



## Montana Healthcare Programs Drug Prior Authorization Coverage Criteria

### Gloperba™ (colchicine)

#### **Review Criteria**

Consideration for this formulation requires clinical rationale why the preferred tablet or capsule formulation cannot be used (i.e., swallowing difficulties, titration schedule that requires the liquid formulation, etc.)

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:**

- Max quantity allowed is 9 tablets per 30 days and max of one fill
  - Additional fills may be considered for the first one to two 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 (i.e., 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  $\geq 3$  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 as 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