GHP Family Pharmacy Customer Service
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Geisinger

KETOROLAC PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

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

☐ New request ☐ Renewal request	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Phone number of office contact:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Ketorolac product requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	DX code (*required*):	Beneficiary's weight:
Will the beneficiary be taking aspirin or any other NSAID (e.g., ibuprofen, naproxen, meloxicam, etc.) while taking ketorolac?	☐ Yes ☐ No *Submit beneficiary's complete medication list.*	
Does the requested duration of therapy exceed the maximum recommended duration of 5 days?	☐ Yes – *Submit documentation from the medical literature supporting the use of the requested duration.* ☐ No	
Including this prescription, will the beneficiary have received more than 5 days of therapy with any ketorolac product within the past 90 days?	☐ Yes – *Submit documentation showing why the beneficiary requires additional treatment with ketorolac.* ☐ No	
KETOROLAC TABLET		
Is the beneficiary less than 17 years of age?	☐ Yes – *Submit documentation from the medical literature supporting the use of oral ketorolac for the beneficiary's age.* ☐ No	
Does the requested dose exceed the maximum recommended daily dose of 40 mg/day?	☐ Yes – *Submit documentation from the medical literature supporting the use of the requested dose.* ☐ No	
KETOROLAC NASAL SPRAY		
Is the beneficiary less than 18 years of age?	☐ Yes – *Submit documentation from the medical literature supporting the use of nasal ketorolac for the beneficiary's age*. ☐ 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)?	☐ Yes - *Submit documentation from the medical literature supporting the use of nasal ketorolac for the beneficiary's age.* ☐ No	
For all other beneficiaries: Does the requested dose exceed 126 mg/day (8 sprays/day)?	☐ Yes – *Submit documentation from the medical literature supporting the dose of nasal ketorolac for the beneficiary's* age. ☐ 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: