

## PHARMACY PRE-AUTHORIZATION CRITERIA



<b>DRUG (S)</b>	Sitavig (acyclovir buccal tablet)
<b>POLICY #</b>	13130
<b>INDICATIONS</b>	Sitavig is indicated for the treatment of recurrent herpes labialis (cold sores) in immunocompetent adults.
<b>CRITERIA</b>	<p>ConnectiCare will consider Sitavig to be medically necessary when the following criteria are met:</p> <ul style="list-style-type: none"><li>• Patient must have a diagnosis of recurrent herpes labialis (cold sores)</li><li>• Patient must be at least 18 years of age.</li><li>• Patient must have had documented intolerance to, or treatment failure of, <b>two</b> of the following: oral acyclovir, valacyclovir, or famciclovir.</li></ul> <p>Sitavig is not to be used for initial treatment.</p>
<b>LIMITATIONS</b>	If the above criteria are met, authorization may be granted for up to 3 months, for 1 tablet per month. The quantity limit for all strengths of Sitavig (acyclovir) is 1 buccal tablet per 28 days.
<b>REFERENCES</b>	Sitavig [Prescribing Information] Charleston, SC: Innocutis Holdings, LLC.
<b>P&amp;T REVIEW HISTORY</b>	11/15, 8/16, 8/17, 7/18
<b>REVISION RECORD</b>	7/18