PATIENT INFORMATION

First Name: Last Name:

Phone Number: ( ) - Birth Date: / / Gender:

Address:

City: State: Zip:

BIN #: PCN #:

Insurance ID #: Group #:

PHYSICIAN INFORMATION

Physician's First Name: Physician's Last Name:

Phone Number: ( ) - NPI #:

Office Contact's First Name: Office Contact's Last Name:

Office Address:

City: State: Zip:

Fax Number: ( ) -

TREATMENT

MEDICATION

SPRIX®
(ketorolac tromethamine)
Nasal Spray
15.75 mg per spray

NDC: 69344-144-43

QUANTITY

◯ **1 Box**
(5 Single-Day Nasal Spray Bottles)

REFILLS

Number of Refills:

Adult patients < 65 years of age

◯ The recommended dose is 31.5 mg of SPRIX (one 15.75-mg spray in each nostril) every 6 to 8 hours. The maximum daily dose is 126 mg (four doses). Must not exceed 5 days.

Patients 65 years of age and older, renally impaired patients, and adult patients less than 110 lb

◯ The recommended dose is 15.75 mg of SPRIX (one 15.75-mg spray in only one nostril) every 6 to 8 hours. The maximum daily dose is 63 mg (four doses). Must not exceed 5 days.

Physician Signature: _____ Date: / /

Patient Authorization: _____ Date: / /

I authorize the SPRIX Direct Program and/or its agents or contractors to use and/or disclose the information in this form for the purpose of dispensing this medication, conducting a benefits investigation, seeking payment for dispensed medications from insurance providers, and performing coverage appeals. I authorize this medication to be dispensed to the address on this form if no copay is required.

IMPORTANT REMINDERS

Please attach a copy of the patient's prescription insurance coverage and a printout of the patient's demographic information to include allergies and medical conditions.

Please see full Prescribing Information, including Boxed Warning and Patient Medication Guide, at www.sprix.com.