

# 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.

<b>ANALGESICS</b>	PREZCOBIX STRIBILD TRIUMEQ TRUVADA
<b>VISCOSUPPLEMENTS</b>	FUSION INHIBITORS FUZEON
GEL-ONE GELSYN-3 SUPARTZ FX VISCO-3	
<b>ANTI-INFECTIVES</b>	INTEGRASE INHIBITORS ISENTRESS TIVICAY
<b>ANTIRETROVIRAL AGENTS</b>	§ NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
§ ANTIRETROVIRAL COMBINATIONS	<i>nevirapine</i> <i>nevirapine ext-rel</i> EDURANT INTELENCE SUSTIVA
<i>abacavir-lamivudine</i> <i>lamivudine-zidovudine</i> ATRIPLA COMPLERA DESCOVY EVOTAZ GENVOYA ODEFSEY	

§ NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	<i>abacavir tablet</i> <i>didanosine</i> <i>lamivudine</i> <i>stavudine</i> <i>zidovudine</i> EMTRIVA
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	VIREAD
§ PROTEASE INHIBITORS	<i>lopinavir-ritonavir solution</i> 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
<i>entecavir tablet</i> <i>lamivudine</i> BARACLUDE SOLUTION VEMLIDY	
§ HEPATITIS C AGENTS	
<i>ribavirin</i> EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6) VOSEVI <sup>2</sup>	
<b>ANTINEOPLASTIC AGENTS</b>	
§ ALKYLATING AGENTS	
<i>temozolomide</i>	
§ ANTIMETABOLITES	
<i>capecitabine</i>	

HORMONAL ANTINEOPLASTIC AGENTS	ANTIANDROGENS
	XTANDI ZYTIGA
§ LUTEINIZING HORMONE- RELEASING HORMONE (LHRH) AGONISTS	<i>leuprolide acetate</i> ELIGARD LUPRON DEPOT ZOLADEX
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  
 ZOLINZA

**CARDIOVASCULAR**

ANTILIPEMICS  
 PCSK9 INHIBITORS  
 PRALUENT  
 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 40 MG  
 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

HUMAN GROWTH  
 HORMONES  
 HUMATROPE

**UREA CYCLE DISORDERS**

§ METABOLIC MODIFIERS  
*sodium phenylbutyrate*

MISCELLANEOUS  
 CYSTAGON

**HEMATOLOGIC****HEMATOPOIETIC GROWTH FACTORS**

ARANESP  
 PROCRIT  
 ZARXIO

**HEMOPHILIA AGENTS**

KOGENATE FS  
 KOVALTRY  
 NOVOEIGHT  
 NUWIQ

**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**

CIMZIA #  
 HUMIRA

# After failure of HUMIRA

**PSORIASIS**

HUMIRA  
 STELARA  
 SUBCUTANEOUS #  
 TALTZ #

# After failure of HUMIRA

**PSORIATIC ARTHRITIS**

COSENTYX  
 ENBREL  
 HUMIRA  
 OTEZLA

**RHEUMATOID ARTHRITIS**

ENBREL  
 HUMIRA  
 KEVZARA  
 ORENCIA CLICKJECT  
 ORENCIA  
 SUBCUTANEOUS

**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 FIBROSIS AGENTS**

ESBRIET  
 OFEV

**TOPICAL****DERMATOLOGY**

ATOPIC DERMATITIS  
 DUPIXENT

**MOUTH / THROAT / DENTAL AGENTS**

PROTECTANTS  
 MUGARD

**QUICK REFERENCE DRUG LIST****A**

*abacavir tablet*  
*abacavir-lamivudine*  
 AFINITOR  
 ARANESP  
 ATRIPLA  
 AUBAGIO  
 AUSTEDO

**B**

BARACLUDE SOLUTION  
 BETASERON  
 BETHKIS  
*bexarotene capsule*  
 BOSULIF

**C**

CABOMETYX  
*capecitabine*

CERDELGA  
 CEREZYME  
 CETROTIDE  
 CIMZIA  
 COMPLERA  
 COPAXONE 40 MG  
 COSENTYX  
*cyclosporine*  
*cyclosporine, modified*  
 CYSTAGON

**D**

DESCOVY  
*didanosine*  
 DUPIXENT

**E**

EDURANT  
 ELIGARD

EMTRIVA  
 ENBREL  
*entecavir tablet*  
 EPCLUSA  
 ESBRIET  
 EVOTAZ

**F**

FORTEO  
 FUZEON

**G**

GEL-ONE  
 GELSYN-3  
 GENVOYA  
 GILENYA  
*glatiramer*  
 GONAL-F

**H**

HARVONI  
 HUMATROPE  
 HUMIRA

**I**

IBRANCE  
*imatinib mesylate*  
 INTELENCE  
 IRESSA  
 ISENTRESS

**K**

KALETRA TABLET  
 KEVZARA  
 KISQALI  
 KISQALI FEMARA CO-  
 PACK  
 KOGENATE FS

KOVALTRY  
 KYLEENA

**L**

*lamivudine*  
*lamivudine-zidovudine*  
 LETAIRIS  
*leuprolide acetate*  
*lopinavir-ritonavir solution*  
 LUPRON DEPOT

**M**

MIRENA  
 MUGARD  
*mycophenolate mofetil*  
*mycophenolate sodium*

<b>N</b>	<b>P</b>	<b>S</b>	TARCEVA TECFIDERA temozolomide tetrabenazine THALOMID TIVICAY tobramycin inhalation solution	VIREAD VISCO-3 VOSEVI <sup>2</sup> VOTRIENT
nevirapine nevirapine ext-rel NEXAVAR NORVIR NOVOEIGHT NUWIQ	PRALUENT PREZCOBIX PREZISTA PROCRIT PROLIA	sildenafil SIMPONI sirolimus tablet SKYLA sodium phenylbutyrate SOMATULINE DEPOT SOMAVERT SPRYCEL stavudine STELARA SUBCUTANEOUS STRIBILD SUPARTZ FX SUSTIVA SUTENT	TRACLEER TRIUMEQ TRUVADA TYKERB TYMLOS TYSABRI	<b>X</b> XTANDI
<b>O</b>	<b>R</b>	<b>T</b>	<b>U</b>	<b>Z</b>
ODEFSEY ODOMZO OFEV OPSUMIT ORALAIR ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS ORENITRAM OTEZLA OVIDREL	RAPAMUNE SOLUTION RASUVO REBIF REPATHA REVLIMID REYATAZ ribavirin RUCONEST RYDAPT	tacrolimus TALTZ	UPTRAVI	ZARXIO zidovudine ZOLADEX ZOLINZA ZYTIGA
			<b>V</b>	
			VEMLIDY	

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

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ADCIRCA	sildenafil	ORTHOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
BERINERT	RUCONEST	OTREXUP	RASUVO
BRAVELLE	GONAL-F	PEGASYS	Consult doctor
BUPHENYL	sodium phenylbutyrate	PROCYSBI	CYSTAGON
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	PROGRAF	tacrolimus
ELELYSO	CERDELGA, CEREZYME	RAVICTI	sodium phenylbutyrate
EUFLEXXA	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	REVIATIO	sildenafil
EXTAVIA	glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA, TYSABRI	SAIZEN	HUMATROPE
FOLLISTIM AQ	GONAL-F	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
GENOTROPIN	HUMATROPE	SYNISC, SYNISC-ONE	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
GLEEVEC	imatinib mesylate, BOSULIF, SPRYCEL	TASIGNA	imatinib mesylate, BOSULIF, SPRYCEL
HELIXATE FS	KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	TECHNIVIE	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
HYALGAN	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	TOBI	tobramycin inhalation solution, BETHKIS
LILETTA	KYLEENA, MIRENA, SKYLA	TOBI PODHALER	tobramycin inhalation solution, BETHKIS
MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI <sup>2</sup>	VIEKIRA PAK	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
MONOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	VIEKIRA XR	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
NEUPOGEN	ZARXIO	XENAZINE	tetrabenazine, AUSTEDO
NORDITROPIN	HUMATROPE	ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
NUTROPIN AQ	HUMATROPE		
OLYSIO	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)		
OMNITROPE	HUMATROPE		

**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	ENTYVIO STELARA	CIMZIA # HUMIRA
PSORIASIS	COSENTYX ENBREL OTEZLA	HUMIRA STELARA SUBCUTANEOUS # TALTZ #
PSORIATIC ARTHRITIS	CIMZIA ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS SIMPONI STELARA SUBCUTANEOUS	COSENTYX ENBREL HUMIRA OTEZLA
RHEUMATOID ARTHRITIS	ACTEMRA CIMZIA KINERET ORENCIA INTRAVENOUS SIMPONI XELJANZ XELJANZ XR	ENBREL HUMIRA KEVZARA ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS
ULCERATIVE COLITIS	ENTYVIO	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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