GHP Family Pharmacy Customer Service
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Geisinger

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

☐New request ☐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:

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
Does the beneficiary have a clinical reason why oral ketorolac tablets cannot be used?	☐Yes – *Submit supporting documentation.* ☐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 requested dose.* ☐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 requested dose.* ☐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**: