Effective Date: 10/1/2020
Revised: 6/2020 Reviewed: 6/2020 Scope: Medicaid

Generic Diclofenac Gel 1% Prescription ONLY

POLICY

I. CRITERIA FOR APPROVAL

An authorization may be granted when all the following criteria are met:

A. The patient has tried and failed, had an inadequate response or intolerance to Voltaren Gel OTC 1%.

II. QUANTITY LIMIT

- 100 grams per 30 days

III. COVERAGE DURATION

- 12 months

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