

Clinical Policy: Diclofenac (Cambia, Flector, Licart, Pennsaid, Solaraze, Zipsor, Zorvolex)

Reference Number: CP.PCH.28

Effective Date: 09.01.20

Last Review Date: 11.21

Line of Business: Commercial, HIM

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The following are nonsteroidal anti-inflammatory drugs (NSAIDs) requiring prior authorization: diclofenac epolamine topical system (Flector[®], Licart[™]), diclofenac potassium (Cambia[®], Zipsor[®]), diclofenac sodium (Pennsaid[®], Solaraze[®]), and diclofenac (Zorvolex[®]).

FDA Approved Indication(s)

- Cambia is indicated for the acute treatment of migraine attacks with or without aura in adults (18 years of age or older).
- Flector is indicated for the topical treatment of acute pain due to minor strains, sprains, and contusions in adults and pediatric patients 6 years and older.
- Licart is indicated for the topical treatment of acute pain due to minor strains, sprains, and contusions.
- Pennsaid is indicated for the treatment of the pain of osteoarthritis (OA) of the knee(s).
- Solaraze is indicated for the topical treatment of actinic keratoses. Sun avoidance is indicated during therapy.
- Zipsor is indicated for relief of mild to moderate acute pain in adults and pediatric patients 12 years of age and older.
- Zorvolex is indicated for management of mild to moderate acute pain and for OA pain.

Limitation(s) of use:

- Cambia is not indicated for the prophylactic therapy of migraine.
- Safety and effectiveness of Cambia is not established for cluster headache, which is present in an older, predominantly male population.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Cambia, Flector, Licart, Pennsaid, Solaraze, Zipsor, and Zorvolex are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Mild to Moderate Acute Pain (must meet all):

1. Diagnosis of acute pain;
2. Request is for Flector or Licart, and member meets all of the following (a, b, and c):

- a. Age \geq 6 years (Flector) or age \geq 18 years (Licart);
 - b. Failure of TWO formulary oral generic NSAIDs (*see Appendix B*) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
 - c. Failure of diclofenac gel 1% (Voltaren[®]) within the past 90 days, unless contraindicated or clinically significant adverse effects are experienced;
3. Request is for Zipsor or Zorvolex, and member meets both of the following (a and b):
- a. Age \geq 12 years (Zipsor) or \geq 18 years (Zorvolex);
 - b. Failure of oral generic diclofenac and one other preferred NSAID (*see Appendix B*) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
4. Dose does not exceed any of the following (a, b, c, or d):
- a. Flector: 2 topical systems per day;
 - b. Licart: 1 topical system per day;
 - c. Zipsor: 100 mg (4 capsules) per day;
 - d. Zorvolex: 105 mg (3 capsules) per day.

Approval duration: 12 months

B. Osteoarthritis Pain (must meet all):

1. Diagnosis of OA;
2. Request is for Pennsaid or Zorvolex;
3. Age \geq 18 years;
4. For Pennsaid requests: Failure of ONE oral generic NSAID plus failure of either diclofenac 1.5% topical solution or diclofenac 1% topical gel, unless clinically significant adverse effects are experienced or all are contraindicated;
5. For Zorvolex requests: Failure of oral generic diclofenac and one other preferred NSAID at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Dose does not exceed:
 - a. Pennsaid: 80 mg (4 pumps) per knee per day;
 - b. Zorvolex: 105 mg (3 capsules) per day.

Approval duration: 12 months

C. Migraines (must meet all):

1. Diagnosis of migraine attacks;
2. Request is for Cambia;
3. Age \geq 18 years;
4. Failure of rizatriptan orally disintegrating tablets at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Documentation supports inability to use oral generic diclofenac;
6. Dose does not exceed 50 mg (1 packet) per day.

Approval duration: 12 months

D. Actinic Keratosis (must meet all):

1. Diagnosis of actinic keratosis;
2. Request is for diclofenac 3% gel (Solaraze);

3. Age \geq 18 years;
4. Failure of 5-fluorouracil and imiquimod cream, unless both are contraindicated or clinically significant adverse effects are experienced;
5. Prescribed quantity does not exceed 1 tube per 30 days.

Approval duration: 90 days

E. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. For Solaraze requests: Additional treatment is for a new lesion or to complete initial treatment (up to 90 days);
4. If request is for a dose increase, new dose does not exceed any of the following (a-g):
 - a. Cambia: 50 mg per day (1 packet per day);
 - b. Flector: 2 topical systems per day;
 - c. Licart: 1 topical system per day;
 - d. Pennsaid: 80 mg (4 pumps) per knee per day;
 - e. Solaraze: 1 tube per 30 days;
 - f. Zipsor: 100 mg (4 capsules) per day;
 - g. Zorvolex: 105 mg (3 capsules) per day.

Approval duration: 12 months (up to 90 days for Solaraze)

B. Other diagnoses/indications(must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CABG: coronary artery bypass graft

FDA: Food and Drug Administration

NSAID: non-steroidal anti-inflammatory drug

OA: osteoarthritis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>Oral NSAIDs</i>		
diclofenac (Voltaren [®])	50 mg PO TID	150 mg/day
etodolac (Lodine [®])	400 – 500 mg PO BID	1,200 mg/day
fenoprofen (Nalfon [®])	400 – 600 mg PO TID to QID	3,200 mg/day
ibuprofen (Motrin [®])	400 – 800 mg PO TID to QID	3,200 mg/day
indomethacin (Indocin [®])	25 – 50 mg PO BID to TID	200 mg/day
indomethacin SR (Indocin SR [®])	75 mg PO QD to BID	150 mg/day
ketoprofen (Orudis [®])	50 mg PO QID or 75 mg PO TID	300 mg/day
meloxicam (Mobic [®])	7.5 mg – 15 mg PO QD	15 mg/day
naproxen (Naprosyn [®])	250 – 500 mg PO BID	1,500 mg/day for up to 6 months
naproxen sodium (Anaprox [®] , Anaprox DS [®])	275 – 550 mg PO BID	1,650 mg/day for up to 6 months
oxaprozin (Daypro [®])	600 – 1,200 mg PO QD	1,800 mg/day
piroxicam (Feldene [®])	10 – 20 mg PO QD	20 mg/day
salsalate (Disalcid [®])	500 – 750 mg PO TID, titrated up to 1,000 mg TID or 1500 mg BID	3,000 mg/day
sulindac (Clinoril [®])	150 mg – 200 mg PO BID	400 mg/day
tolmetin DS (Tolectin [®])	400 mg PO TID maintenance 200-600 mg TID	1,800 mg/day
<i>Topical NSAIDs</i>		
diclofenac 1.5% (Pennsaid [®]) solution	40 drops QID on each painful knee	160 drops/knee/day
diclofenac 1% gel (Voltaren [®] Gel)	2 – 4 g applied to affected area QID	32 g/day
<i>Anti-Migraine Agents</i>		
rizatriptan orally disintegrating tablet (Maxalt [®] MLT)	5 or 10 mg PO QD	30 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>Actinic Keratoses Treatments</i>		
5-fluorouracil (Efudex [®] , Carac [®]) 0.5% or 5% topical cream	Apply topically to affected areas QD or BID	Twice daily for 4 weeks
imiquimod (Aldara [®]) topical cream	Apply topically twice weekly at bedtime	Twice weekly for 16 weeks

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Known hypersensitivity (e.g., anaphylactic reactions and serious skin reactions) to diclofenac or any components of the drug product;
 - All agents except Solaraze: history of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, sometimes fatal, anaphylactic reactions to NSAIDs have been reported in such patients;
 - In the setting of coronary artery bypass graft (CABG) surgery;
 - Flector and Licart: use on non-intact or damaged skin;
 - Zipsor contains gelatin and should not be given to patients with known hypersensitivity to bovine protein.
- Boxed warning(s):
 - Cardiovascular thrombotic events;
 - All agents except Solaraze: gastrointestinal bleeding, ulceration, and perforation;
 - Use in the setting of CABG.

Appendix D: General Information

- Different dose strengths and formulations of oral diclofenac are not interchangeable. This difference should be taken into consideration when changing strengths or formulations.
- For actinic keratosis, complete healing of the lesion(s) or optimal therapeutic effect may not be evident for up to 30 days following cessation of therapy.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Diclofenac potassium (Cambia)	Migraine	One packet (50 mg) PO QD	50 mg/day
Diclofenac epolamine (Flector)	Acute pain due to minor strains, sprains, and contusions	1 topical system BID	2 topical systems /day
Diclofenac epolamine (Licart)	Acute pain due to minor strains, sprains, and contusions	1 topical system QD	1 topical system /day

Drug Name	Indication	Dosing Regimen	Maximum Dose
Diclofenac sodium (Pennsaid)	Pain of OA of the knee(s)	40 mg (2 pump actuations) topically BID per knee	80 mg/knee/day (4 pumps/knee/day)
Diclofenac sodium (Solaraze)	Actinic keratoses	Apply to lesion areas BID. Normally 0.5 g of gel is used on each 5 cm x 5 cm lesion site.	BID for 60-90 days
Diclofenac potassium (Zipsor)	Mild to moderate acute pain	25 mg PO QID	100 mg/day
Diclofenac (Zorvolex)	Mild to moderate acute pain or OA	18 or 35 mg PO TID	105 mg/day

VI. Product Availability

Drug Name	Availability
Diclofenac potassium (Cambia)	Packets: 50 mg in a soluble powder
Diclofenac epolamine (Flector)	Topical system: 1.3%
Diclofenac epolamine (Licart)	Topical system: 1.3%
Diclofenac sodium (Pennsaid)	Topical solution: 2%
Diclofenac sodium (Solaraze)	Topical gel: 3% in tubes of 100 g
Diclofenac potassium (Zipsor)	Capsule: 25 mg
Diclofenac (Zorvolex)	Capsules: 18 mg, 35 mg

VII. References

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created. Retire policies CP.CPA.280 and HIM.PA.123; policies combined for Commercial and HIM lines of business; Commercial: added Flector to the policy; added requirement for Solaraze for a prior trial of 5-FU and imiquimod cream; HIM: added Cambia, Pennsaid, Zipsor, and Zorvolex to the policy to provide more indication-specific redirections than would be required using the standard NF policy; for Commercial and HIM: added Licart to the policy; references reviewed and updated.	05.05.20	08.20
4Q 2020 annual review: no significant changes; references reviewed and updated.	08.21.20	11.20
RT4: revised age limit for Zipsor from 18 years and older to 12 years and older per updated PI.	06.14.21	
4Q 2021 annual review: no significant changes; revised HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	08.19.21	11.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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