Solaraze (diclofenac sodium 3% gel)

Policy Number: 5.01.561    Last Review: 7/2018
LoB: ACA

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for Solaraze when it is determined to be medically necessary because the following criteria are met.

When Policy Topic is covered
Coverage of diclofenac sodium 3% gel is recommended in those who meet the following criteria:

1. Actinic Keratoses. Approve for 6 months.

   Diclofenac sodium 3% gel is indicated for this use.\(^1\) Per the diclofenac sodium 3% gel prescribing information, the recommended duration of therapy is from 60 to 90 days.\(^1\)

Other Uses with Supportive Evidence

2. Actinic Cheilitis (Actinic Keratoses of the Lip[s]). Approve for 6 months.

   A report of six cases treated with diclofenac sodium 3% gel demonstrated complete response for five patients and partial response for one patient, after 6 weeks of treatment.\(^6\) In an open-label study involving 27 patients with actinic cheilitis who completed 30 to 180 days of therapy with diclofenac 3% in 2.5% hyaluronic acid gel, complete remission was observed in 44% of patients (n = 12/27) and a significant improvement in 56% (n = 15/27) of patients was observed.\(^7\) Another open-label study demonstrated efficacy with diclofenac sodium 3% gel when used for 90 days in 19 patients with actinic cheilitis.\(^8\)

3. Bowen's Disease. Approve for 6 months after a trial of at least one other therapy used for the management of Bowen's disease (e.g., topical 5-fluorouracil [5-FU], imiquimod, cryotherapy, photodynamic therapy, curettage, excision, laser, or radiotherapy).

   Bowen's disease is a form of squamous cell carcinoma \textit{in situ}.\(^9,10\) There are two published case series (one involving two patients,\(^10\) another involving five patients\(^9\)) which demonstrated clinical and histological resolution of Bowen's disease in all seven patients. In one case series, patients were treated for 90 days, while in the other case series, patients were treated for 8 weeks. Available guidelines detailing management of Bowen's disease note that evaluation of studies on the treatment of Bowen's disease can be problematic due to the varying healing and success rates with the varying locations of the lesions/patches.\(^11,12\) In addition, the management of Bowen's disease employs several different types of treatment and, like the management of AK, selection of therapy depends on various factors such as lesion characteristics, lesion location, etc. The main treatment options used for Bowen's disease include topical 5-FU, imiquimod, cryotherapy, curettage, excision, photodynamic therapy, radiotherapy, and laser.\(^11\)
4. **Disseminated Superficial Actinic Porokeratosis (DSAP).** Approve for 6 months after a trial of at least two other therapies used for the management of DSAP (e.g., topical 5-fluorouracil [5-FU], imiquimod, topical corticosteroids, topical vitamin D₃ analogues, topical or oral retinoids, cryotherapy, photodynamic therapy, and laser).

The use of diclofenac sodium 3% gel has been studied in a small open-label study (exact formulation not specified) and in one case series for the management of patients with DSAP.¹³⁻¹⁴ In the open-label study, 17 adults with DSAP initially received 12 weeks of therapy with diclofenac sodium 3% gel and could continue for an additional 12 weeks.¹³ At 12 weeks, the target area lesions (treated lesions) had a mean decrease of 4% vs. a 12% mean increase in the total body (global) lesions. For those ten patients who received 24 weeks of therapy, there was a mean increase in the target area lesions of 10% vs. a mean increase of 19% for the total body (global) lesions at that time point. Only three of the ten patients who completed 24 weeks of therapy had a reduction in their number of lesions. In the eight patient case series, all patients received diclofenac sodium 3% gel for at least 6 months.¹⁴ All of these DSAP patients had tried at least one other therapy (mean was three previous therapies) prior to diclofenac sodium 3% gel. Only two of the eight patients (25%) had a partial response at 6 months. Three other patients received more than 6 months of treatment (7 or 13 months), but none experienced a response. As is typical of other therapies tried for the management of DSAP, results with diclofenac sodium 3% gel demonstrated limited, if not marginal, effectiveness. Most of the therapies tried for DSAP are ineffective.¹³⁻¹⁵ Those therapies which have been tried include cryotherapy, topical 5-FU, topical vitamin D₃ analogues, retinoids, keratolytics, imiquimod, laser, and photodynamic therapy.

**When Policy Topic is not covered**

**Conditions Not Recommended for Approval**

Diclofenac sodium 3% gel has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. Rationale for non-coverage for these specific conditions is provided below. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval.)

1. **Osteoarthritis (OA).** There has been one small, randomized, placebo-controlled study assessing the efficacy of a topical diclofenac 3%/sodium hyaluronate 2.5% gel (Canadian formulation) applied as 2 grams four times daily (QID) to one joint for 2 weeks in patients (n = 119) with uncontrolled OA pain despite chronic (≥ 1 month) oral NSAID use.¹⁶ The effect of topical diclofenac 3%/sodium hyaluronate 2.5% gel, in patients who continued their chronic oral NSAID therapy, demonstrated only marginally significantly greater analgesic effect than placebo gel: the mean change from baseline in overall pain from OA (using a 5-point scale) was -0.7 vs. -0.4 for topical diclofenac and placebo, respectively (P = 0.0568). Additional data are needed to define the place in therapy of Solaraze for the treatment of OA. Other topical agents are indicated for this use.

Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

**Considerations**

Solaraze (diclofenac 3% gel) requires prior authorization through the pharmacy services department.

This Blue Cross and Blue Shield of Kansas City policy statement was developed using available resources such as, but not limited to: Food and Drug Administration (FDA) approvals, Facts and Comparisons, National specialty guidelines, Local medical policies of other health plans, Medicare (CMS), Local providers.

**Description of Procedure or Service**

Diclofenac sodium 3% gel is a topical nonsteroidal anti-inflammatory drug (NSAID) indicated for the topical treatment of actinic keratoses (AK).¹ It is also noted in the labeling for diclofenac sodium 3% gel that sun avoidance is indicated during therapy. The mechanism of action of diclofenac sodium in the
treatment of AK is unknown or not completely understood; however, it is hypothesized that diclofenac sodium may clear AK lesions via cell signaling mechanisms and possibly may play a part in the reduction of angiogenesis and induction of apoptosis (either directly or through a cytotoxic independent pathway).

There are other topical NSAIDs commercially available in the US: Voltaren® Gel (diclofenac sodium topical 1% gel) which is indicated for the relief of the pain of osteoarthritis (OA) of joints amenable to topical treatment, such as the knees and those of the hands; Flector® Patch (diclofenac epolamine topical patch) which is indicated for the topical treatment of acute pain due to minor strains, sprains, and contusions; and Pennsaid® (diclofenac sodium 1.5% w/w topical solution) which is indicated for the treatment of signs and symptoms of OA of the knee(s).

References

Billing Coding/Physician Documentation Information
NA Pharmacy benefit
Policy Number: 5.01.561

Policy Implementation/Update Information
06/2014 New Policy titled Solaraze (diclofenac sodium 3% gel)
07/2015 Annual review – no changes made
07/2016 Annual review- no changes to policy statement
03/2017 Added step therapy of 2 preferred alternatives for actinic keratosis.
07/2017 Annual review- no changes to policy statement
07/2018 Annual review – no changes to policy

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.