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 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 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 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 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**

- STRIBILD
- TRIUMEQ
- TRUVADA
- FUSION INHIBITORS
- FUZEON
- INTEGRASE INHIBITORS
- ISENTRESS
- Tivicay
- § NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
- efavirenz
- nevirapine
- nevirapine ext-rel
- EDURANT
- INTELENCE
- § NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (GENOTYPES 1, 2, 3, 4, 5, 6)
- abacavir tablet
- didanosine
- lamivudine
- stavudine
- zidovudine
- EMTRIVA
- NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS
- VIREAD
- § PROTEASE INHIBITORS
- lopinavir-ritonavir solution
- KALETRA TABLET
- NORVIR
- PREZISTA
- REYATAZ
- ANTIVIRALS
- § HEPATITIS B AGENTS
- entecavir tablet
- lamivudine
- BARACLIDE SOLUTION
- VEMILYD
- § HEPATITIS C AGENTS
- ribavirin
- EPCLUSA (GENOTYPES 1, 2, 3, 4, 5, 6)
- HARVONI (GENOTYPES 1, 4, 5, 6)
- VOSEVI 2
- § NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
- EMTRIVA
- NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS
- VIREAD
- § PROTEASE INHIBITORS
- lopinavir-ritonavir solution
- KALETRA TABLET
- NORVIR
- PREZISTA
- REYATAZ
- § ANTIMETABOLITES
- capecitabine
- § ANTIANDROGENS
- § LUTEINIZING HORMONE-RELEASING HORMONE (LH-RH) AGONISTS
- leuprolide acetate
- ELIGARD
- LUPRON DEPOT
- ZOLADEX
- § IMMUNOMODULATORS
- REVLIMID
- THALomid
- § KINASE INHIBITORS
- imatinib mesylate
- AFINITOR

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COVERED DRUGS

Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. For specific information, visit www.caremark.com or contact a CVS Caremark Customer Care representative.

QUICK REFERENCE DRUG LIST

A
abacavir tablet
abacavir-lamivudine

B
BARALUDE SOLUTION
BETASERON
BETHKIS
bexarotene capsule
BOSULIF

C
CABOMETYX
capetitabine
CELERGEL
cerezyme
cetrotide
CIMZIA
COMPLERA
COPAXONE 40 MG
COSENTXY
Cyclosporine
cyclosporine, modified
cystagon

descovy
didanosine
DUPIXENT

e
EDURANT
efavirenz
ELIGARD
EMTRIVA
ENBREL
tentecavir tablet
EPCLUSA
ESBRIET
EVOTAZ

F
Forteo
FUZEO

G
GEL-ONE
GELSYN-3

H
HARVONI
HUMATROPE
HUMIRA

I
IBRANCE
imatinib mesylate
INTELENCE
IRESSA
ISENTRESS

J

K
KALETRA TABLET
KEVZARA
KISQALI
KISQALI FEMARA
CO-PACK
KOGNATE FS
KOVALTRY
KYLEENA

L
lamivudine
lamivudine-zidovudine
LETAIRIS
leuprolide acetate
lopinavir-ritonavir solution
LUPRON Depot

M

N

O

P

Q

R

S

T

U

V

W

X

Y

Z

PCSK9 INHIBITORS
PRALUENT
PULMONARY ARTERIAL HYPERTENSION
ENDOTHELIN RECEPTOR ANTAGONISTS
LETAIRIS
OPSUMIT
TRACLEER
§ PHOSPHODIESTERASE INHIBITORS
sildenafil
PROSTACYCLIN RECEPTOR AGONISTS
UPTRAVI
PROSTAGLANDIN VASODILATORS
ORENTRAM

CENTRAL NERVOUS SYSTEM
§ HUNTINGTON’S DISEASE AGENTS
tetrabenazine
AUSTEDO
§ MULTIPLE SCLEROSIS AGENTS
glatiramer
AUBAGIO
BETASERON
COPAXONE 40 MG
GILENYA
REBIF
TECFIDERA
TYSABRI

ENDOCRINE AND METABOLIC SYSTEM
ACROMEGALY
SOMATULINE DEPOT
SOMAVERT
CALCIUM REGULATORS
PARATHYROID HORMONES
Forteo
TYMLOS
MISCELLANEOUS
PROLIA
CONTRACEPTIVES
PROGESTIN INTRAUTERINE DEVICES
KYLEENA
MIRENA
SKYLA
FERTILITY REGULATORS
GNRH / LH-RH ANTAGONISTS
CETROTIDE

HEMATOLOGIC
HEMATOPOIETIC GROWTH FACTORS
ARANESP
PROCRIT
ZARXIO
HEMOPHILIA AGENTS
KOGNATE FS
KOVALTRY
NOVOEIGHT
NUWIQ
HEREDITARY ANGIOEDEMA
RUCONEST

IMMUNOLOGIC AGENTS
ALLERGENIC EXTRACTS
ORALAIR

AUTOIMMUNE AGENTS
See Table 1 for Indication Based Coverage Details
ANKYLOSING SPONDYLITIS
COSENTXY
ENBREL
HUMIRA
CROHN’S DISEASE
CIMZIA
HUMIRA
# After failure of HUMIRA
PSORIASIS
HUMIRA
STELARA
SUBCUTANEOUS #
TALTZ #
# After failure of HUMIRA
PSORIATIC ARTHRITIS
COSENTXY
ENBREL
HUMIRA
OTEZLA
RHEUMATOID ARTHRITIS
ENBREL
HUMIRA
KEVZARA
ORENcia CLICKJET
ORENcia
SUBCUTANEOUS
ULCERATIVE COLITIS
HUMIRA
SIMPONI #
# After failure of HUMIRA
ALL OTHER CONDITIONS
ENBREL
HUMIRA

DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)
RASUVO
IMMUNOSUPPRESSANTS
§ ANTIMETABOLITES
mycophenolate mofetil
mycophenolate sodium
§ 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
DERMATOLOGY
ATOPIC DERMATITIS
DUPIXENT
MOUTH/THROAT/DENTAL AGENTS
PROTECTANTS
MUGARD
Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. For specific information, visit [www.caremark.com](http://www.caremark.com) or contact a CVS Caremark Customer Care representative.

<table>
<thead>
<tr>
<th>Drug Name(s)</th>
<th>Preferred Option(s)*</th>
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<tbody>
<tr>
<td>ADCIRCA</td>
<td>sildenafil</td>
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<td>BERINERT</td>
<td>RUCONEST</td>
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<tr>
<td>BRAVELLE</td>
<td>GONAL-F</td>
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<tr>
<td>BUPHENYL</td>
<td>sodium phenylbutyrate</td>
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<tr>
<td>DAKLINZA</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
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<tr>
<td>ELEYSO</td>
<td>CERDELGA, CEREZYME</td>
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<tr>
<td>EUFLEXXA</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
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<td>EXTAVIA</td>
<td>glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA, TYSABRI</td>
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<tr>
<td>FOLLISTIM AQ</td>
<td>GONAL-F</td>
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<tr>
<td>GENOTROPIN</td>
<td>HUMATROPE</td>
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<tr>
<td>GLEEVEC</td>
<td>imatinib mesylate, BOSULIF, SPRYCEL</td>
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<td>HELIXATE FS</td>
<td>KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ</td>
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<td>HYALGAN</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
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<td>LILETTA</td>
<td>KYLEENA, MIRENA, SKYL</td>
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<td>MAVYRET</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSPIRI 2</td>
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<tr>
<td>MONOVISC</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
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<td>NEUPOGEN</td>
<td>ZARXIO</td>
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<td>ORENCIA</td>
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<td>mycophenolate mofetil</td>
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<td>sodium phenylbutyrate</td>
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<td>SPRYCEL</td>
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<td>STELARA</td>
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<td>STRIBILD</td>
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<td>SUPARTZ FX</td>
<td>SUTENT</td>
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<td>T</td>
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<td>TIVICAY</td>
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<td>inhalation solution</td>
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<td>TRACLEER</td>
<td>TRIUMEQ</td>
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<tr>
<td>TRUVADA</td>
<td>TYSABRI</td>
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<td>TYKERB</td>
<td>ZIDOVUDINE</td>
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<tr>
<td>TYMLOS</td>
<td>ZIDOVUDINE</td>
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<tr>
<td>U</td>
<td>UPTRAVI</td>
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<tr>
<td>V</td>
<td>VEMLIDY</td>
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<tr>
<td>VIREAD</td>
<td>VISCO-3</td>
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<tr>
<td>VOSPIRI 2</td>
<td>VOTRIENT</td>
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<td>X</td>
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<td>Z</td>
<td>ZARXIO</td>
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<tr>
<td>zidovudine</td>
<td>ZOLADEX</td>
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<td>ZOLINZA</td>
<td>ZYTIGA</td>
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PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS

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<tr>
<th>Drug Name(s)</th>
<th>Preferred Option(s)*</th>
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<tr>
<td>ORTHOVISC</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
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<td>OTREXUP</td>
<td>RASUVO</td>
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<td>PEGASYS</td>
<td>Consult doctor</td>
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<td>PROCYSBI</td>
<td>CYSTAGON</td>
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<td>PROGRAF</td>
<td>tacrolimus</td>
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<td>RAVICTI</td>
<td>sodium phenylbutyrate</td>
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<tr>
<td>REVATIO</td>
<td>sildenafil</td>
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<td>SAIZEN</td>
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<td>TASIGNA</td>
<td>imatinib mesylate, BOSULIF, SPRYCEL</td>
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<td>TECHNIVIE</td>
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<td>TOBI</td>
<td>tobramycin,</td>
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<td>inhalation solution, BETHKIS</td>
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<td>TOBI PODHALER</td>
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<td>XENAZINE</td>
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<td>ZEPATIER</td>
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<td>CONDITION</td>
<td>EXCLUDED DRUG NAME(S)</td>
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<tr>
<td>ANKYLOSING SPONDYLITIS</td>
<td>CIMZIA SIMPONI</td>
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<td>CROHN'S DISEASE</td>
<td>ENTYVIO STELARA</td>
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<td>PSORIASIS</td>
<td>COSENTYX ENBREL OTEZLA</td>
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<td>PSORIATIC ARTHRITIS</td>
<td>CIMZIA ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS SIMPONI STELARA SUBCUTANEOUS</td>
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<td>RHEUMATOID ARTHRITIS</td>
<td>ACTEMRA CIMZIA KINERET ORENCIA INTRAVENOUS SIMPONI XELJANZ XELJANZ XR</td>
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<td>ULCERATIVE COLITIS</td>
<td>ENTYVIO</td>
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<td>ALL OTHER CONDITIONS</td>
<td>ACTEMRA KINERET ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS</td>
</tr>
</tbody>
</table>

# 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 design 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.

\(^\S\) 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 NSSA inhibitor (for genotypes 1-6) or sofosbuvir without an NSSA 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.

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.

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