

Kentucky Employees' Health Plan Advanced Control Specialty Formulary™

The **Kentucky Employees' Health Plan 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.
- 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 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.
- 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 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 information for a specific medicine.

ANALGESICS

VISCOSUPPLEMENTS

GEL-ONE
HYALGAN
SUPARTZ FX

ANTI-INFECTIVES

ANTI-RETROVIRAL AGENTS

§ ANTI-RETROVIRAL COMBINATIONS
lamivudine-zidovudine
ATRIPLA
COMPLERA
EPZICOM
EVOTAZ

PREZCOBIX
STRIBILD
TRIUMEQ
TRUVADA

FUSION INHIBITORS

FUZEON
INTEGRASE INHIBITORS
ISENTRESS
TIVICAY

§ NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
nevirapine
EDURANT

INTELENCE
SUSTIVA
VIRAMUNE XR

§ 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
HARVONI
SOVALDI

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
AFINITOR
BOSULIF
GLEEVEC
NEXAVAR
SPRYCEL
SUTENT
TARCEVA
TYKERB
VOTRIENT

§ MISCELLANEOUS
TARGRETIN CAPSULE
ZOLINZA

CARDIOVASCULAR

ANTILIPEMICS
PCSK9 INHIBITORS
REPATHA
PULMONARY ARTERIAL
HYPERTENSION
ENDOTHELIN RECEPTOR
ANTAGONISTS

LETAIRIS
TRACLEER

§ PHOSPHODIESTERASE
INHIBITORS
sildenafil

PROSTAGLANDIN
VASODILATORS
TYVASO
VENTAVIS

CENTRAL NERVOUS SYSTEM

MULTIPLE SCLEROSIS
AGENTS
AUBAGIO
BETASERON
COPAXONE
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
NEULASTA

IMMUNOLOGIC AGENTS

ALLERGENIC EXTRACTS
ORALAIR
BIOLOGIC DISEASE-
MODIFYING AGENTS
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

TOPICAL

MOUTH / THROAT /
DENTAL AGENTS
PROTECTANTS
MUGARD

QUICK REFERENCE DRUG LIST

A

abacavir
AFINITOR
ARANESP
ATRIPLA
AUBAGIO

B

BARACLUE SOLUTION
BETASERON
BOSULIF

C

capecitabine
CETROTIDE
*chorionic gonadotropin -
Novarel*
COMPLERA
COPAXONE
cyclosporine
cyclosporine, modified

D

didanosine

E

EDURANT
EMTRIVA
ENBREL
entecavir tablet
EPZICOM
EVOTAZ

F

FOLLISTIM AQ
FORTEO
FUZEON

G

GEL-ONE
GILENYA
GLEEVEC

H

HARVONI
HUMATROPE
HUMIRA
HYALGAN

I

INTELENCE
ISENTRESS

K

KALETRA

L

lamivudine
lamivudine-zidovudine
LETAIRIS
leuprolide acetate
LUPRON DEPOT

M

MUGARD
mycophenolate mofetil
MYFORTIC

N

NEULASTA
nevirapine
NEXAVAR
NORVIR

O

ORALAIR
OVIDREL

P

PREZCOBIX
PREZISTA

R

RAPAMUNE SOLUTION
RASUVO
REBIF
REPATHA
REVLIMID
REYATAZ
ribavirin

S

sildenafil
sirolimus tablet
SOVALDI
SPRYCEL
stavudine
STRIBILD
SUPARTZ FX
SUSTIVA
SUTENT

T

tacrolimus
TARCEVA
TARGRETIN CAPSULE
TECFIDERA
temozolomide
THALOMID
TIVICAY
TRACLEER
TRELSTAR
TRIUMEQ
TRUVADA
TYKERB
TYVASO

V

VENTAVIS
VIRAMUNE XR
VIREAD
VOTRIENT

Z

zidovudine
ZOLADEX
ZOLINZA
ZYTIGA



PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS ²

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ACTEMRA	ENBREL, HUMIRA	PEGASYS	Consult doctor
ADCIRCA	<i>sildenafil</i>	PLEGRIDY	AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA
AVONEX	AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA	PRALUENT	REPATHA
BRAVELLE	FOLLISTIM AQ	PROCRIT	ARANESP
CIMZIA	ENBREL, HUMIRA	PROGRAF	<i>tacrolimus</i>
EUFLEXXA	GEL-ONE, HYALGAN, SUPARTZ FX	PROLIA	<i>alendronate, calcitonin-salmon, ibandronate, risedronate, ATELVIA, FORTEO</i>
EXTAVIA	AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA	REMICADE	ENBREL, HUMIRA
GENOTROPIN	HUMATROPE	REPRONEX	CETROTIDE, FOLLISTIM AQ
GONAL-F	FOLLISTIM AQ	REVATIO	<i>sildenafil</i>
KINERET	ENBREL, HUMIRA	SAIZEN	HUMATROPE
MONOVISC	GEL-ONE, HYALGAN, SUPARTZ FX	SIMPONI	ENBREL, HUMIRA
NORDITROPIN	HUMATROPE	STELARA	ENBREL, HUMIRA
NUTROPIN AQ	HUMATROPE	SYNVISC, SYNVISC-ONE	GEL-ONE, HYALGAN, SUPARTZ FX
OMNITROPE	HUMATROPE	TASIGNA	BOSULIF, GLEEVEC, SPRYCEL
OPSUMIT	LETAIRIS, TRACLEER	VIEKIRA PAK	HARVONI
ORENCIA	ENBREL, HUMIRA	XELJANZ	ENBREL, HUMIRA
ORTHOVISC	GEL-ONE, HYALGAN, SUPARTZ FX	XTANDI	ZYTIGA
OTEZLA	ENBREL, 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 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 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 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.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers. 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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www.caremark.com



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