April 2018

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[1] 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[1] 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.

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[1] 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[1] 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 copay[1] information for a specific medicine.

ANALGESICS

VISCOSUPPLEMENTS

GEL-ONE
GELSYN-3
SUPARTZ FX
VISCO-3

ANTI-INFECTIVES

ANTIRETROVIRAL AGENTS

§ ANTIRETROVIRAL COMBINATIONS

abacavir-lamivudine
lamivudine-zidovudine
ATRIPLA
COMPLERA
DESCOVY
EVOTAZ
GENVOYA
ODEFSEY
PREZCOBIX
STRIBILD
TRIUMEQ
TRUVADA

FUSION INHIBITORS

FUZEON

INTEGRASE INHIBITORS

ISENTRESS
TIVICAY

§ NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS

nevirapine
nevirapine ext-rel
EDURANT
INTELENCE
SUSTIVA

§ 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

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 [2]

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
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

nevirapine
nevirapine ext-rel
NEXAVAR
NORVIR
NOVOEIGHT
NUWIQ

O

ODEFSEY
ODOMZO
OFEV
OPSUMIT
ORALAIR
ORENCIA CLICKJECT
ORENCIA SUBCUTANEOUS
ORENITRAM
OTEZLA
OVIDREL

P

PRALUENT
PREZCOBIX
PREZISTA
PROCRIT
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
SUSTIVA
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 [2]
VOTRIENT

X

XTANDI

Z

ZARXIO
zidovudine
ZOLADEX
ZOLINZA
ZYTIGA

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS [3]

DRUG NAME(S)	PREFERRED OPTION(S)*
ADCIRCA	*sildenafil*
BERINERT	RUCONEST
BRAVELLE	GONAL-F
BUPHENYL	*sodium phenylbutyrate*
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
ELELYSO	CERDELGA, CEREZYME
EUFLEXXA	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
EXTAVIA	*glatiramer,* AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA, TYSABRI
FOLLISTIM AQ	GONAL-F
GENOTROPIN	HUMATROPE
GLEEVEC	*imatinib mesylate,* BOSULIF, SPRYCEL
HELIXATE FS	KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
HYALGAN	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
LILETTA	KYLEENA, MIRENA, SKYLA
MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI [2]
MONOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
NEUPOGEN	ZARXIO
NORDITROPIN	HUMATROPE
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
OTREXUP	RASUVO
PEGASYS	Consult doctor
PROCYSBI	CYSTAGON
PROGRAF	*tacrolimus*
RAVICTI	*sodium phenylbutyrate*
REVATIO	*sildenafil*
SAIZEN	HUMATROPE
SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
SYNVISC, SYNVISC-ONE	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
TASIGNA	*imatinib mesylate,* BOSULIF, SPRYCEL
TECHNIVIE	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
TOBI	*tobramycin inhalation solution,* BETHKIS
TOBI PODHALER	*tobramycin inhalation solution,* BETHKIS
VIEKIRA PAK	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
VIEKIRA XR	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
XENAZINE	*tetrabenazine,* AUSTEDO
ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)

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[1] 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 copay[1] 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.

 106-31697C 040118 v2 **www.caremare.com**

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