

Request for Prior Authorization KETOROLAC TROMETHAMINE

FAX Completed Form To1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

(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, or Pharmacy	correct and complete	or form will be returned.
NPI:	NDC	
Prior authorization is required for ketorolac tromethamine, a nonsteroid		
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: I. 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 I20mg/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		
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 ketoro	lac:	
Preferred NSAID Trial #1 Name/Dose:	Trial start date:	Trial end date:
Reason for Failure:		
Preferred NSAID Trial #2 Name/Dose:		
Reason for use of Non-Preferred drug requiring prior approval:_		
Attach lab results and other documentation as necessary.		
Prescriber Signature	Date of Submission	

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.

*MUST MATCH PRESCRIBER LISTED ABOVE