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 representative 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 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 Caremark.com to check coverage and copay information for a specific medicine.

ANALGESICS

VISCOSUPPLEMENTS
DUROLANE
GEL-ONE
GELSYN-3
SUPARTZ FX
VISCO-3

ANTI-INFECTIVES

ANTIRETROVIRAL AGENTS
§ ANTIRETROVIRAL COMBINATIONS
abacavir-lamivudine
lamivudine-zidovudine
ATRIPLA
BIKTARVY
COMPLERA
DESCOVY
EVOTAZ
GENVOYA

NULCEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
ODFSEY
PREZCOBIX
STRIBILD
TRUMEO
TRUVADA

FUSION INHIBITORS
FUZEON

INTEGRASE INHIBITORS
ISENTRRESS
TIVICAY

NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
efavirenz
nevirapine
nevirapine ext-rel
EDURANT
INTELENCE

NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
abacavir tablet
didanosine
lamivudine
 stavudine
zidovudine
EMTRIVA

NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS
VIREAD

PROTEASE INHIBITORS
lopinavir-ritonavir solution
KALETRA TABLET
NORVIR
PREZISTA
REYATAZ

ANTIPROTEASE INHIBITORS

tamivu

ANTIVIRALS
§ HEPATITIS B AGENTS
entecavir tablet
lamivudine
BARACLUDE SOLUTION
VEMLIDY

§ HEPATITIS C AGENTS
ribavirin
EPCLUSA (genotypes 1, 2, 3, 4, 5, 6)
HARVONI (genotypes 1, 4, 5, 6)
VESEVI

ANTINEOPLASTIC AGENTS
§ ALKYLATING AGENTS
temozolomide

§ ANTIMETABOLITES
capcitabine

HORMONAL ANTINEOPLASTIC AGENTS

§ ANTIANDROGENS
abiraterone
ERLEADA
XTANDI

§ LUTEINIZING HORMONE-RELEASING HORMONE (LHRR) AGONISTS
leuprolide acetate
ELIGARD

IMMUNOMODULATORS
REVLIMID
THALOMID

§ KINASE INHIBITORS
imatib mesylate
AFINITOR
BOSULIF
CABOMETYX

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

MIRENA
MUGARD
MULPLETA
mycophenolate mofetil
mycophenolate sodium

nevirapine
nevirapine ext-rel
NEXAVAR
NOVIR
NOVOEIGHT
NUCALA
NUWIQ

ODEFSEY
ODOMZO
OFEV
OPSUMIT
ORALAIR
ORENCIA CLICKJECT
ORENCIA
SUBCUTANEOUS
ORENTRAM

RAPAMUNE SOLUTION
RASUVO
REBIF
REBINYN
REPATHA
RETACRIT
REVlimid
REYATAZ
rubavirin
RUCONEST
RYDAPT

SENSIPAR
sildenafil
SIMPONI
sirolimus tablet
SKYLA

leuprolide acetate
lopinavir-ritonavir solution

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS

<table>
<thead>
<tr>
<th>DRUG NAME(S)</th>
<th>PREFERRED OPTION(S)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADCIRCA</td>
<td>sildenafil, tadalafil</td>
</tr>
<tr>
<td>ALPROLIX</td>
<td>Consult doctor</td>
</tr>
<tr>
<td>BERINERT</td>
<td>RUCONEST</td>
</tr>
<tr>
<td>BRAVELLE</td>
<td>GONAL-F</td>
</tr>
<tr>
<td>BUPHENYL</td>
<td>sodium phenylbutyrate</td>
</tr>
<tr>
<td>DAKLINZA</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
</tr>
<tr>
<td>ELEYSO</td>
<td>CERDELGA, CEREZYME</td>
</tr>
<tr>
<td>ELOCTATE</td>
<td>ADYNOVATE, JIVI, KOKENE FS, KOVALTRY, NOVOEIGHT, NUWIQ</td>
</tr>
<tr>
<td>EPOGEN</td>
<td>ARANESP, RETACRIT</td>
</tr>
<tr>
<td>EUFLEXXA</td>
<td>DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
</tr>
<tr>
<td>EXTAVIA</td>
<td>glatiramer, AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA, TYSABRI</td>
</tr>
<tr>
<td>FASENRA</td>
<td>DUPIXENT, NUCALA</td>
</tr>
<tr>
<td>FOLLISTIM AQ</td>
<td>GONAL-F</td>
</tr>
<tr>
<td>GENOTROPIN</td>
<td>HUMATROPE</td>
</tr>
<tr>
<td>GLEEVEC</td>
<td>imatinib mesylate, BOSULIF, SPRYCEI</td>
</tr>
<tr>
<td>HELIXATE FS</td>
<td>ADYNOVATE, JIVI, KOKENE FS, KOVALTRY, NOVOEIGHT, NUWIQ</td>
</tr>
<tr>
<td>HYALGAN</td>
<td>DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
</tr>
<tr>
<td>LILETTA</td>
<td>KYLEENA, MIRENA, SKYLA</td>
</tr>
<tr>
<td>LUPRON DEPOT</td>
<td>ELIGARD</td>
</tr>
<tr>
<td>(For Prostate Cancer Only)</td>
<td></td>
</tr>
<tr>
<td>MAVYRET</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI 2</td>
</tr>
</tbody>
</table>

sodium phenylbutyrate
SOMATULINE DEPOT
SOMAVENT
SPRYCEI
stavudine
STELARA
SUBCUTANEOUS
STIBILD
SUPARTZ FX
SUTENT

tacrolimus
tadalafil

na

HARVONI
HUMATROPE
HUMIRA

IBRANCE
imatinib mesylate
INTELENCE
IRESSA
ISENTRESS

JUVITA
lamivudine
lamivudine-zidovudine
LETAIRIS

KALETRA TABLET
KEVZARA
KISOQALI
KISOQALI FEMARA
CO-PACK
KOGENATE FS
KOVALTRY
KYLEENA

lamivudine
lamivudine-zidovudine

PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS

<table>
<thead>
<tr>
<th>DRUG NAME(S)</th>
<th>PREFERRED OPTION(S)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONOVISC</td>
<td>DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
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<tr>
<td>NEUPOGEN</td>
<td>ZARXIO</td>
</tr>
<tr>
<td>NORDITROPIN</td>
<td>HUMATROPE</td>
</tr>
<tr>
<td>NUTROPIN AQ</td>
<td>HUMATROPE</td>
</tr>
<tr>
<td>OMNITROPE</td>
<td>HUMATROPE</td>
</tr>
<tr>
<td>ORTHOVISC</td>
<td>DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
</tr>
<tr>
<td>OTEXUP</td>
<td>RASUVO</td>
</tr>
<tr>
<td>PEGASYS</td>
<td>Consult doctor</td>
</tr>
<tr>
<td>PRAVASTATIN</td>
<td>REPATHA</td>
</tr>
<tr>
<td>PROCYSBI</td>
<td>CYSTAGON</td>
</tr>
<tr>
<td>PROGRAF</td>
<td>tacrolimus</td>
</tr>
<tr>
<td>RAVICITI</td>
<td>sodium phenylbutyrate</td>
</tr>
<tr>
<td>REVATIO</td>
<td>sildenafil, tadalafil</td>
</tr>
<tr>
<td>SAIZEN</td>
<td>HUMATROPE</td>
</tr>
<tr>
<td>SANDOSTATIN LAR</td>
<td>SOMATULINE DEPOT, SOMAVENT</td>
</tr>
<tr>
<td>SYNVISC, SYNVISC-ONE</td>
<td>imatinib mesylate, BOSULIF, SPRYCEI</td>
</tr>
<tr>
<td>TASIGNA</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
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<tr>
<td>TECHNIVIE</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
</tr>
<tr>
<td>TOBI</td>
<td>tobramycin inhalation solution, BETHKIS</td>
</tr>
<tr>
<td>TOBI PODHALER</td>
<td>tobramycin inhalation solution, BETHKIS</td>
</tr>
<tr>
<td>VIEKIRA PAK</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>DRUG NAME(S)</th>
<th>PREFERRED OPTION(S)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIEKIRA XR</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
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<tr>
<td>XENAZINE</td>
<td>tetrabenazine, AUSTEDO</td>
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<tr>
<td>ZEMAIRA</td>
<td>ARALAST NP, GLASSIA, PROLASTIN-C</td>
</tr>
<tr>
<td>ZEPATIER</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
</tr>
<tr>
<td>ZYTIGA</td>
<td>abiraterone, XTANDI</td>
</tr>
</tbody>
</table>

### TABLE 1 - PREFERRED OPTIONS FOR INDICATION BASED AUTOIMMUNE EXCLUDED MEDICATIONS

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>EXCLUDED DRUG NAME(S)</th>
<th>PREFERRED OPTION(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANKYLOSING SPONDYLITIS</td>
<td>CIMZIA, SIMPONI</td>
<td>COSENTYX, ENBREL, HUMIRA</td>
</tr>
<tr>
<td>CROHN'S DISEASE</td>
<td>CIMZIA, ENTVYIO</td>
<td>HUMIRA, STELARA SUBCUTANEOUS #</td>
</tr>
<tr>
<td>PSORIASIS</td>
<td>CIMZIA, COSENTYX, ENBREL</td>
<td>HUMIRA, OTEZLA, STELARA SUBCUTANEOUS TALTZ</td>
</tr>
<tr>
<td>PSORIATIC ARTHRITIS</td>
<td>CIMZIA, ORENCIA CLICKJECT, ORENCIA INTRAVENOUS, ORENCIA SUBCUTANEOUS SIMPONI, STELARA SUBCUTANEOUS TALTZ, XELJANZ, XELJANZ XR</td>
<td>COSENTYX, ENBREL, HUMIRA, OTEZLA</td>
</tr>
<tr>
<td>RHEUMATOID ARTHRITIS</td>
<td>ACTEMRA, CIMZIA, KINERET, ORENCIA INTRAVENOUS SIMPONI</td>
<td>ENBREL, HUMIRA, KEVZARA, ORENCIA CLICKJECT, ORENCIA SUBCUTANEOUS XELJANZ, XELJANZ XR</td>
</tr>
<tr>
<td>ULCERATIVE COLITIS</td>
<td>ENTVYIO, XELJANZ</td>
<td>HUMIRA, SIMPONI #</td>
</tr>
<tr>
<td>ALL OTHER CONDITIONS</td>
<td>ACTEMRA, KINERET, ORENCIA CLICKJECT, ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS</td>
<td>ENBREL, HUMIRA</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 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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