pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

KETOROLAC PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for ketorolac, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – NSAIDs (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info (PA#:_____) ☐Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Ketorolac agent requested *(all other NSAID requests – use "NSAIDs Prior Authorization Form")*:
☐Ketorolac tablet (Toradol) ☐Sprix (ketorolac nasal spray) ☐ketorolac injection

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Dx code (required):	

ALL ketorolac requests:

1. Including the currently-requested prescription, will the Recipient have taken more than 5 days of ketorolac in the past 90 days?	☐Yes – *submit documentation of drug regimen and any ketorolac rxs from the past 90 days* ☐No
2. Will the Recipient be taking ketorolac with any other NSAID or aspirin?	☐Yes ☐No *Submit documentation of Recipient's complete current medication list.*
3. Is the prescribed dose within the guidelines listed below for the Recipient's age? • ORAL: ≥ 16 years of age – maximum 40 mg per 24 hours • NASAL (Sprix): ≥ 18 and < 65 years of age – maximum 126 mg per 24 hours; ≥ 65 years of age or weight < 50 kg – max 63 mg per 24 hours • INJECTABLE: ≥ 2 and ≤ 16 years of age – a single injectable dose; ≥ 16 and < 65 years of age and ≥ 50 kg - max 120 mg per 24 hours; ≥ 65 years of age or weight < 50 kg – max 60 mg per 24 hours	☐Yes ☐No *Submit documentation of prescribed dosage and route of administration*

Continue to applicable section –oral, nasal, or injectable.

ORAL ketorolac tablets requests:

1. Is the Recipient 16 years of age or older?	☐Yes ☐No

SPRIX (ketorolac NASAL) requests:

1. Has the Recipient tried and failed, or have a contraindication or intolerance to, oral ketorolac?	☐Yes – *submit all supporting documentation of drug regimen and treatment outcome* ☐No
2. Is the Recipient at least 18 years of age or older?	☐Yes ☐No

INJECTABLE ketorolac requests:

1. Who will be administering the requested injectable ketorolac to the Recipient?	☐self-administration by Recipient ☐administration by a health-care provider	*Submit documentation of administration plan*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: