

# Advanced Control Specialty Formulary™

The **CVS Caremark® Advanced Control Specialty Formulary™** is a guide within select therapeutic categories for clients, plan members and health care providers. **Generics should be considered the first line of prescribing.** If there is no generic available, there may be more than one brand-name medicine to treat a condition. These preferred brand-name medicines are listed to help identify products that are clinically appropriate and cost-effective. Generics listed in therapeutic categories are for representational purposes only. This is not an all-inclusive list. This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*.

## PLAN MEMBER

Your benefit plan provides you with a prescription benefit program administered by CVS Caremark. Ask your doctor to consider prescribing, when medically appropriate, a preferred medicine from this list. Take this list along when you or a covered family member sees a doctor.

### Please note:

- Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. Products recently approved by the U.S. Food and Drug Administration (FDA) may not be covered upon release to the market.
- Your prescription benefit plan design may alter coverage of certain products or vary copay<sup>1</sup> amounts based on the condition being treated.
- You may be responsible for the full cost of non-formulary products that are removed from coverage.
- For specific information regarding your prescription benefit coverage and copay<sup>1</sup> information, please visit [www.caremark.com](http://www.caremark.com) or contact a CVS Caremark Customer Care representative.
- CVS Caremark may contact your doctor after receiving your prescription to request consideration of a drug list product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription.
- In most instances, a brand-name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product to the market.

### ANALGESICS

#### VISCOSUPPLEMENTS

DUROLANE  
GEL-ONE  
GELSYN-3  
SUPARTZ FX  
VISCO-3

### ANTI-INFECTIVES

#### ANTIRETROVIRAL AGENTS

##### § ANTIRETROVIRAL COMBINATIONS

*abacavir-lamivudine*  
*lamivudine-zidovudine*  
ATRIPLA  
BIKTARVY  
COMPLERA  
DESCOVY  
EVOTAZ  
GENVOYA

ODEFSEY  
PREZCOBIX  
STRIBILD  
TRIUMEQ  
TRUVADA

#### FUSION INHIBITORS

FUZEON

#### INTEGRASE INHIBITORS

ISENTRESS  
TIVICAY

#### § NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS

*efavirenz*  
*nevirapine*  
*nevirapine ext-rel*  
EDURANT  
INTELENCE

#### § NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS

*abacavir tablet*  
*didanosine*  
*lamivudine*  
*stavudine*  
*zidovudine*  
EMTRIVA

#### NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS

VIREAD

#### § PROTEASE INHIBITORS

*lopinavir-ritonavir solution*  
KALETRA TABLET  
NORVIR  
PREZISTA  
REYATAZ

## HEALTH CARE PROVIDER

Your patient is covered under a prescription benefit plan administered by CVS Caremark. As a way to help manage health care costs, authorize generic substitution whenever possible. If you believe a brand-name product is necessary, consider prescribing a brand name on this list.

### Please note:

- Generics should be considered the first line of prescribing.
- The member's prescription benefit plan design may alter coverage of certain products or vary copay<sup>1</sup> amounts based on the condition being treated.
- This drug list represents a summary of prescription coverage. It is not all-inclusive and does not guarantee coverage. The member's specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. Products recently approved by the FDA may not be covered upon release to the market.
- The member's prescription benefit plan may have a different copay<sup>1</sup> for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to [www.caremark.com](http://www.caremark.com) to check coverage and copay<sup>1</sup> information for a specific medicine.

#### ANTIVIRALS

##### § HEPATITIS B AGENTS

*entecavir tablet*  
*lamivudine*  
BARACLUDE SOLUTION  
VEMLIDY

##### § HEPATITIS C AGENTS

*ribavirin*  
EPCLUSA (genotypes 1, 2, 3, 4, 5, 6)  
HARVONI (genotypes 1, 4, 5, 6)  
VOSEVI<sup>2</sup>

### ANTINEOPLASTIC AGENTS

#### § ALKYLATING AGENTS

*temozolomide*

#### § ANTIMETABOLITES

*capecitabine*

#### HORMONAL

#### ANTINEOPLASTIC AGENTS

##### ANTIANDROGENS

ERLEADA  
XTANDI  
ZYTIGA

##### § LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS

*leuprolide acetate*  
ELIGARD

#### IMMUNOMODULATORS

REVLIMID  
THALOMID

#### § KINASE INHIBITORS

*imatinib mesylate*  
AFINITOR  
BOSULIF

CABOMETYX  
IBRANCE  
IRESSA  
KISQALI  
KISQALI FEMARA  
CO-PACK  
NEXAVAR  
RYDAPT  
SPRYCEL  
SUTENT  
TARCEVA  
TYKERB  
VOTRIENT

§ MISCELLANEOUS

*bexarotene capsule*  
ODOMZO  
ZEJULA  
ZOLINZA

**CARDIOVASCULAR**

ANTILIPEMICS  
PCSK9 INHIBITORS  
REPATHA

PULMONARY ARTERIAL  
HYPERTENSION  
ENDOTHELIN RECEPTOR  
ANTAGONISTS

LETAIRIS  
OPSUMIT  
TRACLEER

§ PHOSPHODIESTERASE  
INHIBITORS  
*sildenafil*

PROSTACYCLIN RECEPTOR  
AGONISTS  
UPTRAVI

PROSTAGLANDIN  
VASODILATORS  
ORENITRAM

**CENTRAL NERVOUS  
SYSTEM**

§ HUNTINGTON'S DISEASE  
AGENTS

*tetrabenazine*  
AUSTEDO

§ MULTIPLE SCLEROSIS  
AGENTS

*glatiramer*  
AUBAGIO  
BETASERON  
COPAXONE  
GILENYA  
REBIF  
TECFIDERA  
TYSABRI

**ENDOCRINE AND  
METABOLIC**

ACROMEGALY  
SOMATULINE DEPOT  
SOMAVERT

CALCIUM REGULATORS  
PARATHYROID HORMONES  
FORTEO  
TYMLOS

MISCELLANEOUS  
PROLIA

CONTRACEPTIVES  
PROGESTIN INTRAUTERINE  
DEVICES  
KYLEENA  
MIRENA  
SKYLA

FERTILITY REGULATORS  
GNRH / LHRH  
ANTAGONISTS  
CETROTIDE

OVULATION STIMULANTS,  
GONADOTROPINS  
GONAL-F  
OVIDREL

GAUCHER DISEASE  
CERDELGA  
CEREZYME

HEREDITARY TYROSINEMIA  
TYPE 1 AGENTS  
ORFADIN

HUMAN GROWTH  
HORMONES  
HUMATROPE

§ UREA CYCLE DISORDERS  
*sodium phenylbutyrate*

MISCELLANEOUS  
CYSTAGON

**HEMATOLOGIC**

HEMATOPOIETIC GROWTH  
FACTORS  
ARANESP  
PROCRIT  
ZARXIO

HEMOPHILIA A AGENTS  
ADYNOVATE  
JIVI  
KOGENATE FS  
KOVALTRY  
NOVOEIGHT  
NUWIQ

HEMOPHILIA B AGENTS  
REBINYN

HEREDITARY ANGIOEDEMA  
RUCONEST

**IMMUNOLOGIC  
AGENTS**

ALLERGENIC EXTRACTS  
ORALAIR

**AUTOIMMUNE AGENTS**

See Table 1 for Indication Based  
Coverage Details

**ANKYLOSING SPONDYLITIS**

COSENTYX  
ENBREL  
HUMIRA

**CROHN'S DISEASE**

HUMIRA  
STELARA  
SUBCUTANEOUS #  
# After failure of HUMIRA

**PSORIASIS**

HUMIRA  
OTEZLA  
STELARA  
SUBCUTANEOUS  
TALTZ

**PSORIATIC ARTHRITIS**

COSENTYX  
ENBREL  
HUMIRA  
OTEZLA

**RHEUMATOID ARTHRITIS**

ENBREL  
HUMIRA  
KEVZARA  
ORENCIA CLICKJECT  
ORENCIA  
SUBCUTANEOUS  
XELJANZ  
XELJANZ XR

**ULCERATIVE COLITIS**

HUMIRA  
SIMPONI #  
# After failure of HUMIRA

**ALL OTHER CONDITIONS**

ENBREL  
HUMIRA

**DISEASE-MODIFYING  
ANTIRHEUMATIC DRUGS  
(DMARDs)**

RASUVO

**IMMUNOSUPPRESSANTS**

§ ANTIMETABOLITES  
*mycophenolate mofetil*  
*mycophenolate sodium*

§ CALCINEURIN INHIBITORS

*cyclosporine*  
*cyclosporine, modified*  
*tacrolimus*

§ RAPAMYCIN DERIVATIVES

*sirolimus tablet*  
RAPAMUNE SOLUTION

**RESPIRATORY**

§ CYSTIC FIBROSIS

*tobramycin*  
*inhalation solution*  
BETHKIS

**PULMONARY ENZYME  
DEFICIENCY AGENTS**

ARALAST NP  
GLASSIA  
PROLASTIN-C

**PULMONARY FIBROSIS  
AGENTS**

ESBRIET  
OFEV

**SEVERE ASTHMA AGENTS**

NUCALA

**TOPICAL**

**DERMATOLOGY**

ATOPIC DERMATITIS  
DUPIXENT

**MOUTH / THROAT /  
DENTAL AGENTS**

PROTECTANTS  
MUGARD

**QUICK REFERENCE DRUG LIST**

**A**  
*abacavir tablet*  
*abacavir-lamivudine*  
ADYNOVATE  
AFINITOR  
ARALAST NP  
ARANESP  
ATRIPLA  
AUBAGIO  
AUSTEDO

**B**  
BARACLUE SOLUTION  
BETASERON  
BETHKIS

*bexarotene capsule*  
BIKTARVY  
BOSULIF

**C**  
CABOMETYX  
*capecitabine*  
CERDELGA  
CEREZYME  
CETROTIDE  
COMPLERA  
COPAXONE  
COSENTYX  
*cyclosporine*

*cyclosporine, modified*  
CYSTAGON

**D**  
DESCOVY  
*didanosine*  
DUPIXENT  
DUROLANE

**E**  
EDURANT  
*efavirenz*  
ELIGARD  
EMTRIVA  
ENBREL

*entecavir tablet*  
EPCLUSA  
ERLEADA  
ESBRIET  
EVOTAZ

**F**  
FORTEO  
FUZEON

**G**  
GEL-ONE  
GELSYN-3  
GENVOYA  
GILENYA

GLASSIA  
*glatiramer*  
GONAL-F

**H**  
HARVONI  
HUMATROPE  
HUMIRA

**I**  
IBRANCE  
*imatinib mesylate*  
INTELENCE  
IRESSA  
ISENTRESS

<b>J</b> JIVI	<b>N</b> <i>nevirapine</i> <i>nevirapine ext-rel</i> NEXAVAR NORVIR NOVOEIGHT NUCALA NUWIQ	PREZISTA PROCRIT PROLASTIN-C PROLIA	<i>stavudine</i> STELARA SUBCUTANEOUS STRIBILD SUPARTZ FX SUTENT	<b>U</b> UPTRAVI
<b>K</b> KALETRA TABLET KEVZARA KISQALI KISQALI FEMARA CO-PACK KOGENATE FS KOVALTRY KYLEENA	<b>O</b> ODEFSEY ODOMZO OFEV OPSUMIT ORALAIR ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS ORENITRAM ORFADIN OTEZLA OVIDREL	<b>R</b> RAPAMUNE SOLUTION RASUVO REBIF REBINYN REPATHA REVLIMID REYATAZ <i>ribavirin</i> RUCONEST RYDAPT	<b>T</b> <i>tacrolimus</i> TALTZ TARCEVA TECFIDERA <i>temozolomide</i> <i>tetrabenazine</i> THALOMID TIVICAY <i>tobramycin</i> <i>inhalation solution</i> TRACLEER TRIUMEQ TRUVADA TYKERB TYMLOS TYSABRI	<b>V</b> VEMLIDY VIREAD VISCO-3 VOSEVI <sup>2</sup> VOTRIENT
<b>L</b> <i>lamivudine</i> <i>lamivudine-zidovudine</i> LETAIRIS <i>leuprolide acetate</i> <i>lopinavir-ritonavir solution</i>	<b>P</b> PREZCOBIX	<b>S</b> <i>sildenafil</i> SIMPONI <i>sirolimus tablet</i> SKYLA <i>sodium phenylbutyrate</i> SOMATULINE DEPOT SOMAVERT SPRYCEL		<b>X</b> XELJANZ XELJANZ XR XTANDI
<b>M</b> MIRENA MUGARD <i>mycophenolate mofetil</i> <i>mycophenolate sodium</i>				<b>Z</b> ZARXIO ZEJULA <i>zidovudine</i> ZOLINZA ZYTIGA

### PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS<sup>3</sup>

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ADCIRCA	<i>sildenafil</i>	NUTROPIN AQ	HUMATROPE
ALPROLIX	Consult doctor	OMNITROPE	HUMATROPE
BERINERT	RUCONEST	ORTHOVISC	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
BRAVELLE	GONAL-F	OTREXUP	RASUVO
BUPHENYL	<i>sodium phenylbutyrate</i>	PEGASYS	Consult doctor
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	PRALUENT	REPATHA
ELELYSO	CERDELGA, CEREZYME	PROCYSBI	CYSTAGON
ELOCTATE	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	PROGRAF	<i>tacrolimus</i>
EUFLEXXA	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	RAVICTI	<i>sodium phenylbutyrate</i>
EXTAVIA	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA, TYSABRI	REVATIO	<i>sildenafil</i>
FASENRA	NUCALA	SAIZEN	HUMATROPE
FOLLISTIM AQ	GONAL-F	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
GENOTROPIN	HUMATROPE	SYNVISC, SYNVISC-ONE	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
GLEEVEC	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL
HELIXATE FS	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	TECHNIVIE	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
HYALGAN	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	TOBI	<i>tobramycin inhalation solution</i> , BETHKIS
LILETTA	KYLEENA, MIRENA, SKYLA	TOBI PODHALER	<i>tobramycin inhalation solution</i> , BETHKIS
LUPRON DEPOT (For Prostate Cancer Only)	ELIGARD	VIEKIRA PAK	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI <sup>2</sup>	VIEKIRA XR	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
MONOVISC	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	XENAZINE	<i>tetrabenazine</i> , AUSTEDO
NEUPOGEN	ZARXIO	ZEMAIRA	ARALAST NP, GLASSIA, PROLASTIN-C
NORDITROPIN	HUMATROPE	ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)

**TABLE 1 - PREFERRED OPTIONS FOR INDICATION BASED AUTOIMMUNE EXCLUDED MEDICATIONS**

CONDITION	EXCLUDED DRUG NAME(S)	PREFERRED OPTION(S)
ANKYLOSING SPONDYLITIS	CIMZIA SIMPONI	COSENTYX ENBREL HUMIRA
CROHN'S DISEASE	CIMZIA ENTYVIO	HUMIRA STELARA SUBCUTANEOUS #
PSORIASIS	CIMZIA COSENTYX ENBREL	HUMIRA OTEZLA STELARA SUBCUTANEOUS TALTZ
PSORIATIC ARTHRITIS	CIMZIA ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS SIMPONI STELARA SUBCUTANEOUS TALTZ XELJANZ XELJANZ XR	COSENTYX ENBREL HUMIRA OTEZLA
RHEUMATOID ARTHRITIS	ACTEMRA CIMZIA KINERET ORENCIA INTRAVENOUS SIMPONI	ENBREL HUMIRA KEVZARA ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS XELJANZ XELJANZ XR
ULCERATIVE COLITIS	ENTYVIO XELJANZ	HUMIRA SIMPONI #
ALL OTHER CONDITIONS	ACTEMRA KINERET ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS	ENBREL HUMIRA

# After failure of HUMIRA

You may be responsible for the full cost of certain non-formulary products that are removed from coverage. Please check with your plan sponsor for more information.

**FOR YOUR INFORMATION: Generics should be considered the first line of prescribing.** This drug list represents a summary of prescription coverage. It is not all-inclusive and does not guarantee coverage. New-to-market products and new variations of products already in the marketplace will not be added to the formulary immediately. Each product will be evaluated for clinical appropriateness and cost-effectiveness. Recommended additions to the formulary will be presented to the CVS Caremark National Pharmacy and Therapeutics Committee (or other appropriate reviewing body) for review and approval. In most instances, a brand-name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product to the market. Specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. The member's prescription benefit plan may have a different copay<sup>1</sup> for specific products on the list. Unless specifically indicated, drug list products will include all dosage forms. This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*. Generics listed in therapeutic categories are for representational purposes only. Listed products may be available generically in certain strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed. Log in to [www.caremark.com](http://www.caremark.com) to check coverage and copay<sup>1</sup> information for a specific medicine.

\* The preferred options in this list are a broad representation within therapeutic categories of available treatment options and do not necessarily represent clinical equivalency.

§ Generics are available in this class and should be considered the first line of prescribing.

<sup>1</sup> Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

<sup>2</sup> For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).

<sup>3</sup> An exception process is in place for specific clinical or regulatory circumstances that may require coverage of an excluded medication.

**Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.**

CVS Caremark may receive rebates, discounts and service fees from pharmaceutical manufacturers for certain listed products. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber. The document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

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