April 2019

# 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 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 Caremark.com to check coverage and copay[1] information for a specific medicine.

### 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

FUZEON

##### 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

#### 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

*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
NUWIQ

**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

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

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**H**

HARVONI
HUMATROPE
HUMIRA

**I**

IBRANCE
*imatinib mesylate*
INTELENCE
IRESSA
ISENTRESS

**J**

JIVI

**K**

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

**L**

*lamivudine*
*lamivudine-zidovudine*
LETAIRIS
*leuprolide acetate*
*lopinavir-ritonavir solution*

**M**

MIRENA
MUGARD
MULPLETA
*mycophenolate mofetil*
*mycophenolate sodium*

**N**

*nevirapine*
*nevirapine ext-rel*
NEXAVAR
NORVIR
NOVOEIGHT
NUCALA
NUWIQ

**O**

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

**P**

PREZCOBIX
PREZISTA
PROLASTIN-C
PROLIA

**R**

RAPAMUNE SOLUTION
RASUVO
REBIF
REBINYN
REPATHA
RETACRIT
REVLIMID
REYATAZ
*ribavirin*
RUCONEST
RYDAPT

**S**

SENSIPAR
*sildenafil*
SIMPONI
*sirolimus tablet*
SKYLA
*sodium phenylbutyrate*
SOMATULINE DEPOT
SOMAVERT
SPRYCEL
*stavudine*
STELARA SUBCUTANEOUS
STRIBILD
SUPARTZ FX
SUTENT

**T**

*tacrolimus*
*tadalafil*
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**

XELJANZ
XELJANZ XR
XTANDI

**Z**

ZARXIO
ZEJULA
*zidovudine*
ZOLINZA

## PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS [3]

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

| 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<br>SIMPONI | COSENTYX<br>ENBREL<br>HUMIRA |
| CROHN'S DISEASE | CIMZIA<br>ENTYVIO | HUMIRA<br>STELARA SUBCUTANEOUS # |
| PSORIASIS | CIMZIA<br>COSENTYX<br>ENBREL | HUMIRA<br>OTEZLA<br>STELARA SUBCUTANEOUS<br>TALTZ |
| PSORIATIC ARTHRITIS | CIMZIA<br>ORENCIA CLICKJECT<br>ORENCIA INTRAVENOUS<br>ORENCIA SUBCUTANEOUS<br>SIMPONI<br>STELARA SUBCUTANEOUS<br>TALTZ<br>XELJANZ<br>XELJANZ XR | COSENTYX<br>ENBREL<br>HUMIRA<br>OTEZLA |
| RHEUMATOID ARTHRITIS | ACTEMRA<br>CIMZIA<br>KINERET<br>ORENCIA INTRAVENOUS<br>SIMPONI | ENBREL<br>HUMIRA<br>KEVZARA<br>ORENCIA CLICKJECT<br>ORENCIA SUBCUTANEOUS<br>XELJANZ<br>XELJANZ XR |
| ULCERATIVE COLITIS | ENTYVIO<br>XELJANZ | HUMIRA<br>SIMPONI # |
| ALL OTHER CONDITIONS | ACTEMRA<br>KINERET<br>ORENCIA CLICKJECT<br>ORENCIA INTRAVENOUS<br>ORENCIA SUBCUTANEOUS | ENBREL<br>HUMIRA |

# After failure of HUMIRA

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

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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 **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.

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