PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **TOPICAL NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)**

BRAND NAME
(generic)

VOLTAREN GEL (RX AND OTC)
(diclofenac sodium topical gel 1%)

Status: CVS Caremark Criteria
Type: Post Limit Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Voltaren Gel
Voltaren Gel is indicated for the relief of the pain of osteoarthritis of joints amenable to topical treatment, such as the knees and those of the hands.
Voltaren Gel has not been evaluated for use on the spine, hip, or shoulder.

Voltaren Gel (OTC)
Voltaren Arthritis Pain is for the temporary relief of arthritis pain ONLY in the following areas:

- hand, wrist, elbow (upper body areas)
- foot, ankle, knee (lower body areas)

This product may take up to 7 days to work for arthritis pain; it is not for immediate relief. If no relief in 7 days, stop use.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrists, or elbows

Quantity Limits apply.
1000 grams/25 days*
**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

REFERENCES

1. Voltaren Gel [package insert]. Malvern, PA: Endo Pharmaceuticals, Inc.; September 2018.
2. Voltaren Gel (OTC) [package insert]. Warren, NJ: GSK Consumer Healthcare; 2021.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2022; Accessed April 27, 2022.
4. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com. Accessed April 27, 2022.