

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

KETOROLAC (ORAL DOSAGE FORMS ONLY)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Pharmacy NPI#: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992**

CRITERIA:

- Minimum age requirement: 18 years old.
- Available only as a continuation of IV/IM therapy.
- Documented failure of at least three other oral NSAIDS.
- Limited to a total of five days of use.

AUTHORIZATION:

Only one authorization will be granted per acute incident.

RE-AUTHORIZATION:

Same as initial.

09/30/2016

<https://medicaid.utah.gov/pharmacy/>