

**Ketorolac Quantity Limitation Request Form
(Incomplete Forms May Delay Processing)**

PHYSICIAN NAME		PATIENT NAME	
OFFICE CONTACT PERSON		PATIENT INSURANCE ID #	
PHYSICIAN PHONE	PHYSICIAN FAX	PATIENT DATE OF BIRTH	
PHYSICIAN ADDRESS: Street		City	State Zip

QUANTITY LIMITATIONS: short-term only, not appropriate for extended-supply

Ketorolac 20 tablets (10 mg each)/5 day supply within 30-day period OR
20 tablets (10 mg each) within 30 days

*Ketorolac tablets are only indicated as follow up to Ketorolac injection.

Duration Requested: _____ **Quantity Requested:** _____

To request coverage of quantities greater than above, please check all that are applicable.

1. The patient has a diagnosis of moderate to severe acute pain (**not chronic pain, osteoarthritis or rheumatoid arthritis**) YES NO
2. The patient **DOES NOT** have a history (within previous year) of active GI bleed and/or perforation. YES NO
3. The patient **DOES NOT** have a history of active peptic ulcer disease and is not presently taking one of the following medications: YES NO
 - Aciphex (rabeprazole)
 - Axid (nizatidine)
 - Carafate (sucralfate)
 - Kapidex (dexlansoprazole)
 - Nexium (esomeprazole)
 - Pepcid (famotidine)
 - Prevacid (lansoprazole)
 - Prilosec (omeprazole)
 - Protonix (pantoprazole)
 - Tagamet (cimetidine)
 - Zantac (ranitidine)
 - Zegerid (omeprazole/sod bicarb)
4. The patient **DOES NOT** have a documented allergic reaction to aspirin or any other NSAID (i.e., bronchospastic response, chronic urticaria, angioedema). YES NO
5. There is no kidney impairment present (documented serum creatinine within past year <1.2 mg/dl) YES NO
 - Prescribing Ketorolac for more than 5 days is beyond FDA approved labeling.
 - Unless this is the first request, medical records are required.
 - Alert: A pattern of inappropriate prescribing will be flagged and reviewed for potential quality of care issues.

I certify that, to the best of my knowledge, the above information is accurate:

Physician signature required: _____

Please Return Completed Form To: Fax number: 1-888-446-8440
 Address: BCBSNC
 Attention: Exceptions-Health Services
 P.O. Box 17168
 Winston-Salem, NC 27116-7168
 Provider telephone: 1-888-298-7552

10/2009