Pharmacy Pre-Authorization Criteria

Drug (s)	**Sitavig (acyclovir buccal tablet)**
Policy #	**13130**
Indications	Sitavig is indicated for the treatment of recurrent herpes labialis (cold sores) in immunocompetent adults.
Criteria	ConnectiCare will consider Sitavig to be medically necessary when the following criteria are met: • Patient must have a diagnosis of recurrent herpes labialis (cold sores) • Patient must be at least 18 years of age. • Patient must have had documented intolerance to, or treatment failure of, **two** of the following: oral acyclovir, valacyclovir, or famciclovir. Sitavig is not to be used for initial treatment.
Limitations	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.
References	Sitavig [Prescribing Information] Charleston, SC: Innocutis Holdings, LLC.
P&T Review History	11/15, 8/16, 8/17, 7/18
Revision Record	7/18