PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic) (diclofenac sodium gel 3%)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Diclofenac sodium Gel 3% is indicated for the topical treatment of actinic keratoses (AK). Sun avoidance is indicated during therapy.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug [diclofenac sodium gel 3 percent (generic Solaraze)] is being prescribed for the treatment of actinic keratoses (AK)

AND

- The patient experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution

Quantity limit of 100 grams per month.

REFERENCES

1. Solaraze [package insert]. Melville, NY: PharmaDerm; April 2021.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2021; Accessed May 5, 2021.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com. Accessed May 5, 2021.
4. National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology. Squamous Cell Skin Cancer. Version 1.2021. February 5, 2021. NCCN.org. Accessed May 26, 2021.