

**Ketorolac Quantity Limitation Request Form
Incomplete Forms May Delay Processing
(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
<p>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.</p> <p>Duration Requested: _____ Quantity Requested: _____</p>			
<p>To request coverage of quantities greater than above, please check all that are applicable.</p> <p>1. The patient has a diagnosis of moderate to severe acute pain (not chronic pain, osteoarthritis or rheumatoid arthritis) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. The patient DOES NOT have a history (within previous year) of active GI bleed and/or perforation. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. The patient DOES NOT have a history of active peptic ulcer disease and is not presently taking one of the following medications: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <ul style="list-style-type: none"> ▪ Axid (nizatidine) ▪ Carafate (sucralfate) ▪ Pepcid (famotidine) ▪ Prevacid (lansoprazole) ▪ Aciphex (nizatadine) ▪ Prilosec (omeprazole) ▪ Tagamet (cimetidine) ▪ Zantac (ranitidine) ▪ Protonix (pantoprazole) ▪ Nexium (esomeprazole) <p>4. The patient DOES NOT have a documented allergic reaction to aspirin or any other NSAID (i.e., bronchospastic response, chronic urticaria, angioedema). <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. There is no kidney impairment present (documented serum creatinine within past year <1.2 mg/dl) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <ul style="list-style-type: none"> ● Prescribing Ketorolac for more than 5 days is beyond FDA approved labeling. ● Unless this is the first request, medical records are required. ● <u>Alert:</u> A pattern of inappropriate prescribing will be flagged and reviewed for potential quality of care issues. <p>I certify that, to the best of my knowledge, the above information is accurate:</p> <p>Physician signature required: _____</p>			

Please Return Completed Form To: Fax number: 1-888-446-8535
Address: BCBSNC
Attention: Exceptions-Health Services
P.O. Box 17509
Winston-Salem, NC 27116-7509
Provider telephone: 1-888-296-9790

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