January 2017

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 **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.

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 **www.caremark.com** to check coverage and copay [1] information for a specific medicine.

ANALGESICS

VISCOSUPPLEMENTS

GEL-ONE
HYALGAN
SUPARTZ FX

ANTI-INFECTIVES

ANTIRETROVIRAL AGENTS

§ ANTIRETROVIRAL COMBINATIONS

lamivudine-zidovudine
ATRIPLA
COMPLERA
EPZICOM
EVOTAZ
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
didanosine
lamivudine
stavudine
zidovudine
EMTRIVA

NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS

VIREAD

PROTEASE INHIBITORS

KALETRA
NORVIR
PREZISTA
REYATAZ

ANTIVIRALS

§ HEPATITIS B AGENTS

entecavir tablet
lamivudine
BARACLUDE SOLUTION

§ 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

§ KINASE INHIBITORS

imatinib mesylate
AFINITOR
BOSULIF
NEXAVAR
SPRYCEL
SUTENT
TARCEVA

TYKERB
VOTRIENT

§ MISCELLANEOUS
bexarotene capsule
ZOLINZA

CARDIOVASCULAR

ANTILIPEMICS
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

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

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
MYFORTIC

§ 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

MOUTH / THROAT / DENTAL AGENTS
PROTECTANTS
MUGARD

QUICK REFERENCE DRUG LIST

A
abacavir
AFINITOR
ARANESP
ATRIPLA
AUBAGIO

B
BARACLUDE SOLUTION
BETASERON
BETHKIS
bexarotene capsule
BOSULIF

C
capecitabine
CETROTIDE
chorionic gonadotropin - Novarel
COMPLERA
COPAXONE 40 MG
cyclosporine
cyclosporine, modified

D
didanosine

E
EDURANT
EMTRIVA
ENBREL
entecavir tablet
EPCLUSA
EPZICOM
ESBRIET
EVOTAZ

F
FOLLISTIM AQ
FORTEO
FUZEON

G
GEL-ONE
GILENYA
glatiramer

H
HARVONI
HUMATROPE
HUMIRA
HYALGAN

I
imatinib mesylate
INTELENCE
ISENTRESS

K
KALETRA
KOGENATE FS
KOVALTRY

L
lamivudine
lamivudine-zidovudine
LETAIRIS
leuprolide acetate
LUPRON DEPOT

M
MUGARD
mycophenolate mofetil
MYFORTIC

N
nevirapine
nevirapine ext-rel
NEXAVAR
NORVIR
NOVOEIGHT
NUWIQ

O
OFEV
ORALAIR
ORENITRAM
OVIDREL

P
PREZCOBIX
PREZISTA

R
RAPAMUNE SOLUTION
RASUVO
REBIF
REPATHA
REVLIMID
REYATAZ
ribavirin

S
sildenafil
sirolimus tablet
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
VIREAD
VOTRIENT

Z
ZARXIO
zidovudine
ZOLADEX
ZOLINZA
ZYTIGA

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS [2]

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

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 until the product has been evaluated, determined to be clinically appropriate and cost-effective, and approved by the CVS Caremark Pharmacy and Therapeutics Committee (or other appropriate reviewing body). 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 **www.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] 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.

 106-31697C 010117 **www.caremark.com**

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