



Prior Authorization Approval Criteria
Department of Pharmacy Services

Generic Name: diclofenac topical gel

Brand Name: Solaraze

Medication Class: non steroidal anti-inflammatory drug

FDA Approved Uses: topical treatment of actinic keratosis

Usual Dose: applied to lesions twice a day.

Duration of Therapy: 60-90 days

Criteria for Use: *(bullet points below are all inclusive unless otherwise noted)*

- Must have clinically diagnosed actinic keratosis.
- Failed or not a good candidate to receive liquid nitrogen cryotherapy which is the treatment of choice for single or a few scattered small, thin, or shallow lesions.
- Failed or not a good candidate for surgical curettage.

Note: usually for isolated, thick AK's particularly on the dorsal arms or hands, and in patients who are immunocompromised.

- Failed/ intolerant to topical 5 fluorouracil.

Note: for multiple AK's

Contraindications:

- Hypersensitivity to diclofenac, benzyl alcohol, polyethylene glycol monomethyl ether 350 and/or hyaluronate sodium.

Not Approved if:

- Patient does not meet the above stated criteria.
- Patient has any contraindications to the use of Solaraze

Special Considerations:

Complete healing of the lesion or optimal therapeutic effect may not be evident for up to 30 days after the completion of therapy.

Exposure to sunlight and the use of sunlamps should be avoided.

P&T Approval: _____ Date: _____