Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Mitigare™ (colchicine)

Review Criteria
Member must meet all the following criteria for specific diagnosis:

Acute Gout:
- Subject to Preferred Drug List
- Member must have an inadequate response/contraindication/intolerance to a preferred NSAID (refer to Preferred Drug List for preferred options)
  - If NSAID therapy is contraindicated, member must have an inadequate response to prednisone therapy
- Authorization is granted for only one fill

Limitations:
- Maximum quantity allowed is 9 tablets per 30 days and maximum of one fill
  - Additional fills may be considered for the first 1-2 months of diagnosis if quantity is not sufficient for acute attack

Recurrent/Chronic Gout:
- Subject to Preferred Drug List
- Member must be currently taking a gout preventative medication (ie allopurinol, probenecid, or Uloric – refer to Preferred Drug List for preferred options)
- Trial on NSAID not required due to chronic diagnosis and ongoing compliance on preventative therapy
- Initial authorization is granted for 6 months

Renewal Authorization:
- Member must be currently taking a gout preventative medication and remain compliant on therapy
- Member must have need for ongoing colchicine therapy in conjunction with preventative therapy
- Renewal authorization will be granted in one-year intervals

Limitations:
- Maximum daily quantity is 2.0
Familial Mediterranean Fever (FMF):
- Subject to Preferred Drug List
- No trials on any other medications required
- Approval granted in one-year intervals

Limitations:
- Maximum daily quantity is 4.0

Pseudogout/Calcium Pyrophosphate Crystal Deposition Disease (CPPD):
- Acute:
  - Subject to Preferred Drug List
  - Member must have an inadequate response/contraindication/intolerance to NSAIDS (refer to the Preferred Drug List for preferred options)
  - Approval granted for 3 months (approval can be extended as necessary until acute attack resolves)

  Limitations:
  - Maximum daily quantity is 2.0

- Chronic:
  - Subject to Preferred Drug List
  - Member must have ≥ 3 attacks per year
  - Approval granted for 1 year

  Limitations:
  - Maximum daily quantity is 2.0

Pericarditis:
- For both acute and recurrent diagnoses, member must be currently taking an NSAID are aspirin therapy, unless contraindicated or not tolerated (usually used for 1-2 weeks, but may be longer)

- Acute:
  - Subject to Preferred Drug List
  - Approval granted for 3 months

  Limitations:
  - Maximum daily quantity is 2.0

- Recurrent:
  - Subject to Preferred Drug List
  - Approval granted for 1 year

  Limitations:
  - Maximum daily quantity is 2.0
**Bechet’s Disease:**
- Subject to Preferred Drug List
- Approval granted for 1 year

Limitations:
- Maximum daily quantity is 3.0

**Primary Biliary Cirrhosis/Cholangitis:**
- Subject to Preferred Drug List
- Member must have inadequate response to ursodiol or obeticholic acid (refer to Preferred Drug List for preferred option)
- Approval granted for 1 year

Limitations:
- Maximum daily quantity is 2.0