

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% (generic Solaraze Gel) is indicated for the topical treatment of actinic keratoses (AK). Sun avoidance is indicated during therapy.

COVERAGE CRITERIA

The requested drug [diclofenac sodium gel 3 percent (generic Solaraze)] will be covered with prior authorization when being prescribed for the treatment of actinic keratoses (AK).

Quantity limit of 100 grams per month.

REFERENCES

1. Solaraze [package insert]. Melville, NY: PharmaDerm; April 2016.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. <http://online.lexi.com/>. Accessed June 2020.
3. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. <http://www.micromedexsolutions.com/>. Accessed June 2020.