Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

A. Prescriptions That Require Prior Authorization

Prescriptions for NSAIDs that meet any of the following conditions must be prior authorized:

1. A non-preferred NSAID. See the Preferred Drug List (PDL) for the list of preferred NSAIDs at: https://papdl.com/preferred-drug-list.
2. A prescription for oral or nasal ketorolac when more than a 5-day supply is prescribed in the past 90 days.
3. An NSAID when there is a record of a recent paid claim for another NSAID (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an NSAID, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For oral or nasal ketorolac, **all** of the following:
   a. Is age-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   b. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   c. Is not concurrently taking aspirin or any other NSAIDs;

   AND
2. For a non-preferred NSAID, **one** of the following:
   a. **Both** of the following:
      i. For a non-preferred oral NSAID, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred oral NSAIDs (excluding ketorolac)
      ii. For a non-preferred oral NSAID combination drug with more than one active ingredient (e.g., Duexis, Vimovo, etc.), has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently,
   b. For a non-preferred topical NSAID, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical NSAIDs,
   c. For non-preferred nasal ketorolac, has a clinical reason as documented by the prescriber why oral ketorolac cannot be used,
   d. For all other non-preferred non-oral NSAIDs, **one** of the following:
      i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred NSAIDs
      ii. Has a clinical reason as documented by the prescriber why the routes of administration of the preferred NSAIDs cannot be used;

   AND

3. For therapeutic duplication, **one** of the following:

   a. Is being transitioned to another drug in the same class with the intent of discontinuing one of the medications
   b. Has a medical reason for concurrent use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an NSAID. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

NSAIDs – KETOROLAC PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office/LTC facility contact:		Specialty:	NPI:
Contact's phone number:		Street address:	
Beneficiary name:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Ketorolac product requested:		Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	Beneficiary's weight:	

Will the beneficiary be taking aspirin or any other NSAID (e.g., ibuprofen, naproxen, meloxicam, etc.) while taking ketorolac?	☐Yes ☐No *Submit beneficiary's complete medication list.*
Does the requested duration of therapy exceed the maximum recommended duration of 5 days?	☐Yes – *Submit documentation from the medical literature supporting the use of the requested duration.* ☐No
Including this prescription, will the beneficiary have received more than 5 days of therapy with any ketorolac product within the past 90 days?	☐Yes – *Submit documentation showing why the beneficiary requires additional treatment with ketorolac.* ☐No
KETOROLAC TABLET	
Is the beneficiary less than 17 years of age?	☐Yes – *Submit documentation from the medical literature supporting the use of oral ketorolac for the beneficiary's age.* ☐No
Does the requested dose exceed the maximum recommended daily dose of 40 mg/day?	☐Yes – *Submit documentation from the medical literature supporting the use of the requested dose.* ☐No
KETOROLAC NASAL SPRAY	
Is the beneficiary less than 18 years of age?	☐Yes – *Submit documentation from the medical literature supporting the use of nasal ketorolac for the beneficiary's age.* ☐No
Does the beneficiary have a clinical reason why oral ketorolac tablets cannot be used?	☐Yes – *Submit supporting documentation.* ☐No
If the beneficiary is 65 years of age or older, weighs less than 50 kg, and/or has renal impairment: Does the requested dose exceed 63 mg/day (4 sprays/day)?	☐Yes – *Submit documentation from the medical literature supporting the requested dose.* ☐No
For all other beneficiaries: Does the requested dose exceed 126 mg/day (8 sprays/day)?	☐Yes – *Submit documentation from the medical literature supporting the requested dose.* ☐No

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date:

Gateway Health℠ It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM *(form effective 01/01/20)*

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

Please refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:	Dosage form:	Strength:
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Has the beneficiary taken the requested non-preferred medication in the past 90 days? *(submit documentation)*…… ☐Yes ☐No

Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. *Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.*

☐Treatment failure or inadequate response with preferred medication(s) *(include drug name, dose, and start/stop dates)*:

_____

_____

☐Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Contraindication to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Unique clinical or age-specific indications supported by FDA approval or medical literature *(describe)*:

_____

_____

☐Absence of preferred medication(s) with appropriate formulation *(list medical reason formulation is required)*:

_____

_____

☐Drug-drug interaction with preferred medication(s) *(describe)*:

_____

_____

☐Other medical reason(s) the beneficiary cannot use the preferred medication(s) *(describe)*:

_____

_____

☐For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date: