

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>SYMFI</p> <p>SYMFI LO</p> <p>TEMIXYS</p> <p>TRIUMEQ</p> <p>TRUVADA</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>§ 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>§ 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>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>VOSEVI²</p>	<p>HORMONAL</p> <p>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>IMMUNOMODULATORS</p> <p>REVLIMID</p> <p>THALOMID</p> <p>§ KINASE INHIBITORS</p> <p><i>erlotinib</i></p> <p><i>imatinib mesylate</i></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>DESCOVI</p> <p>EVOTAZ</p> <p>GENVOYA</p> <p>ODEFSEY</p> <p>PREZCOBIV</p>			<p>ANTINEOPLASTIC AGENTS</p> <p>§ ALKYLATING AGENTS</p> <p><i>temozolomide</i></p> <p>§ ANTIMETABOLITES</p> <p><i>capecitabine</i></p>	

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

§ MISCELLANEOUS
bexarotene capsule
 LYNPARZA
 ODOMZO
 RUBRACA
 ZEJULA
 ZOLINZA

CARDIOVASCULAR

ANTILIPEMICS
 PCSK9 INHIBITORS
 REPATHA
 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

**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
 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
 TREMFYA

PSORIATIC ARTHRITIS
 COSENTYX
 ENBREL
 HUMIRA
 OTEZLA

RHEUMATOID ARTHRITIS
 ENBREL
 HUMIRA
 ORENCIA CLICKJECT
 ORENCIA
 SUBCUTANEOUS
 RINVOQ
 XELJANZ
 XELJANZ XR

ULCERATIVE COLITIS
 HUMIRA
 XELJANZ #
 XELJANZ XR #

After failure of HUMIRA

ALL OTHER CONDITIONS
 ENBREL
 HUMIRA

DISEASE-MODIFYING
 ANTIRHEUMATIC DRUGS
 (DMARDs)
 RASUVO

HEREDITARY ANGIOEDEMA

FIRAZYR
 RUCONEST

IMMUNOSUPPRESSANTS
 § ANTIMETABOLITES
mycophenolate mofetil
mycophenolate sodium

§ CALCINEURIN INHIBITORS
cyclosporine
cyclosporine, modified
tacrolimus

§ RAPAMYCIN DERIVATIVES
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
 COPAXONE
 COSENTYX
cyclosporine

cyclosporine, modified
 CYSTAGON

D
 DESCOVY
didanosine
 DUPIXENT

E
 EDURANT
efavirenz

ELIGARD
 EMTRIVA
 ENBREL
entecavir
 EPCLUSA
 ERLEADA
erlotinib
 ESBRIET
 EVOTAZ
 EYLEA

F FASENRA FIRAZYR FORTEO FUZEON	KISQALI KISQALI FEMARA CO-PACK KOGENATE FS KOVALTRY KYLEENA	O ODEFSEY ODOMZO OFEV OPSUMIT ORALAIR ORENCIA CLICKJECT ORENCIA SUBCUTANEOUS ORENITRAM ORFADIN OTEZLA OVIDREL	S SENSIPAR <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	TRUVADA TYKERB TYMLOS TYSABRI
G GEL-ONE GELSYN-3 GENVOYA GILENYA <i>glatiramer</i> GONAL-F	L <i>lamivudine</i> <i>lamivudine-zidovudine</i> <i>leuprolide acetate</i> <i>lopinavir-ritonavir solution</i> LUCENTIS LYNPARZA	P PREZCOBIX PREZISTA PROLASTIN-C PROLIA		U UDENYCA UPTRAVI
H HARVONI HUMATROPE HUMIRA	M MAYZENT MIRENA MUGARD MULPLETA <i>mycophenolate mofetil</i> <i>mycophenolate sodium</i>	R RASUVO REBIF REBINYN REPATHA RETACRIT REVLIMID <i>ribavirin</i> RINVOQ RUBRACA RUCONEST RYDAPT		V VEMLIDY <i>vigabatrin</i> VISCO-3 VOSEVI ² VOTRIENT
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		T <i>tacrolimus</i> <i>tadalafil</i> TALTZ TECFIDERA TEMIXYS <i>temozolomide</i> <i>tenofovir disoproxil fumarate</i> <i>tetrabenazine</i> THALOMID TIVICAY <i>tobramycin</i> <i>inhalation solution</i> TREMFYA TRIUMEQ	X XELJANZ XELJANZ XR XOLAIR XTANDI
J JIVI				Y YONSA
K KALETRA TABLET				Z ZEJULA <i>zidovudine</i> ZOLINZA

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS ³

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

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

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 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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