BlueCross BlueShield Federal Employee Program

SPRIX
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Sprix
(ketorolac kromethamine)

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 5 bottles for 30 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ bottles for 30 days
   One bottle delivers 8 actuations which equals one day of therapy

2. Does the patient have a diagnosis of moderate to severe acute pain? ❑Yes* ❑No
   If YES, does the pain require analgesia at the opioid level? ❑Yes ❑No

3. Is the patient at risk for adverse GI (gastrointestinal) events? ❑Yes ❑No

4. Is the patient at risk for bleeding? ❑Yes ❑No

5. Is the patient at risk for cardiovascular events? ❑Yes ❑No

6. Is the patient at risk for renal impairment? ❑Yes ❑No

7. Is this **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***
   ❑**INITIATION** of therapy, please answer the following questions:
   a. Is the patient experiencing any of the following: dysphagia, esophagitis, mucositis, or uncontrollable nausea and/or vomiting? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to oral ketorolac tablets (Toradol)? ❑Yes ❑No
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to prescription strength oral NSAIDs? ❑Yes ❑No

   ❑**CONTINUATION** of therapy **(PA renewal)**,