STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DICLOFENAC TOPICAL

Generic	Brand	HICL	GCN	Exception/Other
DICLOFENAC SODIUM 3%	SOLARAZE		86831	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of Actinic Keratosis and meets **ALL** of the following criteria?
   - The patient had a previous trial of or contraindication to topical fluorouracil (e.g., Efudex, Fluoroplex, Carac)
   - The medication is prescribed by a dermatologist or oncologist

   If yes, **approve for 3 months by GPID with a quantity limit up to #100 grams per 30 days.**
   If no, do not approve.
   DENIAL TEXT: The guideline named **DICLOFENAC SODIUM (Solaraze)** requires a diagnosis of Actinic Keratosis. In addition, the following criteria must also be met:
   - The patient had a previous trial of or contraindication to topical fluorouracil (e.g., Efudex, Fluoroplex, Carac)
   - The medication is prescribed by a dermatologist or oncologist

RATIONALE
To promote clinically appropriate utilization of Solaraze for Actinic Keratosis.

FDA APPROVED INDICATIONS
Solaraze (diclofenac sodium) gel is indicated for the topical treatment of actinic keratoses (AK). Sun avoidance is indicated during therapy.

REFERENCES

- Solaraze [Prescribing Information]. PharmaDerm: Melville, NY. April 2016.
- De Berker D., et al. Guidelines for the Management of Actinic Keratosis. Br J Dermatol. 2007; 156:222-230.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 11/01/16
Created: 02/03
Client Approval: 09/16
P&T Approval: 11/16