LOUISIANA BLUE

Select Topical Antiherpetic Agents

Policy # 00523
Original Effective Date: 01/01/2017
Current Effective Date: 02/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider brand/generic Zovirax®‡ (acyclovir cream), brand/generic Zovirax (acyclovir ointment), and brand/generic Denavir®‡ (penciclovir cream) to be **eligible for coverage**** when the patient selection criteria are met.

<u>Patient Selection Criteria</u>
Coverage eligibility for brand/generic Zovirax (acyclovir cream), brand/generic Zovirax (acyclovir ointment), or brand/generic Denavir (penciclovir cream) will be considered when the following criteria are met for the specific drug requested:

- For brand/generic **Zovirax (acyclovir cream)** or brand/generic **Denavir (penciclovir cream)** requests:
  - o Patient has a diagnosis of recurrent herpes labialis (cold sores) AND is immunocompetent; AND
  - o Patient has tried and failed (e.g., intolerance or inadequate response) at least TWO of the following generic prescription oral antiviral products (acyclovir, famciclovir, valacyclovir) unless there is clinical evidence or patient history that suggests the use of TWO of the following generic prescription oral antiviral products (acyclovir, famciclovir, valacyclovir) will be/was ineffective or will/did cause an adverse reaction to the patient; AND
    *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met)*
  - o If the request is for brand Denavir, patient has tried and failed (e.g., intolerance or inadequate response) generic penciclovir cream unless there is clinical evidence or patient history that suggests the use of generic penciclovir cream will be ineffective or cause an adverse reaction to the patient.
    *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met)*

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- For brand/generic **Zovirax (acyclovir ointment)** requests:
    - Patient will use for the initial treatment of genital herpes OR patient will use for non-life threatening mucocutaneous herpes simplex virus infections and the patient is immunocompromised; AND
    - Patient has tried and failed (e.g., intolerance or inadequate response) at least TWO of the following generic prescription oral antiviral products (acyclovir, famciclovir, valacyclovir) unless there is clinical evidence or patient history that suggests the use of TWO of the following generic prescription oral antiviral products (acyclovir, famciclovir, valacyclovir) will be/was ineffective or will/did cause an adverse reaction to the patient.
      *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met)*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of brand/generic Zovirax (acyclovir cream), brand/generic Zovirax (acyclovir ointment), or brand/generic Denavir (penciclovir cream) WITHOUT evidence that the patient has tried and failed at least TWO of the following generic prescription oral antiviral products (acyclovir, famciclovir, valacyclovir) to be **not medically necessary.****

Based on review of available data, the Company considers the use of brand Denavir (penciclovir cream) WITHOUT evidence that the patient has tried and failed generic penciclovir cream to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of brand/generic Zovirax (acyclovir cream), brand/generic Zovirax (acyclovir ointment), or brand/generic Denavir (penciclovir cream) for any indication other than their respective U.S. Food and Drug Administration (FDA)-approved indications to be **investigational.***

Background/Overview

Zovirax cream (generic included) and Denavir cream (generic included) are approved for the treatment of recurrent herpes labialis (cold sores). Zovirax ointment (generic included) is approved for the management of initial general herpes and in limited non-life-threatening mucocutaneous herpes simplex virus infections in immunocompromised patients. According to the Centers for Disease Control and other sources, the preferred agents for these conditions are oral antiviral medications. Oral antivirals are preferred over the topical antivirals as the topical agents give a modest effect, at most. The topical antiherpetic agents (including generics) are a pricier option, which do not give better clinical outcomes.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Zovirax ointment was approved in 1982. Zovirax cream was approved in 2002. Denavir was approved in 1996. These agents are approved for the treatment of herpes type infections.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests at least TWO of the following generic prescription oral antiviral products (acyclovir, famciclovir, valacyclovir) will be/was ineffective or will/did cause an adverse reaction to the patient. Based on a review of the data, in the absence of the above mentioned caveats, there is no advantage of using brand/generic Zovirax (acyclovir cream), brand/generic Zovirax (acyclovir ointment), or brand/generic Denavir (penciclovir cream) over at least TWO of the following generic prescription oral antiviral products (acyclovir, famciclovir, valacyclovir). This policy is also in place to ensure that the drugs are being used for their FDA approved indications.

References

1. Zovirax ointment [package insert]. GlaxoWellcome. Research Triangle Park, North Carolina.
2. Zovirax cream. [package insert]. Valeant Pharmaceuticals. Bridgewater, New Jersey. Updated April 2014,
3. Denavir cream [package insert]. Prestium Pharma. Newtown, Pennsylvania. Updated September 2013.
4. Treatment of Herpes simplex virus type 1. UpToDate. Updated September 2015.
5. 2015 Sexually transmitted diseases treatment guidelines. Centers for Disease Control. Accessed July 2015.
6. Penciclovir [package insert]. Mylan Pharmaceuticals, Inc. Morgantown, West Virginia. Updated September 2019.

Policy History

Original Effective Date: 01/01/2017
Current Effective Date: 02/01/2026

08/04/2016 Medical Policy Committee review
08/17/2016 Medical Policy Implementation Committee approval. New policy.
08/03/2017 Medical Policy Committee review
08/23/2017 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/09/2018 Medical Policy Committee review

08/15/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/01/2019	Medical Policy Committee review
08/14/2019	Medical Policy Implementation Committee approval. Added generic acyclovir cream.
08/06/2020	Medical Policy Committee review
08/12/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/05/2021	Medical Policy Committee review
08/11/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/04/2022	Medical Policy Committee review
08/10/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/05/2023	Medical Policy Committee review
01/11/2023	Medical Policy Implementation Committee approval. Updated criteria for brand Denavir to require a trial and failure of generic penciclovir cream.
01/04/2024	Medical Policy Committee review
01/10/2024	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/02/2025	Medical Policy Committee review
01/08/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/05/2026	Medical Policy Committee review
01/07/2026	Medical Policy Implementation Committee approval. Removed Sitavig from the policy due to its discontinuation. Title changed from "Select Antiherpetic Products (topical, buccal)" to "Select Topical Antiherpetic Products."

Next Scheduled Review Date: 01/2027

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);

2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.