PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

SOLARAZE
(diclofenac sodium gel, 3%)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Solaraze Gel 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 patient has the diagnosis of actinic keratoses (AK).

Quantity for Approval will be 100 grams per month or 300 grams per 3 months.

REFERENCES

1. Solaraze [package insert]. Melville, NY: PharmaDerm; April 2016.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June 2017.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed June 2017.