PHARMACY PRE-AUTHORIZATION CRITERIA

ConnectiCare

DRUG (S)	**Pennsaid (diclofenac 2% solution)**
POLICY #	**11124**
INDICATIONS	**Pennsaid 2% Solution** is indicated for relief of osteoarthritis pain of the knee.
CRITERIA	**Pennsaid 2% solution** is covered only if the following prior authorization criteria are met: • The medication is being used for its FDA-approved indication **AND** An intolerance to, or treatment failure of **at least two** of the following: • celecoxib (Celebrex) • diclofenac/ER (Voltaren/XR) • etodolac/XL (Lodine/XL) • ibuprofen (Motrin) • indomethacin/SR (Indocin/SR) • meclofenamate (Meclomen) • meloxicam (Mobic) • mefenamic acid (Ponstel) • nabumetone (Relafen) • naproxen/CR (Anaprox/Naprosyn/EC) • naproxen DR • oxaprozin (Daypro) • piroxicam (Feldene) • sulindac (Clinoril) **AND** An intolerance to, or treatment failure of, Voltaren Gel
LIMITATIONS	If the above criteria are met approval may be granted for up to one year for Pennsaid.

Pharmacy Pre-Authorization Criteria

References	Facts & Comparisons Online
P&T Review History	2/17, 1/18
Revision Record	3/19