

# Advanced Control Specialty Formulary<sup>®</sup>

The **CVS Caremark<sup>®</sup> Advanced Control Specialty Formulary<sup>®</sup>** 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<sup>1</sup> 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<sup>1</sup> information, please visit [Caremark.com](http://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.

<b>ANALGESICS</b>	SYMFI SYMFI LO SYMITUZA TEMIXYS TRIUMEQ TRUVADA
<b>VISCOSUPPLEMENTS</b>	
GEL-ONE GELSYN-3 SUPARTZ FX VISCO-3	
<b>ANTI-INFECTIVES</b>	
<b>ANTIRETROVIRAL AGENTS</b>	
<b>§ ANTIRETROVIRAL COMBINATIONS</b>	
<i>abacavir-lamivudine</i> <i>lamivudine-zidovudine</i> ATRIPLA BIKTARVY CIMDUO DESCOVIY EVOTAZ GENVOYA ODEFSEY PREZCOBIV	
<b>FUSION INHIBITORS</b>	FUZEON
<b>INTEGRASE INHIBITORS</b>	ISENTRESS TIVICAY
<b>§ NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS</b>	<i>efavirenz</i> <i>nevirapine</i> <i>nevirapine ext-rel</i> EDURANT INTELENCE

<b>§ NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS</b>
<i>abacavir tablet</i> <i>didanosine</i> <i>lamivudine</i> <i>stavudine</i> <i>zidovudine</i> EMTRIVA

<b>§ NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS</b>
<i>tenofovir disoproxil fumarate</i>

<b>§ PROTEASE INHIBITORS</b>
<i>atazanavir</i> <i>lopinavir-ritonavir solution</i> KALETRA TABLET NORVIR PREZISTA

## 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<sup>1</sup> 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<sup>1</sup> for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to [Caremark.com](http://Caremark.com) to check coverage and copay<sup>1</sup> information for a specific medicine.

<b>ANTIVIRALS</b>
<b>§ HEPATITIS B AGENTS</b>
<i>entecavir</i> <i>lamivudine</i> <i>tenofovir disoproxil fumarate</i> BARACLUDE SOLUTION VEMLIDY

<b>§ HEPATITIS C AGENTS</b>
<i>ribavirin</i> EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6) VOSEVI <sup>2</sup>

## ANTINEOPLASTIC AGENTS

<b>§ ALKYLATING AGENTS</b>
<i>temozolomide</i>
<b>§ ANTIMETABOLITES</b>
<i>capecitabine</i>

<b>HORMONAL ANTINEOPLASTIC AGENTS</b>
<b>§ ANTIANDROGENS</b>
<i>abiraterone</i> ERLEADA NUBEQA XTANDI YONSA
<b>§ LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS</b>
<i>leuprolide acetate</i> ELIGARD

<b>IMMUNOMODULATORS</b>
REVLIMID THALOMID
<b>§ KINASE INHIBITORS</b>
<i>erlotinib</i> <i>imatinib mesylate</i>

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  
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

§ 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  
NUVIQ

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  
*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  
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

**G**  
GEL-ONE  
GELSYN-3  
GENVOYA  
GILENYA  
glatiramer  
GONAL-F

**H**  
HARVONI  
HUMATROPE  
HUMIRA

**I**  
IBRANCE  
imatinib mesylate  
INGREZZA  
INTELENCE  
IRESSA  
ISENTRESS

**J**  
JIVI

**K**  
KALETRA TABLET  
KISQALI  
KISQALI FEMARA  
CO-PACK  
KOGENATE FS  
KOVALTRY  
KYLEENA

**L**  
lamivudine  
lamivudine-zidovudine  
leuprolide acetate  
lopinavir-ritonavir solution  
LUCENTIS  
LYNPARZA

**M**  
MAYZENT  
MIRENA  
MUGARD  
MULPLETA  
mycophenolate mofetil  
mycophenolate sodium

**N**  
NEULASTA  
nevirapine

nevirapine ext-rel  
NIVESTYM  
NORVIR  
NOVOEIGHT  
NUBEQA  
NUCALA  
NUVIQ

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

**P**  
PRALUENT  
PREZCOBIX  
PREZISTA  
PROLASTIN-C  
PROLIA

**R**  
RASUVO  
REBIF  
REBINYN  
RETACRIT  
REVLIMID  
ribavirin  
RINVOQ  
RUBRACA  
RUCONEST  
RYDAPT

**S**  
sildenafil  
sirolimus  
SKYLA  
SKYRIZI  
sodium phenylbutyrate  
SOMATULINE DEPOT  
SOMAVERT  
SPRYCEL  
stavudine  
STELARA  
SUBCUTANEOUS  
SUPARTZ FX  
SUTENT  
SYMFI  
SYMFI LO  
SYMITUZA

**T**  
tacrolimus  
tadalafil  
TAKHZYRO  
TALTZ  
TECFIDERA  
TEMIXYS  
temozolomide  
tenofovir disoproxil fumarate  
tetrabenazine  
THALOMID  
TIVICAY  
tobramycin  
inhalation solution  
TREMIFYA  
TRIUMEQ  
TRUVADA  
TYKERB  
TYMLOS  
TYSABRI

**U**  
UDENYCA  
UPTRAVI

**V**  
VEMLIDY  
vigabatrin  
VISCO-3  
VOSEVI<sup>2</sup>  
VOTRIENT  
VUMERITY

**X**  
XELJANZ  
XELJANZ XR  
XOLAIR  
XTANDI

**Y**  
YONSA

**Z**  
ZEJULA  
zidovudine  
ZOLINZA

## PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS <sup>3</sup>

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

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI <sup>2</sup>	REPATHA	PRALUENT
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</i> , BOSULIF, SPRYCEL
ORTHOVISC	GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3	TOBI, TOBI PODHALER	<i>tobramycin inhalation solution</i> , BETHKIS
OTREXUP	RASUVO	VIEKIRA PAK	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
PEGASYS	Consult doctor	XENAZINE	<i>tetrabenazine</i> , AUSTEDO
PLEGRIDY	<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE, GILENYA, MAYZENT, REBIF, TECFIDERA, TYSABRI, VUMERITY	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>sirolimus</i>
PROGRAF	<i>tacrolimus</i>	ZYTIGA	<i>abiraterone</i> , XTANDI, YONSA
RAPAMUNE	<i>sirolimus</i>		
RAVICTI	<i>sodium phenylbutyrate</i>		

**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 copay<sup>1</sup> 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 copay<sup>1</sup> 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.

<sup>1</sup> 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.

<sup>2</sup> 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).

<sup>3</sup> 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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