

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

<b>ANTIVIRALS</b>	§ HEPATITIS B AGENTS <i>entecavir tablet</i> <i>lamivudine</i> BARACLUDE SOLUTION VEMLIDY	HORMONAL ANTINEOPLASTIC AGENTS ANTIANDROGENS XTANDI ZYTIGA
<b>ANTINEOPLASTIC AGENTS</b>	§ HEPATITIS C AGENTS <i>ribavirin</i> EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6) VOSEVI <sup>2</sup>	§ LUTEINIZING HORMONE- RELEASING HORMONE (LHRH) AGONISTS <i>leuprolide acetate</i> ELIGARD LUPRON DEPOT ZOLADEX
§ ALKYLATING AGENTS <i>temozolomide</i>	IMMUNOMODULATORS REVLIMID THALOMID	§ KINASE INHIBITORS <i>imatinib mesylate</i> AFINITOR
§ ANTIMETABOLITES <i>capecitabine</i>		

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

§ MISCELLANEOUS  
*bexarotene capsule*  
ZOLINZA

## CARDIOVASCULAR

ANTILIPEMICS  
MICROSOMAL  
TRIGLYCERIDE TRANSFER  
PROTEIN INHIBITORS  
JUXTAPID

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*

§ 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

FERTILITY REGULATORS  
GNRH / LHRH  
ANTAGONISTS  
CETROTIDE

§ OVULATION STIMULANTS,  
GONADOTROPINS

*chorionic gonadotropin -  
Novarel*  
GONAL-F  
OVIDREL

GAUCHER DISEASE  
CERDELGA  
CEREZYME

HUMAN GROWTH  
HORMONES  
HUMATROPE

## HEMATOLOGIC

HEMATOPOIETIC GROWTH  
FACTORS  
ARANESP  
PROCRT  
ZARXIO

HEMOPHILIA AGENTS  
KOGENATE FS  
KOVALTRY  
NOVOEIGHT  
NUWIQ

HEREDITARY ANGIOEDEMA  
RUCONEST

## IMMUNOLOGIC AGENTS

ALLERGENIC EXTRACTS  
ORLAIR

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)  
RASUJO

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

**B**  
BARACLUDE SOLUTION  
BETASERON  
BETHKIS  
*bexarotene capsule*  
BOSULIF

**C**  
CABOMETYX  
*capecitabine*  
CERDELGA  
CEREZYME  
CETROTIDE

*chorionic gonadotropin -  
Novarel*  
CIMZIA  
COMPLERA  
COPAXONE 40 MG  
COSENTYX  
*cyclosporine*  
*cyclosporine, modified*

**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

**J**  
JUXTAPID

**K**  
KALETRA TABLET  
KEVZARA  
KISQALI  
KISQALI FEMARA  
CO-PACK  
KOGENATE FS  
KOVALTRY

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

**M**  
MUGARD  
*mycophenolate mofetil*  
*mycophenolate sodium*

**N**  
*nevirapine*  
*nevirapine ext-rel*  
NEXAVAR  
NORVIR  
NOVOEIGHT  
NUWIQ

<b>O</b> ODEFSEY OFEV OPSUMIT ORALAIR ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS ORENITRAM OTEZLA OVIDREL	PROCRIT PROLIA	<i>sirolimus tablet</i> SOMATULINE DEPOT SOMAVERT SPRYCEL <i>stavudine</i> STELARA SUBCUTANEOUS STRIBILD SUPARTZ FX SUSTIVA SUTENT	<i>temozolomide</i> <i>tetrabenazine</i> THALOMID TIVICAY <i>tobramycin inhalation solution</i> TRACLEER TRIUMEQ TRUVADA TYKERB TYMLOS TYSABRI	<b>V</b> VEMLIDY VIREAD VISCO-3 VOSEVI <sup>2</sup> VOTRIENT
<b>P</b> PRALUENT PREZCOBIX PREZISTA	<b>R</b> RAPAMUNE SOLUTION RASUVO REBIF REPATHA REVLIMID REYATAZ <i>ribavirin</i> RUCONEST RYDAPT	<b>T</b> <i>tacrolimus</i> TALTZ TARCEVA TECFIDERA	<b>U</b> UPTRAVI	<b>X</b> XTANDI
	<b>S</b> <i>sildenafil</i> SIMPONI			<b>Z</b> ZARXIO <i>zidovudine</i> ZOLADEX 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>	ORTHOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
BERINERT	RUCONEST	OTREXUP	RASUVO
BRAVELLE	GONAL-F	PEGASYS	Consult doctor
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	PROGRAF	<i>tacrolimus</i>
ELELYSO	CERDELGA, CEREZYME	REVATIO	<i>sildenafil</i>
EUFLEXXA	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	SAIZEN	HUMATROPE
EXTAVIA	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA, TYSABRI	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
FOLLISTIM AQ	GONAL-F	SYNVISC, SYNVISC-ONE	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
GENOTROPIN	HUMATROPE	TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL
GLEEVEC	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	TECHNIVIE	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
HELIXATE FS	KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	TOBI	<i>tobramycin inhalation solution</i> , BETHKIS
HYALGAN	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	TOBI PODHALER	<i>tobramycin inhalation solution</i> , 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	<i>tetrabenazine</i>
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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