BlueCross BlueShield
Federal Employee Program

SOLARAZE
(diclofenac sodium)

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Actinic keratosis

AND the following:

1. Inadequate treatment response, intolerance, or contraindication to a topical pyrimidine analog (e.g., fluorouracil) and another topical antineoplastic (e.g., imiquimod)

Prior - Approval Limits

Duration 3 months

Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Actinic keratosis

AND the following:

1. Re-evaluation of lesion(s) for improvement

Prior - Approval *Renewal* Limits

Duration 3 months (One renewal only)