PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

SITAVIG
(acyclovir buccal tablet)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization with Quantity Limit

POLICY

FDA-APPROVED INDICATIONS
Sitavig is indicated for the treatment of recurrent herpes labialis (cold sores) in immunocompetent adults.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of recurrent herpes labialis (cold sores) in an immunocompetent adult

AND

- The patient has experienced an inadequate treatment response, intolerance or contraindication to a generic oral antiviral medication (e.g., acyclovir, famciclovir, valacyclovir)

AND

- The patient does not require use of more than 2 tablets of the requested drug per month

Quantity Limits 2 tablets/25 days
Sitavig is indicated for acute use of herpes labialis; therefore the retail and mail limit will be the same.

REFERENCES

1. Sitavig [package insert]. Charleston, SC: Cipher Pharmaceuticals U.S. LLC; April, 2017.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed December 2018.
3. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed December 2018.
4. Cernik C, Gallina K et al. The Treatment of Herpes Simplex Infections – An Evidence-Based Review. *Arch Intern Med*. 2008; 168(11):1137-1144.
5. Usatine RP, Tinitigan R. Nongenital Herpes Simplex Virus. *Am Fam Physician*. 2010; 82(9):1075-1082.