

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	STRIBILD TRIUMEQ TRUVADA
VISCOSUPPLEMENTS	FUSION INHIBITORS FUZEON
GEL-ONE GELSYN-3 SUPARTZ FX VISCO-3	INTEGRASE INHIBITORS ISENTRESS TIVICAY
ANTI-INFECTIVES	§ NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS <i>nevirapine</i> <i>nevirapine ext-rel</i> EDURANT INTELENCE SUSTIVA
ANTIRETROVIRAL AGENTS § ANTIRETROVIRAL COMBINATIONS <i>abacavir-lamivudine</i> <i>lamivudine-zidovudine</i> ATRIPLA COMPLERA DESCOVI EVOTAZ GENVOYA ODEFSEY PREZCOBIV	§ 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	HORMONAL ANTINEOPLASTIC AGENTS ANTIANDROGENS XTANDI ZYTIGA
§ HEPATITIS C AGENTS <i>ribavirin</i> EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6) VOSEVI ²	§ LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS <i>leuprolide acetate</i> ELIGARD LUPRON DEPOT ZOLADEX
ANTINEOPLASTIC AGENTS	IMMUNOMODULATORS REVLIMID THALOMID
§ ALKYLATING AGENTS <i>temozolomide</i>	§ KINASE INHIBITORS <i>imatinib mesylate</i> AFINITOR
§ ANTIMETABOLITES <i>capecitabine</i>	

BOSULIF
CABOMETYX
IBRANCE
IRESSA
KISQALI
KISQALI FEMARA
CO-PACK
NEXAVAR
RYDAPT
SPRYCEL
SUTENT
TARCEVA
TYKERB
VOTRIENT

§ MISCELLANEOUS
bexarotene capsule
ZOLINZA

CARDIOVASCULAR

ANTILIPEMICS
MICROSOMAL
TRIGLYCERIDE TRANSFER
PROTEIN INHIBITORS
JUXTAPID

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

§ 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

FERTILITY REGULATORS
GNRH / LHRH
ANTAGONISTS
CETROTIDE

§ OVULATION STIMULANTS,
GONADOTROPINS
*chorionic gonadotropin -
Novarel*
GONAL-F
OVIDREL

GAUCHER DISEASE
CERDELGA
CEREZYME

HUMAN GROWTH
HORMONES
HUMATROPE

HEMATOLOGIC

HEMATOPOIETIC GROWTH
FACTORS
ARANESP
PROCRT
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

B
BARACLUDE SOLUTION
BETASERON
BETHKIS
bexarotene capsule
BOSULIF

C
CABOMETYX
capecitabine
CERDELGA
CEREZYME
CETROTIDE

*chorionic gonadotropin -
Novarel*
CIMZIA
COMPLERA
COPAXONE 40 MG
COSENTYX
cyclosporine
cyclosporine, modified

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

J
JUXTAPID

K
KALETRA TABLET
KEVZARA
KISQALI
KISQALI FEMARA
CO-PACK
KOGENATE FS
KOVALTRY

L
lamivudine
lamivudine-zidovudine
LETAIRIS
leuprolide acetate
lopinavir-ritonavir solution
LUPRON DEPOT

M
MUGARD
mycophenolate mofetil
mycophenolate sodium

N
nevirapine
nevirapine ext-rel
NEXAVAR
NORVIR
NOVOEIGHT
NUWIQ

O	PROCRIT PROLIA	<i>sirolimus</i> tablet SOMATULINE DEPOT SOMAVERT SPRYCEL <i>stavudine</i> STELARA SUBCUTANEOUS STRIBILD SUPARTZ FX SUSTIVA SUTENT	<i>temozolomide</i> <i>tetrabenazine</i> THALOMID TIVICAY <i>tobramycin</i> <i>inhalation solution</i> TRACLEER TRIUMEQ TRUVADA TYKERB TYMLOS TYSABRI	V	VEMLIDY VIREAD VISCO-3 VOSEVI ² VOTRIENT
	R			X	XTANDI
	RAPAMUNE SOLUTION RASUVO REBIF REPATHA REVLIMID REYATAZ <i>ribavirin</i> RUCONEST RYDAPT			Z	ZARXIO <i>zidovudine</i> ZOLADEX ZOLINZA ZYTIGA
P	S	T	U		
PRALUENT PREZCOBIX PREZISTA	<i>sildenafil</i> SIMPONI	<i>tacrolimus</i> TALTZ TARCEVA TECFIDERA	UPTRAVI		

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS ³

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ADCIRCA	<i>sildenafil</i>	ORTHOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
BERINERT	RUCONEST	OTREXUP	RASUVO
BRAVELLE	GONAL-F	PEGASYS	Consult doctor
DAKLINZA	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)	PROGRAF	<i>tacrolimus</i>
ELELYSO	CERDELGA, CEREZYME	REVATIO	<i>sildenafil</i>
EUFLEXXA	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	SAIZEN	HUMATROPE
EXTAVIA	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA, TYSABRI	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
FOLLISTIM AQ	GONAL-F	SYNVISC, SYNVISC-ONE	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
GENOTROPIN	HUMATROPE	TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL
GLEEVEC	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	TECHNIVIE	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
HELIXATE FS	KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	TOBI	<i>tobramycin inhalation solution</i> , BETHKIS
HYALGAN	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	TOBI PODHALER	<i>tobramycin inhalation solution</i> , 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	<i>tetrabenazine</i>
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.

©2017 CVS Caremark. All rights reserved. 106-31697C 010118

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.

