



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: |
| <input type="checkbox"/> Check if requesting brand | | | Directions for Use: | | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | | | |
| Clinical Information (required) | | | | | |
| Select the diagnosis below: | | | | | |
| <input type="checkbox"/> Short-term management of moderately severe acute pain. | | | | | |
| <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | | | | | |
| Drug-Specific Information (required) | | | | | |
| <input type="checkbox"/> Treatment is a continuation of IV or IM therapy. | | | | | |
| <input type="checkbox"/> Treatment will not exceed five days. | | | | | |
| <input type="checkbox"/> 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.

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