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 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 Caremark.com to check coverage and copay\(^1\) information for a specific medicine.

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**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

ODEFSEY
PREZCOBIX
STRIBIILD
TRUMEO
TRUVADA

FUSION INHIBITORS
FUZEON
INTEGRASE INHIBITORS
ISENTRESS
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

§ HEPATITIS B AGENTS
entecavir tablet
lamivudine
BARACLUDE SOLUTION
VELMIDY

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

ANTINEOPLASTIC AGENTS

§ ALKYLATED AGENTS
temozolomide

§ IMMUNOMODULATORS
REVLIMID
THALOMID

§ KINASE INHIBITORS
imbiribivir mesylate
AFINITOR
BOSULIF
CABOMETYX

ANTIVIRALS

§ HORMONAL ANTINEOPLASTIC AGENTS

§ ANTIMETABOLITES

capcitabine

§ ANTIANDROGENS

§ ANTIANDROGENS

§ ANTIANDROGENS

§ ANTIANDROGENS

§ ANTIANDROGENS
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
lornopavir-ritonavir solution

M
MIRENA
MUGARD
MULTPLETA
mycophenolate mofetil
mycophenolate sodium

N
nevirapine
nevirapine ext-rel
NEXAVAR
NOORIR
NOVOEOIGHT
NUCALA
NUWIQ

O
ODEFSEY
ODOMZO
OFEV
OPSUMIT
ORALAIR
ORENCIA CLICKJECT
ORENCEA
SUBCUTANEOUS
ORENITRAM

P
PREZCOBIX
PREZISTA
PROLASTIN-C
PROLIA

Q
RENURA
REPOLIV
repamycin
rinogaline
rubasculin
RUCONEST
RYDAPT

S
SENSIPAR
sirolimus tablet
SKYLA

T
tacrolimus
tadalafil

U
UPTRAVID

V
VEMLIDY
VIRED
VISCO-3
VOSEVI

W
XEJANZ
XEJANZ XR
XTANDI

X
ZARXIO
ZEJULA
ZIDOVUDINE
ZOLINZA

Y
sodium phenylbutyrate
sodium phenylbutyrate

Z
HUMATROPE
HUMIRA
HARVONI

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, KOKENATE FS, KOVALTRY, NOVOEOIGHT, 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, SPRYCEL</td>
</tr>
<tr>
<td>HELIXATE FS</td>
<td>ADYNOVATE, JIVI, KOKENATE FS, KOVALTRY, NOVOEOIGHT, 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 (For Prostate Cancer Only)</td>
<td>ELIGARD</td>
</tr>
<tr>
<td>MAVYRET</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI</td>
</tr>
</tbody>
</table>

* For specific information, visit Caremark.com or contact a CVS Caremark Customer Care representative.
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.

<table>
<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>
</tr>
<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 ENTYVIO</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>ENTYVIO 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 copay¹ 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 copay¹ 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 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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