TEXAS MEDICAID
Clinical Edit Prior Authorization
ketorolac (TORADOL equiv) injection, ketorolac nasal spray

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA
1. Is the request for injectable ketorolac? ☐ Yes (Go to #2) ☐ No (Go to #3)
2. Is the client greater than or equal to (≥) 2 years of age? ☐ Yes (Go to #5) ☐ No (Deny)
3. Is the request for nasal ketorolac? ☐ Yes (Go to #4) ☐ No (Deny)
4. Is the client greater than or equal to (≥) 18 years of age? ☐ Yes (Go to #5) ☐ No (Deny)
5. Does the client have a diagnosis of ONE (1) of the following in the last 730 days? • Advanced Renal Failure (ARF) • Cerebrovascular Bleeding • Coagulation Disorder • Gastrointestinal (GI) Bleed • Peptic Ulcer Disease (PUD) ☐ Yes (Deny) ☐ No (Go to #6)
6. Does the client have a history of an aspirin or nonsteroidal anti-inflammatory drug (NSAID) agent in the last 30 days? NSAIDs include ibuprofen (MOTRIN, DUEXIS), naproxen (ALEVE, VIMOVO), diclofenac (VOLTAREN, FLECTOR, PENNSAID, SOLARAZE, ZIPSOR), meloxicam (MOBIC), celecoxib (CELEBREX), indomethacin (INDOCIN), piroxicam, sulindac and others. ☐ Yes (Deny) ☐ No (Go to #7)
7. Does the client have a history of ONE (1) of the following in the last 60 days? • heparin • low-molecular-weight heparin (LMWH) such as enoxaparin (LOVENOX) or FRAGMIN • warfarin • other antihemophilic agent ☐ Yes (Deny) ☐ No (Go to #8)
8. Has the client received less than or equal to (≤) 5 days total supply of ketorolac therapy in the last 30 days? ☐ Yes (Approve – 1 day) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.