

# 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 [Caremark.com](http://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  
CIMDUO  
COMPLERA  
DESCOVY  
EVOTAZ  
GENVOYA

ODEFSEY  
PREZCOBIX  
STRIBILD  
SYMFI  
SYMFI LO  
TRIUMEQ  
TRUVADA

#### FUSION INHIBITORS

FUZEON

#### INTEGRASE INHIBITORS

ISENTRISS  
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 [Caremark.com](http://Caremark.com) to check coverage and copay<sup>1</sup> information for a specific medicine.

## ANTIVIRALS

### § HEPATITIS B AGENTS

*entecavir tablet*  
*lamivudine*  
BARACLUDE SOLUTION

### § 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

*abiraterone*  
ERLEADA  
XTANDI

#### § 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*  
*tadalafil*

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 RECEPTOR  
ANTAGONISTS  
SENSIPAR

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  
NEULASTA  
NIVESTYM  
RETACRIT  
UDENYCA

HEMOPHILIA A AGENTS

ADYNOVATE  
JIVI  
KOGENATE FS  
KOVALTRY  
NOVOEIGHT  
NUWIQ

HEMOPHILIA B AGENTS

REBINYN

HEREDITARY ANGIOEDEMA

RUCONEST

THROMBOCYTOPENIA  
AGENTS

MULPLETA

### 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

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*

### RESPIRATORY

ALPHA-1 ANTITRYPSIN  
DEFICIENCY AGENTS

ARALAST NP  
GLASSIA  
PROLASTIN-C

§ CYSTIC FIBROSIS

*tobramycin*  
*inhalation solution*  
BETHKIS

PULMONARY FIBROSIS  
AGENTS

ESBRIET  
OFEV

SEVERE ASTHMA AGENTS

DUPIXENT  
NUCALA

### TOPICAL

DERMATOLOGY

ATOPIC DERMATITIS  
DUPIXENT

MOUTH / THROAT /  
DENTAL AGENTS

PROTECTANTS  
MUGARD

OPHTHALMIC

RETINAL DISORDERS  
EYLEA  
LUCENTIS

## QUICK REFERENCE DRUG LIST

### A

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

### B

BARACLUDE SOLUTION  
BETASERON  
BETHKIS  
*bexarotene capsule*  
BIKTARVY  
BOSULIF

### C

CABOMETYX  
*capecitabine*  
CERDELGA

CEREZYME  
CETROTIDE  
CIMDUO  
COMPLERA  
COPAXONE  
COSENTYX  
*cyclosporine*  
*cyclosporine, modified*  
CYSTAGON

### D

DESCOVY  
*didanosine*

DUPIXENT  
DUROLANE

### E

EDURANT  
*efavirenz*  
ELIGARD  
EMTRIVA  
ENBREL  
*entecavir tablet*  
EPCLUSA  
ERLEADA  
ESBRIET

EVOTAZ  
EYLEA

### F

FORTEO  
FUZEON

### G

GEL-ONE  
GELSYN-3  
GENVOYA  
GILENYA  
GLASSIA

<i>glatiramer</i> GONAL-F	<b>L</b> <i>lamivudine</i> <i>lamivudine-zidovudine</i> LETAIRIS <i>leuprolide acetate</i> <i>lopinavir-ritonavir solution</i> LUCENTIS	OFEV OPSUMIT ORALAIR ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS ORENITRAM ORFADIN OTEZLA OVIDREL	<b>S</b> SENSIPAR <i>sildenafil</i> SIMPONI <i>sirolimus</i> SKYLA <i>sodium phenylbutyrate</i> SOMATULINE DEPOT SOMAVERT SPRYCEL <i>stavudine</i> STELARA SUBCUTANEOUS STRIBILD SUPARTZ FX SUTENT SYMFI SYMFI LO	<i>tobramycin</i> <i>inhalation solution</i> TRACLEER TRIUMEQ TRUVADA TYKERB TYMLOS TYSABRI
<b>H</b> HARVONI HUMATROPE HUMIRA	<b>M</b> MIRENA MUGARD MULPLETA <i>mycophenolate mofetil</i> <i>mycophenolate sodium</i>	<b>P</b> PREZCOBIX PREZISTA PROLASTIN-C PROLIA	stacrolimus <i>tadalafil</i> TALTZ TARCEVA TECFIDERA <i>temozolomide</i> <i>tetrabenazine</i> THALOMID TIVICAY	<b>U</b> UDENYCA UPTRAVI
<b>I</b> IBRANCE <i>imatinib mesylate</i> INTELENCE IRESSA ISENTRESS	<b>N</b> NEULASTA <i>nevirapine</i> <i>nevirapine ext-rel</i> NEXAVAR NIVESTYM NORVIR NOVOEIGHT NUCALA NUWIQ	<b>R</b> RASUVO REBIF REBINYN REPATHA RETACRIT REVLIMID REYATAZ <i>ribavirin</i> RUCONEST RYDAPT	<b>T</b>	<b>V</b> VIREAD VISCO-3 VOSEVI <sup>2</sup> VOTRIENT
<b>J</b> JIVI	<b>O</b> ODEFSEY ODOMZO			<b>X</b> XELJANZ XELJANZ XR XTANDI
<b>K</b> KALETRA TABLET KEVZARA KISQALI KISQALI FEMARA CO-PACK KOGENATE FS KOVALTRY KYLEENA				<b>Z</b> ZEJULA <i>zidovudine</i> ZOLINZA

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

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ADCIRCA	<i>sildenafil, tadalafil</i>	GENOTROPIN	HUMATROPE
ALPROLIX	Consult doctor	GLEEVEC	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL
ASTAGRAF XL	<i>cyclosporine; cyclosporine, modified; tacrolimus</i>	GRANIX	NIVESTYM
BARACLUDE TABLET	<i>entecavir tablet, lamivudine</i> , BARACLUDE SOLUTION, VIREAD	HELIXATE FS	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
BERINERT	RUCONEST	HEPSERA	<i>entecavir tablet, lamivudine</i> , BARACLUDE SOLUTION, VIREAD
BRAVELLE	GONAL-F	HYALGAN	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
BUPHENYL	<i>sodium phenylbutyrate</i>	LILETTA	KYLEENA, MIRENA, SKYLA
CELLCEPT	<i>mycophenolate mofetil, mycophenolate sodium</i>	LUPRON DEPOT (For Prostate Cancer Only)	ELIGARD
CHORIONIC GONADOTROPIN	OVIDREL	MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI <sup>2</sup>
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	MONOVISC	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
ELELYSO	CERDELGA, CERZYMME	MYFORTIC	<i>mycophenolate mofetil, mycophenolate sodium</i>
ELOCTATE	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	NEUPOGEN	NIVESTYM
ENVARUSUS XR	<i>cyclosporine; cyclosporine, modified; tacrolimus</i>	NORDITROPIN	HUMATROPE
EPIVIR HBV	<i>entecavir tablet, lamivudine</i> , BARACLUDE SOLUTION, VIREAD	NOVAREL	OVIDREL
EPOGEN	ARANESP, RETACRIT	NUTROPIN AQ	HUMATROPE
EUFLEXXA	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	OMNITROPE	HUMATROPE
EXTAVIA	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA, TYSABRI	ORTHOVISC	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
FASENRA	DUPIXENT, NUCALA	OTREXUP	RASUVO
FOLLISTIM AQ	GONAL-F	PEGASYS	Consult doctor
FULPHILA	NEULASTA, UDENYCA	PRALUENT	REPATHA
		PREGNYL	OVIDREL

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
PROCRIT	ARANESP, RETACRIT	TOBI PODHALER	<i>tobramycin inhalation solution</i> , BETHKIS
PROCYSBI	CYSTAGON	VEMLIDY	<i>entecavir tablet, lamivudine</i> , BARACLUDE SOLUTION, VIREAD
PROGRAF	<i>tacrolimus</i>	VIEKIRA PAK	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
RAPAMUNE	<i>sirolimus</i>	VIEKIRA XR	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
RAVICTI	<i>sodium phenylbutyrate</i>	XENAZINE	<i>tetrabenazine</i> , AUSTEDO
REVATIO	<i>sildenafil, tadalafil</i>	ZARXIO	NIVESTYM
SAIZEN	HUMATROPE	ZEMAIRA	ARALAST NP, GLASSIA, PROLASTIN-C
SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT	ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
SYNVISC, SYNVISC-ONE	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	ZORTRESS	<i>sirolimus</i>
TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	ZYTIGA	<i>abiraterone</i> , XTANDI
TECHNIVIE	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)		
TOBI	<i>tobramycin inhalation solution</i> , BETHKIS		

**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 [Caremark.com](http://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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