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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION LODOCO® (colchicine)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page).

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 12-months approval:

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Does the member have established atherosclerotic disease or multiple risk factors for cardiovascular disease (CVD) (e.g., overweight or obesity, type 2 diabetes mellitus, hyperlipidemia, hypertension)?
   ☐ Yes ☐ No
3. Does the member have a pre-existing cytopenia?
   ☐ Yes ☐ No
4. Does the member have renal failure (creatinine clearance less than 15 mL/minute)?
   ☐ Yes ☐ No
5. Does the member have severe hepatic impairment?
   ☐ Yes ☐ No
6. Is the member taking any of the following:
   - A strong CYP3A4 inhibitor (e.g., ketoconazole, ritonavir, HIV antiretroviral drugs); **OR**
   - A strong P-glycoprotein inhibitor (e.g., cyclosporine, ranolazine); **OR**
   - A 0.6 mg colchicine formulation during treatment with colchicine (Lodoco)?

   ☐ Yes ☐ No
7. Does the prescriber attest to ongoing monitoring of kidney and liver function and regular assessment of potential drug interactions?
   ☐ Yes ☐ No

(Form continued on next page).

Member's Last Name: **Member's First Name:**

For renewal, complete the following questions to receive a 1-year approval:

8. Does the member continue to meet the above criteria?
   ☐ Yes ☐ No
9. Does the member continue to experience clinical benefit from the requested treatment?
   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.