https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

# Ketorolac Tablets & Ketorolac Tromethamine Injection

## Prior Authorization of Benefits (PAB) Form

**Complete form in its entirety and fax to:**
**Prior Authorization of Benefits Center at 1-844-512-9004**
**Provider Help Desk 1-800-454-3730**

| 1. PATIENT INFORMATION | 2. PHYSICIAN INFORMATION |
|---|---|
| Patient Name: _____ | Prescribing Physician: _____ |
| Patient ID #: _____ | Physician Address: _____ |
| Patient DOB: _____ | Physician Phone #: _____ |
| Date of Rx: _____ | Physician Fax #: _____ |
| Patient Phone #: _____ | Physician Specialty: _____ |
| Patient Email Address: _____ | Physician DEA: _____ |
| | Physician NPI #: _____ |
| | Physician Email Address: _____ |

| 3. MEDICATION | 4. STRENGTH | 5. DIRECTIONS | 6. QUANTITY PER 30 DAYS |
|---|---|---|---|
| □ Ketorolac Tablets<br>□ Ketorolac Tromethamine Injection | _____ | _____ | Specify: _____ |

**7. DIAGNOSIS:** _____

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

**Requests for Ketorolac Tromethamine Injection:**

□ Yes □ No Documentation of previous trials and therapy failures with at least two preferred non-steroidal anti-inflammatory drugs* at therapeutic doses been provided

□ Yes □ No Patient has a diagnosis indicating moderately severe, acute pain

*The preferred non-steroidal anti-nflammatory drugs are: diclofenac potassium, diclofenac sodium, etodolac tab 400 mg, etodolac tab 500 mg, flurbiprofen, Ibuprofen Susp 100 MG/5ML (OTC), Ibuprofen Tab 200 MG (OTC), ibuprofen tab 400 mg, ibuprofen tab 600 mg, ibuprofen tab 800 mg, indomethacin, ketoprofen, NAPROSYN SUSP, naproxen, naproxen sodium tab 550 mg, sulindac.

**Requests for Ketorolac Tablets:**

□ Yes □ No Documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given is provided

□ Yes □ No Patient has a diagnosis indicating moderately severe, acute pain

**Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

**Dosing guidelines: maximum oral dose is 40 mg/day; maximum IV/IM dose is 120 mg/day; combined duration of use of IV/IM and oral is not to exceed five (5) days.**


**CONTINUED ON PAGE 2**

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**Patient Name:** _____ **Patient ID#:** _____

**9. PHYSICIAN SIGNATURE**

| | |
|---|---|
| Prescriber or Authorized Signature | Date |

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.*

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.