

# 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

GEL-ONE  
GELSYN-3  
SUPARTZ FX  
VISCO-3

### ANTI-INFECTIVES

#### ANTI-RETROVIRAL AGENTS

##### § ANTI-RETROVIRAL COMBINATIONS

*abacavir-lamivudine*  
*lamivudine-zidovudine*  
ATRIPLA  
BIKTARVY  
COMPLERA  
DESCOVI  
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

XTANDI  
ZYTIGA

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

*leuprolide acetate*  
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  
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

HEREDITARY TYROSINEMIA  
TYPE 1 AGENTS  
ORFADIN

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*  
BIKTARVY  
BOSULIF

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

**D**  
DESCOVY  
*didanosine*  
DUPIXENT

**E**  
EDURANT  
*efavirenz*  
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*

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

**O**  
 ODEFSEY  
 ODOMZO  
 OFEV  
 OPSUMIT  
 ORALAIR  
 ORENCIA CLICKJECT  
 ORENCIA  
 SUBCUTANEOUS  
 ORENITRAM  
 ORFADIN

OTEZLA  
 OVIDREL

**P**  
 PREZCOBIX  
 PREZISTA  
 PROCIT  
 PROLIA

**R**  
 RAPAMUNE SOLUTION  
 RASUVO  
 REBIF  
 REPATHA  
 REVLIMID  
 REYATAZ  
*ribavirin*  
 RUCONEST  
 RYDAPT

**S**  
*sildenafil*  
 SIMPONI  
*sirolimus tablet*  
 SKYLA  
*sodium phenylbutyrate*  
 SOMATULINE DEPOT  
 SOMAVERT  
 SPRYCEL  
*stavudine*  
 STELARA  
 SUBCUTANEOUS  
 STRIBILD  
 SUPARTZ FX  
 SUTENT

**T**  
*tacrolimus*  
 TALTZ

TARCEVA  
 TECFIDERA  
*temozolomide*  
*tetrabenazine*  
 THALOMID  
 TIVICAY  
*tobramycin*  
*inhalation solution*  
 TRACLEER  
 TRIUMEQ  
 TRUVADA  
 TYKERB  
 TYMLOS  
 TYSABRI

**U**  
 UPTRAVI

**V**  
 VEMLIDY  
 VIREAD  
 VISCO-3  
 VOSEVI<sup>2</sup>  
 VOTRIENT

**X**  
 XTANDI

**Z**  
 ZARXIO  
*zidovudine*  
 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>	OTREXUP	RASUVO
BERINERT	RUCONEST	PEGASYS	Consult doctor
BRAVELLE	GONAL-F	PRALUENT	REPATHA
BUPHENYL	<i>sodium phenylbutyrate</i>	PROCYSBI	CYSTAGON
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	PROGRAF	<i>tacrolimus</i>
ELELYSO	CERDELGA, CEREZYME	RAVICTI	<i>sodium phenylbutyrate</i>
EUFLEXXA	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	REVATIO	<i>sildenafil</i>
EXTAVIA	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA, TYSABRI	SAIZEN	HUMATROPE
FOLLISTIM AQ	GONAL-F	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
GENOTROPIN	HUMATROPE	SYNVISC, SYNVISC-ONE	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
GLEEVEC	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	TASIGNA	<i>imatinib mesylate</i> , 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	<i>tobramycin inhalation solution</i> , BETHKIS
LILETTA	KYLEENA, MIRENA, SKYLA	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> , 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		
ORTHOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3		

**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	CIMZIA COSENTYX ENBREL OTEZLA	HUMIRA 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 XELJANZ XELJANZ XR	ENBREL HUMIRA KEVZARA ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS
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.

The information contained in this document is proprietary. The information may not be copied in whole or in part without written permission.

©2018 CVS Caremark. All rights reserved. 106-31697C 100118

[www.caremark.com](http://www.caremark.com)