



Colcrlys[®] Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans Pharmacy Department at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
Requesting Physician: _____ Specialty: _____
(Please print)
Office Contact Person: _____ Phone #: (____)____-____ ext ____
Office Address: _____
Medication/Dose Requested: _____ Fax #: (____)____-____
Expected Duration of Therapy: _____ ICD-9: _____

1. Please mark the applicable indication:

Prophylaxis of gout flares

a. Please provide the number of acute gout attacks that have occurred in the past year _____

b. Does the patient have evidence of tophi or radiographic joint damage? Please indicate _____

c. Has the patient tried allopurinol? YES NO

Please describe the patient's response _____

d. Has the patient tried Uloric (febuxostat)? YES NO

Please describe the patient's response _____

Treatment of gout flares

Physician's Signature: _____ Date: ____/____/____