

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 copay¹ 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 copay¹ information, please visit 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	PREZCOBIX STRIBILD TRIUMEQ TRUVADA
VISCOSUPPLEMENTS	FUSION INHIBITORS FUZEON
GEL-ONE GELSYN-3 SUPARTZ FX VISCO-3	
ANTI-INFECTIVES	INTEGRASE INHIBITORS ISENTRESS TIVICAY
ANTIRETROVIRAL AGENTS	§ 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 DESCOBY 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 copay¹ 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 copay¹ for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to www.caremark.com to check coverage and copay¹ 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 ²	
ANTINEOPLASTIC AGENTS	
§ 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

N	P	S	TARCEVA TECFIDERA temozolomide tetrabenazine THALOMID TIVICAY tobramycin inhalation solution	VIREAD VISCO-3 VOSEVI ² 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	X XTANDI
O	R	T	U	Z
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
			V	
			VEMLIDY	

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS³

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	SYNVISC, SYNVISC-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 ²	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 copay¹ 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 to check coverage and copay¹ 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.

¹ 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.

² 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).

³ 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 040118 v2

www.caremark.com

Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. For specific information, visit www.caremark.com or contact a CVS Caremark Customer Care representative.

