Provider Help Desk
1.866.399.0928

FAX Completed Form To
1.877.386.4695

REQUEST FOR PRIOR AUTHORIZATION
KETOROLAC TROMETHAMINE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for ketorolac tromethamine , a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a Black Box Warning. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions:
1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given. 2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum intranasal dose is 126mg/day. Maximum combined duration of therapy is 5 days per month. 3. Diagnosis indicating moderately severe, acute pain. Requests for IV/IM and intranasal ketorolac must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs at therapeutic doses.

PLEASE NOTE THERE IS A BLACK BOX WARNING FOR THIS PRODUCT

Non-Preferred

Ketorolac Tablets ☐
Ketorolac Tromethamine Injection ☐
Sprix ☐

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____ (5 DAYS MAX)

Ketorolac tromethamine IM/IV Administration Date: _____ Admin Time: _____

Diagnosis:

- ❑ **Pain, moderately severe acute**
- ❑ **Pain, chronic**
- ❑ **Other (specify):**_____

Documentation of trials for IV, IM, and intranasal ketorolac:

Preferred NSAID Trial #1 Name/Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred NSAID Trial #2 Name/Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Reason for use of Non-Preferred drug requiring prior approval:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.