

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.

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.

<p>ANALGESICS</p> <p>VISCOSUPPLEMENTS</p> <p>GEL-ONE</p> <p>GELSYN-3</p> <p>SUPARTZ FX</p> <p>VISCO-3</p>	<p>PREZCOBIX</p> <p>SYMFI</p> <p>SYMFI LO</p> <p>SYMITUZA</p> <p>TEMIXYS</p> <p>TRIUMEQ</p> <p>TRUVADA</p>	<p>§ NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS</p> <p><i>abacavir tablet</i></p> <p><i>didanosine</i></p> <p><i>lamivudine</i></p> <p><i>stavudine</i></p> <p><i>zidovudine</i></p> <p>EMTRIVA</p>	<p>ANTIVIRALS</p> <p>§ HEPATITIS B AGENTS</p> <p><i>entecavir</i></p> <p><i>lamivudine</i></p> <p><i>tenofovir disoproxil fumarate</i></p> <p>BARACLUDE SOLUTION</p> <p>VEMLIDY</p> <p>§ HEPATITIS C AGENTS</p> <p><i>ribavirin</i></p> <p>EPCLUSA <small>(genotypes 1, 2, 3, 4, 5, 6)</small></p> <p>HARVONI <small>(genotypes 1, 4, 5, 6)</small></p> <p>VOSEVI ²</p>	<p>HORMONAL ANTINEOPLASTIC AGENTS</p> <p>§ ANTIANDROGENS</p> <p><i>abiraterone</i></p> <p>ERLEADA</p> <p>NUBEQA</p> <p>XTANDI</p> <p>YONSA</p> <p>§ LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS</p> <p><i>leuprolide acetate</i></p> <p>ELIGARD</p>
<p>ANTI-INFECTIVES</p> <p>ANTIRETROVIRAL AGENTS</p> <p>§ ANTIRETROVIRAL COMBINATIONS</p> <p><i>abacavir-lamivudine</i></p> <p><i>lamivudine-zidovudine</i></p> <p>ATRIPLA</p> <p>BIKTARVY</p> <p>CIMDUO</p> <p>DESCOVY</p> <p>DOVATO</p> <p>EVOTAZ</p> <p>GENVOYA</p> <p>ODEFSEY</p>	<p>FUSION INHIBITORS</p> <p>FUZEON</p> <p>INTEGRASE INHIBITORS</p> <p>ISENTRESS</p> <p>TIVICAY</p> <p>§ NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS</p> <p><i>efavirenz</i></p> <p><i>nevirapine</i></p> <p><i>nevirapine ext-rel</i></p> <p>EDURANT</p> <p>INTELENCE</p>	<p>§ NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS</p> <p><i>tenofovir disoproxil fumarate</i></p> <p>§ PROTEASE INHIBITORS</p> <p><i>atazanavir</i></p> <p><i>lopinavir-ritonavir solution</i></p> <p>KALETRA TABLET</p> <p>NORVIR</p> <p>PREZISTA</p>	<p>ANTINEOPLASTIC AGENTS</p> <p>§ ALKYLATING AGENTS</p> <p><i>temozolomide</i></p> <p>§ ANTIMETABOLITES</p> <p><i>capecitabine</i></p>	<p>IMMUNOMODULATORS</p> <p>REVLIMID</p> <p>THALOMID</p> <p>§ KINASE INHIBITORS</p> <p><i>ertotinib</i></p> <p><i>imatinib mesylate</i></p>

AFINITOR
BOSULIF
CABOMETYX
COPIKTRA
IBRANCE
IRESSA
KISQALI
KISQALI FEMARA
CO-PACK
RYDAPT
SPRYCEL
SUTENT
TYKERB
VOTRIENT

§ MISCELLANEOUS

bexarotene capsule
LYNPARZA
ODOMZO
RUBRACA
ZEJULA
ZOLINZA

CARDIOVASCULAR

ANTILIPEMICS
PCSK9 INHIBITORS
PRALUENT

PULMONARY ARTERIAL
HYPERTENSION
§ ENDOTHELIN RECEPTOR
ANTAGONISTS

ambrisentan
bosentan
OPSUMIT

§ PHOSPHODIESTERASE
INHIBITORS

sildenafil
tadalafil

PROSTACYCLIN RECEPTOR
AGONISTS
UPTRAVI

PROSTAGLANDIN
VASODILATORS
ORENITRAM

SOLUBLE GUANYLATE
CYCLASE STIMULATORS
ADEMPAS

**CENTRAL NERVOUS
SYSTEM**

§ ANTICONVULSANTS

vigabatrin

§ MOVEMENT DISORDERS

tetrabenazine
AUSTEDO
INGREZZA

**§ MULTIPLE SCLEROSIS
AGENTS**

glatiramer
AUBAGIO
BETASERON
COPAXONE
GILENYA
MAYZENT
REBIF
TECFIDERA
TYSABRI
VUMERITY

**ENDOCRINE AND
METABOLIC**

ACROMEGALY
SOMATULINE DEPOT
SOMAVERT

**§ CALCIUM RECEPTOR
ANTAGONISTS**

cinacalcet

**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

POLYNEUROPATHY

TEGSEDI

§ UREA CYCLE DISORDERS

sodium phenylbutyrate

**MISCELLANEOUS
CYSTAGON**

HEMATOLOGIC

**HEMATOPOIETIC GROWTH
FACTORS**

ARANESP
NEULASTA
NIVESTYM
RETACRIT
UDENYCA

HEMOPHILIA A AGENTS

ADYNOVATE
JIVI
KOGENATE FS
KOVALTRY
NOVOEIGHT
NUWIQ

HEMOPHILIA B AGENTS

REBINYN

**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
SKYRIZI
STELARA
SUBCUTANEOUS
TALTZ
TREMIFYA

PSORIATIC ARTHRITIS

COSENTYX
ENBREL
HUMIRA
OTEZLA

RHEUMATOID ARTHRITIS

ENBREL
HUMIRA
ORENCIA CLICKJECT
ORENCIA
SUBCUTANEOUS
RINVOQ
XELJANZ
XELJANZ XR

ULCERATIVE COLITIS

HUMIRA
STELARA
SUBCUTANEOUS #
XELJANZ #
XELJANZ XR #

After failure of HUMIRA

ALL OTHER CONDITIONS

ENBREL
HUMIRA

**DISEASE-MODIFYING
ANTIRHEUMATIC DRUGS
(DMARDs)**

RASUVO

HEREDITARY ANGIOEDEMA

FIRAZYR
RUCONEST
TAKHZYRO

IMMUNOSUPPRESSANTS

§ ANTIMETABOLITES
mycophenolate mofetil
mycophenolate sodium

§ CALCINEURIN INHIBITORS

cyclosporine
cyclosporine, modified
tacrolimus

§ RAPAMYCIN DERIVATIVES

everolimus
sirolimus

RESPIRATORY

ALPHA-1 ANTITRYPSIN
DEFICIENCY AGENTS
PROLASTIN-C

§ CYSTIC FIBROSIS

tobramycin
inhalation solution
BETHKIS

**PULMONARY FIBROSIS
AGENTS**

ESBRIET
OFEV

SEVERE ASTHMA AGENTS

DUPIXENT
FASENRA
NUCALA
XOLAIR

TOPICAL

DERMATOLOGY
ATOPIC DERMATITIS
DUPIXENT

**MOUTH / THROAT /
DENTAL AGENTS**

PROTECTANTS
MUGARD

OPHTHALMIC
RETINAL DISORDERS
EYLEA
LUCENTIS

QUICK REFERENCE DRUG LIST

A
abacavir tablet
abacavir-lamivudine
abiraterone
ADEMPAS
ADYNOVATE
AFINITOR
ambrisentan
ARANESP

atazanavir
ATRIPLA
AUBAGIO
AUSTEDO

B
BARACLUDE SOLUTION
BETASERON
BETHKIS

bexarotene capsule
BIKTARVY
bosentan
BOSULIF

C
CABOMETYX
capecitabine
CERDELGA

CEREZYME
CETROTIDE
CIMDUO
cinacalcet
COPAXONE
COPIKTRA
COSENTYX
cyclosporine

cyclosporine, modified
CYSTAGON

D
DESCOVY
didanosine
DOVATO
DUPIXENT

E EDURANT <i>efavirenz</i> ELIGARD EMTRIVA ENBREL <i>entecavir</i> EPCLUSA ERLEADA <i>erlotinib</i> ESBRIET <i>everolimus</i> EVOTAZ EYLEA	I IBRANCE <i>imatinib mesylate</i> INGREZZA INTELENCE IRESSA ISENTRESS	N NEULASTA <i>nevirapine</i> <i>nevirapine ext-rel</i> NIVESTYM NORVIR NOVOEIGHT NUBEQA NUCALA NUWIQ	RETACRIT REVLIMID <i>ribavirin</i> RINVOQ RUBRACA RUCONEST RYDAPT	THALOMID TIVICAY <i>tobramycin</i> <i>inhalation solution</i> TREMFYA TRIUMEQ TRUVADA TYKERB TYMLOS TYSABRI
F FASENRA FIRAZYR FORTEO FUZEON	J JIVI	O ODEFSEY ODOMZO OFEV OPSUMIT ORALAIR ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS ORENITRAM ORFADIN OTEZLA OVIDREL	S <i>sildenafil</i> <i>sirolimus</i> SKYLA SKYRIZI <i>sodium phenylbutyrate</i> SOMATULINE DEPOT SOMAVERT SPRYCEL <i>stavudine</i> STELARA SUBCUTANEOUS SUPARTZ FX SUTENT SYMFI SYMFI LO SYMITUZA	U UDENYCA UPTRAVI
G GEL-ONE GELSYN-3 GENVOYA GILENYA <i>glatiramer</i> GONAL-F	K KALETRA TABLET KISQALI KISQALI FEMARA CO-PACK KOGENATE FS KOVALTRY KYLEENA	P PRALUENT PREZCOBIX PREZISTA PROLASTIN-C PROLIA	T <i>tacrolimus</i> <i>tadalafil</i> TAKHZYRO TALTZ TECFIDERA TEGSEDI TEMIXYS <i>temozolomide</i> <i>tenofovir disoproxil fumarate</i> <i>tetrabenazine</i>	V VEMLIDY <i>vigabatrin</i> VISCO-3 VOSEVI ² VOTRIENT VUMERITY
H HARVONI HUMATROPE HUMIRA	L <i>lamivudine</i> <i>lamivudine-zidovudine</i> <i>leuprolide acetate</i> <i>lopinavir-ritonavir solution</i> LUCENTIS LYNPARZA	R RASUVO REBIF REBINYN		X XELJANZ XELJANZ XR XOLAIR XTANDI
	M MAYZENT MIRENA MUGARD MULPLETA <i>mycophenolate mofetil</i> <i>mycophenolate sodium</i>			Y YONSA
				Z ZEJULA <i>zidovudine</i> ZOLINZA

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS³

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ADCIRCA	<i>sildenafil, tadalafil</i>	EPIVIR HBV	<i>entecavir, lamivudine, tenofovir disoproxil fumarate, BARACLUDE SOLUTION, VEMLIDY</i>
ALIQOPA	COPIKTRA	EPOGEN	ARANESP, RETACRIT
ALPROLIX	Consult doctor	EUFLEXXA	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
ASTAGRAF XL	<i>tacrolimus</i>	EXTAVIA	<i>glatiramer, AUBAGIO, BETASERON, COPAXONE, GILENYA, MAYZENT, REBIF, TECFIDERA, TYSABRI, VUMERITY</i>
AVONEX	<i>glatiramer, AUBAGIO, BETASERON, COPAXONE, GILENYA, MAYZENT, REBIF, TECFIDERA, TYSABRI, VUMERITY</i>	FOLLISTIM AQ	GONAL-F
BARACLUDE TABLET	<i>entecavir, lamivudine, tenofovir disoproxil fumarate, BARACLUDE SOLUTION, VEMLIDY</i>	FULPHILA	NEULASTA, UDENYCA
BERINERT	FIRAZYR, RUCONEST	GENOTROPIN	HUMATROPE
BUPHENYL	<i>sodium phenylbutyrate</i>	GLEEVEC	<i>imatinib mesylate, BOSULIF, SPRYCEL</i>
CELLCEPT	<i>mycophenolate mofetil, mycophenolate sodium</i>	GRANIX	NIVESTYM
CHORIONIC GONADOTROPIN	OVIDREL	HEPSERA	<i>entecavir, lamivudine, tenofovir disoproxil fumarate, BARACLUDE SOLUTION, VEMLIDY</i>
COMPLERA	ATRIPLA, BIKTARVY, GENVOYA, ODEFSEY, SYMFI, SYMFI LO, SYMTUZA, TRIUMEQ	HYALGAN	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
DUROLANE	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	LETAIRIS	<i>ambrisentan, bosentan, OPSUMIT</i>
ELELYSO	CERDELGA, CEREZYME	LILETTA	KYLEENA, MIRENA, SKYLA
ELOCTATE	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ	LUPRON DEPOT (For Prostate Cancer Only)	ELIGARD
ENVARUSUS XR	<i>tacrolimus</i>	MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI ²

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
MONOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	REVATIO	<i>sildenafil, tadalafil</i>
MYFORTIC	<i>mycophenolate mofetil, mycophenolate sodium</i>	SABRIL	<i>vigabatrin</i>
NEUPOGEN	NIVESTYM	SAIZEN	HUMATROPE
NORDITROPIN	HUMATROPE	SANDOSTATIN LAR	SOMATULINE DEPOT, SOMAVERT
NOVAREL	OVIDREL	STRIBILD	ATRIPLA, BIKTARVY, GENVOYA, ODEFSEY, SYMFI, SYMFI LO, SYMTUZA, TRIUMEQ
NUTROPIN AQ	HUMATROPE	SYNVISC, SYNVISC-ONE	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
OMNITROPE	HUMATROPE	TASIGNA	<i>imatinib mesylate, BOSULIF, SPRYCEL</i>
ORTHOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	TOBI, TOBI PODHALER	<i>tobramycin inhalation solution, BETHKIS</i>
OTREXUP	RASUVO	VIEKIRA PAK	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
PEGASYS	Consult doctor	XENAZINE	<i>tetrabenazine, AUSTEDO</i>
PLEGRIDY	<i>glatiramer, AUBAGIO, BETASERON, COPAXONE, GILENYA, MAYZENT, REBIF, TECFIDERA, TYSABRI, VUMERITY</i>	ZARXIO	NIVESTYM
PREGNYL	OVIDREL	ZEMAIRA	PROLASTIN-C
PROCRIT	ARANESP, RETACRIT	ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
PROCYSBI	CYSTAGON	ZORTRESS	<i>everolimus, sirolimus</i>
PROGRAF	<i>tacrolimus</i>	ZYDELIG	COPIKTRA
RAPAMUNE	<i>everolimus, sirolimus</i>	ZYTIGA	<i>abiraterone, XTANDI, YONSA</i>
RAVICTI	<i>sodium phenylbutyrate</i>		
REPATHA	PRALUENT		

TABLE 1 - PREFERRED OPTIONS FOR INDICATION BASED AUTOIMMUNE EXCLUDED MEDICATIONS

CONDITION	EXCLUDED DRUG NAME(S)	PREFERRED OPTION(S)
ANKYLOSING SPONDYLITIS	CIMZIA SIMPONI TALTZ	COSENTYX ENBREL HUMIRA
CROHN'S DISEASE	CIMZIA ENTYVIO	HUMIRA STELARA SUBCUTANEOUS #
PSORIASIS	CIMZIA COSENTYX ENBREL	HUMIRA OTEZLA SKYRIZI STELARA SUBCUTANEOUS TALTZ TREMIFYA
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 ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS RINVOQ XELJANZ XELJANZ XR
ULCERATIVE COLITIS	ENTYVIO SIMPONI	HUMIRA STELARA SUBCUTANEOUS # XELJANZ # XELJANZ XR #
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.

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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