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

Herpes Labialis (Cold Sores)
Authorization may be granted when the requested drug is being prescribed for the treatment of recurrent herpes labialis (cold sores) in an immunocompetent adult when ONE of the following criteria are met:

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

QUANTITY LIMITS APPLY
2 tablets per 25 days*
** The duration of 25 days is used for a 30-day fill period to allow time for refill processing. This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit*

DURATION OF APPROVAL (DOA)
- 1545-C: DOA: 12 months

REFERENCES

1. Sitavig [package insert]. Charleston, SC: EPI Health, LLC; December, 2019.
2. Lexicomp Online, Lexi-Drugs Online. Waltham, MA: UpToDate, Inc.; 2023. https://online.lexi.com. Accessed December 7, 2023.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 12/07/2023).
4. Usatine RP, Tinitigan R. Nongenital Herpes Simplex Virus. *Am Fam Physician*. 2010; 82(9):1075-1082.