



Updated: 10/2018
PARP Approved: 10/2018

Gateway Health
Prior Authorization Criteria
Voltaren (diclofenac) 1% Gel

All requests for Voltaren (diclofenac) 1% Gel require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Voltaren (diclofenac) 1% Gel Prior Authorization Criteria:

Members with historical pharmacy claims data meeting the following criteria will receive automatic authorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the criteria. Claims will automatically adjudicate on-line, without a requirement to submit for prior authorization when the following criteria is met:

Coverage may be provided with a diagnosis of Osteoarthritis and all of the following criteria is met:

- Member is age 18 years of age or older.
Member must have a history of trial and failure, contraindication, or intolerance to two or more formulary oral NSAIDS for at least 2 weeks.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
 - Must provide chart documentation demonstrating clinical benefit and tolerance to Voltaren
 - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
 - Documentation the member has been on Voltaren within the last 45 days

Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



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**VOLTAREN (DICLOFENAC 1% GEL)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway HealthSM Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated:	

Billing Information

This medication will be billed: at a pharmacy **OR**
 medically (if medically please provide a JCODE: _____)

Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why / Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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