STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DICLOFENAC TOPICAL GEL

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
DICLOFENAC SODIUM	SOLARAZE, DICLOFENAC SODIUM		86831	GPI-10 (9037403530)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of actinic keratosis and meet **ALL** of the following criteria?
   - Therapy is prescribed by or in consultation with a dermatologist or oncologist
   - The patient had a trial of or contraindication to topical fluorouracil (e.g., Efudex, Fluoroplex, Carac)

   If yes, **approve for 3 months by GPID or GPI-10 with a quantity limit of #100 grams per 30 days.**
   If no, do not approve.
   DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **DICLOFENAC TOPICAL GEL (Solaraze)** requires the following rule(s) be met for approval:
   A. You have actinic keratosis (a type of skin condition)
   B. Therapy is prescribed by or in consultation with a dermatologist (a type of skin doctor) or oncologist (a type of cancer doctor)
   C. You had a trial of or contraindication (harmful for) to topical fluorouracil (such as Efudex, Fluoroplex, Carac)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Solaraze.

REFERENCES

- Solaraze [Prescribing Information]. PharmaDerm: Melville, NY; May 2016.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 11/01/22
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P&T Approval: 01/22

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