BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINES	
SECTION: DRUGS	
ORIGINAL EFFECTIVE DATE:	**3/15/2018**
LAST REVIEW DATE:	**5/19/2022**
LAST CRITERIA REVISION DATE:	**5/19/2022**
ARCHIVE DATE:	

Diclofenac gel 3% transdermal

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

Diclofenac gel 3% transdermal

Criteria:

- **Criteria for initial therapy:** Diclofenac 3% gel is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Dermatologist
  2. Individual is 18 years of age or older
  3. A confirmed diagnosis of actinic keratoses (AK) that involves scalp, forehead, face, forearm(s), or hand(s)
  4. Documented failure, contraindication per FDA label, intolerance to **BOTH** Tolak (fluorouracil) 4% cream and imiquimod 5% cream
  5. There are **NO** FDA-label contraindications, such as:
     a. In the setting of coronary artery bypass graft (CABG) surgery.

  Initial approval duration: Up to one 100 gm tube/30 days for 90 days

- **Criteria for continuation of coverage (renewal request):** Diclofenac 3% gel is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Dermatologist
  2. Individual's condition has not worsened while on therapy
     a. Worsening is defined as:
        i. Actinic keratosis lesions are larger
  3. It has been over 30 days since stopping the initial therapy with diclofenac 3% gel
  4. Individual has been adherent with the medication for 90 days
  5. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
     a. Contraindications as listed in the criteria for initial therapy section
  6. There are no significant interacting drugs

  Renewal duration: Up to one 100 gm tube for 2 months

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- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

  1. **Off-Label Use of Non-Cancer Medications**

  2. **Off-Label Use of Cancer Medications**

Resources:

Diclofenac sodium 3% gel product information, revised by E. Fougera & Co. a division of Fougera Pharmaceuticals Inc. 02-2016. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed May 07, 2022.

Berman B. Treatment of actinic keratosis. In: UpToDate, Dellavalle RP, Robinson JK, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated July 13, 2021. Accessed May 07, 2022.