

NSAIDs – KETOROLAC PRIOR AUTHORIZATION FORM

Prior authorization guidelines for NSAIDs (including ketorolac) and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

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|--------------------------------------|--|---------------------------|------------------|--|
| <input type="checkbox"/> New request | <input type="checkbox"/> Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office/LTC facility contact: | | Specialty: | NPI: | |
| Contact's phone number: | | Street address: | | |
| Beneficiary name: | | City/State/Zip: | | |
| Beneficiary ID#: | DOB: | Phone: | Fax: | |
| Beneficiary address: | | Beneficiary phone number: | | |

CLINICAL INFORMATION

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|---|---|-----------------------|----------|
| Ketorolac product requested: | | Strength: | |
| Directions: | | Quantity: | Refills: |
| Diagnosis (<i>submit documentation</i>): | DX code (<i>required</i>): | Beneficiary's weight: | |
| Will the beneficiary be taking aspirin or any other NSAID (e.g., ibuprofen, naproxen, meloxicam, etc.) while taking ketorolac? | <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit beneficiary's complete medication list.</i> | | |
| Does the requested duration of therapy exceed the maximum recommended duration of 5 days? | <input type="checkbox"/> Yes – <i>Submit documentation from the medical literature supporting the use of the requested duration.</i> <input type="checkbox"/> No | | |
| Including this prescription, will the beneficiary have received more than 5 days of therapy with any ketorolac product within the past 90 days? | <input type="checkbox"/> Yes – <i>Submit documentation showing why the beneficiary requires additional treatment with ketorolac.</i> <input type="checkbox"/> No | | |

KETOROLAC TABLET

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|---|---|
| Is the beneficiary less than 17 years of age? | <input type="checkbox"/> Yes – <i>Submit documentation from the medical literature supporting the use of oral ketorolac for the beneficiary's age.</i> <input type="checkbox"/> No |
| Does the requested dose exceed the maximum recommended daily dose of 40 mg/day? | <input type="checkbox"/> Yes – <i>Submit documentation from the medical literature supporting the use of the requested dose.</i> <input type="checkbox"/> No |

KETOROLAC NASAL SPRAY

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| Is the beneficiary less than 18 years of age? | <input type="checkbox"/> Yes – <i>Submit documentation from the medical literature supporting the use of nasal ketorolac for the beneficiary's age.</i> <input type="checkbox"/> No |
| Does the beneficiary have a clinical reason why oral ketorolac tablets cannot be used? | <input type="checkbox"/> Yes – <i>Submit supporting documentation.</i> <input type="checkbox"/> No |
| If the beneficiary is 65 years of age or older, weighs less than 50 kg, and/or has renal impairment: Does the requested dose exceed 63 mg/day (4 sprays/day)? | <input type="checkbox"/> Yes – <i>Submit documentation from the medical literature supporting the requested dose.</i> <input type="checkbox"/> No |
| For all other beneficiaries: Does the requested dose exceed 126 mg/day (8 sprays/day)? | <input type="checkbox"/> Yes – <i>Submit documentation from the medical literature supporting the requested dose.</i> <input type="checkbox"/> No |

Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:

Date:

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