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 see 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](http://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](http://www.caremark.com) to check coverage and copay information for a specific medicine.

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**ANTALGESICS**

**VISCOSUPPLEMENTS**

- STRIBILD
- TRIUMEQ
- TRUVADA
- FUSION INHIBITORS
- FUZEON
- INTEGRASE INHIBITORS
- ISENTRESS
- Tivicay

**ANTI-INFECTIVES**

**ANTIRETROVIRAL AGENTS**

- § ANTIRETROVIRAL COMBINATIONS
- abacavir-lamivudine
- lamivudine-zidovudine

- ATRIPLA
- COMPLERA
- DESCovy
- EVOTAZ
- GENVOYA
- ODEFSEY
- PREZCOBIX

- § 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

**ANTIVIRALS**

- § HEPATITIS B AGENTS
- entecavir tablet
- lamivudine

- BARACLADE SOLUTION
- VEMLIDY

- § HEPATITIS C AGENTS
- ribavirin

- EPCLUSA (genotypes 1, 2, 3, 4, 5, 6)
- HARVONI (genotypes 1, 4, 5, 6)

- VOSева ²

**HORMONAL ANTI NEOPLASTIC AGENTS**

- § ANTI ANDROGENS
- XTANDI
- ZYTIGA

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

- LUPRON DEPOT
- ZOLADEX

**IMMUNOMODULATORS**

- REVlimid
- THALOMID

- § KINASE INHIBITORS
- imatinib mesylate
- AFINITOR

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**CARDIOVASCULAR**
- Antilipemics
- Microsomal triglyceride transfer
- Protein inhibitors
- Juxtapid

**CENTRAL NERVOUS SYSTEM**
- Huntington's disease agents
- Multiple sclerosis agents

**ENDOCRINE AND METABOLIC**
- Acromegaly
- Somatuline depot
- Somavert
- Calcium regulators
- Parathyroid hormones
- Forteo
- Tymlos
- Miscellaneous prola

**FERTILITY REGULATORS**
- GnRH / LHRH antagonists
- Cetrotide
- Ovulation stimulants, gonadotropins
  - chorionic gonadotropin - Novarel
  - Gonal-F
  - Ovidrel

**HEMATOLOGY**
- Hematicoietic growth factors
- Aranesp
- Procrit
- Zarxio

**HEMATOLOGY**
- Hemophilia agents
  - Kogenate FS
  - Koavaltry
  - Novoeight
  - Nuwiq
- Hereditary angioedema
  - Ruconest

**IMMUNOLOGIC AGENTS**
- Allergenic extracts
- Oralair

**QUICK REFERENCE DRUG LIST**

<table>
<thead>
<tr>
<th>Alphabet</th>
<th>Product Name</th>
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<tbody>
<tr>
<td>A</td>
<td>abacavir tablet</td>
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<tr>
<td>B</td>
<td>Baradac solution</td>
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<tr>
<td>C</td>
<td>Cabometyx</td>
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<tr>
<td>D</td>
<td>Descovy</td>
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<td>E</td>
<td>Edurant</td>
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<td>Forteo</td>
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<td>G</td>
<td>Gel-One</td>
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<td>Ibrance</td>
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<td>Juxtapid</td>
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<td>K</td>
<td>Kaletra tablet</td>
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<td>L</td>
<td>Lamivudine</td>
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<td>M</td>
<td>Mugard</td>
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<tr>
<td>N</td>
<td>Nevirapine</td>
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**DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)**
- Rasuvo

**IMMUNOSUPPRESSANTS**
- Antimetabolites
- Calcineurin inhibitors
- Cyclosporine
- Tacrolimus
- Rakamycin derivatives
- Sirolimus tablet

**RESPIRATORY**
- Cystic fibrosis
- Tobramycin
- Inhilation solution

**PULMONARY FIBROSIS AGENTS**
- Pulmonary fibrosis
genes

**TOPICAL**
- Dermatology
  - Atopic dermatitis
  - Dupixent
- Mouth / Throat / Dental agents
  - Protectants
  - Mugar

**OTHERS**
- Miscellaneous prola
  - Bexarotene capsule
  - Zolinza
- Cardiovascular
  - Antilipemics
  - Microsomal triglyceride transfer
  - Protein inhibitors
  - Juxtapid
- Endothelin receptor antagonists
  - Letairis
  - Osumit
  - Tracleer
- Multiple phosphodiesterase inhibitors
  - Sildenafil
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.

### PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS

<table>
<thead>
<tr>
<th>DRUG NAME(S)</th>
<th>PREFERRED OPTION(S)*</th>
<th>DRUG NAME(S)</th>
<th>PREFERRED OPTION(S)*</th>
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<tr>
<td>ADCIRCA</td>
<td>sildenafil</td>
<td>ORTHOVISC</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
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<td>BERINERT</td>
<td>RUCONEST</td>
<td>OTREXUP</td>
<td>RASUVO</td>
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<td>BRAVELLE</td>
<td>GONAL-F</td>
<td>PEGASYS</td>
<td>Consult doctor</td>
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<td>DAKLINZA</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
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<td>tacrolimus</td>
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<td>ELELYSO</td>
<td>CERDELGA, CEREZYME</td>
<td>REVATIO</td>
<td>sildenafil</td>
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<td>EUFLEXZA</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
<td>SAIZEN</td>
<td>HUMATROPE</td>
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<td>EXTAVIA</td>
<td>glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA, TYSABRI</td>
<td>SANDOSTATIN LAR</td>
<td>SOMATULINE DEPOT, SOMAVERT</td>
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<td>FOLLISTIM AQ</td>
<td>GONAL-F</td>
<td>SYNVISC, SYNVISC-ONE</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
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<td>GENOTROPIN</td>
<td>HUMATROPE</td>
<td>TASIGNA</td>
<td>imatinib mesylate, BOSULIF, SPRYCEL</td>
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<td>GLEEVEC</td>
<td>imatinib mesylate, BOSULIF, SPRYCEL</td>
<td>TECHNIVIE</td>
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<td>HELIXATE FS</td>
<td>KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ</td>
<td>TOBI</td>
<td>tobramycin inhalation solution, BETHKIS</td>
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<td>HYALGAN</td>
<td>GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3</td>
<td>TOBI PODHALER</td>
<td>tobramycin inhalation solution, BETHKIS</td>
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<td>MAVYRET</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI 2</td>
<td>VIEKIRA PAK</td>
<td>EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)</td>
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<td>MONOVISC</td>
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<td>PREFERRED OPTION(S)</td>
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<td>ANKYLOSING SPONDYLITIS</td>
<td>CIMZIA, SIMPONI</td>
<td>COSENTYX, ENBREL, HUMIRA</td>
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<td>CROHN'S DISEASE</td>
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<td>PSORIASIS</td>
<td>COSENTYX, ENBREL, OTEZLA</td>
<td>HUMIRA STELARA SUBCUTANEOUS # TALTZ #</td>
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<td>PSORIATIC ARTHRITIS</td>
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<td>RHEUMATOID ARTHRITIS</td>
<td>ACTEMRA, CIMZIA, KINERET, SIMPONI, XELJANZ, XELJANZ XR</td>
<td>ENBREL, HUMIRA KEVZARA ORENCIA CLICKJECT, ORENCIA SUBCUTANEOUS</td>
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<td>ULCERATIVE COLITIS</td>
<td>ENTYVIO</td>
<td>HUMIRA SIMPONI #</td>
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<td>ALL OTHER CONDITIONS</td>
<td>ACTEMRA, KINERET, ORENCIA CLICKJECT, ORENCIA INTRAVENOUS, ORENCIA SUBCUTANEOUS</td>
<td>ENBREL, HUMIRA</td>
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# 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 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 www.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 NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A 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.
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