

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 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
COMPLERA
DESCOVY
EVOTAZ
GENVOYA

ODEFSEY
PREZCOBIX
STRIBILD
TRIUMEQ
TRUVADA

FUSION INHIBITORS

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 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 Caremark.com to check coverage and copay¹ 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)
VOSEVI²

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
RETACRIT
ZARXIO

HEMOPHILIA A AGENTS
ADYNOVATE
JIVI
KOGENATE FS
KOVALTRY
NOVOEIGHT
NUVIQ

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 #

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

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

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
COMPLERA
COPAXONE
COSENTYX
cyclosporine
cyclosporine, modified
CYSTAGON

D
DESCOVY
didanosine
DUPIXENT
DUROLANE

E
EDURANT
efavirenz
ELIGARD
EMTRIVA
ENBREL
entecavir tablet
EPCLUSA
ERLEADA
ESBRIET
EVOTAZ

F
FORTEO
FUZEON

G
GEL-ONE
GELSYN-3
GENVOYA
GILENYA
GLASSIA
glatiramer
GONAL-F

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

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS³

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ADCIRCA	<i>sildenafil, tadalafil</i>	MONOVISC	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
ALPROLIX	Consult doctor	NEUPOGEN	ZARXIO
BERINERT	RUCONEST	NORDITROPIN	HUMATROPE
BRAVELLE	GONAL-F	NUTROPIN AQ	HUMATROPE
BUPHENYL	<i>sodium phenylbutyrate</i>	OMNITROPE	HUMATROPE
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	ORTHOVISC	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
ELELYSO	CERDELGA, CEREZYME	OTREXUP	RASUVO
ELOCTATE	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	PEGASYS	Consult doctor
EPOGEN	ARANESP, RETACRIT	PRALUENT	REPATHA
EUFLEXXA	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	PROCRIT	ARANESP, RETACRIT
EXTAVIA	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA, TYSABRI	PROCYSBI	CYSTAGON
FASENRA	DUPIXENT, NUCALA	PROGRAF	<i>tacrolimus</i>
FOLLISTIM AQ	GONAL-F	RAVICTI	<i>sodium phenylbutyrate</i>
GENOTROPIN	HUMATROPE	REVATIO	<i>sildenafil, tadalafil</i>
GLEEVEC	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	SAIZEN	HUMATROPE
HELIXATE FS	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
HYALGAN	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	SYNVISC, SYNVISC-ONE	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
LILETTA	KYLEENA, MIRENA, SKYLA	TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL
LUPRON DEPOT (For Prostate Cancer Only)	ELIGARD	TECHNIVIE	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI ²	TOBI	<i>tobramycin inhalation solution</i> , BETHKIS
		TOBI PODHALER	<i>tobramycin inhalation solution</i> , BETHKIS
		VIEKIRA PAK	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
VIEKIRA XR	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
XENAZINE	tetrabenazine, AUSTEDO	ZYTIGA	abiraterone, XTANDI
ZEMAIRA	ARALAST NP, GLASSIA, PROLASTIN-C		

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 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 [Caremark.com](https://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.

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