The **CVS Caremark® Advanced Control Specialty Formulary™** is a guide for select specialty therapeutic categories adopted by JPMorgan Chase for its prescription drug plan members. **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**

CVS Caremark administers your prescription drug benefit plan on behalf of JPMorgan Chase. 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:**

- JPMorgan Chase’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 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 equivalent in place of your original prescription.
- If there is no generic equivalent in place of your original prescription. Your doctor should consider prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription.

**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.
CENTRAL NERVOUS SYSTEM

§ HUNTINGTON’S DISEASE AGENTS
- tetrabenazine

§ MULTIPLE SCLEROSIS AGENTS
- glatiramer
- Aubagio
- Betaseron
- Copaxone 40 mg
- Gilenya
- Rebif
- Tecfidera

Hematologic

HEMATOPOIETIC GROWTH FACTORS
- Aranesp
- Zarfitor

HEMOPHILIA AGENTS
- Kogenate FS
- Kovaltry
- NovoEight
- Nuvig

IMMUNOLOGIC AGENTS

ALLERGENIC EXTRACTS
- Oralair

BIOLOGIC DISEASE-MODIFYING AGENTS
- Humira
- Stelara (after failure of HUMIRA)
- Taltz (after failure of HUMIRA)

IMMUNOSUPPRESSANTS
- § Antimetabolites
- Mycophenolate mofetil
- Myfortic

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QUICK REFERENCE DRUG LIST

A

- abacavir
- Afinitor
- Aranesp
- Atripla
- Aubagio

B

- Baraclude solution
- Betaseron
- Benthik
- Bexarotene capsule
- Bosulif

C

- capcitabine
- Cetrotide
- Chorionic gonadotropin - Novarel
- Complera
- Copaxone 40 mg
- Cyclosporine
- Cyclosporine, modified

D

- didanosine

E

- Edurant
- Emtriva
- Enbrel
- Entecavir tablet
- Epclusa
- Epzicom
- Eshriet
- Evotaz

F

- Follistim AQ
- Forteo
- Fuzeon

G

- Gel-one
- Gilenya
- Glatiramer

H

- Harvoni
- Humatrope
- Humira
- Hyalgan

I

- Imatinib mesylate
- Inteleone
- ISENTRESS

K

- Kaletra
- Kogenate FS
- Kovaltry

L

- Lamivudine
- Lamivudine-zidovudine
- Letairis
- Leuprolide acetate
- Lupron depot

M

- Mugard

N

- Nevirapine
- Nevirapine ext-rel
- Nexavar
- Norvir
- Nuvig

O

- Ofev
- Oralair
- Orenitram
- Ovidrel

P

- Prezobix
- Prezista

R

- Rapamune solution
- Rasuvo
- Rebif
- Repatha
- Revlimid
- Reyataz
- Ribavirin

S

- Sildenafil
- Sirolimus tablet
- Sprycel
- Stavudine
- Stelara
- StriBold
- Supartiz FX

T

- Tacrolimus
- Taltz
- Tarceva
- Tecfidera
- Temozolomide
- Tetragen
- Thalomid
- Tivicay
- Tobramycin inhalation solution
- Tracleer
- Trelstar
- Triumeq
- Truvada
- Tykerb

V

- Viread
- Votrient

Z

- Zarfitor
- Zidovudine
- Zoladex
- Zolinza
- Zytilga

You 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.
<table>
<thead>
<tr>
<th>DRUG NAME(S)</th>
<th>PREFERRED OPTION(S)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTEMRA</td>
<td>ENBREL, HUMIRA</td>
</tr>
<tr>
<td>ADCIRCA</td>
<td>sildenafil</td>
</tr>
<tr>
<td>AVONEX</td>
<td>glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA</td>
</tr>
<tr>
<td>BRAVELLE</td>
<td>FOLLISTIM AQ</td>
</tr>
<tr>
<td>CIMZIA</td>
<td>ENBREL, HUMIRA</td>
</tr>
<tr>
<td>DAKLINZA</td>
<td>EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)</td>
</tr>
<tr>
<td>EUFLEXXA</td>
<td>GEL-ONE, HYALGAN, SUPARTZ FX</td>
</tr>
<tr>
<td>EXTAVIA</td>
<td>glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA</td>
</tr>
<tr>
<td>GENOTROPIN</td>
<td>HUMATROPE</td>
</tr>
<tr>
<td>GLEEVEC</td>
<td>imatinib mesylate, BOSULIF, SPRYCEL</td>
</tr>
<tr>
<td>GONAL-F</td>
<td>FOLLISTIM AQ</td>
</tr>
<tr>
<td>HELIXATE FS</td>
<td>Kogenate FS, KOVALTRY, NOVOEIGHT, NUWIQ</td>
</tr>
<tr>
<td>KINERET</td>
<td>ENBREL, HUMIRA</td>
</tr>
<tr>
<td>MONOVISC</td>
<td>GEL-ONE, HYALGAN, SUPARTZ FX</td>
</tr>
<tr>
<td>NEUPOGEN</td>
<td>ZARXIO</td>
</tr>
<tr>
<td>NORDITROPIN</td>
<td>HUMATROPE</td>
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<tr>
<td>NUTROPIN AQ</td>
<td>HUMATROPE</td>
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<tr>
<td>OLYSIO</td>
<td>EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)</td>
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<tr>
<td>OMNITROPE</td>
<td>HUMATROPE</td>
</tr>
<tr>
<td>OPSUMIT</td>
<td>LETAIRIS, TRACLEER</td>
</tr>
<tr>
<td>ORENCA</td>
<td>ENBREL, HUMIRA</td>
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<tr>
<td>ORTHOVISC</td>
<td>GEL-ONE, HYALGAN, SUPARTZ FX</td>
</tr>
<tr>
<td>OTEZLA</td>
<td>ENBREL (for non-psoriasis conditions), HUMIRA, STELARA (psoriasis, after failure of HUMIRA), TALTZ (psoriasis, after failure of HUMIRA)</td>
</tr>
<tr>
<td>PEGASYS</td>
<td>Consult doctor</td>
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<tr>
<td>PLEGRIDY</td>
<td>glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA</td>
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<tr>
<td>PRALUENT</td>
<td>REPATHA</td>
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<tr>
<td>PROCRIT</td>
<td>ARANESP</td>
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<tr>
<td>PROGRAF</td>
<td>tacrolimus</td>
</tr>
<tr>
<td>PROLIA</td>
<td>alendronate, calciton-salmon, ibandronate, risedronate, ATELVIA, FORTEO</td>
</tr>
<tr>
<td>REMICADE</td>
<td>ENBREL (for non-psoriasis conditions), HUMIRA, STELARA (psoriasis, after failure of HUMIRA), TALTZ (psoriasis, after failure of HUMIRA)</td>
</tr>
<tr>
<td>REPRONEX</td>
<td>CETROTIDE, FOLLISTIM AQ</td>
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<tr>
<td>REVATIO</td>
<td>sildenafil</td>
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<tr>
<td>SAIZEN</td>
<td>HUMATROPE</td>
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<tr>
<td>SIMPONI</td>
<td>ENBREL, HUMIRA</td>
</tr>
<tr>
<td>SYNVISC, SYNVISC-ONE</td>
<td>GEL-ONE, HYALGAN, SUPARTZ FX</td>
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<td>TASIGNA</td>
<td>imatinib mesylate, BOSULIF, SPRYCEL</td>
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<tr>
<td>TECHNIVIE</td>
<td>EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)</td>
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<td>TOBI</td>
<td>tobramycin inhalation solution, BETHKIS</td>
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<tr>
<td>TOBI PODHALER</td>
<td>tobramycin inhalation solution, BETHKIS</td>
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<tr>
<td>VIEKIRA PAK</td>
<td>EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)</td>
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<tr>
<td>XELJANZ</td>
<td>ENBREL, HUMIRA</td>
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<tr>
<td>XENAZINE</td>
<td>tetrabenazine</td>
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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. 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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