

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

VISCOSUPPLEMENTS

GEL-ONE
HYALGAN
SUPARTZ FX

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
BARACLUD SOLUTION
VEMLIDY

§ HEPATITIS C AGENTS
ribavirin
EPCLUSA (genotypes 2, 3)
HARVONI (genotypes 1, 4, 5, 6)

ANTINEOPLASTIC AGENTS

§ ALKYLATING AGENTS
temozolomide

§ ANTIMETABOLITES
capecitabine

HORMONAL ANTINEOPLASTIC AGENTS
ANTIANDROGENS
ZYTIGA

§ LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS
leuprolide acetate
LUPRON DEPOT
TRELSTAR
ZOLADEX

IMMUNOMODULATORS
REVLIMID
THALOMID

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.

§ KINASE INHIBITORS

imatinib mesylate
AFINITOR
BOSULIF
CABOMETYX
NEXAVAR
SPRYCEL
SUTENT
TARCEVA
TYKERB
VOTRIENT

§ MISCELLANEOUS

bexarotene capsule
ZOLINZA

CARDIOVASCULAR

ANTILIPEMICS
MICROSOMAL
TRIGLYCERIDE TRANSFER
PROTEIN INHIBITORS
JUXTAPID

PCSK9 INHIBITORS
REPATHA

PULMONARY ARTERIAL
HYPERTENSION

ENDOTHELIN RECEPTOR
ANTAGONISTS
LETAIRIS

TRACLEER

**§ PHOSPHODIESTERASE
INHIBITORS**

sildenafil

PROSTAGLANDIN
VASODILATORS

ORENITRAM

**CENTRAL NERVOUS
SYSTEM****§ HUNTINGTON'S DISEASE
AGENTS**

tetrabenazine

**§ MULTIPLE SCLEROSIS
AGENTS**

glatiramer
AUBAGIO
BETASERON
COPAXONE 40 MG
GILENYA
REBIF
TECFIDERA

**ENDOCRINE AND
METABOLIC**

ACROMEGALY
SOMATULINE DEPOT
SOMAVERT

CALCIUM REGULATORS

PARATHYROID HORMONES
FORTEO

FERTILITY REGULATORS

GNRH / LHRH
ANTAGONISTS
CETROTIDE

**§ OVULATION STIMULANTS,
GONADOTROPINS**

*chorionic gonadotropin -
Novarel*
FOLLISTIM AQ
OVIDREL

HUMAN GROWTH
HORMONES
HUMATROPE

HEMATOLOGIC**HEMATOPOIETIC GROWTH
FACTORS**

ARANESP
ZARXIO

HEMOPHILIA AGENTS

KOGENATE FS
KOVALTRY
NOVOEIGHT
NUWIQ

HEREDITARY ANGIOEDEMA

RUCONEST

**IMMUNOLOGIC
AGENTS**

ALLERGENIC EXTRACTS
ORALAIR

BIOLOGIC DISEASE-
MODIFYING AGENTS
PSORIASIS

HUMIRA
STELARA (after failure of HUMIRA)
TALTZ (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
CETROTIDE
*chorionic gonadotropin -
Novarel*
COMPLERA
COPAXONE 40 MG
cyclosporine
cyclosporine, modified

D

DESCOVY
didanosine
DUPIXENT

E

EDURANT
EMTRIVA
ENBREL
entecavir tablet
EPCLUSA
ESBRIET
EVOTAZ

F

FOLLISTIM AQ
FORTEO
FUZEON

G

GEL-ONE
GENVOYA
GILENYA
glatiramer

H

HARVONI
HUMATROPE
HUMIRA
HYALGAN

I

imatinib mesylate
INTELENCE
ISENTRESS

J

JUXTAPID

K

KALETRA TABLET
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

ODEFSEY
OFEV
ORALAIR
ORENITRAM
OVIDREL

P

PREZCOBIX
PREZISTA

R

RAPAMUNE SOLUTION
RASUVO
REBIF
REPATHA
REVLIMID
REYATAZ
ribavirin
RUCONEST

S

sildenafil
sirolimus tablet
SOMATULINE DEPOT
SOMAVERT
SPRYCEL
stavudine
STELARA
STRIBILD
SUPARTZ FX

SUSTIVA
SUTENT

T

tacrolimus
TALTZ
TARCEVA
TECFIDERA
temozolomide
tetrabenazine
THALOMID
TIVICAY
tobramycin inhalation
solution
TRACLEER
TRELSTAR
TRIUMEQ
TRUVADA
TYKERB

V

VEMLIDY
VIREAD
VOTRIENT

Z

ZARXIO
zidovudine
ZOLADEX
ZOLINZA
ZYTIGA

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS ²

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ACTEMRA	ENBREL, HUMIRA	OTREXUP	RASUVO
ADCIRCA	<i>sildenafil</i>	PEGASYS	Consult doctor
AVONEX	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA	PLEGRIDY	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA
BERINERT	RUCONEST	PRALUENT	REPATHA
BRAVELLE	FOLLISTIM AQ	PROCRIT	ARANESP
CIMZIA	ENBREL, HUMIRA	PROGRAF	<i>tacrolimus</i>
COSENTYX	ENBREL (for non-psoriasis conditions), HUMIRA, STELARA (psoriasis, after failure of HUMIRA), TALTZ (psoriasis, after failure of HUMIRA)	PROLIA	<i>alendronate</i> , <i>calcitonin-salmon</i> , <i>ibandronate</i> , <i>risedronate</i> , ATELVIA, FORTEO
DAKLINZA	EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)	REMICADE	ENBREL (for non-psoriasis conditions), HUMIRA, STELARA (psoriasis, after failure of HUMIRA), TALTZ (psoriasis, after failure of HUMIRA)
EUFLEXXA	GEL-ONE, HYALGAN, SUPARTZ FX	REVATIO	<i>sildenafil</i>
EXTAVIA	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA	SAIZEN	HUMATROPE
GENOTROPIN	HUMATROPE	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
GLEEVEC	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	SIMPONI	ENBREL, HUMIRA
GONAL-F	FOLLISTIM AQ	SYNVISC, SYNVISC-ONE	GEL-ONE, HYALGAN, SUPARTZ FX
HELIXATE FS	KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL
KINERET	ENBREL, HUMIRA	TECHNIVIE	HARVONI (genotypes 1, 4, 5, 6)
MONOVISC	GEL-ONE, HYALGAN, SUPARTZ FX	TOBI	<i>tobramycin inhalation solution</i> , BETHKIS
NEUPOGEN	ZARXIO	TOBI PODHALER	<i>tobramycin inhalation solution</i> , BETHKIS
NORDITROPIN	HUMATROPE	VIEKIRA PAK	HARVONI (genotypes 1, 4, 5, 6)
NUTROPIN AQ	HUMATROPE	VIEKIRA XR	HARVONI (genotypes 1, 4, 5, 6)
OLYSIO	HARVONI (genotypes 1, 4, 5, 6)	XELJANZ	ENBREL, HUMIRA
OMNITROPE	HUMATROPE	XENAZINE	<i>tetrabenazine</i>
OPSUMIT	LETAIRIS, TRACLEER	XTANDI	ZYTIGA
ORENCIA	ENBREL, HUMIRA	ZEPATIER	HARVONI (genotypes 1, 4, 5, 6)
ORTHOVISC	GEL-ONE, HYALGAN, SUPARTZ FX		
OTEZLA	ENBREL (for non-psoriasis conditions), HUMIRA, STELARA (psoriasis, after failure of HUMIRA), TALTZ (psoriasis, 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 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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