TEXAS MEDICAID
Clinical Edit Prior Authorization
diclofenac 3% gel (SOLARAZE 3% GEL)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of Actinic Keratosis in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a history of a gastrointestinal (GI) bleed in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a claim for topical fluorouracil (EFUDEX, TOLAK), imiquimod cream (ALDARA, ZYCLARA) or ingenol mebutate gel (PICATO) in the last 730 days?

   ☐ Yes (Approve - 90 days) ☐ No (Go to #5)

5. Has the client tried laser surgery, electrosurgery, cryosurgery, chemosurgery or surgical curettement in the last 730 days?

   ☐ Yes (Approve - 90 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.