TRICARE Prior Authorization Request Form for low dose colchicine 0.5 mg (**Lodoco**)

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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior Authorization does not expire. Please note Lodoco will be completely excluded from the TRICARE pharmacy benefit starting on 6/12/2024, regardless of how long the PA is approved.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. The provider acknowledges that Lodoco will be completely excluded from the Tricare Pharmacy Benefit starting on June 12th, 2024, regardless of how long the PA is approved.	☐ Acknowledged **Proceed to question 2**	
2. The provider acknowledges that colchicine 0.6 mg tabs (generic Colcrys) and colchicine 0.6 mg caps (generic Mitigare) are available to DoD beneficiaries without prior authorization.	☐ Acknowledged **Proceed to question 3**	
3. Is the patient greater than or equal to 18 years of age?	☐ Yes **Proceed to question 4**	☐ No **STOP Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a cardiologist?	☐ Yes **Proceed to question 5**	☐ No **STOP Coverage not approved**
5. Has the patient had a previous myocardial infarction or a history of an acute coronary syndrome, angina, history of stroke or transient ischemic attack, coronary artery disease, peripheral arterial disease?	☐ Yes **Proceed to question 7**	☐ No **Proceed to question 6**
6. Has the patient undergone a coronary or other arterial revascularization procedure in the past?	☐ Yes **Proceed to question 7**	☐ No **STOP Coverage not approved**

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7. Is the patient on guideline-directed standard therapies for the secondary prevention of cardiovascular (CV) events?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a creatinine clearance greater than or equal to 50 mL/min?	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have severe liver disease or pre-existing blood dyscrasias?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[14 Feb 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: