic impairment.

\*Including, but not limited to: atazanavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, amprenavir, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, grapefruit juice, verapamil.

\*\*Including, but not limited to: cyclosporine and ranolazine.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

**Key References:**

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: <http://www.clinicalpharmacology.com>. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. <http://dailymed.nlm.nih.gov/dailymed/about.cfm>. Accessed January 30, 2017.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

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