

Market Applicability/Effective Date														
Market	FL & FHK	FL MMA	FL LTC	GA	KS	KY	LA	MD	NJ	NV	NY	TN	TX	WA
Applicable	X	NA	NA	X	NA	X	X	X	X	X	X	NA	NA	X

*FHK- Florida Healthy Kids

Solaraze (diclofenac sodium 3%)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	90 days of treatment per year

Medications	Quantity Limit
Solaraze 3% gel (diclofenac sodium-3%)	100 grams per 30 days; 90 days of treatment per year

APPROVAL CRITERIA

Requests for Solaraze (diclofenac sodium-3%) may be approved based on the following criteria:

- I. Individual has a diagnosis of Actinic Keratosis (AK); **AND**
- II. Individual is 18 years of age or older; **AND**
- III. Individual has tried and failed ONE of the following preferred agents for actinic keratosis: fluorouracil 5% cream, fluorouracil 2% topical solution, fluorouracil 5% topical solution, imiquimod 5% cream packets.
- IV. If Solaraze (diclofenac sodium-3%) is requested to treat additional actinic keratosis lesions, an additional course of treatment may be approved.

Note: Applies to new starts only

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2016. URL: <http://www.clinicalpharmacology.com>. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. <http://dailymed.nlm.nih.gov/dailymed/about.cfm>.

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2016; Updated periodically.

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