UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1159-6
Program	Prior Authorization – Notification
Medication	Solaraze (diclofenac 3% gel)
P&T Approval Date	8/2015, 7/2016, 7/2018, 7/2019, 7/2020, 7/2021
Effective Date	10/1/2021; Oxford only: 10/1/2021

1. Background:

Solaraze (diclofenac 3% gel) is indicated for the topical treatment of actinic keratosis (AK). The recommended duration of therapy is from 60 to 90 days.

2. Coverage Criteria[a]:

A. Authorization

1. **Solaraze*** will be approved based on the following criterion:

   a. Diagnosis of actinic keratosis

   Authorization will be issued for 3 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

*Applies to brand and generic Solaraze.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4. References:

1. Solaraze [package insert]. Melville, NY: PharmDerm; April 2021.

Program	Solaraze Prior Authorization - Notification
Change Control	
Date	Change
8/2015	New program.
7/2016	Updated references.
7/2018	Annual review. No changes.
7/2019	Annual review. No changes.
7/2020	Annual review. No changes.
7/2021	Annual review. Added state mandate language.