Executive Summary

**Purpose:** The MO HealthNet Pharmacy Program will implement a state-specific preferred drug list.

**Why Issue Selected:** Cold sores, also known as fever blisters, are small sores, or blister-like lesions on the face or inside the mouth. They usually cause pain, a burning sensation, or itching before they burst and crust over. Most commonly, cold sores appear on the lips, chin, cheeks, inside the nostrils, and less frequently on the gums or the palate (roof of the mouth). The sores are caused by the herpes simplex viruses; the most common cause of sores around the mouth is herpes simplex type 1, or HSV-1. Antivirals do not eradicate the infections, but rather partially control the signs and symptoms associated with the disease. These drugs are used for treatment of initial and recurrent episodes.

Total program savings for the PDL classes will be regularly reviewed.

<table>
<thead>
<tr>
<th>Program-Specific Information:</th>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Docosanol</td>
<td>• Abreva® OTC</td>
<td></td>
</tr>
<tr>
<td>• Zovirax® Crm</td>
<td>• Acyclovir Crm/Oint</td>
<td></td>
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<td></td>
<td>• Denavir®</td>
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<td>• Sitavir®</td>
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<td></td>
<td>• Xerese®</td>
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<tr>
<td></td>
<td>• Zovirax® Oint</td>
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</tbody>
</table>

**Type of Criteria:**
- ☒ Preferred Drug List
- □ Increased risk of ADE
- □ Appropriate Indications
- □ Clinical Edit

**Data Sources:**
- □ Only Administrative Databases
- ☒ Databases + Prescriber-Supplied

**Setting & Population**

- Drug class for review: Antivirals, Topical
- Age range: All appropriate MO HealthNet participants
Approval Criteria

- Failure to achieve desired therapeutic outcomes with trial on 2 or more preferred agents
  - Documented trial period of preferred agents OR
  - Documented ADE/ADR to preferred agents

Denial Criteria

- Lack of adequate trial on required preferred agents
- Therapy will be denied if all approval criteria are not met
- Claim exceeds maximum dosing limitation for the following:

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Generic Equivalent</th>
<th>Max Dosing Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZOVIRAX 5% CREAM</td>
<td>ACYCLOVIR</td>
<td>5 g per 14 days OR 10 g per 28 days</td>
</tr>
</tbody>
</table>

Required Documentation

- Laboratory Results: 
- Progress Notes: 
- MedWatch Form: 
- Other:

Disposition of Edit

- Denial: Exception Code “0160” (Preferred Drug List)
- Rule Type: PDL

Default Approval Period

- 1 year

References

- USPDI, Micromedex; 2022.
- Facts and Comparisons eAnswers (online); 2022 Clinical Drug Information, LLC.