

New Hampshire Medicaid Fee-for-Service Program Topical NSAIDs Legend (Rx Required) Criteria

Approval Date: December 3, 2019

Indications

Indicated for relief of pain.

Medications

Brand Names	Generic Names	Dosage
Flector Patch®	diclofenac	180 mg/patch
Voltaren Gel®	diclofenac	10 mg/gm (100 gm tube)
Pennsaid®	diclofenac	1.5% topical solution
Solaraze®	diclofenac	30 mg/gm (100 gm tube)

Criteria for Approval

1. Patient is ≥ 18 years old (for Voltaren Gel®, Pennsaid®, Solaraze®) or ≥ 6 years old (for Flector Patch® only); **AND**
2. Electronic look-back of 100 days for oral generic diclofenac product; **AND**
3. Electronic look-back of 100 days for oral generic NSAID (non-diclofenac) product; **OR**
4. Patient is unable to swallow, tolerate, or absorb oral NSAIDs.

Criteria for Denial

1. Criteria for approval not met.
2. Concurrent use of oral NSAIDs.
3. For the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery.
4. History of gastrointestinal contraindications to oral NSAIDs.

Length of Approval: One year

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic Committee	New	11/06/2008
Commissioner	Approval	12/01/2008
DUR Board	Revision	03/23/2011
Commissioner	Approval	06/07/2011
	New drug to market	09/02/2014
DUR Board	Review	03/20/2017
Commissioner	Approval	06/08/2017
DUR Board	Review	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Review	10/28/2019
Commissioner Designee	Approval	12/03/2019