Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Toradol® (ketorolac tromethamine)
Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Short-term management of moderately severe acute pain.
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Drug-Specific Information (required)

- ❑ Treatment is a continuation of IV or IM therapy.
- ❑ Treatment will not exceed five days.
- ❑ The requested dose does not exceed 40mg per day.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.