

**Search Tip:**

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of the drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

**GHC-SCW 4-Tier Complete Formulary  
Alphabetical Index  
Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
8-MOP CAP	-	2	DERMATOLOGICALS
abacavir soln (ZIAGEN equiv)	-	2	ANTIVIRALS
abacavir tab (ZIAGEN equiv)	-	2	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	2	ANTIVIRALS
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	2	ANTIVIRALS
ABILIFY SOLN	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tab/day; )	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABSORICA CAP	-	EXC	DERMATOLOGICALS
ABSTRAL SL TAB (QL= 120 tabs/30 days; Dosage limits may apply)	PA-QL	3	ANALGESICS - OPIOID
acamprosate calcium DR tab (CAMPRAL equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	1	ANTIDIABETICS
acebutolol cap (SECTRAL equiv)	-	1	BETA BLOCKERS
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
acetaminophen/caffeine/dihydrocodeine tab (PANLOR SS equiv) (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
acetaminophen/codeine soln (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
ACETASOL HC OTIC SOLN	-	3	OTIC AGENTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	2	DIURETICS
acetazolamide tab	-	2	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	1	OTIC AGENTS
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	1	COUGH/COLD/ALLERGY
ACIDIC VAGINAL JELLY	-	2	VAGINAL PRODUCTS
acitretin cap (SORIATANE equiv)	-	2	DERMATOLOGICALS
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA SC INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ACTOPLUS MET XR TAB	-	3	ANTIDIABETICS
acyclovir cap (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir susp (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	1	ANTIVIRALS
adapalene cream (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
adapalene gel 0.3% (DIFFERIN equiv) (Acne Only- members age 35 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
ADAPALENE LOTION (DIFFERIN equiv)	PA	3	DERMATOLOGICALS
ADDERALL XR CAP	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
adefovir dipivoxil tab (HEPSERA equiv)	-	2	ANTIVIRALS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
ADVAIR DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AEROCHAMBER	OTC	DME	MEDICAL DEVICES AND SUPPLIES
AFINITOR DISPERZ (QL= 1 tab/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB (QL= 1 tab/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	2	MIGRAINE PRODUCTS
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
ALAMAST OPHTH SOLN	-	2	OPHTHALMIC AGENTS
albendazole tab (ALBENZA equiv)	-	2	ANTHELMINTICS
albuterol neb soln 0.083% (PROVENTIL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 0.5% (VENTOLIN equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 0.63mg (ACCUNEB equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 1.25mg (ACCUNEB equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL TAB ER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
alclometasone cream (ACLOVATE equiv)	-	2	DERMATOLOGICALS
alclometasone oint (ACLOVATE OINT equiv)	-	2	DERMATOLOGICALS
ALCOHOL SWABS	OTC	DME	MEDICAL DEVICES AND SUPPLIES
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALENDRONATE SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
alendronate tab (FOSAMAX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALENDRONATE TAB 40MG	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALFERON-N INJ	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alfuzosin SR tab (UROXATRAL equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS - MISC.
ALINIA TAB (QL= 6 tabs/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS - MISC.
allopurinol tab (ZYLOPRIM equiv)	-	1	GOUT AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
ALOCRILOPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALOMIDOPHTH SOLN	-	2	OPHTHALMIC AGENTS
alosectron tab (LOTROXEX equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPHTH SOLN 0.1%	-	2	OPHTHALMIC AGENTS
alprazolam ER tab (XANAX XR equiv)	-	2	ANTIAXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	3	ANTIAXIETY AGENTS
alprazolam tab (XANAX equiv)	-	1	ANTIAXIETY AGENTS
ALREX OPHTH SUSP, LOTEMAX OPHTH SUSP	-	2	OPHTHALMIC AGENTS
ALTABAX OINT	-	3	DERMATOLOGICALS
aluminum chloride soln (DRYSOL equiv)	-	1	DERMATOLOGICALS
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
amantadine cap (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
amantadine syrup (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
amantadine tab	-	2	ANTIPARKINSON AGENTS
amethyst tab (LYBREL equiv) (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
AMICAR SOLN	-	3	HEMOSTATICS
amiloride tab (MIDAMOR equiv)	-	1	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1	DIURETICS
aminophylline tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
amiodarone tab (CORDARONE equiv)	-	1	ANTIARRHYTHMICS
amitriptyline tab (ELAVIL equiv)	-	1	ANTIDEPRESSANTS
amlodipine tab (NORVASC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
amlodipine/benazepril cap (LOTREL equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR equiv)	-	2	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	2	ANTIHYPERTENSIVES
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	2	ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	1	DERMATOLOGICALS
AMOXAPINE TAB	-	1	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin chew tab (AMOXIL equiv)	-	1	PENICILLINS
AMOXICILLIN CHEW TAB 250MG	-	1	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	1	PENICILLINS
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1	PENICILLINS
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	3	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1	PENICILLINS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ampicillin cap (PRINCIPEN equiv)	-	1	PENICILLINS
ampicillin susp (PRINCIPEN equiv)	-	1	PENICILLINS
AMTURNIDE TAB	-	3	ANTIHYPERTENSIVES
anagrelide cap (AGRYLIN equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
ANALPRAM-E KIT	-	3	ANORECTAL AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
anastrozole tab (ARIMIDEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROXY TAB	-	2	ANDROGENS-ANABOLIC
ANORO ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ANZEMET TAB (QL= 9 tabs/fill)	QL	3	ANTIEMETICS
APHTHASOL PASTE	-	2	MOUTH/THROAT/DENTAL AGENTS
APOKYN INJ (Only available through CVS Specialty 800-237-2767)	LD	MSP	ANTIPARKINSON AGENTS
apraclonidine ophth soln (IOPIDINE equiv)	-	2	OPHTHALMIC AGENTS
aprepitant cap (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
aprepitant pak (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
apri tab (DESOGEN equiv)	-	\$0	CONTRACEPTIVES
APRISO CAP	-	2	GASTROINTESTINAL AGENTS - MISC.
APTIVUS CAP	-	2	ANTIVIRALS
APTIVUS SOLN	-	2	ANTIVIRALS
aranelle tab (TRI-NORINYL equiv)	-	\$0	CONTRACEPTIVES
aripiprazole ODT (ABILIFY equiv) (QL= 2 tabs/day)	QL	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ARMOUR THYROID TAB, NATURE THROID TAB	-	1	THYROID AGENTS
ARNUITY ELLIPTA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASPIRIN CHEW TAB 75MG (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction) )	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction) )	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 81mg (Covered for males age 45-79; Covered for females (no age restriction) )	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin/codeine tab (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
aspirin/dipyridamole cap (AGGRENOLX equiv)	-	2	HEMATOLOGICAL AGENTS - MISC.
atazanavir cap (REYATAZ equiv)	-	2	ANTIVIRALS
atenolol tab (TENORMIN equiv)	-	1	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1	ANTIHYPERTENSIVES
atomoxetine cap (STRATTERA CAP equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
atorvastatin tab 10mg (LIPITOR equiv) (QL= 1 tab/day)	QL	\$0	ANTIHYPERLIPIDEMICS
atorvastatin tab 20mg (LIPITOR equiv) (QL= 1 tab/day)	QL	\$0	ANTIHYPERLIPIDEMICS
atorvastatin tab 40mg (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
atorvastatin tab 80mg (LIPITOR equiv)	-	1	ANTIHYPERTENSIVES
atovaquone susp (MEPRON equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	2	ANTIMALARIALS
ATRIPLA TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
atropine ophth oint	-	1	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1	OPHTHALMIC AGENTS
ATROVENT HFA INHALER	-	2	ASTHMA AND BRONCHODILATOR AGENTS
AUBAGIO TAB	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVANDAMET TAB	-	2	ANTIDIABETICS
AVANDARYL TAB	-	2	ANTIDIABETICS
AVANDIA TAB	-	2	ANTIDIABETICS
AVAR AEROSOL FOAM	-	3	DERMATOLOGICALS
AVAR GEL	-	2	DERMATOLOGICALS
AVAR PAD	-	EXC	DERMATOLOGICALS
AVC VAGINAL CREAM	-	2	VAGINAL PRODUCTS
aviane tab (ALESSE equiv)	-	\$0	CONTRACEPTIVES
AVONEX INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AZASAN TAB	-	3	ASSORTED CLASSES
AZASITE SOLN	-	2	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	1	ASSORTED CLASSES
azelaic acid gel (FINACEA equiv)	-	2	DERMATOLOGICALS
azelastine nasal spray 0.1% (ASTELIN equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine nasal spray 0.15% (ASTEPRO equiv)	-	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	1	OPHTHALMIC AGENTS
AZELEX CREAM	PA	3	DERMATOLOGICALS
azithromycin susp (ZITHROMAX equiv)	-	1	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	1	MACROLIDES
AZOPT OPHTH SUSP	-	2	OPHTHALMIC AGENTS
BACITRACIN OPHTH OINT	-	2	OPHTHALMIC AGENTS
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
baclofen tab 10mg, 20mg	-	1	MUSCULOSKELETAL THERAPY AGENTS
BACTROBAN NASAL OINT	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
balsalazide cap (COLAZAL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
BANZEL SUSP	-	2	ANTICONVULSANTS
BANZEL TAB	-	2	ANTICONVULSANTS
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	2	FLUOROQUINOLONES
B-D INSULIN SYRINGE	--OTC	DME	MEDICAL DEVICES AND SUPPLIES
B-D PEN NEEDLE	OTC	DME	MEDICAL DEVICES AND SUPPLIES
BELLADONNA ALKALOID/OPIUM SUPP	-	2	ULCER DRUGS
BELVIQ TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
BELVIQ XR TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
benazepril tab (LOTENSIN equiv)	-	1	ANTIHYPERTENSIVES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1	ANTIHYPERTENSIVES
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	MSP-PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSES
BENLYSTA INJ (QL= 4 inj/28 day)	MSP-PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSES
BENZNIDAZOLE TAB	PA	2	ANTHELMINTICS
benzonatate cap (TESSALON equiv)	-	1	COUGH/COLD/ALLERGY
benzoyl peroxide gel (BENZAC equiv)	OTC	1	DERMATOLOGICALS
benzoyl peroxide lotion (BENZAC equiv)	-	1	DERMATOLOGICALS
benzoyl peroxide wash kit (BENZAC equiv)	-	1	DERMATOLOGICALS
benztropine tab	-	1	ANTIPARKINSON AGENTS
BEPREVE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone augmented gel	-	1	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate lotion	-	1	DERMATOLOGICALS
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone valerate cream	-	1	DERMATOLOGICALS
betamethasone valerate lotion	-	1	DERMATOLOGICALS
betamethasone valerate oint	-	1	DERMATOLOGICALS
betaxolol ophth soln (BETOPTIC-S equiv)	-	1	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	1	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	1	URINARY ANTISPASMODICS
BETIMOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
BETOPTIC-S OPHTH SOLN	-	2	OPHTHALMIC AGENTS
bexarotene cap (TARGRETIN equiv)	MSP-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BEYAZ TAB	-	EXC	CONTRACEPTIVES
BIAFINE EMULSION	-	2	DERMATOLOGICALS
bicalutamide tab (CASODEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIKTARVY TAB	-	2	ANTIVIRALS
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
bimatoprost topical soln (LATISSE equiv)	-	EXC	DERMATOLOGICALS
bisoprolol tab (ZEBETA equiv)	-	1	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1	ANTIHYPERTENSIVES
BLEPHAMIDE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
BLEPHAMIDE S.O.P. OPHTH OINT	-	3	OPHTHALMIC AGENTS
BOSULIF TAB ( )	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BREO ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BRILINTA TAB (Restricted to Cardiology Specialist)	RS	3	HEMATOLOGICAL AGENTS - MISC.
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2%	-	1	OPHTHALMIC AGENTS
bromfenac ophth soln (BROMDAY equiv)	-	2	OPHTHALMIC AGENTS
BROMFENAC OPHTH SOLN 0.09% (ONCE DAILY)	-	2	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	2	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	2	ANTIPARKINSON AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
BROVANA NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	3	CORTICOSTEROIDS
budesonide inh susp (PULMICORT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide SR cap (ENTOCORT EC equiv) (Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine)	ST	2	CORTICOSTEROIDS
bumetanide tab (BUMEX equiv)	-	1	DIURETICS
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Dosage limits may apply)	QL	3	ANALGESICS - OPIOID
BUPRENORPHINE PATCH, BUTRANS PATCH (QL= 4 patches/28 days; Dosage limits may apply)	QL	3	ANALGESICS - OPIOID
bupropion ER tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion XL tab (WELLBUTRIN XL equiv) (QL= 1 tab/day)	QL	1	ANTIDEPRESSANTS
bupirone tab (BUSPAR equiv)	-	1	ANTIAXIETY AGENTS
bupirone tab 30mg (BUSPAR equiv)	-	2	ANTIAXIETY AGENTS
BUTISOL ELIXIR	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
BUTISOL TAB	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days; Dosage limits may apply)	QL	2	ANALGESICS - OPIOID
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYDUREON INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYETTA INJ (QL= 1 pen/30 days)	QL	3	ANTIDIABETICS
BYSTOLIC TAB	¢	2	BETA BLOCKERS
cabergoline tab (DOSTINEX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
calcipotriene cream (DOVONEX CREAM equiv)	-	2	DERMATOLOGICALS
calcipotriene oint	-	2	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	2	DERMATOLOGICALS
calcipotriene/betamethasone oint (TACLONEX equiv)	-	3	DERMATOLOGICALS
calcitonin nasal spray (MIACALCIN equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL INJ	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol inj (CALCIJEX equiv)	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL OINT	-	2	DERMATOLOGICALS
calcitriol soln (ROCALTROL SOLN equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
calcium acetate cap (PHOSLO equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES
CALQUENCE CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAMBIA POWDER PACKET	-	EXC	MIGRAINE PRODUCTS
candesartan tab (ATACAND equiv)	-	3	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	3	ANTIHYPERTENSIVES
CANTIL TAB	-	3	ULCER DRUGS
capecitabine tab (XELODA equiv)	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPEX SHAMPOO	-	3	DERMATOLOGICALS
CAPITAL/CODEINE SUSP (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
captopril tab (CAPOTEN equiv)	-	2	ANTIHYPERTENSIVES
CARAFATE SUSP	-	2	ULCER DRUGS
carbamazepine chew tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	2	ANTICONVULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	2	ANTICONVULSANTS
carbamazepine susp (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbidopa tab (LODOSYN equiv)	-	2	ANTIPARKINSON AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	1	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2	ANTIPARKINSON AGENTS
carbinoxamine soln (PALGIC equiv)	-	3	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	3	ANTIHISTAMINES
CARDENE SR CAP	-	3	CALCIUM CHANNEL BLOCKERS
carisoprodol tab (SOMA equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol tab 250mg (SOMA equiv)	-	EXC	MUSCULOSKELETAL THERAPY AGENTS
CARTEOLOL OPHTH SOLN	-	1	OPHTHALMIC AGENTS
carteolol ophth soln (OCUPRESS equiv)	-	1	OPHTHALMIC AGENTS
carvedilol tab (COREG equiv)	-	1	BETA BLOCKERS
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ANTI-INFECTIVE AGENTS - MISC.
CEDAX CAP	-	3	CEPHALOSPORINS
CEDAX SUSP	-	3	CEPHALOSPORINS
cefaclor cap (CECLOR equiv)	-	3	CEPHALOSPORINS
CEFACLOR ER TAB	-	3	CEPHALOSPORINS
CEFACLOR SUSP	-	3	CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	1	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	2	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	2	CEPHALOSPORINS
CEFDITOREN TAB	-	3	CEPHALOSPORINS
cefixime susp (SUPRAX equiv)	-	3	CEPHALOSPORINS
cefpodoxime proxetil susp (VANTIN equiv)	-	2	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	2	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	2	CEPHALOSPORINS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
cefprozil tab (CEFZIL equiv)	-	2	CEPHALOSPORINS
CEFTIN SUSP	-	2	CEPHALOSPORINS
cefuroxime susp (CEFTIN equiv)	-	1	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	1	CEPHALOSPORINS
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	2	ANALGESICS - ANTI-INFLAMMATORY
CELONTIN CAP	-	2	ANTICONVULSANTS
CENESTIN TAB	-	3	ESTROGENS
CENTANY OINT	-	3	DERMATOLOGICALS
cephalexin cap (KEFLEX equiv)	-	1	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	1	CEPHALOSPORINS
CERVICAL CAP	-	\$0	MEDICAL DEVICES AND SUPPLIES
CESAMET CAP	-	3	ANTIEMETICS
cesia tab (CYCLESSA equiv)	-	\$0	CONTRACEPTIVES
cetirizine chew tab (Zyrtec equiv)	OTC	2	ANTIHISTAMINES
cetirizine syrup (Zyrtec equiv)	OTC	1	ANTIHISTAMINES
cetirizine tab (Zyrtec equiv)	OTC	1	ANTIHISTAMINES
cevimeline cap (EVOXAC equiv)	-	2	MOUTH/THROAT/DENTAL AGENTS
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHANTIX TAB (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	1	ANTIANKXIETY AGENTS
chlordiazepoxide/amitriptyline tab (LIMBITROL equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	2	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
chloroquine tab (ARALEN equiv)	-	1	ANTIMALARIALS
chlorothiazide tab (DIURIL equiv)	-	1	DIURETICS
CHLOROTHIAZIDE TAB 250MG	-	1	DIURETICS
chlorpheniramine ER cap	-	1	ANTIHISTAMINES
chlorpromazine tab (THORAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
chlorpropamide tab (DIABINESE equiv)	-	1	ANTIDIABETICS
CHLORTHALIDONE TAB	-	1	DIURETICS
CHLORZOXAZONE TAB 500MG	-	1	MUSCULOSKELETAL THERAPY AGENTS
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1	ANTIHYPERTENSIVES
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1	ANTIHYPERTENSIVES
cholestyramine powder (QUESTRAN equiv)	-	1	ANTIHYPERTENSIVES
cholestyramine powder pack (QUESTRAN equiv)	-	1	ANTIHYPERTENSIVES
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1	ANALGESICS - NONNARCOTIC
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1	ANALGESICS - NONNARCOTIC
ciclopirox cream (LOPROX CREAM equiv)	-	1	DERMATOLOGICALS
ciclopirox gel (LOPROX GEL equiv)	-	1	DERMATOLOGICALS
ciclopirox nail soln (PENLAC equiv)	-	1	DERMATOLOGICALS
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	2	DERMATOLOGICALS
ciclopirox topical susp (LOPROX SUSP equiv)	-	1	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
CILOXAN OPHTH OINT	-	2	OPHTHALMIC AGENTS
CIMDUO TAB	-	2	ANTIVIRALS
CIMETIDINE SOLN	-	1	ULCER DRUGS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
cimetidine tab (TAGAMET equiv)	-	1	ULCER DRUGS
CIMZIA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	MSP-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
CIPRO HC OTIC SUSP	-	3	OTIC AGENTS
CIPRO SUSP 5%	-	3	FLUOROQUINOLONES
CIPRODEX OTIC SUSP	-	2	OTIC AGENTS
CIPROFLOXACIN 100MG TAB	-	3	FLUOROQUINOLONES
CIPROFLOXACIN ER TAB	-	3	FLUOROQUINOLONES
ciprofloxacin ophth soln (CILOXAN equiv)	-	1	OPHTHALMIC AGENTS
CIPROFLOXACIN OTIC SOLN	-	2	OTIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	2	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	1	FLUOROQUINOLONES
citalopram soln (CELEXA equiv)	-	1	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	1	ANTIDEPRESSANTS
CLARITHROMYC SUSP	-	2	MACROLIDES
clarithromycin ER tab (BIAXIN XL equiv)	-	3	MACROLIDES
clarithromycin susp (BIAXIN equiv)	-	1	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
CLENPIQ SOLN	-	2	LAXATIVES
CLEOCIN VAGINAL SUPP	-	3	VAGINAL PRODUCTS
clindamycin cap (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
clindamycin foam (EVOCLIN equiv)	-	EXC	DERMATOLOGICALS
clindamycin gel (CLEOCIN GEL equiv)	-	1	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	1	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	3	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv)	-	1	VAGINAL PRODUCTS
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	PA	3	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	PA	3	DERMATOLOGICALS
CLINDAMYCIN/BENZOYL PEROXIDE GEL, ACANYA GEL	-	EXC	DERMATOLOGICALS
clindamycin/tretinoin gel (ZIANA GEL equiv)	-	EXC	DERMATOLOGICALS
CLINDESSE VAGINAL CREAM	-	3	VAGINAL PRODUCTS
CLINISTIX TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
clobazam tab (ONFI equiv)	PA	1	ANTICONVULSANTS
clobetasol foam (OLUX equiv)	-	3	DERMATOLOGICALS
clobetasol lotion (CLOBEX LOTION equiv)	-	3	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	-	2	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	2	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	2	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	2	DERMATOLOGICALS
clobetasol propionate soln (TEMOVATE equiv)	-	2	DERMATOLOGICALS
clobetasol shampoo (CLOBEX SHAMPOO equiv)	-	3	DERMATOLOGICALS
CLOCORTOLONE CREAM, CLODERM CREAM	-	3	DERMATOLOGICALS
CLOMIPHENE CITRATE TAB	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
clomiphene citrate tab (CLOMID equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
clomipramine cap (ANAFRANIL equiv)	-	3	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	3	ANTICONVULSANTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
clonazepam tab (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonidine patch (CATAPRES-TTS equiv)	-	2	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	1	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
clorazepate tab (TRANXENE-T equiv)	-	2	ANTIANKXIETY AGENTS
clotrimazole troches (MYCELEX TROCHES equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	2	DERMATOLOGICALS
CLOZAPINE ODT	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
clozapine ODT 12.5mg, 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
clozapine tab (CLOZARIL equiv)	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CODEINE SULFATE SOLN (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
codeine sulfate tab (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
colchicine/probenecid tab (COL-BENEMID equiv)	-	1	GOUT AGENTS
colesevelam pack (WELCHOL equiv)	-	2	ANTIHYPERLIPIDEMICS
colesevelam tab (WELCHOL equiv)	-	2	ANTIHYPERLIPIDEMICS
colestipol granule (COLESTID equiv)	-	2	ANTIHYPERLIPIDEMICS
colestipol powder packet (COLESTID equiv)	-	3	ANTIHYPERLIPIDEMICS
colestipol tab (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
COLY-MYCIN S OTIC SUSP	-	2	OTIC AGENTS
COMBIGAN OPHTH SOLN	-	2	OPHTHALMIC AGENTS
COMBIVENT INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
COMBIVENT RESPIMAT INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COMPLERA TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
CONDYLOX GEL	-	3	DERMATOLOGICALS
CONTRACEPTIVE FOAM	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE GEL	OTC	\$0	VAGINAL PRODUCTS
CORDRAN TAPE	-	3	DERMATOLOGICALS
CORLANOR TAB	PA	3	CARDIOVASCULAR AGENTS - MISC.
CORTIFOAM	-	3	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	2	CORTICOSTEROIDS
CORTISPORIN CREAM	-	3	DERMATOLOGICALS
CORTISPORIN OINT	-	3	DERMATOLOGICALS
CORZIDE TAB 80-5MG	-	3	ANTIHYPERTENSIVES
COSENTYX INJ (1-PACK) (QL= 1 inj/28 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
COSENTYX INJ (2-PACK) (QL= 2 inj/28 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COVERA-HS TAB	-	3	CALCIUM CHANNEL BLOCKERS
CREON CAP	-	2	DIGESTIVE AIDS
CRINONE GEL	-	EXC	VAGINAL PRODUCTS
CRIVAN CAP	-	2	ANTIVIRALS
cromolyn conc (GASTROCROM equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
cromolyn ophth soln (CROLOM equiv)	-	1	OPHTHALMIC AGENTS
crotamiton lotion (EURAX equiv)	-	3	DERMATOLOGICALS
cryselle tab	-	\$0	CONTRACEPTIVES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
CUVPOSA SOLN	-	3	ULCER DRUGS
cyanocobalamin inj	-	1	HEMATOPOIETIC AGENTS
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	3	MUSCULOSKELETAL THERAPY AGENTS
CYCLOMYDRIL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1	OPHTHALMIC AGENTS
cyclophosphamide cap	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclophosphamide tab (CYTOXAN equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOSET TAB	-	3	ANTIDIABETICS
cyclosporine cap (SANDIMMUNE equiv)	-	2	ASSORTED CLASSES
CYCLOSPORINE MODIFIED CAP	-	2	MISCELLANEOUS THERAPEUTIC CLASSES
cyclosporine modified cap (NEORAL equiv)	-	2	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	2	ASSORTED CLASSES
cyproheptadine syrup	-	1	ANTIHISTAMINES
cyproheptadine tab	-	1	ANTIHISTAMINES
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD-PA	MSP	GENITOURINARY AGENTS - MISCELLANEOUS
CYSTARAN OPHTH SOLN (QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP	OPHTHALMIC AGENTS
CYTRA-3 SYRUP	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day)	MSP-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
danazol cap (DANOCRINE equiv)	-	2	ANDROGENS-ANABOLIC
dantrolene cap (DANTRIUM equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS
dapsone tab	-	1	ANTI-INFECTIVE AGENTS - MISC.
DARAPRIM TAB (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP	ANTIMALARIALS
DDAVP NASAL SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
demeclocycline tab (DECLOMYCIN equiv)	-	3	TETRACYCLINES
DEPEN TITRATAB, D-PENAMINE TAB	-	2	ASSORTED CLASSES
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
DESCOVY TAB	PA	2	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	2	ANTIDEPRESSANTS
DESLORATADINE ODT	-	EXC	ANTIHISTAMINES
desloratadine tab (CLARINEX equiv)	-	EXC	ANTIHISTAMINES
desmopressin acetate tab (DDAVP equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin nasal soln (DDAVP equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
desonide cream	-	2	DERMATOLOGICALS
desonide lotion	-	2	DERMATOLOGICALS
desonide oint	-	2	DERMATOLOGICALS
desoximetasone cream (TOPICORT CREAM equiv)	-	3	DERMATOLOGICALS
desoximetasone gel (TOPICORT equiv)	-	2	DERMATOLOGICALS
desoximetasone oint (TOPICORT equiv)	-	2	DERMATOLOGICALS
desvenlafaxine ER tab (PRISTIQ equiv)	-	2	ANTIDEPRESSANTS

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
DEXAMETHASONE CONC	-	1	CORTICOSTEROIDS
dexamethasone elixir	-	1	CORTICOSTEROIDS
dexamethasone ophth soln	-	1	OPHTHALMIC AGENTS
dexamethasone soln	-	1	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	1	CORTICOSTEROIDS
DEXCOM G6 RECEIVER (QL= 1 receiver/year)	PA-QL	DME	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 SENSOR (QL= 3 sensors/28 days)	PA-QL	DME	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days)	PA-QL	DME	MEDICAL DEVICES AND SUPPLIES
dexmethylphenidate tab (FOCALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DEXPAK TAB	-	3	CORTICOSTEROIDS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine soln (PROCENTRA equiv)	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DIALYVITE TAB	-	1	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	-	1	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	1	MULTIVITAMINS
DIAPHRAGM	-	\$0	MEDICAL DEVICES AND SUPPLIES
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	2	ANTICONVULSANTS
diazepam conc (VALIUM equiv)	-	1	ANTIANKXIETY AGENTS
DIAZEPAM SOLN	-	1	ANTIANKXIETY AGENTS
diazepam tab (VALIUM equiv)	-	1	ANTIANKXIETY AGENTS
DICLEGIS TAB	-	EXC	ANTIEMETICS
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	3	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	2	DERMATOLOGICALS
diclofenac potassium tab (CATAFLAM equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium EC tab (VOLTAREN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1	OPHTHALMIC AGENTS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	3	ANALGESICS - ANTI-INFLAMMATORY
dicloxacillin cap (DYNAPEN equiv)	-	1	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	2	ULCER DRUGS
dicyclomine tab (BENTYL equiv)	-	1	ULCER DRUGS
didanosine DR cap (VIDEX EC equiv)	-	2	ANTIVIRALS
DIFFERIN LOTION 0.1%	PA	3	DERMATOLOGICALS
DIFFERIN OTC GEL 0.1%	OTC	1	DERMATOLOGICALS
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN)	QL-ST	2	MACROLIDES
diffunisal tab (DOLOBID equiv)	-	1	ANALGESICS - NONNARCOTIC
digoxin soln (LANOXIN equiv)	-	1	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	1	CARDIOTONICS
DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY (QL= 8 sprays/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
DILANTIN CAP 30MG	-	2	ANTICONVULSANTS
diltiazem ER cap (CARDIZEM CD equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
MSP	Plan Exclusion	OTC	Infertility	LD	Limited Distribution
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	PA	Prior Authorization
SMKG	Quantity Limit	ST	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
¢	Smoking Cessation		Step Therapy	VAC	Vaccine Program
	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
diltiazem ER cap (DILACOR XR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	2	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	1	CALCIUM CHANNEL BLOCKERS
DIPENTUM CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
diphenoxylate/atropine liquid (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
dipyridamole tab (PERSANTINE equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	1	ANTIARRHYTHMICS
disopyramide ER cap (NORPACE CR equiv)	-	2	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIURIL SUSP	-	2	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	1	ANTICONVULSANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
dofetilide cap (TIKOSYN equiv)	-	2	ANTIARRHYTHMICS
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
dorzolamide ophth soln (TRUSOPT equiv)	-	1	OPHTHALMIC AGENTS
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	1	OPHTHALMIC AGENTS
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
doxazosin tab (CARDURA equiv)	-	1	ANTIHYPERTENSIVES
doxepin cap (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	PA	3	DERMATOLOGICALS
doxercalciferol cap (HECTOROL equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
DOXYCYCLINE CAP, ORACEA CAP	-	EXC	DERMATOLOGICALS
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1	TETRACYCLINES
doxycycline hyclate DR tab (DORYX equiv)	-	EXC	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 100mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	3	TETRACYCLINES
doxycycline monohydrate cap 50mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate tab	-	2	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	2	TETRACYCLINES
dronabinol cap (MARINOL equiv)	-	2	ANTIEMETICS
DROXIA CAP	-	2	HEMATOPOIETIC AGENTS
DRYSOL SOLN	-	1	DERMATOLOGICALS
DULERA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
duloxetine EC cap (CYMBALTA equiv)	-	1	ANTIDEPRESSANTS
DUPIXENT INJ (QL= 2 inj/ 28 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
DUREZOL OPHTH EMULSION	-	2	OPHTHALMIC AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
dutasteride cap (AVODART equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
dutasteride/tamsulosin cap (JALYN equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
DVORAH TAB, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	2	ANALGESICS - OPIOID
DYNACIRC CR TAB	-	3	CALCIUM CHANNEL BLOCKERS
DYRENIUM CAP	-	2	DIURETICS
econazole cream (SPECTAZOLE equiv)	-	3	DERMATOLOGICALS
EDLUAR SL TAB	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
EDURANT TAB	-	2	ANTIVIRALS
efavirenz cap (SUSTIVA equiv)	-	2	ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	2	ANTIVIRALS
eletriptan tab (RELPAX equiv) (QL= 6 tabs/fill, 2 fills/ 30 days)	QL	2	MIGRAINE PRODUCTS
ELIQUIS TAB	-	2	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	\$0	CONTRACEPTIVES
ELMIRON CAP	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
EMADINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
EMCYT CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2	MIGRAINE PRODUCTS
EMSAM PATCH	-	3	ANTIDEPRESSANTS
EMTRIVA CAP	-	2	ANTIVIRALS
EMTRIVA SOLN	-	2	ANTIVIRALS
enalapril tab (VASOTEC equiv)	-	1	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1	ANTIHYPERTENSIVES
ENBREL INJ 25MG (QL= 8 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ENBREL MINI INJ (QL= 4 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ENDOMETRIN INSERT	-	EXC	VAGINAL PRODUCTS
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	2	ANTICOAGULANTS
enpresse tab (TRI-LEVELLEN equiv)	-	\$0	CONTRACEPTIVES
entacapone tab (COMTAN equiv)	-	2	ANTIPARKINSON AGENTS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	2	ANTIVIRALS
ENTRESTO TAB (QL= 2 tabs/day)	PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
EPANED PREMIXED SOLN	PA	3	ANTIHYPERTENSIVES
EPANED SOLN	PA	3	ANTIHYPERTENSIVES
EPCLUSA TAB, SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTIVIRALS
EPIFOAM AEROSOL	-	2	DERMATOLOGICALS
epinastine ophth soln (ELESTAT equiv)	-	3	OPHTHALMIC AGENTS
EPINEPHRINE PEN INJ 0.15MG (MYLAN) (QL= 2 inj/fill)	QL	2	VASOPRESSORS
epinephrine pen inj 0.3mg (EPIPEN equiv) (QL= 2 inj/fill)	QL	2	VASOPRESSORS
EPIVIR HBV SOLN	-	2	ANTIVIRALS
eplerenone tab (INSPIRA equiv)	¢	2	ANTIHYPERTENSIVES
EQUETRO CAP	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ergotamine/caffeine tab (CAFERGOT equiv)	-	3	MIGRAINE PRODUCTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
ERIVEDGE CAP ( )	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERTACZO CREAM	-	3	DERMATOLOGICALS
ERYPED SUSP	-	3	MACROLIDES
ERY-TAB	-	3	MACROLIDES
erythromycin DR cap (ERYC equiv)	-	2	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv)	-	2	MACROLIDES
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2	MACROLIDES
erythromycin gel	-	2	DERMATOLOGICALS
erythromycin ophth oint	-	1	OPHTHALMIC AGENTS
erythromycin pad	-	1	DERMATOLOGICALS
erythromycin soln	-	1	DERMATOLOGICALS
erythromycin stearate tab	-	2	MACROLIDES
erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE)	-	2	MACROLIDES
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
ESBRIET CAP (QL= 9 caps/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 267MG (QL= 9 tabs/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 801MG (QL= 3 tabs/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
escitalopram soln (LEXAPRO equiv)	-	2	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	1	ANTIDEPRESSANTS
esomeprazole cap (NEXIUM equiv) (Step Therapy requires trial of omeprazole)	ST	1	ULCER DRUGS
estazolam tab (PROSOM equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1	ESTROGENS
estradiol cream (ESTRACE equiv)	-	1	VAGINAL PRODUCTS
estradiol patch (CLIMARA equiv) (QL= 1 patch/week)	QL	1	ESTROGENS
estradiol patch (VIVELLE-DOT equiv) (QL= 2 patches/week)	QL	1	ESTROGENS
estradiol tab (ESTRACE equiv)	-	1	ESTROGENS
estradiol vaginal tab, yuvaferm vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days (18 tabs on first fill))	QL	2	VAGINAL PRODUCTS
estradiol/norethindrone tab (ACTIVELLA equiv)	-	3	ESTROGENS
ESTRING (3 copays per Rx)	-	2	VAGINAL PRODUCTS
ESTROPIPATE TAB	-	1	ESTROGENS
estropipate tab (OGEN equiv)	-	1	ESTROGENS
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ethacrynic tab (EDECIN equiv)	-	2	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	2	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	2	ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	1	ANTICONVULSANTS
etidronate disodium tab 200mg (DIDRONEL equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
etodolac cap (LODINE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	3	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
etoposide cap (VEPESID equiv)	MSP	MSP	ANTINEOPLASTICS
EURAX CREAM	-	2	DERMATOLOGICALS
EVOCLIN FOAM	-	EXC	DERMATOLOGICALS
EVOTAZ TAB	-	2	ANTIVIRALS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
EXELDERM CREAM	-	3	DERMATOLOGICALS
EXELDERM SOLN	-	3	DERMATOLOGICALS
EXELON SOLN	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
exemestane tab (AROMASIN equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXJADE TAB	MSP	MSP	ANTIDOTES
EXTAVIA INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ezetimibe tab (ZETIA equiv)	-	1	ANTHYPERLIPIDEMICS
ezetimibe/simvastatin tab (VYTORIN equiv) (QL= 1 tab/day (10-80mg is Not Covered))	QL	3	ANTHYPERLIPIDEMICS
famciclovir tab (FAMVIR equiv)	-	2	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	2	ULCER DRUGS
famotidine tab (PEPCID equiv)	-	1	ULCER DRUGS
FANAPT TAB (QL= 2 tabs/day)	PA-QL	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANAPT TITRATION PACK (QL= 1 pack/plan year)	PA-QL	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANSIDAR TAB	-	3	ANTIMALARIALS
FARESTON TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FARXIGA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
FARYDAK CAP (QL= 6 caps/21 days)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
felbamate susp (FELBATOL equiv)	-	2	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	2	ANTICONVULSANTS
FELBATOL TAB	-	2	ANTICONVULSANTS
felodipine ER tab (PLENDIL equiv)	-	2	CALCIUM CHANNEL BLOCKERS
FEM PH GEL	-	3	VAGINAL PRODUCTS
FEMALE CONDOMS	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FEMRING (3 copays per Rx)	-	3	VAGINAL PRODUCTS
fenofibrate cap 67mg, 134mg, 200mg (ANTARA equiv)	-	1	ANTHYPERLIPIDEMICS
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1	ANTHYPERLIPIDEMICS
fenofibric acid DR cap (TRILIPIX equiv)	-	1	ANTHYPERLIPIDEMICS
FENOFIBRIC TAB, FIBRICOR TAB	-	3	ANTHYPERLIPIDEMICS
fenoprofen calcium tab	-	3	ANALGESICS - ANTI-INFLAMMATORY
fantanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days; Dosage limits may apply)	PA-QL	2	ANALGESICS - OPIOID
fantanyl patch (DURAGESIC equiv) (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
FENTORA TAB (QL= 120 tabs/30 days; Dosage limits may apply)	PA-QL	3	ANALGESICS - OPIOID
ferrex 150 forte cap	-	1	HEMATOPOIETIC AGENTS
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1	HEMATOPOIETIC AGENTS
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	MSP	ANTIDOTES
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	MSP	ANTIDOTES
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FERROUS SULFATE SYRUP (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FINACEA FOAM	-	2	DERMATOLOGICALS
FINACEA PLUS KIT	-	2	DERMATOLOGICALS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
finasteride tab (PROSCAR equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
finasteride tab (PROPECIA equiv)	-	EXC	DERMATOLOGICALS
FIRST METRONIDAZOLE SUSP	-	3	ANTI-INFECTIVE AGENTS - MISC.
FIRVANQ SOLN	-	1	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL ER TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
FLAREX OPHTH SUSP	-	3	OPHTHALMIC AGENTS
flecainide tab (TAMBOCOR equiv)	-	1	ANTIARRHYTHMICS
FLECTOR PATCH (QL= 30 patches/fill)	QL	3	DERMATOLOGICALS
FLOINASE SENSIMIST	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
FLOVENT DISKUS INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLOVENT HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluconazole susp (DIFLUCAN equiv)	-	1	ANTIFUNGALS
fluconazole tab (DIFLUCAN equiv)	-	1	ANTIFUNGALS
flucytosine cap (ANCOBON equiv)	-	2	ANTIFUNGALS
fludrocortisone tab (FLORINEF equiv)	-	1	CORTICOSTEROIDS
FLUNISOLIDE NASAL SPRAY (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluocinolone acetonide cream	-	1	DERMATOLOGICALS
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	2	DERMATOLOGICALS
fluocinolone acetonide oint	-	1	DERMATOLOGICALS
fluocinolone acetonide soln	-	2	DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	2	OTIC AGENTS
fluocinonide cream 0.05% (LIDEX equiv)	-	1	DERMATOLOGICALS
fluocinonide emollient cream	-	1	DERMATOLOGICALS
fluocinonide gel	-	1	DERMATOLOGICALS
fluocinonide oint	-	1	DERMATOLOGICALS
fluocinonide soln	-	1	DERMATOLOGICALS
FLUORABON SOLN (Covered at \$0 for members 5 years or younger)	-	2	MINERALS & ELECTROLYTES
FLUOR-A-DAY CHEW TAB	-	1	MINERALS & ELECTROLYTES
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1	OPHTHALMIC AGENTS
FLUOROPLEX CREAM	-	2	DERMATOLOGICALS
fluorouracil cream (EFUDEX CREAM equiv)	-	1	DERMATOLOGICALS
FLUOROURACIL CREAM 0.5%	-	2	DERMATOLOGICALS
FLUOROURACIL SOLN	-	2	DERMATOLOGICALS
fluoxetine cap (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine soln (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine tab 10mg, 20mg (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluphenazine tab (PROLIXIN equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
flurandrenolide cream (CORDRAN equiv)	-	3	DERMATOLOGICALS
flurandrenolide lotion (CORDRAN equiv)	-	3	DERMATOLOGICALS
FLURAZEPAM CAP	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
flurbiprofen ophth soln (OCUFEN equiv)	-	1	OPHTHALMIC AGENTS
flurbiprofen tab (ANSAID equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
flutamide cap (EULEXIN equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fluticasone nasal spray (FLOINASE equiv) (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1	DERMATOLOGICALS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
fluticasone propionate oint (CUTIVATE equiv)	-	1	DERMATOLOGICALS
FLUTICASONE/SALMETEROL INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvastatin cap (LESCOL equiv) (QL= 1 cap/day)	QL	2	ANTIHYPERLIPIDEMICS
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	2	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	1	ANTIDEPRESSANTS
FML FORTE OPHTH SUSP	-	3	OPHTHALMIC AGENTS
FML S.O.P. OPHTH OINT	-	3	OPHTHALMIC AGENTS
FOLBEE PLUS CZ TAB	-	1	MULTIVITAMINS
folbee tab	-	1	HEMATOPOIETIC AGENTS
folic acid tab 1mg (Covered at \$0 for females only)	-	1	HEMATOPOIETIC AGENTS
fondaparinux inj (ARIXTRA equiv)	PA	2	ANTICOAGULANTS
FORADIL AEROLIZER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FORTICAL NASAL SPRAY	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX+D TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosamprenavir tab (LEXIVA equiv)	-	2	ANTIVIRALS
fosinopril tab (MONOPRIL equiv)	-	1	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1	ANTIHYPERTENSIVES
FOSRENOL POWDER PACK	-	2	GASTROINTESTINAL AGENTS - MISC.
FRAGMIN INJ	-	2	ANTICOAGULANTS
FREESTYLE FREEDOM LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
FREESTYLE LANCETS	OTC	DME	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year)	PA-QL	DME	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (10-DAY) (QL= 3 sensors/30 days)	PA-QL	DME	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days)	PA-QL	DME	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
FREESTYLE PRECISION NEO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE PRECISION NEO TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
FULPHILA INJ	MSP	MSP	HEMATOPOIETIC AGENTS
FUROSEMIDE SOLN	-	1	DIURETICS
furosemide soln (LASIX equiv)	-	1	DIURETICS
furosemide tab (LASIX equiv)	-	1	DIURETICS
FUZEON INJ	MSP-PA	MSP	ANTIVIRALS
gabapentin cap (NEURONTIN equiv)	-	1	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv)	-	2	ANTICONVULSANTS
gabapentin tab (NEURONTIN equiv)	-	1	ANTICONVULSANTS
galantamine ER cap (RAZADYNE ER equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALANTAMINE SOLN	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
galantamine tab (RAZADYNE equiv)	¢	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
GALZIN CAP	-	2	MINERALS & ELECTROLYTES
GANCICLOVIR CAP	-	2	ANTIVIRALS
gatifloxacin ophth soln (ZYMAXID equiv) (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	2	OPHTHALMIC AGENTS
GELNIQUE	-	3	URINARY ANTISPASMODICS
gemfibrozil tab (LOPID equiv)	-	1	ANTIHYPERTENSIVES
GENTAK OPHTH OINT	-	1	OPHTHALMIC AGENTS
gentamicin ophth oint (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	1	DERMATOLOGICALS
gentamicin sulfate oint	-	1	DERMATOLOGICALS
GENVOYA TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0	CONTRACEPTIVES
GILENYA CAP	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glatiramer inj (COPAXONE equiv)	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GLEOSTINE/LOMUSTINE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	1	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	1	ANTIDIABETICS
glipizide tab (GLUCOTROL equiv)	-	1	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	1	ANTIDIABETICS
GLUCAGEN HYPOKIT INJ (QL= 1 kit/fill, 2 fills/30 days)	QL	2	ANTIDIABETICS
GLUCAGEN INJ (QL= 1 kit/fill, 2 fills/30 days)	QL	2	DIAGNOSTIC PRODUCTS
GLUCAGON INJ KIT (QL= 1 kit/fill, 2 fills/30 days)	QL	2	ANTIDIABETICS
glyburide micronized tab (GLYNASE equiv)	-	1	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	1	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	1	ANTIDIABETICS
glycopyrrolate tab (ROBINUL equiv)	-	2	ULCER DRUGS
GLYXAMBI TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	1	ANTIEMETICS
GRANISOL SOLN (QL= 60ml/fill)	QL	3	ANTIEMETICS
GRANIX INJ	MSP	MSP	HEMATOPOIETIC AGENTS
GRANIX INJ (Required through specialty pharmacy: GHC, UW Specialty or Walgreens Specialty)	MSP	MSP	HEMATOPOIETIC AGENTS
griseofulvin micro tab (GRIFULVIN V equiv)	-	2	ANTIFUNGALS
griseofulvin susp (GRIFULVIN equiv)	-	2	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	2	ANTIFUNGALS
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	1	COUGH/COLD/ALLERGY
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1	COUGH/COLD/ALLERGY
GUANABENZ TAB	-	3	ANTIHYPERTENSIVES
guanfacine ER tab (INTUNIV equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
guanfacine IR tab (TENEX equiv)	-	1	ANTIHYPERTENSIVES
halobetasol propionate cream (ULTRAVATE equiv)	-	2	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv)	-	2	DERMATOLOGICALS
haloperidol lactate conc (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
haloperidol tab (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
HARVONI TAB, LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTIVIRALS
HEMLIBRA INJ	MSP-PA	MSP	HEMATOLOGICAL AGENTS - MISC.
HEXALEN CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HIZENTRA INJ	MSP-PA	MSP	PASSIVE IMMUNIZING AGENTS
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1	OPHTHALMIC AGENTS
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, fill/plan year)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN R INJ U-500	-	2	ANTIDIABETICS
HUMULIN R U-500 KWIKPEN INJ	-	2	ANTIDIABETICS
HYCAMTIN CAP	MSP-PA	MSP	ANTINEOPLASTICS
hydralazine tab (APRESOLINE equiv)	-	1	ANTIHYPERTENSIVES
hydrochlorothiazide cap (MICROZIDE equiv)	-	1	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1	DIURETICS
hydrocodone/acetaminophen cap (LORCET equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab (LORTAB equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv) (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	3	COUGH/COLD/ALLERGY
HYDROCODONE/CHLORPHENIRAMINE/PSEUDOEPHEDRINE LIQUID (QL= 120ml/fill, 2 fills/month)	QL	3	COUGH/COLD/ALLERGY
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	QL	3	COUGH/COLD/ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1	COUGH/COLD/ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv) (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
hydrocortisone butyrate cream (LOCOID equiv)	-	2	DERMATOLOGICALS
hydrocortisone butyrate oint (LOCOID equiv)	-	2	DERMATOLOGICALS
hydrocortisone butyrate soln (LOCOID equiv)	-	2	DERMATOLOGICALS
hydrocortisone cream (PROCTOCORT equiv)	-	1	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	2	ANORECTAL AGENTS
hydrocortisone lotion (HYTONE equiv)	-	1	DERMATOLOGICALS
hydrocortisone oint	-	1	DERMATOLOGICALS
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	2	DERMATOLOGICALS
hydrocortisone supp (ANUSOL HC equiv)	-	2	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	1	CORTICOSTEROIDS
hydrocortisone valerate cream	-	3	DERMATOLOGICALS
hydrocortisone valerate oint (WESTCORT equiv)	-	3	DERMATOLOGICALS
hydromorphone ER tab (EXALGO equiv) (Dosage limits may apply)	-	3	ANALGESICS - OPIOID

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
HYDROMORPHONE SUPP (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
hydroquinone cream (LUSTRA equiv)	-	EXC	DERMATOLOGICALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	1	ANTIMALARIALS
hydroxyurea cap (HYDREA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTIAXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTIAXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTIAXIETY AGENTS
hyoscyamine sulfate CR tab (LEVBID equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate soln (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1	ULCER DRUGS
hyoscyamine tab (LEVSIN equiv)	-	1	ULCER DRUGS
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
IBRANCE CAP (QL= 21 caps/28 days)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab (RX only)	-	1	ANALGESICS - ANTI-INFLAMMATORY
ICLUSIG TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ILEVRO OPHTH SUSP	-	2	OPHTHALMIC AGENTS
imatinib tab (GLEEVEC equiv)	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 140MG (QL= 3 caps/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 70MG (QL= 1 cap/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
imipramine pamoate cap (TOFRANIL PM equiv)	-	3	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	1	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	2	DERMATOLOGICALS
INCRELEX INJ	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER	-	2	ASTHMA AND BRONCHODILATOR AGENTS
indapamide tab (LOZOL equiv)	-	1	DIURETICS
INDOCIN SUPP	-	2	ANALGESICS - ANTI-INFLAMMATORY
INDOCIN SUSP	-	2	ANALGESICS - ANTI-INFLAMMATORY
indomethacin cap (INDOCIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
INFERGEN INJ	MSP-PA	MSP	ANTIVIRALS
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
INTELENCE TAB	-	2	ANTIVIRALS
INTRON-A INJ	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INVIRASE CAP	-	2	ANTIVIRALS
INVIRASE TAB	-	2	ANTIVIRALS
iodoquinol/hydrocortisone cream 1% (VYTONA equiv)	-	3	DERMATOLOGICALS
IOPIDINE OPHTH SOLN 1%	-	2	OPHTHALMIC AGENTS
ipratropium nasal spray (ATROVENT equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
ipratropium neb soln (ATROVENT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
irbesartan tab (AVAPRO equiv)	-	1	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1	ANTIHYPERTENSIVES
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ISENTRESS (HD) TAB	-	2	ANTIVIRALS
ISENTRESS CHEW TAB	-	2	ANTIVIRALS
ISENTRESS POWDER PACK	-	2	ANTIVIRALS
ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	2	MIGRAINE PRODUCTS
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	2	MIGRAINE PRODUCTS
ISONIAZID SYRUP	-	1	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	1	ANTIMYCOBACTERIAL AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ISOPTO HOMATROPINE OPHTH SOLN 2%	-	2	OPHTHALMIC AGENTS
ISOPTO HYOSCINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate SL tab	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	1	ANTIANGINAL AGENTS
ISOSORBIDE DINITRATE TAB 30MG, 40MG	-	3	ANTIANGINAL AGENTS
isosorbide mononitrate ER tab (IMDUR equiv)	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	1	ANTIANGINAL AGENTS
isotretinoin cap (ACUTANE equiv)	-	2	DERMATOLOGICALS
isoxsuprine tab	-	3	CARDIOVASCULAR AGENTS - MISC.
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
itraconazole cap (SPORANOX equiv)	PA	2	ANTIFUNGALS
itraconazole soln (SPORANOX equiv)	PA	3	ANTIFUNGALS
ivermectin tab (STROMEKTOL equiv)	-	2	ANTHELMINTICS
JADENU SPRINKLE	MSP	MSP	ANTIDOTES AND SPECIFIC ANTAGONISTS
JADENU TAB	MSP	MSP	ANTIDOTES
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JANUMET TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
JANUMET XR TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
JANUVIA TAB (QL= 1 tab/day)	QL-¢	2	ANTIDIABETICS
JARDIANCE TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
JENTADUETO TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
jinteli tab (FEMHRT equiv)	-	2	ESTROGENS
jolesa tab, amethia tab (SEASONALE, SEASONIQUE equiv)	-	\$0	CONTRACEPTIVES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
JUBLIA SOLN	-	EXC	DERMATOLOGICALS
JULUCA TAB	-	2	ANTIVIRALS
junel FE tab (LOESTRIN FE equiv)	-	\$0	CONTRACEPTIVES
junel tab (LOESTRIN equiv)	-	\$0	CONTRACEPTIVES
JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
K/NA CITRATE SOLN CITRIC ACID	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
KALETRA TAB	-	2	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
kariva tab (MIRCETTE equiv)	-	\$0	CONTRACEPTIVES
kelnor tab (DEMULEN equiv)	-	\$0	CONTRACEPTIVES
KERYDIN SOLN	-	EXC	DERMATOLOGICALS
KETEK TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
ketoconazole cream (NIZORAL CREAM equiv)	-	1	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	1	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
KETOPROFEN CAP	-	1	ANALGESICS - ANTI-INFLAMMATORY
ketoprofen cap (ORUDIS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
KETOPROFEN ER CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
ketorolac ophth soln (ACULAR (LS) equiv)	-	1	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
KETOSTIX	OTC	DME	DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv) (OTC covered only)	OTC	1	OPHTHALMIC AGENTS
KEVZARA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
KINERET INJ (QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644)	LD-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
KISQALI PAK (QL= 91 tabs/28 days)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KISQALI TAB (QL= 63 tabs/28 days)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KLOR-CON M15 TAB	-	2	MINERALS & ELECTROLYTES
KLOR-CON POWDER PACKET 25MEQ	-	3	MINERALS & ELECTROLYTES
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	MSP	ANTIDIABETICS
K-PHOS TAB	-	2	MINERALS & ELECTROLYTES
KRISTALOSE PACKET	-	3	LAXATIVES
KUVAN POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
KUVAN TAB (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
labetalol tab (NORMODYNE equiv)	-	1	BETA BLOCKERS
LACRISERT OPHTH INSERT	-	2	OPHTHALMIC AGENTS
lactulose pack (KRISTALOSE equiv)	-	3	LAXATIVES
lactulose soln	-	1	GASTROINTESTINAL AGENTS - MISC.
LAMICTAL CHEW TAB 2MG	-	2	ANTICONSULSANTS
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	3	ANTICONSULSANTS
lamivudine soln (EPIVIR equiv)	-	2	ANTIVIRALS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
MSP	Plan Exclusion	OTC	Infertility	LD	Limited Distribution
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	PA	Prior Authorization
SMKG	Quantity Limit	ST	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
¢	Smoking Cessation		Step Therapy	VAC	Vaccine Program
	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
lamivudine tab (EPIVIR equiv)	-	2	ANTIVIRALS
lamivudine tab 100mg (EPIVIR HBV equiv)	-	2	ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv)	-	2	ANTIVIRALS
lamotrigine chew tab (LAMICTAL equiv)	-	1	ANTICONVULSANTS
lamotrigine ER tab (LAMICTAL XR equiv)	-	3	ANTICONVULSANTS
lamotrigine ODT (LAMICTAL equiv)	-	3	ANTICONVULSANTS
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	3	ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	1	ANTICONVULSANTS
LANCETS	OTC	DME	MEDICAL DEVICES AND SUPPLIES
lansoprazole cap (PREVACID equiv)	OTC	1	ULCER DRUGS
lansoprazole odt (PREVACID SOLUTAB equiv) (No Prior Authorization required for members 12 years and younger.)	PA	2	ULCER DRUGS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	3	ULCER DRUGS
lanthanum carbonate chew tab (FOSRENOL equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
LANTUS INJ	-	2	ANTIDIABETICS
LANTUS SOLOSTAR INJ	-	2	ANTIDIABETICS
LASTACRAFT OPHTH SOLN (QL= 3ml/30 days)	QL	3	OPHTHALMIC AGENTS
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
LATISSE SOLN	-	EXC	DERMATOLOGICALS
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days; Dosage limits may apply)	PA-QL	3	ANALGESICS - OPIOID
leflunomide tab (ARAVA equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LETAIRIS TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
letrozole tab (FEMARA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKERAN TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKINE INJ	MSP-PA	MSP	HEMATOPOIETIC AGENTS
levalbuterol neb soln (XOPENEX equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVATOL TAB	-	3	BETA BLOCKERS
LEVEMIR FLEXTOUCH INJ	-	2	ANTIDIABETICS
LEVEMIR INJ	-	2	ANTIDIABETICS
levetiracetam ER tab (KEPPRA XR equiv)	-	1	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	1	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	1	ANTICONVULSANTS
LEVITRA TAB	-	EXC	CARDIOVASCULAR AGENTS - MISC.
levobunolol ophth soln (BETAGAN equiv)	-	1	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocarnitine tab (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocetirizine tab (XYZAL equiv)	-	2	ANTIHISTAMINES
levofloxacin ophth soln (QUIXIN equiv)	-	1	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
levonorgestrel tab (PLAN B equiv)	OTC	\$0	CONTRACEPTIVES
LEVONORGESTREL TAB 0.75MG	-	\$0	CONTRACEPTIVES
LEXIVA SUSP	-	2	ANTIVIRALS
LIALDA TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
lidocaine cream 3% (LIDAMANTLE equiv)	-	1	DERMATOLOGICALS
lidocaine cream 4%	OTC	1	DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine oint (QL= 107gm/30 days)	QL	1	DERMATOLOGICALS
LIDOCAINE ORAL SOLN 4%	-	2	MOUTH/THROAT/DENTAL AGENTS
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	2	DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine viscous soln	-	1	MOUTH/THROAT/DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	2	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
LINDANE LOTION	-	3	DERMATOLOGICALS
lindane shampoo	-	3	DERMATOLOGICALS
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	2	ANTI-INFECTIVE AGENTS - MISC.
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	2	ANTI-INFECTIVE AGENTS - MISC.
LINZESS CAP	PA	2	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	1	THYROID AGENTS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1	ANTIHYPERTENSIVES
lithium carbonate cap (ESKALITH ER equiv)	-	1	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	1	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
lithium carbonate tab	-	1	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
lithium citrate soln	-	1	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
LITHOSTAT TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
LIVALO TAB (Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	ST	3	ANTIHYPERLIPIDEMICS
L-METHYLFOLATE TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LO LOESTRIN TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
LO MINASTRIN 24 FE CHEW TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
LOESTRIN 24 FE TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
LONHALA MAGNAIR SOLN (Step Therapy requires trial of INCRUSE ELLIPTA INHALER)	ST	2	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
LONSURF TAB (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ANTI-NEOPLASTICS AND ADJUNCTIVE THERAPIES
lopinavir/ritonavir soln (KALETRA equiv)	-	2	ANTIVIRALS
loratadine ODT (CLARITIN equiv)	OTC	1	ANTI-HISTAMINES
loratadine syrup (CLARITIN equiv)	OTC	1	ANTI-HISTAMINES
loratadine tab (CLARITIN equiv)	OTC	1	ANTI-HISTAMINES
lorazepam conc (ATIVAN equiv)	-	1	ANTI-ANXIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	1	ANTI-ANXIETY AGENTS
LORTAB ELIXIR (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
losartan tab (COZAAR equiv)	-	1	ANTIHYPERTENSIVES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1	ANTIHYPERTENSIVES
LOTEMAX OPHTH GEL	-	2	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	2	OPHTHALMIC AGENTS
lovastatin tab (MEVACOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
loxapine cap (LOXITANE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LUFYLLIN TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
LYNPARZA CAP (Only available through Biologics 800-850-4306, QL= 16 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYNPARZA TAB (Only available through Biologics 800-850-4306, QL= 4 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYRICA CAP	PA	2	ANTICONVULSANTS
LYRICA SOLN	PA	2	ANTICONVULSANTS
LYSODREN TAB (Only available through Direct Success 732-919-1234)	LD	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	3	DERMATOLOGICALS
maldemar tab (SCOPACE equiv)	-	1	ANTIEMETICS
MAPROTILINE TAB	-	1	ANTIDEPRESSANTS
MARPLAN TAB	-	2	ANTIDEPRESSANTS
MATULANE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MAVYRET TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP	ANTIVIRALS
MAXIDEX OPHTH SOLN	-	2	OPHTHALMIC AGENTS
meclizine chew tab (BONINE equiv)	OTC	1	ANTIEMETICS
meclizine tab (ANTIVERT equiv)	OTC	1	ANTIEMETICS
MECLOFENAMATE CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	1	PROGESTINS
mefenamic acid cap (PONSTEL equiv)	-	3	ANALGESICS - ANTI-INFLAMMATORY
MEFLOQUINE TAB	-	2	ANTIMALARIALS
mefloquine tab (LARIAM equiv)	-	2	ANTIMALARIALS
megestrol ES susp (MEGACE ES equiv)	-	3	PROGESTINS
megestrol susp (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam tab (MOBIC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
mephalan tab (ALKERAN equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
memantine ER cap (NAMENDA XR equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine soln (NAMENDA equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine tab (NAMENDA equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MENTAX CREAM	-	3	DERMATOLOGICALS
meperidine tab (DEMEROL equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
meprobamate tab (MILTOWN equiv)	-	1	ANTIANKXIETY AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
mercaptapurine tab (PURINETHOL equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mesalamine enema (ROWASA equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
mesalamine supp (CANASA equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
MESNEX TAB	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESTINON SYRUP	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
METAPROTERENOL SYRUP	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
METAPROTERENOL TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
metaxalone tab (SKELAXIN equiv)	-	3	MUSCULOSKELETAL THERAPY AGENTS
METAXALONE TAB 400MG	-	3	MUSCULOSKELETAL THERAPY AGENTS
metformin ER osmotic tab (FORTAMET equiv)	-	EXC	ANTIDIABETICS
metformin ER osmotic tab (GLUMETZA equiv)	-	EXC	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	1	ANTIDIABETICS
metformin XL tab (GLUCOPHAGE XR equiv)	-	1	ANTIDIABETICS
METHADONE SOLN (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
methadose tab (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
methazolamide tab (NEPTAZANE equiv)	-	2	DIURETICS
methenamine hippurate tab (HIPREX equiv)	-	2	URINARY ANTI-INFECTIVES
methenamine mandelate tab	-	1	URINARY ANTI-INFECTIVES
methimazole tab (TAPAZOLE equiv)	-	1	THYROID AGENTS
METHITEST TAB	PA	3	ANDROGENS-ANABOLIC
methocarbamol tab (ROBAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
methotrexate inj	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methoxsalen cap (OXSORALEN ULTRA equiv)	-	2	DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	3	ULCER DRUGS
METHYCLOTHIAZIDE TAB	-	1	DIURETICS
methyldopa tab (ALDOMET equiv)	-	1	ANTIHYPERTENSIVES
methyldopa/hydrochlorothiazide tab (ALDORIL equiv)	-	1	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	2	OXYTOCICS
methylphenidate CD cap (METADATE CD equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate chew tab (METHYLIN equiv)	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate ER cap (RITALIN LA equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
METHYLPHENIDATE ER TAB	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate ER tab (CONCERTA equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate ER tab 10mg, 20mg (RITALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
methylphenidate tab (RITALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylprednisolone dose pack (MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	1	CORTICOSTEROIDS
METHYLTESTOSTERONE CAP	PA	3	ANDROGENS-ANABOLIC
METIPRANOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
metoclopramide soln (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	1	DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	1	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	1	BETA BLOCKERS
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	2	ANTIHYPERTENSIVES
METZOZLV ODT	-	EXC	GASTROINTESTINAL AGENTS - MISC.
metronidazole cap (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	2	DERMATOLOGICALS
metronidazole gel (METROGEL equiv)	-	2	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	1	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
metronidazole vaginal gel (METROGEL equiv)	-	1	VAGINAL PRODUCTS
mexiletine cap (MEXITIL equiv)	-	2	ANTIARRHYTHMICS
mibelas chew tab (MINASTRIN equiv) (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
midodrine tab (PROAMATINE equiv)	-	1	VASOPRESSORS
MIGERGOT SUPP	-	2	MIGRAINE PRODUCTS
miglitol tab (GLYSET equiv)	-	3	ANTIDIABETICS
miglustat cap (ZAVESCA equiv) (Only available through Accredited 888-773-7376 )	LD-PA	MSP	HEMATOPOIETIC AGENTS
MILLIPRED DP PAK	-	3	CORTICOSTEROIDS
MILLIPRED TAB	-	3	CORTICOSTEROIDS
minocycline cap (MINOCIN equiv)	-	1	TETRACYCLINES
minocycline ER tab (SOLODYN equiv)	-	EXC	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	1	ANTIHYPERTENSIVES
mirtazapine ODT (REMERON equiv)	-	1	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	1	ANTIDEPRESSANTS
misoprostol tab (CYTOTEC equiv)	-	1	ULCER DRUGS
MITIGARE CAP	-	2	GOUT AGENTS
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MODERIBA DOSE PACK	-	2	ANTIVIRALS
MODERIBA PAK	-	2	ANTIVIRALS
moexipril tab (UNIVASC equiv)	-	2	ANTIHYPERTENSIVES
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1	ANTIHYPERTENSIVES
mometasone cream (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone nasal spray (NASONEX equiv) (Step Therapy requires trial of two: fluticasone, triamcinolone OTC, or budesonide)	ST	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
mometasone oint (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	1	DERMATOLOGICALS
mononessa tab (ORTHO-CYCLEN equiv)	-	\$0	CONTRACEPTIVES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
montelukast chew tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast granule pack (SINGULAIR equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
MONUROL GRANULE PACK	-	2	URINARY ANTI-INFECTIVES
morphine sulfate ER tab (MS CONTIN equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
morphine sulfate soln (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
morphine sulfate supp (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
morphine sulfate tab (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
MOVANTIK TAB	PA	2	GASTROINTESTINAL AGENTS - MISC.
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	2	FLUOROQUINOLONES
MULTAQ TAB	-	2	ANTIARRHYTHMICS
multigen folic tab (CHROMAGEN FA equiv)	-	1	HEMATOPOIETIC AGENTS
multigen plus tab (CHROMAGEN FORTE equiv)	-	1	HEMATOPOIETIC AGENTS
multigen tab (CHROMAGEN equiv)	-	1	HEMATOPOIETIC AGENTS
multivitamin/minerals tab (STROVITE equiv)	-	1	MULTIVITAMINS
mupirocin oint (BACTROBAN OINT equiv)	-	1	DERMATOLOGICALS
mycophenolate DR tab (MYFORTIC equiv)	-	2	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	2	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	1	ASSORTED CLASSES
MYLERAN TAB	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MYRBETRIQ TAB	-	2	URINARY ANTISPASMODICS
nabumetone tab (RELAFEN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	2	BETA BLOCKERS
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	3	ANTIHYPERTENSIVES
naftifine cream (NAFTIN equiv)	-	3	DERMATOLOGICALS
NAFTIN GEL 1%	-	3	DERMATOLOGICALS
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	1	ANTIDOTES
NAMENDA XR TITRATION PACK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC CAP (Step Therapy requires trial of donepezil and memantine)	ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC STARTER PACK (Step Therapy requires trial of donepezil and memantine)	ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
naproxen EC tab (NAPROSYN EC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	-	2	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY (QL= 2 sprays/fill)	QL	2	ANTIDOTES
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
NASCOBAL NASAL SPRAY	-	3	HEMATOPOIETIC AGENTS
NATAZIA TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
nateglinide tab (STARLIX equiv)	-	3	ANTIDIABETICS
NATROBA SUSP (QL= 1 bottle/fill)	QL	3	DERMATOLOGICALS
NEBUPENT NEB SOLN	-	2	ANTI-INFECTION AGENTS - MISC.
NEBUSAL NEB SOLN	-	2	COUGH/COLD/ALLERGY
necon tab (ORTHO-NOVUM equiv)	-	\$0	CONTRACEPTIVES
necon tab 1-50 (NORYNIL equiv)	-	\$0	CONTRACEPTIVES
NEFAZODONE TAB	-	1	ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	1	ANTIDEPRESSANTS
neomycin tab	-	1	AMINOGLYCOSIDES
NEOMYCIN/POLYMYXIN/GRAMICIDIN OPHTH SOLN	-	1	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymixin/dexamethasone ophth oint (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
neomycin/polymixin/dexamethasone ophth soln (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone ophth soln (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
NEOTUSS PLUS LIQUID	-	3	COUGH/COLD/ALLERGY
NEPHRON FA TAB	-	2	HEMATOPOIETIC AGENTS
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NEUMEGA INJ	MSP-PA	MSP	HEMATOPOIETIC AGENTS
NEUPRO PATCH	-	3	ANTIPARKINSON AGENTS
NEVANAC OPHTH SUSP	-	2	OPHTHALMIC AGENTS
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	2	ANTIVIRALS
nevirapine susp (VIRAMUNE equiv)	-	2	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	1	ANTIVIRALS
NEXAVAR TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NEXICLON XR SUSP	-	3	ANTIHYPERTENSIVES
NEXICLON XR TAB	-	3	ANTIHYPERTENSIVES
niacin cap	OTC	1	VITAMINS
niacin CR tab (SLO-NIACIN equiv)	OTC	1	VITAMINS
niacin ER tab (NIASPAN equiv)	-	1	ANTIHYPERLIPIDEMICS
niacin tab	OTC	1	VITAMINS
NIACIN TR TAB	OTC	1	VITAMINS
niacinamide tab	OTC	1	VITAMINS
nicardipine cap (CARDENE equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTINE KIT	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	1	CALCIUM CHANNEL BLOCKERS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
nifedipine ER tab (ADALAT CC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nilutamide tab (NILANDRON equiv)	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	3	CALCIUM CHANNEL BLOCKERS
NINLARO CAP	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nisoldipine ER tab (SULAR equiv)	-	2	CALCIUM CHANNEL BLOCKERS
NITRO-BID OINT	-	3	ANTIANGINAL AGENTS
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin susp (FURADANTIN equiv)	-	2	URINARY ANTI-INFECTIVES
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	3	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SR cap	-	1	ANTIANGINAL AGENTS
NITROMIST SPRAY	-	3	ANTIANGINAL AGENTS
nizatidine cap (AXID equiv)	-	1	ULCER DRUGS
nizatidine soln (AXID equiv)	-	3	ULCER DRUGS
NORDITROPIN INJ	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone tab (NORA-QD equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	1	PROGESTINS
NORINYL TAB 1-50 (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
NOROXIN TAB	-	3	FLUOROQUINOLONES
NORPACE CR CAP	-	2	ANTIARRHYTHMICS
nortrel tab (OVCON 35 equiv)	-	\$0	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	1	ANTIDEPRESSANTS
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1	ANTIDEPRESSANTS
NORTRIPTYLINE SOLN	-	1	ANTIDEPRESSANTS
NORVIR CAP	-	2	ANTIVIRALS
NORVIR POWDER PACK	-	2	ANTIVIRALS
NORVIR SOLN	-	2	ANTIVIRALS
NOVOFINE PEN NEEDLE	OTC	DME	MEDICAL DEVICES AND SUPPLIES
NOVOLIN INJ	OTC	2	ANTIDIABETICS
NOVOLOG FLEXPEN INJ, FIASP FLEXTOUCH INJ	-	2	ANTIDIABETICS
NOVOLOG INJ, FIASP INJ	-	2	ANTIDIABETICS
NOVOLOG MIX FLEXPEN INJ	-	2	ANTIDIABETICS
NOVOLOG MIX INJ	-	2	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	2	ANTIDIABETICS
NOVOTWIST PEN NEEDLE	OTC	DME	MEDICAL DEVICES AND SUPPLIES
NOXAFIL SUSP	-	3	ANTIFUNGALS
NOXAFIL TAB	-	3	ANTIFUNGALS
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1	THYROID AGENTS
NUCYNTA ER TAB (QL= 2 tabs/day; Dosage limits may apply)	QL	2	ANALGESICS - OPIOID
NUCYNTA TAB (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NUQUIN HP GEL	-	EXC	DERMATOLOGICALS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
NUVAIL SOLN	-	EXC	DERMATOLOGICALS
NUVARING	-	\$0	CONTRACEPTIVES
nystatin cream (MYCOSTATIN CREAM equiv)	-	1	DERMATOLOGICALS
nystatin oint	-	1	DERMATOLOGICALS
nystatin powder	-	1	ANTIFUNGALS
nystatin susp	-	1	MOUTH/THROAT/DENTAL AGENTS
nystatin tab	-	1	ANTIFUNGALS
nystatin topical powder	-	1	DERMATOLOGICALS
NYSTATIN VAGINAL TAB	-	1	VAGINAL PRODUCTS
OCALIVA TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF-¢	MSP	GASTROINTESTINAL AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
ODACTRA SL TAB	PA	3	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
ODEFSEY TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
ODOMZO CAP	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
ofloxacin ophth soln (OCUFLOX equiv)	-	1	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	2	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	1	FLUOROQUINOLONES
OGESTREL TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
olanzapine ODT (ZYPREXA equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine tab (ZYPREXA equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
OLEPTRO TAB	-	3	ANTIDEPRESSANTS
olmesartan tab (BENICAR equiv)	-	1	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1	ANTIHYPERTENSIVES
olopatadine nasal spray (PATANASE equiv)	-	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
olopatadine ophth soln 0.1% (PATANOL equiv)	-	1	OPHTHALMIC AGENTS
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
OLUMIANT TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
omega-3-acid ethyl esters cap (LOVAZA equiv)	PA	2	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	1	ULCER DRUGS
ondansetron ODT (ZOFTRAN equiv)	-	1	ANTIEMETICS
ondansetron soln (ZOFTRAN equiv)	-	1	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	1	ANTIEMETICS
ONEXTON GEL	-	EXC	DERMATOLOGICALS
opium tincture	-	3	ANTIDIARRHEALS
OPSUMIT TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
ORACIT SOLN	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ORAVIG TAB	-	3	MOUTH/THROAT/DENTAL AGENTS
ORAXYL CAP	-	3	TETRACYCLINES
ORENCIA CLICK INJ (QL= 4 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
MSP	Plan Exclusion	OTC	Infertility	PA	Limited Distribution
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	ST	Restricted to Specialist	VAC	Limited to two 15 day fills per month for first 3 months
¢	Smoking Cessation		Step Therapy		Vaccine Program
	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ORKAMBI GRANULES PACKET (QL= 2 packets/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
ORPHENADRINE/ASPIRIN/CAFFEINE TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	3	MUSCULOSKELETAL THERAPY AGENTS
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	2	ANTIVIRALS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	2	ANTIVIRALS
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	2	ANTIVIRALS
OSMOPREP TAB	-	3	LAXATIVES
OTEZLA STARTER PACK (QL= 2 tabs/day)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
OVACE PLUS CREAM	-	3	DERMATOLOGICALS
oxandrolone tab (OXANDRIN equiv)	-	1	ANDROGENS-ANABOLIC
oxaprozin tab (DAYPRO equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	1	ANTI-ANXIETY AGENTS
OXAZEPAM CAP	-	2	ANTI-ANXIETY AGENTS
oxcarbazepine susp (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxiconazole nitrate cream (OXISTAT equiv)	-	3	DERMATOLOGICALS
OXISTAT LOTION	-	3	DERMATOLOGICALS
oxybutynin ER tab (DITROPAN XL equiv)	-	1	URINARY ANTISPASMODICS
oxybutynin syrup	-	1	URINARY ANTISPASMODICS
oxybutynin tab (DITROPAN equiv)	-	1	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv) (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv) (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv) (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
oxycodone/acetaminophen cap (TYLOX equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
oxycodone/acetaminophen tab (PERCOCET equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
oxycodone/aspirin tab (PERCODAN equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
OXYCODONE/IBUPROFEN TAB (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
oxycodone/ibuprofen tab (COMBUNOX equiv) (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
OXYTROL PATCH	PA	3	URINARY ANTISPASMODICS
OZEMPIC INJ (QL= 1 pack/28 days)	QL	2	ANTIDIABETICS
paliperidone ER tab (INVEGA equiv)	PA	2	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
PALYNZIQ INJ (QL= 1 inj/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
PANDEL CREAM	-	3	DERMATOLOGICALS
pantoprazole EC tab (PROTONIX equiv)	-	1	ULCER DRUGS
paricalcitol cap (ZEMPLAR equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
paromomycin cap (HUMATIN equiv)	-	3	AMINOGLYCOSIDES
paroxetine cap (BRISDELLE equiv)	-	EXC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
paroxetine ER tab (PAXIL CR equiv)	-	2	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	1	ANTIDEPRESSANTS
pb-belladonna elixir (DONNATAL equiv)	-	3	ULCER DRUGS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
PCE TAB	-	3	MACROLIDES
PEAK FLOW METER	OTC	DME	MEDICAL DEVICES AND SUPPLIES
pediatric multiple vitamins/fluoride chew tab	-	3	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	1	MULTIVITAMINS
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year)	QL	1	LAXATIVES
PEGANONE TAB	-	2	ANTICONVULSANTS
PEGASYS INJ	MSP-PA	MSP	ANTIVIRALS
PEGASYS INJ KIT	MSP-PA	MSP	ANTIVIRALS
PEG-INTRON INJ	MSP-PA	MSP	ANTIVIRALS
penicillin vk soln (VEETIDS equiv)	-	1	PENICILLINS
penicillin vk tab (VEETIDS equiv)	-	1	PENICILLINS
pentazocine/acetaminophen tab (TALACEN equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
pentazocine/naloxone tab (TALWIN NX equiv) (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
pentoxifylline ER tab (TRENAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
PERFOROMIST NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	1	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
phenazopyridine tab (PYRIDIUM equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenelzine tab (NARDIL equiv)	-	1	ANTIDEPRESSANTS
phenobarbital elixir	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenobarbital tab	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenoxybenzamine cap (DIBENZYLINE equiv)	MSP-PA	MSP	ANTIHYPERTENSIVES
phentermine cap (ADIPEX equiv)	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
phentermine tab (ADIPEX equiv)	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
phenylephrine ophth soln (MYDFRIN equiv)	-	1	OPHTHALMIC AGENTS
phenytoin cap (DILANTIN equiv)	-	1	ANTICONVULSANTS
phenytoin chew tab (DILANTIN equiv)	-	2	ANTICONVULSANTS
phenytoin susp (DILANTIN equiv)	-	1	ANTICONVULSANTS
PHISOHEX LIQUID	-	3	ANTISEPTICS & DISINFECTANTS
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1	MINERALS & ELECTROLYTES
PHOSPHOLINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
phytonadione tab (MEPHYTON equiv)	-	2	VITAMINS
PICATO GEL (QL= 1 box/fill)	QL	3	DERMATOLOGICALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
PILOPINE HS OPHTH GEL	-	3	OPHTHALMIC AGENTS
pimecrolimus cream (ELIDEL equiv)	-	2	DERMATOLOGICALS
PIMOZIDE TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
pindolol tab (VISKEN equiv)	-	1	BETA BLOCKERS
pioglitazone tab (ACTOS equiv)	-	1	ANTIDIABETICS
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	3	ANTIDIABETICS
piroxicam cap (FELDENE equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
PLEGRIDY INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLEGRIDY PEN INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PODOCON SOLN	-	2	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	2	DERMATOLOGICALS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1	OPHTHALMIC AGENTS
POTABA POWDER PACKET	-	2	VITAMINS
POTABA TAB	-	2	VITAMINS
potassium bicarbonate effer tab (K-LYTE equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride effer tab (K-LYTE/CL equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride ER cap (MICRO-K equiv)	-	1	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE ER TAB	-	1	MINERALS & ELECTROLYTES
potassium chloride ER tab (KLOR-CON equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride micro tab (K-DUR equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride powder packet (KLOR-CON equiv)	-	2	MINERALS & ELECTROLYTES
potassium chloride soln	-	2	MINERALS & ELECTROLYTES
potassium citrate CR tab (UROCIT-K TAB equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
POTIGA TAB (QL= 3 tabs/day)	QL	2	ANTICONSULSANTS
PRADAXA CAP	-	2	ANTICOAGULANTS
PRALUENT INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANTIHYPERTENSIVES
pramipexole ER tab (MIRAPEX ER equiv)	-	3	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	1	ANTIPARKINSON AGENTS
PRAMOSONE CREAM	-	2	DERMATOLOGICALS
PRAMOSONE E CREAM	-	2	DERMATOLOGICALS
PRAMOSONE LOTION	-	3	DERMATOLOGICALS
PRAMOSONE OINT	-	2	DERMATOLOGICALS
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1	ANORECTAL AGENTS
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1	ANORECTAL AGENTS
PRASCION RA CREAM	-	2	DERMATOLOGICALS
prasugrel tab (EFFIENT equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
pravastatin tab (PRAVACHOL equiv)	-	\$0	ANTIHYPERTENSIVES
praziquantel tab (BILTRICIDE equiv)	-	2	ANTHELMINTICS
prazosin cap (MINIPRESS equiv)	-	1	ANTIHYPERTENSIVES
PRECISION XTRA METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
PRED FORTE OPHTH SUSP 1%	-	2	OPHTHALMIC AGENTS
PRED MILD OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PRED-G OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PREDNICARBATE CREAM	-	2	DERMATOLOGICALS
prednicarbate cream (DERMATOP equiv)	-	2	DERMATOLOGICALS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
PREDNICARBATE OIN	-	2	DERMATOLOGICALS
prednisolone ODT (ORAPRED equiv)	-	3	CORTICOSTEROIDS
prednisolone ophth soln (PRED FORTE equiv)	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
prednisolone soln (PEDIAPRED equiv)	-	1	CORTICOSTEROIDS
PREDNISOLONE SYRUP	-	1	CORTICOSTEROIDS
prednisolone syrup (PRELONE equiv)	-	1	CORTICOSTEROIDS
PREDNISON PAK	-	2	CORTICOSTEROIDS
PREDNISON SOLN	-	1	CORTICOSTEROIDS
PREDNISON TAB	-	1	CORTICOSTEROIDS
prednison tab (DELTASONE equiv)	-	1	CORTICOSTEROIDS
PREMARIN TAB	-	2	ESTROGENS
PREMARIN VAGINAL CREAM	-	2	VAGINAL PRODUCTS
PREMPHASE TAB, PREMPRO TAB	-	2	ESTROGENS
PRENATAL CHEWABLE	-	1	VITAMINS
PRENATAL VITAMIN (RX ONLY)	-	1	VITAMINS
PRENATAL VITAMINS (RX ONLY)	PA	2	MULTIVITAMINS
PREVACID OTC CAP	OTC	1	ULCER DRUGS
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger)	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT PASTE	-	2	MOUTH/THROAT/DENTAL AGENTS
PREZCOBIX TAB	-	2	ANTIVIRALS
PREZISTA SUSP	-	2	ANTIVIRALS
PREZISTA TAB	-	2	ANTIVIRALS
PRIFTIN TAB	-	2	ANTIMYCOBACTERIAL AGENTS
PRIMAQUINE TAB	-	2	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	1	ANTICONSULSANTS
PRIMSOL SOLN	-	3	ANTI-INFECTIVE AGENTS - MISC.
probenecid tab (BENEMID equiv)	-	1	GOUT AGENTS
prochlorperazine supp (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PROCTOFOAM HC FOAM	-	2	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	1	ANORECTAL AGENTS
PRODRIN TAB	-	2	MIGRAINE PRODUCTS
progesterone cap (PROMETRIUM equiv)	-	2	PROGESTINS
progesterone oil inj	-	1	PROGESTINS
PROGLYCEM SUSP	-	3	ANTIDIABETICS
PROLENSA OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PROMACTA TAB	MSP-PA	MSP	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	3	COUGH/COLD/ALLERGY
promethazine supp (PHENERGAN equiv)	-	2	ANTIHISTAMINES
promethazine syrup	-	1	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	1	ANTIHISTAMINES
PROMETHAZINE VC SYRUP	-	1	COUGH/COLD/ALLERGY
promethazine VC syrup (PHENERGAN VC equiv)	-	1	COUGH/COLD/ALLERGY
PROMETHAZINE VC/CODEINE SYRUP	-	1	COUGH/COLD/ALLERGY
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1	COUGH/COLD/ALLERGY
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1	COUGH/COLD/ALLERGY
propafenone ER cap (RYTHMOL SR equiv)	-	2	ANTIARRHYTHMICS
propafenone tab (RYTHMOL equiv)	-	1	ANTIARRHYTHMICS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
PROPANTHELINE TAB	-	2	ULCER DRUGS
proparacaine ophth soln (ALCAINE equiv)	-	1	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	1	BETA BLOCKERS
PROPRANOLOL SOLN	-	1	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1	ANTIHYPERTENSIVES
propylthiouracil tab	-	1	THYROID AGENTS
PROSTIGMIN TAB	-	2	ANTIMYASTHENIC/CHOLINERGIC AGENTS
protriptyline tab (VIVACTIL equiv)	-	3	ANTIDEPRESSANTS
PULMOZYME INH SOLN	MSP-PA	MSP	RESPIRATORY AGENTS - MISC.
PYLERA CAP	-	3	ULCER DRUGS
pyrazinamide tab	-	1	ANTIMYCOBACTERIAL AGENTS
pyridostigmine CR tab (MESTINON equiv)	-	2	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	1	ANTIMYASTHENIC/CHOLINERGIC AGENTS
QBRELIS SOLN	PA	3	ANTIHYPERTENSIVES
QSYMIA CAP	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
quetiapine tab (SEROQUEL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv)	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
QUFLORA PEDIATRIC CHEW TAB	-	3	MULTIVITAMINS
quinapril tab (ACCUPRIL equiv)	-	1	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	2	ANTIARRHYTHMICS
QUINIDINE SULFATE ER TAB	-	3	ANTIARRHYTHMICS
quinidine sulfate tab	-	1	ANTIARRHYTHMICS
rabeprazole EC tab (ACIPHEX equiv)	-	1	ULCER DRUGS
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramipril cap (ALTACE equiv)	-	1	ANTIHYPERTENSIVES
RANEXA TAB	-	2	ANTIANGINAL AGENTS
ranitidine cap (ZANTAC equiv)	-	1	ULCER DRUGS
ranitidine syrup (ZANTAC equiv)	-	1	ULCER DRUGS
ranitidine tab (Rx Only) (ZANTAC equiv)	-	1	ULCER DRUGS
RAPAMUNE SOLN	-	2	ASSORTED CLASSES
rasagiline tab (AZILECT equiv)	¢	2	ANTIPARKINSON AGENTS
RAYOS TAB	-	EXC	CORTICOSTEROIDS
REBETOL SOLN	-	2	ANTIVIRALS
REBIF INJ ( )	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REGRANEX GEL (QL= 30gm/fill)	QL	2	DERMATOLOGICALS
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2	ANTIVIRALS
renaphro cap (NEPHROCAP equiv)	-	1	MULTIVITAMINS
RENOVA CREAM	-	EXC	DERMATOLOGICALS
repaglinide tab (PRANDIN equiv)	-	1	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANTIHYPERTENSIVES
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	MSP-PA-QL	MSP	ANTIHYPERTENSIVES
REPREXAIN TAB (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
RESCRIPTOR TAB	-	2	ANTIVIRALS
RESERPINE TAB	-	3	ANTIHYPERTENSIVES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
RESTASIS OPHTH EMULSION (Restricted to Ophthalmology or Optometry Specialist)	RS	2	OPHTHALMIC AGENTS
RETACRIT INJ	MSP	MSP	HEMATOPOIETIC AGENTS
REVLIMID CAP (QL= 1 cap/day)	MSP-PA-QL	MSP	ASSORTED CLASSES
REYATAZ POWDER PACK	-	2	ANTIVIRALS
RHEUMATREX TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
rhinocort allergy nasal spray (RHINOCORT AQUA equiv) (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
ribavirin cap (REBETOL equiv)	-	2	ANTIVIRALS
ribavirin tab (COPEGUS equiv)	-	2	ANTIVIRALS
RIDAURA CAP	-	2	ANALGESICS - ANTI-INFLAMMATORY
rifabutin cap (MYCOBUTIN equiv)	-	2	ANTIMYCOBACTERIAL AGENTS
RIFAMATE CAP	-	2	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	2	ANTIMYCOBACTERIAL AGENTS
riluzole tab (RILUTEK equiv)	-	2	NEUROMUSCULAR AGENTS
rimantadine tab (FLUMADINE equiv)	-	1	ANTIVIRALS
RIOMET SOLN, METFORMIN SOLN	-	3	ANTIDIABETICS
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
risedronate tab (ACTONEL equiv) (Step Therapy requires trial of alendronate.)	ST	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
RISPERIDONE ODT	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone ODT (RISPERDAL M equiv)	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone soln (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone tab (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RITALIN LA CAP 60MG	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ritonavir tab (NORVIR equiv)	-	2	ANTIVIRALS
rivastigmine cap (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rivastigmine patch (EXELON equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1	MIGRAINE PRODUCTS
ropinirole ER tab (REQUIP XL equiv)	-	3	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	1	ANTIPARKINSON AGENTS
rosuvastatin tab 10mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0	ANTIHYPERLIPIDEMICS
rosuvastatin tab 20mg (CRESTOR equiv) (QL= 1.5 tabs/day)	QL	1	ANTIHYPERLIPIDEMICS
rosuvastatin tab 40mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
rosuvastatin tab 5mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0	ANTIHYPERLIPIDEMICS
RUBRACA TAB (QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RYDAPT CAP	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SABRIL TAB (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ANTICONVULSANTS
salicylic acid shampoo (SALEX equiv)	-	2	DERMATOLOGICALS
salsalate tab (DISALCID equiv)	-	2	ANALGESICS - NONNARCOTIC
SANCUSO PATCH (QL= 4 patches/fill)	QL	3	ANTIEMETICS
SANDIMMUNE SOLN 100MG/ML	-	2	ASSORTED CLASSES
SANTYL OINT (QL= 90gm/30 days)	QL	2	DERMATOLOGICALS
SAPHRIS SL TAB (QL= 2 tabs/day)	PA-QL	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
SAVELLA PAK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB (QL= 2 tabs/day)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
scopolamine patch (TRANSDERM-SCOP equiv) (QL= 5 patches/fill)	QL	3	ANTIEMETICS
seb-prev cream (OVACE CREAM equiv)	-	3	DERMATOLOGICALS
SECONAL CAP	-	2	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
selegiline cap (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selenium sulfide lotion	-	1	DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	2	DERMATOLOGICALS
SELZENTRY SOLN	-	2	ANTIVIRALS
SELZENTRY TAB	-	2	ANTIVIRALS
SENSIPAR TAB	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
SEREVENT DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
sertraline conc (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
SEVELAMER CARBONATE TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
sevelamer powder pak (REVELA equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (REVELA TAB equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
sildenafil tab (VIAGRA equiv) (QL=8 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab 20mg (REVATIO equiv) (QL= 40 tabs/30 days)	QL	1	CARDIOVASCULAR AGENTS - MISC.
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1	DERMATOLOGICALS
SIMBRINZA OPHTH SUSP	-	2	OPHTHALMIC AGENTS
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0	ANTIHYPERTENSIVES
sirolimus tab (RAPAMUNE equiv)	-	2	ASSORTED CLASSES
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2	ANTI-INFECTIVE AGENTS - MISC.
SKELID TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
SKLICE LOTION (QL= 1 tube/fill)	PA-QL	3	DERMATOLOGICALS
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
sodium chloride neb soln (HYPER-SAL equiv)	-	1	COUGH/COLD/ALLERGY
sodium citrate/citric acid soln (BICITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride chew tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger)	-	1	MINERALS & ELECTROLYTES
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger)	-	1	MINERALS & ELECTROLYTES
sodium fluoride lozenge (LOZI-FLUR equiv) (Covered at \$0 for members 5 years or younger)	-	1	MINERALS & ELECTROLYTES
sodium fluoride paste (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride rinse (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger)	-	1	MINERALS & ELECTROLYTES
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger)	-	1	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium phenylbutyrate powder (BUPHENYL equiv)	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium phenylbutyrate tab (BUPHENYL equiv)	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	2	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	1	ASSORTED CLASSES
sodium sulfacetamide gel (OVACE PLUS equiv)	-	3	DERMATOLOGICALS
sodium sulfacetamide lotion (KLARON equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide shampoo (OVACE equiv)	-	3	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	3	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	2	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR LOTION	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	2	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR SUSP	-	3	DERMATOLOGICALS
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	3	DERMATOLOGICALS
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/urea pad (ROSULA equiv)	-	3	DERMATOLOGICALS
SOLODYN TAB	-	EXC	TETRACYCLINES
SOLOSEC GRANULES PACKET (QL= 1 packet/fill)	PA-QL	3	AMEBICIDES
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOMNOTE CAP	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
SORIATANE CK KIT	-	2	DERMATOLOGICALS
SORILUX FOAM	-	3	DERMATOLOGICALS
sotalol AF tab (BETAPACE AF equiv)	-	1	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	1	BETA BLOCKERS
SPECTRACEF TAB	-	3	CEPHALOSPORINS
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2	DERMATOLOGICALS
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone tab (ALDACTONE equiv)	-	1	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1	DIURETICS
SPRYCEL TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SSKI SOLN	-	2	COUGH/COLD/ALLERGY
stavudine cap (ZERIT equiv)	-	2	ANTIVIRALS
STIMATE NASAL SOLN	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
STIOLTO INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIBILD TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SUBOXONE SL FILM, BUNAVAIL FILM	-	2	ANALGESICS - OPIOID
sucralfate tab (CARAFATE equiv)	-	1	ULCER DRUGS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1	OPHTHALMIC AGENTS
SULFADIAZINE TAB	-	1	SULFONAMIDES
SULFAMYLON CREAM	-	2	DERMATOLOGICALS
sulfasalazine EC tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulfasalazine tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulindac tab (CLINORIL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
SUPRAX CAP	-	3	CEPHALOSPORINS
SUPRAX CHEW TAB	-	3	CEPHALOSPORINS
SUPRAX SUSP 500MG/5ML	-	3	CEPHALOSPORINS
SUPRAX TAB	-	3	CEPHALOSPORINS
SUTENT CAP	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYLATRON INJ	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYMAX DUOTAB	-	3	ULCER DRUGS
SYMDEKO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	2	ANTIVIRALS
SYMPROIC TAB	PA	2	GASTROINTESTINAL AGENTS - MISC.
SYMTUZA TAB	-	2	ANTIVIRALS
SYNAREL NASAL SOLN	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
SYNJARDY TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	2	ANTIDIABETICS
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
SYNTHROID TAB	-	1	THYROID AGENTS
TABLOID TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TACLONEX SCALP SUSP	PA	3	DERMATOLOGICALS
tacrolimus cap (PROGRAF equiv)	-	2	ASSORTED CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	2	DERMATOLOGICALS
tadalafil tab (PAH) (ADCIRCA equiv)	MSP-PA	MSP	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day; BPH Only, Additional criteria required)	PA-QL	3	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP (QL= 4 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
TARCEVA TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGRETIN GEL	MSP-PA	MSP	DERMATOLOGICALS
TARKA TAB	-	3	ANTIHYPERTENSIVES
TASIGNA CAP	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAVALISSE TAB (QL= 2 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	MSP	HEMATOLOGICAL AGENTS - MISC.
TECFIDERA CAP	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECFIDERA STARTER PACK	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TEKAMLO TAB	-	3	ANTIHYPERTENSIVES
TEKTURNA HCT TAB	-	3	ANTIHYPERTENSIVES
TEKTURNA TAB	¢	3	ANTIHYPERTENSIVES
telmisartan tab (MICARDIS equiv)	-	2	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 22.5mg (RESTORIL equiv)	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 7.5mg (RESTORIL equiv)	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temozolomide cap (TEMODAR equiv)	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	2	ANTIVIRALS
terazosin cap (HYTRIN equiv)	-	1	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv)	-	1	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
TERCONAZOLE CREAM 8%	-	1	VAGINAL PRODUCTS
terconazole supp (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
TEST STRIP (all other test strips)	OTC-PA	DME	DIAGNOSTIC PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
tetrabenazine tab (XENAZINE equiv)	MSP-PA	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracycline cap	-	3	TETRACYCLINES
THALOMID CAP	MSP-PA	MSP	ASSORTED CLASSES
theophylline CR tab (QUIBRON-T equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
thioridazine tab (MELLARIL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
THYROLAR TAB	-	2	THYROID AGENTS
tiagabine tab (GABITRIL equiv)	-	2	ANTICONVULSANTS
ticlopidine tab (TICLID equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	2	OPHTHALMIC AGENTS
timolol maleate ophth soln (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	2	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	1	BETA BLOCKERS
TIMOLOL OPHTH GEL SOLN	-	2	OPHTHALMIC AGENTS
TIMOPTIC OCUDOSE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
tinidazole tab (TINDAMAX equiv)	-	3	ANTI-INFECTIVE AGENTS - MISC.
TIROSINT CAP	-	3	THYROID AGENTS
TIVICAY TAB (QL= 2 tabs/day)	QL	2	ANTIVIRALS
tizanidine cap (ZANAFLEX equiv)	-	3	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	MSP	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	2	OPHTHALMIC AGENTS
TOBRADEX ST OPHTH SUSP	-	3	OPHTHALMIC AGENTS
tobramycin neb soln (TOBI equiv)	MSP-PA	MSP	AMINOGLYCOSIDES
tobramycin ophth soln (TOBEX equiv)	-	1	OPHTHALMIC AGENTS
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1	OPHTHALMIC AGENTS
TOBEX OPHTH OINT	-	2	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	\$0	VAGINAL PRODUCTS
tolazamide tab (TOLINASE equiv)	-	1	ANTIDIABETICS
TOLBUTAMIDE TAB	-	2	ANTIDIABETICS
tolcapone tab (TASMAR equiv)	-	3	ANTIPARKINSON AGENTS
TOLMETIN CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
tolmetin cap (TOLECTIN DS equiv)	-	3	ANALGESICS - ANTI-INFLAMMATORY
tolterodine SR cap (DETROL LA equiv)	-	2	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	¢	2	URINARY ANTISPASMODICS
topiramate sprinkle cap (TOPAMAX equiv)	-	1	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	1	ANTICONVULSANTS
torsemide tab (DEMADEX equiv)	-	1	DIURETICS
TOUJEO MAX SOLOSTAR INJ	-	2	ANTIDIABETICS
TOUJEO SOLOSTAR INJ	-	2	ANTIDIABETICS
TRACLEER TAB 32MG (QL=4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
TRACLEER TAB 62.5MG, 125MG (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
TRADJENTA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
tramadol ER tab (ULTRAM ER equiv) (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv) (Dosage limits may apply)	-	3	ANALGESICS - OPIOID
trandolapril tab (MAVIK equiv)	-	1	ANTIHYPERTENSIVES
trandolapril/verapamil ER tab (TARKA equiv)	-	3	ANTIHYPERTENSIVES
tranexamic acid tab (LYSTEDA equiv)	-	2	HEMOSTATICS
TRANSDERM-SCOP PATCH (QL= 5 patches/fill)	QL	3	ANTIEMETICS
tranylcypromine tab (PARNATE equiv)	-	2	ANTIDEPRESSANTS
TRAVATAN Z OPHTH SOLN (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	1	ANTIDEPRESSANTS
TRELEGY ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TRESIBA FLEXTOUCH INJ	-	2	ANTIDIABETICS
TRESIBA INJ	-	2	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	MSP-PA	MSP	ANTINEOPLASTICS
tretinoin cream	-	2	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv)	-	2	DERMATOLOGICALS
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	3	ANALGESICS - OPIOID
triamcinolone cream	-	1	DERMATOLOGICALS
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
triamcinolone lotion	-	1	DERMATOLOGICALS
triamcinolone oint	-	1	DERMATOLOGICALS
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamcinolone spray (KENALOG equiv)	-	3	DERMATOLOGICALS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1	DIURETICS
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1	DIURETICS
triazolam tab (HALCION equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
tricitrates soln (POLYCITRA-LC equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
tricon cap (TRINSICON equiv)	-	1	HEMATOPOIETIC AGENTS
trientine cap (SYPRINE equiv)	MSP-PA	MSP	MISCELLANEOUS THERAPEUTIC CLASSE
trifluoperazine tab (STELAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
trifluridine ophth soln (VIROPTIC equiv)	-	2	OPHTHALMIC AGENTS
trihexyphenidyl elixir (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
tri-legest tab (ESTROSTEP FE equiv)	-	\$0	CONTRACEPTIVES
TRI-LUMA CREAM	-	EXC	DERMATOLOGICALS
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1	LAXATIVES
trimethobenzamide cap (TIGAN equiv)	-	1	ANTIEMETICS
trimethoprim tab (PROLOPRIM equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
trimipramine cap (SURMONTIL equiv)	-	3	ANTIDEPRESSANTS
tri-nessa (LO) tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0	CONTRACEPTIVES
TRIUMEQ TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
TROKENDI XR CAP	-	EXC	ANTICONVULSANTS
tropicamide ophth soln (MYDRIACYL equiv)	-	1	OPHTHALMIC AGENTS
tropium chloride SR cap (SANCTURA XR equiv)	PA	3	URINARY ANTISPASMODICS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
trosipium tab (SANCTURA equiv)	-	3	URINARY ANTISPASMODICS
TRUVADA TAB	PA	2	ANTIVIRALS
TYKERB TAB	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYMLOS INJ	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYVASO INH SOLN (QL= 1 ampule/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
UCERIS RECTAL FOAM	PA	3	ANORECTAL AGENTS
U-CORT CREAM	-	2	DERMATOLOGICALS
ULESFIA LOTION (QL= 4 bottles/fill)	QL	3	DERMATOLOGICALS
ULORIC TAB (Step Therapy requires trial of allopurinol)	ST-¢	2	GOUT AGENTS
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
urea cream ( )	-	1	DERMATOLOGICALS
urea lotion (KERALAC LOTION equiv)	-	1	DERMATOLOGICALS
UROQID #2 TAB	-	3	URINARY ANTI-INFECTIVES
ursodiol cap (ACTIGALL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
valacyclovir tab (VALTREX equiv)	-	1	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	DERMATOLOGICALS
valganciclovir soln (VALCYTE equiv)	-	2	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	2	ANTIVIRALS
valproic acid cap (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valproic acid syrup (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valsartan tab (DIOVAN equiv)	-	1	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1	ANTIHYPERTENSIVES
VALTURNA TAB	-	3	ANTIHYPERTENSIVES
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	2	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN SOLN KIT	-	1	ANTI-INFECTIVE AGENTS - MISC.
VANIQA CREAM	-	EXC	DERMATOLOGICALS
vardenafil tab (LEVITRA equiv)	-	EXC	CARDIOVASCULAR AGENTS - MISC.
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
vasoalex oint (XENADERM equiv)	-	2	DERMATOLOGICALS
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0	VAGINAL PRODUCTS
VEMLIDY TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
venlafaxine ER cap (EFFEXOR XR equiv)	-	1	ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv)	-	1	ANTIDEPRESSANTS
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER (QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
verapamil SR cap (VERELAN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil SR cap (VERELAN PM equiv)	-	3	CALCIUM CHANNEL BLOCKERS
VERAPAMIL SR CAP 360mg	-	1	CALCIUM CHANNEL BLOCKERS

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VERELAN SR CAP 360mg	-	3	CALCIUM CHANNEL BLOCKERS
VERZENIO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VESICARE TAB	¢	2	URINARY ANTISPASMODICS
VEXOL OPHTH SUSP	-	2	OPHTHALMIC AGENTS
V-GO INJ KIT (QL= 1 kit/day)	QL	2	MEDICAL DEVICES AND SUPPLIES
VIBRAMYCIN SYRUP	-	3	TETRACYCLINES
VICTOZA INJ (QL= 9ml/30 days)	QL	2	ANTIDIABETICS
VIDEX EC CAP 125MG	-	2	ANTIVIRALS
VIDEX SOLN	-	2	ANTIVIRALS
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416)	LD-PA	MSP	ANTICONVULSANTS
VIMOVO TAB	-	EXC	ANALGESICS - ANTI-INFLAMMATORY
VIMPAT SOLN	-	2	ANTICONVULSANTS
VIMPAT TAB (QL= 2 tabs/day)	QL	2	ANTICONVULSANTS
VIRACEPT POWDER	-	2	ANTIVIRALS
VIRACEPT TAB	-	2	ANTIVIRALS
VIREAD TAB	-	2	ANTIVIRALS
VISICOL TAB	-	3	LAXATIVES
vitamin D cap (RX strength only)	-	1	VITAMINS
vitamin D cap 1000unit (Covered for members 65 years or older)	OTC	\$0	VITAMINS
vitamin D cap 2000IU (Only covered for members 65 years old or older.)	OTC	\$0	VITAMINS
VITAMIN D CAP 400IU (Only covered for members 65 years old or older.)	OTC	\$0	VITAMINS
vitamin D cap 400unit (Covered for members 65 years or older)	OTC	\$0	VITAMINS
vitamin D tab 2000IU (Only covered for members 65 years old or older.)	OTC	\$0	VITAMINS
VITAMIN D TAB 400UNIT (Covered for members 65 years or older)	OTC	\$0	VITAMINS
VITEKTA TAB	-	2	ANTIVIRALS
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2	VACCINES
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	3	ANTIFUNGALS
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	3	ANTIFUNGALS
VOSEVI TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTIVIRALS
VOTRIENT TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VYVANSE CAP	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
VYVANSE CHEW TAB	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
warfarin tab (COUMADIN equiv)	-	1	ANTICOAGULANTS
wymzya FE tab (FEMCON FE equiv)	-	\$0	CONTRACEPTIVES
XADAGO TAB (QL= 1 tab/day)	PA-QL	3	ANTIPARKINSON AGENTS
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XARELTO STARTER PACK	-	2	ANTICOAGULANTS
XARELTO TAB	-	2	ANTICOAGULANTS
XENADERM OINT	-	2	DERMATOLOGICALS
XERESE CREAM	-	EXC	DERMATOLOGICALS
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	QL	3	ANTI-INFECTIVE AGENTS - MISC.
XIFAXAN TAB 550MG	PA	3	ANTI-INFECTIVE AGENTS - MISC.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Alphabetical Index**  
**Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	2	ANTIDIABETICS
XTAMPZA ER CAP (QL= 120 caps/30 days; Dosage limits may apply)	QL	2	ANALGESICS - OPIOID
XTANDI CAP (QL= 4 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XULANE PATCH	-	\$0	CONTRACEPTIVES
XULTOPHY INJ (QL= 15ml/30 days)	PA-QL	2	ANTIDIABETICS
XYREM SOLN (Only available through Xyrem Central Pharmacy 866-997-3688)	LD-PA	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
YODOXIN TAB	-	3	AMEBICIDES
zafirlukast tab (ACCOLATE equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZARXIO INJ	MSP	MSP	HEMATOPOIETIC AGENTS
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELAPAR ODT	-	3	ANTIPARKINSON AGENTS
ZELBORAF TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZERIT SOLN	-	3	ANTIVIRALS
zidovudine cap (RETROVIR equiv)	-	2	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	2	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	2	ANTIVIRALS
zileuton ER tab (ZYFLO CR equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zinc sulfate cap	-	1	MINERALS & ELECTROLYTES
ziprasidone cap (GEODON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZIRGAN OPHTH GEL	-	2	OPHTHALMIC AGENTS
ZITHROMAX POWDER PACK	-	3	MACROLIDES
ZMAX SUSP	-	3	MACROLIDES
ZOLINZA CAP	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
zolpidem ER tab (AMBIEN CR equiv) (Step Therapy requires trial of zolpidem IR)	ST	2	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
zolpidem tab (AMBIEN equiv)	-	1	HYPNOTICS
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZOLPIMIST SPRAY	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZOMIG NASAL SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
zonisamide cap (ZONEGRAN equiv)	-	1	ANTICONVULSANTS
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	2	HEMATOLOGICAL AGENTS - MISC.
ZORPRIN TAB	-	3	ANALGESICS - NONNARCOTIC
ZORTRESS TAB	PA	2	ASSORTED CLASSES
ZUBSOLV SL TAB	-	2	ANALGESICS - OPIOID
ZUPLENZ SL FILM	-	EXC	ANTIEMETICS
ZYCLARA CREAM	-	EXC	DERMATOLOGICALS

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary Cont.  
 Alphabetical Index  
 Last Updated 1/1/2019**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYFLO TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYKADIA CAP (QL= 3 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2	OPHTHALMIC AGENTS

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS</b>		
<b>AMPHETAMINES</b>		
ADDERALL XR CAP	-	1
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1
dextroamphetamine tab (DEXEDRINE equiv)	-	1
dextroamphetamine ER cap (DEXEDRINE equiv)	-	2
VYVANSE CAP	-	2
VYVANSE CHEW TAB	-	2
dextroamphetamine soln (PROCENTRA equiv)	-	3
<b>ANALECTICS</b>		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	2
<b>ANOREXIANTS NON-AMPHETAMINE</b>		
phentermine cap (ADIPEX equiv)	-	EXC
phentermine tab (ADIPEX equiv)	-	EXC
QSYMIA CAP	-	EXC
<b>ANTI-OBESITY AGENTS</b>		
BELVIQ TAB	-	EXC
BELVIQ XR TAB	-	EXC
<b>ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS</b>		
guanfacine ER tab (INTUNIV equiv)	-	1
atomoxetine cap (STRATTERA CAP equiv)	-	2
<b>STIMULANTS - MISC.</b>		
dexmethylphenidate tab (FOCALIN equiv)	-	1
methylphenidate CD cap (METADATE CD equiv)	-	1
methylphenidate ER tab 10mg, 20mg (RITALIN equiv)	-	1
methylphenidate tab (RITALIN equiv)	-	1
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	2
methylphenidate ER cap (RITALIN LA equiv)	-	2
METHYLPHENIDATE ER TAB	-	2
methylphenidate ER tab (CONCERTA equiv)	-	2
methylphenidate soln (METHYLIN equiv)	-	2
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	2
methylphenidate chew tab (METHYLIN equiv)	-	3
RITALIN LA CAP 60MG	-	3
<b>ALLERGENIC EXTRACTS/BIOLOGICALS MISC</b>		
<b>ALLERGENIC EXTRACTS</b>		
ODACTRA SL TAB	PA	3
<b>AMEBICIDES</b>		
<b>AMEBICIDES</b>		
SOLOSEC GRANULES PACKET (QL= 1 packet/fill)	PA-QL	3
YODOXIN TAB	-	3
<b>AMINOGLYCOSIDES</b>		
<b>AMINOGLYCOSIDES</b>		
neomycin tab	-	1
paromomycin cap (HUMATIN equiv)	-	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>AMINOGLYCOSIDES Cont.</b>		
TOBI PODHALER (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	MSP
tobramycin neb soln (TOBI equiv)	MSP-PA	MSP
<b>ANALGESICS - ANTI-INFLAMMATORY</b>		
<b>ANTIRHEUMATIC - ENZYME INHIBITORS</b>		
OLUMIANT TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
<b>ANTIRHEUMATIC ANTIMETABOLITES</b>		
RHEUMATREX TAB	-	3
<b>ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES</b>		
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	MSP-PA-QL	MSP
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	MSP-PA-QL	MSP
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	MSP-PA-QL	MSP
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	MSP
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	MSP
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	MSP
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	MSP-PA-QL	MSP
<b>GOLD COMPOUNDS</b>		
RIDAURA CAP	-	2
<b>INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)</b>		
KINERET INJ (QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644)	LD-PA-QL	MSP
<b>INTERLEUKIN-6 RECEPTOR INHIBITORS</b>		
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
ACTEMRA SC INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
KEVZARA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>		
diclofenac potassium tab (CATAFLAM equiv)	-	1
diclofenac sodium EC tab (VOLTAREN equiv)	-	1
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1
etodolac cap (LODINE equiv)	-	1
etodolac tab	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	1
ibuprofen tab	-	1
ibuprofen tab (RX only)	-	1
indomethacin cap (INDOCIN equiv)	-	1
indomethacin CR cap (INDOCIN SR equiv)	-	1
KETOPROFEN CAP	-	1
ketoprofen cap (ORUDIS equiv)	-	1
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1
meloxicam tab (MOBIC equiv)	-	1
nabumetone tab (RELAFEN equiv)	-	1
naproxen EC tab (NAPROSYN EC equiv)	-	1
naproxen tab (NAPROSYN equiv)	-	1
sulindac tab (CLINORIL equiv)	-	1
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	2
INDOCIN SUPP	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANALGESICS - ANTI-INFLAMMATORY Cont.</b>		
INDOCIN SUSP	-	2
naproxen sodium tab (ANAPROX equiv)	-	2
NAPROXEN SUSP	-	2
oxaprozin tab (DAYPRO equiv)	-	2
piroxicam cap (FELDENE equiv)	-	2
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	3
etodolac ER tab (LODINE XL equiv)	-	3
fenoprofen calcium tab	-	3
KETOPROFEN ER CAP	-	3
MECLOFENAMATE CAP	-	3
mefenamic acid cap (PONSTEL equiv)	-	3
TOLMETIN CAP	-	3
tolmetin cap (TOLECTIN DS equiv)	-	3
VIMOVO TAB	-	EXC

**PHOSPHODIESTERASE 4 (PDE4) INHIBITORS**

OTEZLA STARTER PACK (QL= 2 tabs/day)	MSP-PA-QL	MSP
OTEZLA TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP

**PYRIMIDINE SYNTHESIS INHIBITORS**

leflunomide tab (ARAVA equiv)	-	1
-------------------------------	---	---

**SELECTIVE COSTIMULATION MODULATORS**

ORENCIA CLICK INJ (QL= 4 inj/28 days)	MSP-PA-QL	MSP
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	MSP-PA-QL	MSP
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	MSP-PA-QL	MSP
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	MSP-PA-QL	MSP

**SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS**

ENBREL INJ 25MG (QL= 8 inj/28 days)	MSP-PA-QL	MSP
ENBREL INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	MSP
ENBREL MINI INJ (QL= 4 inj/28 days)	MSP-PA-QL	MSP
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	MSP

**ANALGESICS - NONNARCOTIC**

**SALICYLATES**

ASPIRIN CHEW TAB 75MG (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction) )	OTC	\$0
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction) )	OTC	\$0
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin tab 81mg (Covered for males age 45-79; Covered for females (no age restriction) )	OTC	\$0
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1
diflunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	2
ZORPRIN TAB	-	3

**ANALGESICS - OPIOID**

**OPIOID AGONISTS**

codeine sulfate tab (Dosage limits may apply)	-	1
---	---	---

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANALGESICS - OPIOID Cont.</b>		
HYDROMORPHONE SUPP (Dosage limits may apply)	-	1
hydromorphone tab (DILAUDID equiv) (Dosage limits may apply)	-	1
meperidine tab (DEMEROL equiv) (Dosage limits may apply)	-	1
methadone soln (Dosage limits may apply)	-	1
methadone tab (DOLOPHINE equiv) (Dosage limits may apply)	-	1
methadose tab (Dosage limits may apply)	-	1
morphine sulfate ER tab (MS CONTIN equiv) (Dosage limits may apply)	-	1
morphine sulfate soln (Dosage limits may apply)	-	1
morphine sulfate tab (Dosage limits may apply)	-	1
oxycodone tab (ROXICODONE equiv) (Dosage limits may apply)	-	1
tramadol tab (ULTRAM equiv) (Dosage limits may apply)	-	1
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days; Dosage limits may apply)	PA-QL	2
fentanyl patch (DURAGESIC equiv) (Dosage limits may apply)	-	2
morphine sulfate supp (Dosage limits may apply)	-	2
NUCYNTA ER TAB (QL= 2 tabs/day; Dosage limits may apply)	QL	2
oxycodone cap (OXYIR equiv) (Dosage limits may apply)	-	2
oxycodone conc (ROXICODONE equiv) (Dosage limits may apply)	-	2
oxycodone soln (ROXICODONE equiv) (Dosage limits may apply)	-	2
XTAMPZA ER CAP (QL= 120 caps/30 days; Dosage limits may apply)	QL	2
ABSTRAL SL TAB (QL= 120 tabs/30 days; Dosage limits may apply)	PA-QL	3
CODEINE SULFATE SOLN (Dosage limits may apply)	-	3
FENTORA TAB (QL= 120 tabs/30 days; Dosage limits may apply)	PA-QL	3
hydromorphone ER tab (EXALGO equiv) (Dosage limits may apply)	-	3
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days; Dosage limits may apply)	PA-QL	3
NUCYNTA TAB (Dosage limits may apply)	-	3
tramadol ER tab (ULTRAM ER equiv) (Dosage limits may apply)	-	3
<b>OPIOID COMBINATIONS</b>		
acetaminophen/codeine soln (Dosage limits may apply)	-	1
acetaminophen/codeine tab (TYLENOL/CODEINE equiv) (Dosage limits may apply)	-	1
aspirin/codeine tab (Dosage limits may apply)	-	1
hydrocodone/acetaminophen cap (LORCET equiv) (Dosage limits may apply)	-	1
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv) (Dosage limits may apply)	-	1
hydrocodone/acetaminophen tab (LORTAB equiv) (Dosage limits may apply)	-	1
oxycodone/acetaminophen cap (TYLOX equiv) (Dosage limits may apply)	-	1
oxycodone/acetaminophen tab (PERCOCET equiv) (Dosage limits may apply)	-	1
oxycodone/aspirin tab (PERCODAN equiv) (Dosage limits may apply)	-	1
pentazocine/acetaminophen tab (TALACEN equiv) (Dosage limits may apply)	-	1
acetaminophen/caffeine/dihydrocodeine tab (PANLOR SS equiv) (Dosage limits may apply)	-	2
DVORAH TAB, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	2
OXYCODONE/ACETAMINOPHEN SOLN (Dosage limits may apply)	-	2
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP (Dosage limits may apply)	-	3
CAPITAL/CODEINE SUSP (Dosage limits may apply)	-	3
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv) (Dosage limits may apply)	-	3
hydrocodone/ibuprofen tab (VICOPROFEN equiv) (Dosage limits may apply)	-	3
LORTAB ELIXIR (Dosage limits may apply)	-	3
OXYCODONE/IBUPROFEN TAB (Dosage limits may apply)	-	3
oxycodone/ibuprofen tab (COMBUNOX equiv) (Dosage limits may apply)	-	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANALGESICS - OPIOID Cont.</b>		
REPREXAIN TAB (Dosage limits may apply)	-	3
tramadol/acetaminophen tab (ULTRACET equiv) (Dosage limits may apply)	-	3
TREXIZ CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	3
<b>OPIOID PARTIAL AGONISTS</b>		
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days; Dosage limits may apply)	QL	2
SUBOXONE SL FILM, BUNAVAIL FILM	-	2
ZUBSOLV SL TAB	-	2
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Dosage limits may apply)	QL	3
BUPRENORPHINE PATCH, BUTRANS PATCH (QL= 4 patches/28 days; Dosage limits may apply)	QL	3
pentazocine/naloxone tab (TALWIN NX equiv) (Dosage limits may apply)	-	3
<b>ANDROGENS-ANABOLIC</b>		
<b>ANABOLIC STEROIDS</b>		
oxandrolone tab (OXANDRIN equiv)	-	1
<b>ANDROGENS</b>		
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2
ANDROXY TAB	-	2
danazol cap (DANOCRINE equiv)	-	2
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	2
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	2
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	2
testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	2
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	2
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	2
METHITEST TAB	PA	3
METHYLTESTOSTERONE CAP	PA	3
<b>ANORECTAL AGENTS</b>		
<b>INTRARECTAL STEROIDS</b>		
hydrocortisone enema (CORTENEMA equiv)	-	2
CORTIFOAM	-	3
UCERIS RECTAL FOAM	PA	3
<b>RECTAL COMBINATIONS</b>		
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	2
PROCTOFOAM HC FOAM	-	2
ANALPRAM-E KIT	-	3
<b>RECTAL STEROIDS</b>		
proctosol HC cream (ANUSOL HC equiv)	-	1
hydrocortisone supp (ANUSOL HC equiv)	-	2

**ANTHELMINTICS**

**ANTHELMINTICS**

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTIARRHYTHMICS Cont.</b>		
quinidine sulfate tab	-	1
disopyramide ER cap (NORPACE CR equiv)	-	2
NORPACE CR CAP	-	2
quinidine gluconate CR tab	-	2
QUINIDINE SULFATE ER TAB	-	3
<b>ANTIARRHYTHMICS TYPE I-B</b>		
mexiletine cap (MEXITIL equiv)	-	2
<b>ANTIARRHYTHMICS TYPE I-C</b>		
flecainide tab (TAMBOCOR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1
propafenone ER cap (RYTHMOL SR equiv)	-	2
<b>ANTIARRHYTHMICS TYPE III</b>		
amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	2
MULTAQ TAB	-	2
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS</b>		
<b>BRONCHODILATORS - ANTICHOLINERGICS</b>		
ipratropium neb soln (ATROVENT equiv)	-	1
ATROVENT HFA INHALER	-	2
INCRUSE ELLIPTA INHALER	-	2
LONHALA MAGNAIR SOLN (Step Therapy requires trial of INCRUSE ELLIPTA INHALER)	ST	2
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2
<b>LEUKOTRIENE MODULATORS</b>		
montelukast chew tab (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
montelukast granule pack (SINGULAIR equiv)	-	2
zafirlukast tab (ACCOLATE equiv)	-	3
zileuton ER tab (ZYFLO CR equiv)	-	3
ZYFLO TAB	-	3
<b>STEROID INHALANTS</b>		
ARNUITY ELLIPTA INHALER	-	1
ASMANEX HFA INHALER	-	1
ASMANEX INHALER	-	1
budesonide inh susp (PULMICORT equiv)	-	1
FLOVENT DISKUS INHALER	-	1
FLOVENT HFA INHALER	-	1
<b>SYMPATHOMIMETICS</b>		
albuterol neb soln 0.083% (PROVENTIL equiv)	-	1
albuterol neb soln 0.5% (VENTOLIN equiv)	-	1
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1
albuterol sulfate syrup	-	1
albuterol sulfate tab	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
FLUTICASONE/SALMETEROL INHALER	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.</b>		
METAPROTERENOL SYRUP	-	1
terbutaline sulfate tab (BRETHINE equiv)	-	1
ADVAIR DISKUS INHALER	-	2
ADVAIR HFA INHALER	-	2
ALBUTEROL TAB ER	-	2
ANORO ELLIPTA INHALER	-	2
BREO ELLIPTA INHALER	-	2
COMBIVENT INHALER	-	2
COMBIVENT RESPIMAT INHALER	-	2
DULERA INHALER	-	2
FORADIL AEROLIZER	-	2
SEREVENT DISKUS INHALER	-	2
STIOLTO INHALER	-	2
TRELEGY ELLIPTA INHALER	-	2
VENTOLIN HFA INHALER (QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler)	QL	2
albuterol neb soln 0.63mg (ACCUNEB equiv)	-	3
albuterol neb soln 1.25mg (ACCUNEB equiv)	-	3
BROVANA NEB SOLN	-	3
levalbuterol neb soln (XOPENEX equiv)	-	3
METAPROTERENOL TAB	-	3
PERFOROMIST NEB SOLN	-	3
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	3
<b>XANTHINES</b>		
aminophylline tab	-	1
theophylline CR tab (QUIBRON-T equiv)	-	1
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
ELIXOPHYLLIN ELIXIR	-	2
LUFYLLIN TAB	-	3
<b>ANTICOAGULANTS</b>		
<b>COUMARIN ANTICOAGULANTS</b>		
warfarin tab (COUMADIN equiv)	-	1
<b>DIRECT FACTOR XA INHIBITORS</b>		
ELIQUIS TAB	-	2
XARELTO STARTER PACK	-	2
XARELTO TAB	-	2
<b>HEPARINS AND HEPARINOID-LIKE AGENTS</b>		
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	2
fondaparinux inj (ARIXTRA equiv)	PA	2
FRAGMIN INJ	-	2
<b>THROMBIN INHIBITORS</b>		
PRADAXA CAP	-	2
<b>ANTICONVULSANTS</b>		
<b>ANTICONVULSANTS - BENZODIAZEPINES</b>		
clobazam tab (ONFI equiv)	PA	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTICONVULSANTS Cont.</b>		
clonazepam tab (KLONOPIN equiv)	-	1
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	2
clonazepam ODT (KLONOPIN equiv)	-	3
<b>ANTICONVULSANTS - MISC.</b>		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine susp (TEGRETOL equiv)	-	1
carbamazepine tab (TEGRETOL equiv)	-	1
gabapentin cap (NEURONTIN equiv)	-	1
gabapentin tab (NEURONTIN equiv)	-	1
lamotrigine chew tab (LAMICTAL equiv)	-	1
lamotrigine tab (LAMICTAL equiv)	-	1
levetiracetam ER tab (KEPPRA XR equiv)	-	1
levetiracetam soln (KEPPRA equiv)	-	1
levetiracetam tab (KEPPRA equiv)	-	1
oxcarbazepine susp (TRILEPTAL equiv)	-	1
oxcarbazepine tab (TRILEPTAL equiv)	-	1
primidone tab (MYSOLINE equiv)	-	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
BANZEL SUSP	-	2
BANZEL TAB	-	2
carbamazepine ER cap (CARBATROL equiv)	-	2
carbamazepine ER tab (TEGRETOL XR equiv)	-	2
gabapentin soln (NEURONTIN equiv)	-	2
LAMICTAL CHEW TAB 2MG	-	2
LYRICA CAP	PA	2
LYRICA SOLN	PA	2
POTIGA TAB (QL= 3 tabs/day)	QL	2
VIMPAT SOLN	-	2
VIMPAT TAB (QL= 2 tabs/day)	QL	2
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	3
lamotrigine ER tab (LAMICTAL XR equiv)	-	3
lamotrigine ODT (LAMICTAL equiv)	-	3
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	3
TROKENDI XR CAP	-	EXC
<b>CARBAMATES</b>		
felbamate susp (FELBATOL equiv)	-	2
felbamate tab (FELBATOL equiv)	-	2
FELBATOL TAB	-	2
<b>GABA MODULATORS</b>		
tiagabine tab (GABITRIL equiv)	-	2
SABRIL TAB (Only available through Walgreens 888-347-3416)	LD-PA	MSP
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416)	LD-PA	MSP
<b>HYDANTOINS</b>		
phenytoin cap (DILANTIN equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTICONVULSANTS Cont.</b>		
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2
phenytoin chew tab (DILANTIN equiv)	-	2
<b>SUCCINIMIDES</b>		
ethosuximide soln (ZARONTIN equiv)	-	1
CELONTIN CAP	-	2
ethosuximide cap (ZARONTIN equiv)	-	2
<b>VALPROIC ACID</b>		
divalproex ER tab (DEPAKOTE ER equiv)	-	1
divalproex sodium DR tab (DEPAKOTE equiv)	-	1
divalproex sprinkle cap (DEPAKOTE equiv)	-	1
valproic acid cap (DEPAKENE equiv)	-	1
valproic acid syrup (DEPAKENE equiv)	-	1
<b>ANTIDEPRESSANTS</b>		
<b>ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)</b>		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
<b>ANTIDEPRESSANTS - MISC.</b>		
bupropion ER tab (WELLBUTRIN equiv)	-	1
bupropion tab (WELLBUTRIN equiv)	-	1
bupropion XL tab (WELLBUTRIN XL equiv) (QL= 1 tab/day)	QL	1
MAPROTILINE TAB	-	1
<b>MONOAMINE OXIDASE INHIBITORS (MAOIS)</b>		
phenelzine tab (NARDIL equiv)	-	1
MARPLAN TAB	-	2
tranylcypromine tab (PARNATE equiv)	-	2
EMSAM PATCH	-	3
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)</b>		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA equiv)	-	1
escitalopram tab (LEXAPRO equiv)	-	1
fluoxetine cap (PROZAC equiv)	-	1
fluoxetine soln (PROZAC equiv)	-	1
fluoxetine tab 10mg, 20mg (PROZAC equiv)	-	1
fluvoxamine tab (LUVOX equiv)	-	1
paroxetine tab (PAXIL equiv)	-	1
sertraline conc (ZOLOFT equiv)	-	1
sertraline tab (ZOLOFT equiv)	-	1
escitalopram soln (LEXAPRO equiv)	-	2
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	2
paroxetine ER tab (PAXIL CR equiv)	-	2
<b>SEROTONIN MODULATORS</b>		
NEFAZODONE TAB	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTIDEPRESSANTS Cont.</b>		
nefazodone tab 50mg, 250mg	-	1
trazodone tab (DESYREL equiv)	-	1
OLEPTRO TAB	-	3
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)</b>		
duloxetine EC cap (CYMBALTA equiv)	-	1
venlafaxine ER cap (EFFEXOR XR equiv)	-	1
venlafaxine tab (EFFEXOR equiv)	-	1
desvenlafaxine ER tab (PRISTIQ equiv)	-	2
<b>TRICYCLIC AGENTS</b>		
amitriptyline tab (ELAVIL equiv)	-	1
AMOXAPINE TAB	-	1
doxepin cap (SINEQUAN equiv)	-	1
doxepin conc (SINEQUAN equiv)	-	1
imipramine tab (TOFRANIL equiv)	-	1
nortriptyline cap (PAMELOR equiv)	-	1
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1
NORTRIPTYLINE SOLN	-	1
desipramine tab (NORPRAMIN equiv)	-	2
clomipramine cap (ANAFRANIL equiv)	-	3
imipramine pamoate cap (TOFRANIL PM equiv)	-	3
protriptyline tab (VIVACTIL equiv)	-	3
trimipramine cap (SURMONTIL equiv)	-	3
<b>ANTIDIABETICS</b>		
<b>ALPHA-GLUCOSIDASE INHIBITORS</b>		
acarbose tab (PRECOSE equiv)	-	1
miglitol tab (GLYSET equiv)	-	3
<b>ANTIDIABETIC COMBINATIONS</b>		
glipizide/metformin tab (METAGLIP equiv)	-	1
glyburide/metformin tab (GLUCOVANCE equiv)	-	1
AVANDAMET TAB	-	2
AVANDARYL TAB	-	2
GLYXAMBI TAB (QL= 1 tab/day)	QL	2
JANUMET TAB (QL= 2 tabs/day)	QL	2
JANUMET XR TAB (QL= 2 tabs/day)	QL	2
JENTADUETO TAB (QL= 2 tabs/day)	QL	2
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	2
SYNJARDY TAB (QL= 2 tabs/day)	QL	2
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	2
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	2
XULTOPHY INJ (QL= 15ml/30 days)	PA-QL	2
ACTOPLUS MET XR TAB	-	3
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	3
<b>BIGUANIDES</b>		
metformin tab (GLUCOPHAGE equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTIDIABETICS Cont.</b>		
metformin XL tab (GLUCOPHAGE XR equiv)	-	1
RIOMET SOLN, METFORMIN SOLN	-	3
metformin ER osmotic tab (FORTAMET equiv)	-	EXC
metformin ER osmotic tab (GLUMETZA equiv)	-	EXC
<b>DIABETIC OTHER</b>		
GLUCAGEN HYPOKIT INJ (QL= 1 kit/fill, 2 fills/30 days)	QL	2
GLUCAGON INJ KIT (QL= 1 kit/fill, 2 fills/30 days)	QL	2
PROGLYCEM SUSP	-	3
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	MSP
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS</b>		
JANUVIA TAB (QL= 1 tab/day)	QL-¢	2
TRADJENTA TAB (QL= 1 tab/day)	QL	2
<b>DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC</b>		
CYCLOSET TAB	-	3
<b>INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)</b>		
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days)	QL	2
BYDUREON INJ (QL= 4 inj/28 days)	QL	2
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2
OZEMPIC INJ (QL= 1 pack/28 days)	QL	2
VICTOZA INJ (QL= 9ml/30 days)	QL	2
BYETTA INJ (QL= 1 pen/30 days)	QL	3
<b>INSULIN</b>		
HUMULIN R INJ U-500	-	2
HUMULIN R U-500 KWIKPEN INJ	-	2
LANTUS INJ	-	2
LANTUS SOLOSTAR INJ	-	2
LEVEMIR FLEXTOUCH INJ	-	2
LEVEMIR INJ	-	2
NOVOLIN INJ	OTC	2
NOVOLOG FLEXPEN INJ, FIASP FLEXTOUCH INJ	-	2
NOVOLOG INJ, FIASP INJ	-	2
NOVOLOG MIX FLEXPEN INJ	-	2
NOVOLOG MIX INJ	-	2
NOVOLOG PENFILL INJ	-	2
TOUJEO MAX SOLOSTAR INJ	-	2
TOUJEO SOLOSTAR INJ	-	2
TRESIBA FLEXTOUCH INJ	-	2
TRESIBA INJ	-	2
<b>INSULIN SENSITIZING AGENTS</b>		
pioglitazone tab (ACTOS equiv)	-	1
AVANDIA TAB	-	2
<b>MEGLITINIDE ANALOGUES</b>		
repaglinide tab (PRANDIN equiv)	-	1
nateglinide tab (STARLIX equiv)	-	3
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS</b>		

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTIDIABETICS Cont.</b>		
FARXIGA TAB (QL= 1 tab/day)	QL	2
JARDIANCE TAB (QL= 1 tab/day)	QL	2
<b>SULFONYLUREAS</b>		
chlorpropamide tab (DIABINESE equiv)	-	1
gliimepiride tab (AMARYL equiv)	-	1
glipizide ER tab (GLUCOTROL XL equiv)	-	1
glipizide tab (GLUCOTROL equiv)	-	1
glyburide micronized tab (GLYNASE equiv)	-	1
glyburide tab (MICRONASE equiv)	-	1
tolazamide tab (TOLINASE equiv)	-	1
TOLBUTAMIDE TAB	-	2
<b>ANTIDIARRHEALS</b>		
<b>ANTIPERISTALTIC AGENTS</b>		
diphenoxylate/atropine liquid (LOMOTIL equiv)	-	1
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
opium tincture	-	3
<b>ANTIDOTES</b>		
<b>ANTIDOTES - CHELATING AGENTS</b>		
CHEMET CAP	-	2
EXJADE TAB	MSP	MSP
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	MSP
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	MSP
JADENU TAB	MSP	MSP
<b>OPIOID ANTAGONISTS</b>		
naltrexone tab (REVIA equiv)	-	1
NARCAN NASAL SPRAY (QL= 2 sprays/fill)	QL	2
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS</b>		
<b>ANTIDOTES - CHELATING AGENTS</b>		
JADENU SPRINKLE	MSP	MSP
<b>OPIOID ANTAGONISTS</b>		
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	2
<b>ANTIEMETICS</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS</b>		
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	1
ondansetron ODT (ZOFTRAN equiv)	-	1
ondansetron soln (ZOFTRAN equiv)	-	1
ondansetron tab (ZOFTRAN equiv)	-	1
ANZEMET TAB (QL= 9 tabs/fill)	QL	3
GRANISOL SOLN (QL= 60ml/fill)	QL	3
SANCUSO PATCH (QL= 4 patches/fill)	QL	3
ZUPLENZ SL FILM	-	EXC
<b>ANTIEMETICS - ANTICHOLINERGIC</b>		
maldemar tab (SCOPACE equiv)	-	1
meclizine chew tab (BONINE equiv)	OTC	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTIEMETICS Cont.</b>		
meclizine tab (ANTIVERT equiv)	OTC	1
trimethobenzamide cap (TIGAN equiv)	-	1
scopolamine patch (TRANSDERM-SCOP equiv) (QL= 5 patches/fill)	QL	3
TRANSDERM-SCOP PATCH (QL= 5 patches/fill)	QL	3
<b>ANTIEMETICS - MISCELLANEOUS</b>		
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
dronabinol cap (MARINOL equiv)	-	2
CESAMET CAP	-	3
DICLEGIS TAB	-	EXC
<b>SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS</b>		
aprepitant cap (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
aprepitant pak (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2
<b>ANTIFUNGALS</b>		
<b>ANTIFUNGALS</b>		
nystatin powder	-	1
nystatin tab	-	1
terbinafine tab (LAMISIL equiv)	-	1
flucytosine cap (ANCOBON equiv)	-	2
griseofulvin micro tab (GRIFULVIN V equiv)	-	2
griseofulvin susp (GRIFULVIN equiv)	-	2
griseofulvin tab (GRIS-PEG equiv)	-	2
<b>IMIDAZOLE-RELATED ANTIFUNGALS</b>		
fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
ketoconazole tab (NIZORAL equiv)	-	1
itraconazole cap (SPORANOX equiv)	PA	2
itraconazole soln (SPORANOX equiv)	PA	3
NOXAFIL SUSP	-	3
NOXAFIL TAB	-	3
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	3
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	3
<b>ANTIHISTAMINES</b>		
<b>ANTIHISTAMINES - ALKYLAMINES</b>		
chlorpheniramine ER cap	-	1
<b>ANTIHISTAMINES - ETHANOLAMINES</b>		
carbinoxamine soln (PALGIC equiv)	-	3
carbinoxamine tab (PALGIC equiv)	-	3
<b>ANTIHISTAMINES - NON-SEDATING</b>		
cetirizine syrup (ZYRTEC equiv)	OTC	1
cetirizine tab (ZYRTEC equiv)	OTC	1
loratadine ODT (CLARITIN equiv)	OTC	1
loratadine syrup (CLARITIN equiv)	OTC	1
loratadine tab (CLARITIN equiv)	OTC	1
cetirizine chew tab (ZYRTEC equiv)	OTC	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTIHISTAMINES Cont.</b>		
levocetirizine tab (XYZAL equiv)	-	2
DESLORATADINE ODT	-	EXC
desloratadine tab (CLARINEX equiv)	-	EXC
<b>ANTIHISTAMINES - PHENOTHIAZINES</b>		
promethazine syrup	-	1
promethazine tab (PHENERGAN equiv)	-	1
promethazine supp (PHENERGAN equiv)	-	2
<b>ANTIHISTAMINES - PIPERIDINES</b>		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
<b>ANTIHYPERTENSIVES</b>		
<b>ANTIHYPERTENSIVES - COMBINATIONS</b>		
ezetimibe/simvastatin tab (VYTORIN equiv) (QL= 1 tab/day (10-80mg is Not Covered))	QL	3
<b>ANTIHYPERTENSIVES - MISC.</b>		
omega-3-acid ethyl esters cap (LOVAZA equiv)	PA	2
<b>BILE ACID SEQUESTRANTS</b>		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1
cholestyramine powder (QUESTRAN equiv)	-	1
cholestyramine powder pack (QUESTRAN equiv)	-	1
colestipol tab (COLESTID equiv)	-	1
colesevelam pack (WELCHOL equiv)	-	2
colesevelam tab (WELCHOL equiv)	-	2
colestipol granule (COLESTID equiv)	-	2
colestipol powder packet (COLESTID equiv)	-	3
<b>FIBRIC ACID DERIVATIVES</b>		
fenofibrate cap 67mg, 134mg, 200mg (ANTARA equiv)	-	1
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1
fenofibric acid DR cap (TRILIPIX equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
FENOFIBRIC TAB, FIBRICOR TAB	-	3
<b>HMG COA REDUCTASE INHIBITORS</b>		
atorvastatin tab 10mg (LIPITOR equiv) (QL= 1 tab/day)	QL	\$0
atorvastatin tab 20mg (LIPITOR equiv) (QL= 1 tab/day)	QL	\$0
lovastatin tab (MEVACOR equiv)	-	\$0
pravastatin tab (PRAVACHOL equiv)	-	\$0
rosuvastatin tab 10mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0
rosuvastatin tab 5mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0
atorvastatin tab 40mg (LIPITOR equiv)	-	1
atorvastatin tab 80mg (LIPITOR equiv)	-	1
rosuvastatin tab 20mg (CRESTOR equiv) (QL= 1.5 tabs/day)	QL	1
rosuvastatin tab 40mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1
fluvastatin cap (LESCOL equiv) (QL= 1 cap/day)	QL	2
LIVALO TAB (Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	ST	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTIHYPERTENSIVES Cont.</b>		
<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS</b>		
ezetimibe tab (ZETIA equiv)	-	1
<b>NICOTINIC ACID DERIVATIVES</b>		
niacin ER tab (NIASPAN equiv)	-	1
<b>PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS</b>		
PRALUENT INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
REPATHA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	MSP-PA-QL	MSP
<b>ANTIHYPERTENSIVES</b>		
<b>ACE INHIBITORS</b>		
benazepril tab (LOTENSIN equiv)	-	1
enalapril tab (VASOTEC equiv)	-	1
fosinopril tab (MONOPRIL equiv)	-	1
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1
perindopril tab (ACEON equiv)	-	1
quinapril tab (ACCUPRIL equiv)	-	1
ramipril cap (ALTACE equiv)	-	1
trandolapril tab (MAVIK equiv)	-	1
captopril tab (CAPOTEN equiv)	-	2
moexipril tab (UNIVASC equiv)	-	2
EPANED PREMIXED SOLN	PA	3
EPANED SOLN	PA	3
QBRELIS SOLN	PA	3
<b>AGENTS FOR PHEOCHROMOCYTOMA</b>		
phenoxybenzamine cap (DIBENZYLIN equiv)	MSP-PA	MSP
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
irbesartan tab (AVAPRO equiv)	-	1
losartan tab (COZAAR equiv)	-	1
olmesartan tab (BENICAR equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
telmisartan tab (MICARDIS equiv)	-	2
candesartan tab (ATACAND equiv)	-	3
<b>ANTIADRENERGIC ANTIHYPERTENSIVES</b>		
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1
terazosin cap (HYTRIN equiv)	-	1
clonidine patch (CATAPRES-TTS equiv)	-	2
GUANABENZ TAB	-	3
NEXICLON XR SUSP	-	3
NEXICLON XR TAB	-	3
RESERPINE TAB	-	3
<b>ANTIHYPERTENSIVE COMBINATIONS</b>		

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTIHYPERTENSIVES Cont.</b>		
amlodipine/benazepril cap (LOTREL equiv)	-	1
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1
methyldopa/hydrochlorothiazide tab (ALDORIL equiv)	-	1
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	1
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
amlodipine/olmesartan tab (AZOR equiv)	-	2
amlodipine/valsartan tab (EXFORGE equiv)	-	2
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	2
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	2
AMTURNIDE TAB	-	3
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	3
CORZIDE TAB 80-5MG	-	3
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	3
TARKA TAB	-	3
TEKAMLO TAB	-	3
TEKTURNA HCT TAB	-	3
trandolapril/verapamil ER tab (TARKA equiv)	-	3
VALTURNA TAB	-	3
<b>DIRECT RENIN INHIBITORS</b>		
TEKTURNA TAB	¢	3
<b>SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)</b>		
eplerenone tab (INSPRA equiv)	¢	2
<b>VASODILATORS</b>		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
metronidazole cap (FLAGYL equiv)	-	1
metronidazole tab (FLAGYL equiv)	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
NEBUPENT NEB SOLN	-	2
FIRST METRONIDAZOLE SUSP	-	3
FLAGYL ER TAB	-	3
PRIMSOL SOLN	-	3
tinidazole tab (TINDAMAX equiv)	-	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTI-INFECTIVE AGENTS - MISC. Cont.</b>		
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	QL	3
XIFAXAN TAB 550MG	PA	3
<b>ANTI-INFECTIVE MISC. - COMBINATIONS</b>		
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
<b>ANTIPROTOZOAL AGENTS</b>		
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2
ALINIA TAB (QL= 6 tabs/3 days)	PA-QL	2
atovaquone susp (MEPRON equiv)	-	2
<b>GLYCOPEPTIDES</b>		
FIRVANQ SOLN	-	1
VANCOMYCIN SOLN KIT	-	1
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	2
<b>KETOLIDES</b>		
KETEK TAB	-	3
<b>LEPROSTATICS</b>		
dapsone tab	-	1
<b>LINCOSAMIDES</b>		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	3
<b>MONOBACTAMS</b>		
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	MSP
<b>OXAZOLIDINONES</b>		
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	2
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	2
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2
<b>ANTIMALARIALS</b>		
<b>ANTIMALARIAL COMBINATIONS</b>		
atovaquone/proguanil tab (MALARONE equiv)	-	2
FANSIDAR TAB	-	3
<b>ANTIMALARIALS</b>		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
MEFLOQUINE TAB	-	2
mefloquine tab (LARIAM equiv)	-	2
PRIMAQUINE TAB	-	2
DARAPRIM TAB (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>		
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>		
pyridostigmine tab (MESTINON equiv)	-	1
PROSTIGMIN TAB	-	2
pyridostigmine CR tab (MESTINON equiv)	-	2
MESTINON SYRUP	-	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ANTIMYCOBACTERIAL AGENTS</b>		
<b>ANTI TB COMBINATIONS</b>		
RIFAMATE CAP	-	2
<b>ANTIMYCOBACTERIAL AGENTS</b>		
ISONIAZID SYRUP	-	1
isoniazid tab	-	1
pyrazinamide tab	-	1
ethambutol tab (MYAMBUTOL equiv)	-	2
PRIFTIN TAB	-	2
rifabutin cap (MYCOBUTIN equiv)	-	2
rifampin cap (RIFADIN equiv)	-	2
<b>ANTINEOPLASTICS</b>		
<b>ANTINEOPLASTICS MISC.</b>		
tretinoin cap (VESANOID equiv)	MSP-PA	MSP
<b>MITOTIC INHIBITORS</b>		
etoposide cap (VEPESID equiv)	MSP	MSP
<b>TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN CAP	MSP-PA	MSP
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES</b>		
<b>ALKYLATING AGENTS</b>		
cyclophosphamide cap	-	2
cyclophosphamide tab (CYTOXAN equiv)	-	2
GLEOSTINE/LOMUSTINE CAP	-	2
HEXALEN CAP	-	2
LEUKERAN TAB	-	2
melphalan tab (ALKERAN equiv)	-	2
AFINITOR TAB (QL= 1 tab/day)	MSP-PA-QL-SF	MSP
MYLERAN TAB	MSP	MSP
temozolomide cap (TEMODAR equiv)	MSP	MSP
<b>ANTIMETABOLITES</b>		
methotrexate inj	-	1
methotrexate tab (TREXALL equiv)	-	1
mercaptopurine tab (PURINETHOL equiv)	-	2
TABLOID TAB	-	2
capecitabine tab (XELODA equiv)	MSP	MSP
<b>ANTINEOPLASTIC - BCL-2 INHIBITORS</b>		
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP
<b>ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS</b>		
ERIVEDGE CAP ( )	MSP-PA-SF	MSP
ODOMZO CAP	MSP-PA-SF	MSP
<b>ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS</b>		
anastrozole tab (ARIMIDEX equiv)	-	1
bicalutamide tab (CASODEX equiv)	-	1
letrozole tab (FEMARA equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.</b>		
megestrol susp (MEGACE equiv)	-	1
megestrol tab (MEGACE equiv)	-	1
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older)	-	1
EMCYT CAP	-	2
exemestane tab (AROMASIN equiv)	-	2
FARESTON TAB	-	2
flutamide cap (EULEXIN equiv)	-	2
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tab/day; )	MSP-PA-QL-SF	MSP
LYSODREN TAB (Only available through Direct Success 732-919-1234)	LD	MSP
nilutamide tab (NILANDRON equiv)	MSP	MSP
XTANDI CAP (QL= 4 caps/day)	MSP-PA-QL-SF	MSP
<b>ANTINEOPLASTIC COMBINATIONS</b>		
KISQALI PAK (QL= 91 tabs/28 days)	MSP-PA-QL	MSP
LONSURF TAB (Only available through Walgreens 888-347-3416)	LD-PA	MSP
<b>ANTINEOPLASTIC ENZYME INHIBITORS</b>		
AFINITOR DISPERZ (QL= 1 tab/day)	MSP-PA-QL-SF	MSP
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	MSP
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	MSP
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	MSP
BOSULIF TAB ( )	MSP-PA-SF	MSP
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	MSP
CALQUENCE CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	MSP
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP
FARYDAK CAP (QL= 6 caps/21 days)	MSP-PA-QL	MSP
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
IBRANCE CAP (QL= 21 caps/28 days)	MSP-PA-QL	MSP
ICLUSIG TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	MSP
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
imatinib tab (GLEEVEC equiv)	MSP-PA-SF	MSP
IMBRUVICA CAP 140MG (QL= 3 caps/day)	MSP-PA-QL	MSP
IMBRUVICA CAP 70MG (QL= 1 cap/day)	MSP-PA-QL	MSP
IMBRUVICA TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	MSP
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	MSP
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP
KISQALI TAB (QL= 63 tabs/28 days)	MSP-PA-QL	MSP
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
LYNPARZA CAP (Only available through Biologics 800-850-4306, QL= 16 caps/day)	LD-PA-QL-SF	MSP
LYNPARZA TAB (Only available through Biologics 800-850-4306, QL= 4 tabs/day)	LD-PA-QL-SF	MSP
MEKINIST TAB	MSP-PA	MSP
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP
NEXAVAR TAB	MSP-PA-SF	MSP
NINLARO CAP	MSP-PA	MSP
RUBRACA TAB (QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779)	LD-PA-QL-SF	MSP

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.</b>		
RYDAPT CAP	MSP-PA	MSP
SPRYCEL TAB	MSP-PA-SF	MSP
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP
SUTENT CAP	MSP-PA-SF	MSP
TAFINLAR CAP (QL= 4 caps/day)	MSP-PA-QL-SF	MSP
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP
TARCEVA TAB	MSP-PA-SF	MSP
TASIGNA CAP	MSP-PA-SF	MSP
TYKERB TAB	MSP-PA	MSP
VERZENIO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	MSP
VOTRIENT TAB	MSP-PA-SF	MSP
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	MSP
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP
ZELBORAF TAB	MSP-PA-SF	MSP
ZOLINZA CAP	MSP-PA-SF	MSP
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	MSP
ZYKADIA CAP (QL= 3 caps/day)	MSP-PA-QL-SF	MSP

**ANTINEOPLASTICS MISC.**

hydroxyurea cap (HYDREA equiv)	-	1
MATULANE CAP	-	2
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD-PA	MSP
ALFERON-N INJ	MSP-PA	MSP
bexarotene cap (TARGRETIN equiv)	MSP-SF	MSP
INTRON-A INJ	MSP-PA	MSP
SYLATRON INJ	MSP	MSP

**CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS**

leucovorin tab	-	1
MESNEX TAB	MSP	MSP

**ANTIPARKINSON AGENTS**

**ANTIPARKINSON ADJUVANTS**

carbidopa tab (LODOSYN equiv)	-	2
-------------------------------	---	---

**ANTIPARKINSON ANTICHOLINERGICS**

benztropine tab	-	1
trihexyphenidyl elixir (ARTANE equiv)	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1

**ANTIPARKINSON COMT INHIBITORS**

entacapone tab (COMTAN equiv)	-	2
tolcapone tab (TASMAR equiv)	-	3

**ANTIPARKINSON DOPAMINERGICS**

amantadine cap (SYMMETREL equiv)	-	1
amantadine syrup (SYMMETREL equiv)	-	1
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1
carbidopa/levodopa ODT (PARCOPA equiv)	-	1
carbidopa/levodopa tab (SINEMET equiv)	-	1
pramipexole tab (MIRAPEX equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTIPARKINSON AGENTS Cont.</b>		
ropinirole tab (REQUIP equiv)	-	1
amantadine tab	-	2
bromocriptine cap (PARLODEL equiv)	-	2
bromocriptine tab (PARLODEL equiv)	-	2
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2
NEUPRO PATCH	-	3
pramipexole ER tab (MIRAPEX ER equiv)	-	3
ropinirole ER tab (REQUIP XL equiv)	-	3
APOKYN INJ (Only available through CVS Specialty 800-237-2767)	LD	MSP
<b>ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS</b>		
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
rasagiline tab (AZILECT equiv)	¢	2
XADAGO TAB (QL= 1 tab/day)	PA-QL	3
ZELAPAR ODT	-	3
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS</b>		
<b>ANTIMANIC AGENTS</b>		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
lithium citrate soln	-	1
<b>ANTIPSYCHOTICS - MISC.</b>		
ziprasidone cap (GEODON equiv)	-	1
EQUETRO CAP	-	2
<b>BENZISOXAZOLES</b>		
risperidone soln (RISPERDAL equiv)	-	1
risperidone tab (RISPERDAL equiv)	-	1
paliperidone ER tab (INVEGA equiv)	PA	2
RISPERIDONE ODT	-	2
risperidone ODT (RISPERDAL M equiv)	-	2
FANAPT TAB (QL= 2 tabs/day)	PA-QL	3
FANAPT TITRATION PACK (QL= 1 pack/plan year)	PA-QL	3
<b>BUTYROPHENONES</b>		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1
<b>DIBENZAPINES</b>		
loxapine cap (LOXITANE equiv)	-	1
olanzapine ODT (ZYPREXA equiv)	-	1
olanzapine tab (ZYPREXA equiv)	-	1
quetiapine tab (SEROQUEL equiv)	-	1
CLOZAPINE ODT	-	2
clozapine ODT 12.5mg, 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	2
clozapine tab (CLOZARIL equiv)	-	2
quetiapine XR tab (SEROQUEL XR equiv)	-	2
SAPHRIS SL TAB (QL= 2 tabs/day)	PA-QL	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
----------	--------------	------

**ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.**

**PHENOTHIAZINES**

chlorpromazine tab (THORAZINE equiv)	-	1
fluphenazine tab (PROLIXIN equiv)	-	1
perphenazine tab (TRILAFON equiv)	-	1
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine tab (MELLARIL equiv)	-	1
trifluoperazine tab (STELAZINE equiv)	-	1

**QUINOLINONE DERIVATIVES**

aripiprazole tab (ABILIFY equiv)	-	1
ABILIFY SOLN	-	2
aripiprazole ODT (ABILIFY equiv) (QL= 2 tabs/day)	QL	2
aripiprazole soln (ABILIFY equiv)	-	2

**THIOXANTHENES**

thiothixene cap (NAVANE equiv)	-	1
--------------------------------	---	---

**ANTISEPTICS & DISINFECTANTS**

**CHLORINE ANTISEPTICS**

PHISOHEX LIQUID	-	3
-----------------	---	---

**ANTIVIRALS**

**ANTIRETROVIRALS**

nevirapine tab (VIRAMUNE equiv)	-	1
abacavir soln (ZIAGEN equiv)	-	2
abacavir tab (ZIAGEN equiv)	-	2
abacavir/lamivudine tab (EPZICOM equiv)	-	2
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	2
APTIVUS CAP	-	2
APTIVUS SOLN	-	2
atazanavir cap (REYATAZ equiv)	-	2
ATRIPLA TAB (QL= 1 tab/day)	QL	2
BIKTARVY TAB	-	2
CIMDUO TAB	-	2
COMPLERA TAB (QL= 1 tab/day)	QL	2
CRIXIVAN CAP	-	2
DESCOVY TAB	PA	2
didanosine DR cap (VIDEX EC equiv)	-	2
EDURANT TAB	-	2
efavirenz cap (SUSTIVA equiv)	-	2
efavirenz tab (SUSTIVA equiv)	-	2
EMTRIVA CAP	-	2
EMTRIVA SOLN	-	2
EVOTAZ TAB	-	2
fosamprenavir tab (LEXIVA equiv)	-	2
GENVOYA TAB (QL= 1 tab/day)	QL	2
INTELENCE TAB	-	2
INVIRASE CAP	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTIVIRALS Cont.</b>		
INVIRASE TAB	-	2
ISENTRESS (HD) TAB	-	2
ISENTRESS CHEW TAB	-	2
ISENTRESS POWDER PACK	-	2
JULUCA TAB	-	2
KALETRA TAB	-	2
lamivudine soln (EPIVIR equiv)	-	2
lamivudine tab (EPIVIR equiv)	-	2
lamivudine/zidovudine tab (COMBIVIR equiv)	-	2
LEXIVA SUSP	-	2
lopinavir/ritonavir soln (KALETRA equiv)	-	2
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	2
nevirapine susp (VIRAMUNE equiv)	-	2
NORVIR CAP	-	2
NORVIR POWDER PACK	-	2
NORVIR SOLN	-	2
ODEFSEY TAB (QL= 1 tab/day)	QL	2
PREZCOBIX TAB	-	2
PREZISTA SUSP	-	2
PREZISTA TAB	-	2
RESCRIPTOR TAB	-	2
REYATAZ POWDER PACK	-	2
ritonavir tab (NORVIR equiv)	-	2
SELZENTRY SOLN	-	2
SELZENTRY TAB	-	2
stavudine cap (ZERIT equiv)	-	2
STRIBILD TAB (QL= 1 tab/day)	QL	2
SYMFI (LO) TAB	-	2
SYMTUZA TAB	-	2
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	2
TIVICAY TAB (QL= 2 tabs/day)	QL	2
TRIUMEQ TAB (QL= 1 tab/day)	QL	2
TRUVADA TAB	PA	2
VIDEX EC CAP 125MG	-	2
VIDEX SOLN	-	2
VIRACEPT POWDER	-	2
VIRACEPT TAB	-	2
VIREAD TAB	-	2
VITEKTA TAB	-	2
zidovudine cap (RETROVIR equiv)	-	2
zidovudine syrup (RETROVIR equiv)	-	2
zidovudine tab (RETROVIR equiv)	-	2
ZERIT SOLN	-	3
FUZEON INJ	MSP-PA	MSP

**CMV AGENTS**

GANCICLOVIR CAP	-	2
valganciclovir soln (VALCYTE equiv)	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ANTIVIRALS Cont.</b>		
valganciclovir tab (VALCYTE equiv)	-	2
<b>HEPATITIS AGENTS</b>		
adefovir dipivoxil tab (HEPSERA equiv)	-	2
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	2
EPIVIR HBV SOLN	-	2
lamivudine tab 100mg (EPIVIR HBV equiv)	-	2
MODERIBA DOSE PACK	-	2
MODERIBA PAK	-	2
REBETOL SOLN	-	2
ribavirin cap (REBETOL equiv)	-	2
ribavirin tab (COPEGUS equiv)	-	2
VEMLIDY TAB (QL= 1 tab/day)	QL	2
EPCLUSA TAB, SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
HARVONI TAB, LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
INFERGEN INJ	MSP-PA	MSP
MAVYRET TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP
PEGASYS INJ	MSP-PA	MSP
PEGASYS INJ KIT	MSP-PA	MSP
PEG-INTRON INJ	MSP-PA	MSP
VOSEVI TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
<b>HERPES AGENTS</b>		
acyclovir cap (ZOVIRAX equiv)	-	1
acyclovir susp (ZOVIRAX equiv)	-	1
acyclovir tab (ZOVIRAX equiv)	-	1
valacyclovir tab (VALTREX equiv)	-	1
famciclovir tab (FAMVIR equiv)	-	2
<b>INFLUENZA AGENTS</b>		
rimantadine tab (FLUMADINE equiv)	-	1
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	2
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	2
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	2
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2
<b>ASSORTED CLASSES</b>		
<b>CHELATING AGENTS</b>		
DEPEN TITRATAB, D-PENAMINE TAB	-	2
<b>IMMUNOMODULATORS</b>		
REVLIMID CAP (QL= 1 cap/day)	MSP-PA-QL	MSP
THALOMID CAP	MSP-PA	MSP
<b>IMMUNOSUPPRESSIVE AGENTS</b>		
azathioprine tab (IMURAN equiv)	-	1
mycophenolate mofetil cap (CELLCEPT equiv)	-	1
mycophenolate mofetil tab (CELLCEPT equiv)	-	1
cyclosporine cap (SANDIMMUNE equiv)	-	2
cyclosporine modified cap (NEORAL equiv)	-	2
cyclosporine modified soln (NEORAL equiv)	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ASSORTED CLASSES Cont.</b>		
mycophenolate DR tab (MYFORTIC equiv)	-	2
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	2
RAPAMUNE SOLN	-	2
SANDIMMUNE SOLN 100MG/ML	-	2
sirolimus tab (RAPAMUNE equiv)	-	2
tacrolimus cap (PROGRAF equiv)	-	2
ZORTRESS TAB	PA	2
AZASAN TAB	-	3

**POTASSIUM REMOVING RESINS**

sodium polystyrene susp (SPS equiv)	-	1
sodium polystyrene powder (KAYEXALATE equiv)	-	2

**BETA BLOCKERS**

**ALPHA-BETA BLOCKERS**

carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1

**BETA BLOCKERS CARDIO-SELECTIVE**

acebutolol cap (SECTRAL equiv)	-	1
atenolol tab (TENORMIN equiv)	-	1
betaxolol tab (KERLONE equiv)	-	1
bisoprolol tab (ZEBETA equiv)	-	1
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
BYSTOLIC TAB	¢	2

**BETA BLOCKERS NON-SELECTIVE**

pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
PROPRANOLOL SOLN	-	1
propranolol tab (INDERAL equiv)	-	1
sotalol AF tab (BETAPACE AF equiv)	-	1
sotalol tab (BETAPACE equiv)	-	1
timolol maleate tab (BLOCADREN equiv)	-	1
nadolol tab (CORGARD equiv)	-	2
LEVATOL TAB	-	3

**CALCIUM CHANNEL BLOCKERS**

**CALCIUM CHANNEL BLOCKERS**

amlodipine tab (NORVASC equiv)	-	1
diltiazem ER cap (CARDIZEM CD equiv)	-	1
diltiazem ER cap (CARDIZEM SR equiv)	-	1
diltiazem ER cap (DILACOR XR equiv)	-	1
diltiazem ER cap (TIAZAC equiv)	-	1
diltiazem tab (CARDIZEM equiv)	-	1
isradipine cap (DYNACIRC equiv)	-	1
nicardipine cap (CARDENE equiv)	-	1
nifedipine cap (PROCARDIA equiv)	-	1
nifedipine ER tab (ADALAT CC equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>CALCIUM CHANNEL BLOCKERS Cont.</b>		
verapamil SR cap (VERELAN SR equiv)	-	1
VERAPAMIL SR CAP 360mg	-	1
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1
verapamil tab (CALAN equiv)	-	1
diltiazem ER tab (CARDIZEM LA equiv)	-	2
felodipine ER tab (PLENDIL equiv)	-	2
nisoldipine ER tab (SULAR equiv)	-	2
CARDENE SR CAP	-	3
COVERA-HS TAB	-	3
DYNACIRC CR TAB	-	3
nimodipine cap (NIMOTOP equiv)	-	3
verapamil SR cap (VERELAN PM equiv)	-	3
VERELAN SR CAP 360mg	-	3
<b>CARDIOTONICS</b>		
<b>CARDIAC GLYCOSIDES</b>		
digoxin soln (LANOXIN equiv)	-	1
digoxin tab (LANOXIN equiv)	-	1
<b>CARDIOVASCULAR AGENTS - MISC.</b>		
<b>CARDIOVASCULAR AGENTS MISC. - COMBINATIONS</b>		
ENTRESTO TAB (QL= 2 tabs/day)	PA-QL	2
<b>IMPOTENCE AGENTS</b>		
sildenafil tab (VIAGRA equiv) (QL=8 tabs/30 days)	QL	2
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day; BPH Only, Additional criteria required)	PA-QL	3
LEVITRA TAB	-	EXC
vardenafil tab (LEVITRA equiv)	-	EXC
<b>PERIPHERAL VASODILATORS</b>		
isoxsuprine tab	-	3
<b>PROSTAGLANDIN VASODILATORS</b>		
TYVASO INH SOLN (QL= 1 ampule/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
<b>PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS</b>		
LETAIRIS TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP
OPSUMIT TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP
TRACLEER TAB 32MG (QL=4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP
TRACLEER TAB 62.5MG, 125MG (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP
<b>PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS</b>		
sildenafil tab 20mg (REVATIO equiv) (QL= 40 tabs/30 days)	QL	1
tadalafil tab (PAH) (ADCIRCA equiv)	MSP-PA	MSP
<b>PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST</b>		
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
<b>PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
<b>SINUS NODE INHIBITORS</b>		
CORLANOR TAB	PA	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
----------	--------------	------

**CEPHALOSPORINS**

**CEPHALOSPORINS - 1ST GENERATION**

cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1
cephalexin susp (KEFLEX equiv)	-	1

**CEPHALOSPORINS - 2ND GENERATION**

cefuroxime susp (CEFTIN equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
cefprozil susp (CEFZIL equiv)	-	2
cefprozil tab (CEFZIL equiv)	-	2
CEFTIN SUSP	-	2
cefaclor cap (CECLOR equiv)	-	3
CEFACTOR ER TAB	-	3
CEFACTOR SUSP	-	3

**CEPHALOSPORINS - 3RD GENERATION**

cefdinir cap (OMNICEF equiv)	-	2
cefdinir susp (OMNICEF equiv)	-	2
cefpodoxime proxetil susp (VANTIN equiv)	-	2
cefpodoxime proxetil tab (VANTIN equiv)	-	2
CEDAX CAP	-	3
CEDAX SUSP	-	3
CEFDITOREN TAB	-	3
cefixime susp (SUPRAX equiv)	-	3
SPECTRACEF TAB	-	3
SUPRAX CAP	-	3
SUPRAX CHEW TAB	-	3
SUPRAX SUSP 500MG/5ML	-	3
SUPRAX TAB	-	3

**CONTRACEPTIVES**

**COMBINATION CONTRACEPTIVES - ORAL**

amethyst tab (LYBREL equiv) (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
apri tab (DESOGEN equiv)	-	\$0
aranelle tab (TRI-NORINYL equiv)	-	\$0
aviane tab (ALESSE equiv)	-	\$0
cesia tab (CYCLESSA equiv)	-	\$0
cryselle tab	-	\$0
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0
jolessa tab, amethia tab (SEASONALE, SEASONIQUE equiv)	-	\$0
junel FE tab (LOESTRIN FE equiv)	-	\$0
junel tab (LOESTRIN equiv)	-	\$0
kariva tab (MIRCETTE equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
LO LOESTRIN TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
LO MINASTRIN 24 FE CHEW TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>CONTRACEPTIVES Cont.</b>		
LOESTRIN 24 FE TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
mibelas chew tab (MINASTRIN equiv) (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
mononessa tab (ORTHO-CYCLEN equiv)	-	\$0
NATAZIA TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
necon tab (ORTHO-NOVUM equiv)	-	\$0
necon tab 1-50 (NORYNIL equiv)	-	\$0
NORINYL TAB 1-50 (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
nortrel tab (OVCON 35 equiv)	-	\$0
OGESTREL TAB (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
tri-legest tab (ESTROSTEP FE equiv)	-	\$0
tri-nessa (LO) tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0
wymzya FE tab (FEMCON FE equiv)	-	\$0
BEYAZ TAB	-	EXC
<b>COMBINATION CONTRACEPTIVES - TRANSDERMAL</b>		
XULANE PATCH	-	\$0
<b>COMBINATION CONTRACEPTIVES - VAGINAL</b>		
NUVARING	-	\$0
<b>EMERGENCY CONTRACEPTIVES</b>		
ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0
LEVONORGESTREL TAB 0.75MG	-	\$0
<b>PROGESTIN CONTRACEPTIVES - INJECTABLE</b>		
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0
<b>PROGESTIN CONTRACEPTIVES - ORAL</b>		
norethindrone tab (NORA-QD equiv)	-	\$0
<b>CORTICOSTEROIDS</b>		
<b>GLUCOCORTICOSTEROIDS</b>		
DEXAMETHASONE CONC	-	1
dexamethasone elixir	-	1
dexamethasone soln	-	1
dexamethasone tab (DECADRON equiv)	-	1
hydrocortisone tab (CORTEF equiv)	-	1
methylprednisolone dose pack (MEDROL equiv)	-	1
methylprednisolone tab (MEDROL equiv)	-	1
prednisolone soln (PEDIAPRED equiv)	-	1
PREDNISOLONE SYRUP	-	1
prednisolone syrup (PRELONE equiv)	-	1
PREDNISON SOLN	-	1
PREDNISON TAB	-	1
prednisone tab (DELTASONE equiv)	-	1
budesonide SR cap (ENTOCORT EC equiv) (Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine)	ST	2
CORTISONE ACETATE TAB	-	2
PREDNISON PAK	-	2
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>CORTICOSTEROIDS Cont.</b>		
DEXPAK TAB	-	3
MILLIPRED DP PAK	-	3
MILLIPRED TAB	-	3
prednisolone ODT (ORAPRED equiv)	-	3
RAYOS TAB	-	EXC
<b>MINERALOCORTICIDS</b>		
fludrocortisone tab (FLORINEF equiv)	-	1
<b>COUGH/COLD/ALLERGY</b>		
<b>ANTITUSSIVES</b>		
benzonatate cap (TESSALON equiv)	-	1
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1
<b>COUGH/COLD/ALLERGY COMBINATIONS</b>		
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	1
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1
PROMETHAZINE VC SYRUP	-	1
promethazine VC syrup (PHENERGAN VC equiv)	-	1
PROMETHAZINE VC/CODEINE SYRUP	-	1
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	3
HYDROCODONE/CHLORPHENIRAMINE/PSEUDOEPHEDRINE LIQUID (QL= 120ml/fill, 2 fills/month)	QL	3
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	QL	3
NEOTUSS PLUS LIQUID	-	3
promethazine DM syrup	-	3
<b>EXPECTORANTS</b>		
SSKI SOLN	-	2
<b>MISC. RESPIRATORY INHALANTS</b>		
sodium chloride neb soln (HYPER-SAL equiv)	-	1
NEBUSAL NEB SOLN	-	2
<b>MUCOLYTICS</b>		
acetylcysteine soln (MUCOMYST equiv)	-	1
<b>DERMATOLOGICALS</b>		
<b>ACNE PRODUCTS</b>		
benzoyl peroxide gel (BENZAC equiv)	OTC	1
benzoyl peroxide lotion (BENZAC equiv)	-	1
benzoyl peroxide wash kit (BENZAC equiv)	-	1
clindamycin gel (CLEOCIN GEL equiv)	-	1
clindamycin lotion (CLEOCIN- T equiv)	-	1
clindamycin pad (CLEOCIN-T equiv)	-	1
clindamycin topical soln (CLEOCIN-T equiv)	-	1
DIFFERIN OTC GEL 0.1%	OTC	1
erythromycin pad	-	1
erythromycin soln	-	1
adapalene cream (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	2
adapalene gel 0.3% (DIFFERIN equiv) (Acne Only- members age 35 or older require Prior Authorization)	PA	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
AVAR GEL	-	2
erythromycin gel	-	2
isotretinoin cap (ACCUTANE equiv)	-	2
PRASCION RA CREAM	-	2
sodium sulfacetamide lotion (KLARON equiv)	-	2
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	2
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	2
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	2
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	2
SODIUM SULFACETAMIDE/SULFUR LOTION	-	2
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	2
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	2
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	2
tretinoin cream	-	2
tretinoin gel (RETIN-A GEL equiv)	-	2
ADAPALENE LOTION (DIFFERIN equiv)	PA	3
AVAR AEROSOL FOAM	-	3
AZELEX CREAM	PA	3
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	PA	3
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	PA	3
DIFFERIN LOTION 0.1%	PA	3
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	3
SODIUM SULFACETAMIDE/SULFUR SUSP	-	3
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	3
ABSORICA CAP	-	EXC
AVAR PAD	-	EXC
clindamycin foam (EVOCLIN equiv)	-	EXC
CLINDAMYCIN/BENZOYL PEROXIDE GEL, ACANYA GEL	-	EXC
clindamycin/tretinoin gel (ZIANA GEL equiv)	-	EXC
EVOCLIN FOAM	-	EXC
ONEXTON GEL	-	EXC

**AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES**

RENOVA CREAM	-	EXC
--------------	---	-----

**ANTIBIOTICS - TOPICAL**

gentamicin sulfate cream	-	1
gentamicin sulfate oint	-	1
mupirocin oint (BACTROBAN OINT equiv)	-	1
ALTABAX OINT	-	3
CENTANY OINT	-	3
CORTISPORIN CREAM	-	3
CORTISPORIN OINT	-	3

**ANTIFUNGALS - TOPICAL**

ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1
ciclopirox nail soln (PENLAC equiv)	-	1
ciclopirox topical susp (LOPROX SUSP equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>DERMATOLOGICALS Cont.</b>		
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1
ketoconazole cream (NIZORAL CREAM equiv)	-	1
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	2
clotrimazole/betamethasone lotion (LOTTRISONE LOTION equiv)	-	2
econazole cream (SPECTAZOLE equiv)	-	3
ERTACZO CREAM	-	3
EXELDERM CREAM	-	3
EXELDERM SOLN	-	3
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	3
MENTAX CREAM	-	3
naftifine cream (NAFTIN equiv)	-	3
NAFTIN GEL 1%	-	3
oxiconazole nitrate cream (OXISTAT equiv)	-	3
OXISTAT LOTION	-	3
JUBLIA SOLN	-	EXC
KERYDIN SOLN	-	EXC
<b>ANTI-INFLAMMATORY AGENTS - TOPICAL</b>		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	2
FLECTOR PATCH (QL= 30 patches/fill)	QL	3
<b>ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL</b>		
fluorouracil cream (EFUDEX CREAM equiv)	-	1
FLUOROPLEX CREAM	-	2
FLUOROURACIL CREAM 0.5%	-	2
FLUOROURACIL SOLN	-	2
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	3
PICATO GEL (QL= 1 box/fill)	QL	3
TARGRETIN GEL	MSP-PA	MSP
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
<b>ANTIPRURITICS - TOPICAL</b>		
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	PA	3
<b>ANTIPSORIATICS</b>		
8-MOP CAP	-	2
acitretin cap (SORIATANE equiv)	-	2
calcipotriene cream (DOVONEX CREAM equiv)	-	2
calcipotriene oint	-	2
calcipotriene soln (DOVONEX SOLN equiv)	-	2
CALCITRIOL OINT	-	2
methoxsalen cap (OXSORALEN ULTRA equiv)	-	2
SORIATANE CK KIT	-	2
SORILUX FOAM	-	3
COSENTYX INJ (1-PACK) (QL= 1 inj/28 days)	MSP-PA-QL	MSP
COSENTYX INJ (2-PACK) (QL= 2 inj/28 days)	MSP-PA-QL	MSP

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
<b>ANTISEBORRHEIC PRODUCTS</b>		
selenium sulfide lotion	-	1
selenium sulfide shampoo (SELSEB equiv)	-	2
sodium sulfacetamide wash (OVACE WASH equiv)	-	2
OVACE PLUS CREAM	-	3
seb-prev cream (OVACE CREAM equiv)	-	3
sodium sulfacetamide gel (OVACE PLUS equiv)	-	3
sodium sulfacetamide shampoo (OVACE equiv)	-	3
sodium sulfacetamide/urea pad (ROSULA equiv)	-	3
<b>ANTIVIRALS - TOPICAL</b>		
XERESE CREAM	-	EXC
<b>BURN PRODUCTS</b>		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
SULFAMYLON CREAM	-	2
<b>CORTICOSTEROIDS - TOPICAL</b>		
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
betamethasone augmented gel	-	1
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1
betamethasone dipropionate lotion	-	1
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	1
betamethasone valerate cream	-	1
betamethasone valerate lotion	-	1
betamethasone valerate oint	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oint	-	1
fluocinonide cream 0.05% (LIDEX equiv)	-	1
fluocinonide emollient cream	-	1
fluocinonide gel	-	1
fluocinonide oint	-	1
fluocinonide soln	-	1
fluticasone propionate cream (CUTIVATE equiv)	-	1
fluticasone propionate oint (CUTIVATE equiv)	-	1
hydrocortisone cream (PROCTOCORT equiv)	-	1
hydrocortisone lotion (HYTONE equiv)	-	1
hydrocortisone oint	-	1
mometasone cream (ELOCON equiv)	-	1
mometasone oint (ELOCON equiv)	-	1
mometasone soln (ELOCON equiv)	-	1
triamcinolone cream	-	1
triamcinolone lotion	-	1
triamcinolone oint	-	1
alclometasone cream (ACLOVATE equiv)	-	2
alclometasone oint (ACLOVATE OINT equiv)	-	2
clobetasol propionate cream (TEMOVATE equiv)	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>DERMATOLOGICALS Cont.</b>		
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	2
clobetasol propionate gel (TEMOVATE GEL equiv)	-	2
clobetasol propionate oint (TEMOVATE equiv)	-	2
clobetasol propionate soln (TEMOVATE equiv)	-	2
desonide cream	-	2
desonide lotion	-	2
desonide oint	-	2
desoximetasone gel (TOPICORT equiv)	-	2
desoximetasone oint (TOPICORT equiv)	-	2
EPIFOAM AEROSOL	-	2
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	2
fluocinolone acetonide soln	-	2
halobetasol propionate cream (ULTRAVATE equiv)	-	2
halobetasol propionate oint (ULTRAVATE equiv)	-	2
hydrocortisone butyrate cream (LOCOID equiv)	-	2
hydrocortisone butyrate oint (LOCOID equiv)	-	2
hydrocortisone butyrate soln (LOCOID equiv)	-	2
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	2
PRAMOSONE CREAM	-	2
PRAMOSONE E CREAM	-	2
PRAMOSONE OINT	-	2
PREDNICARBATE CREAM	-	2
prednicarbate cream (DERMATOP equiv)	-	2
PREDNICARBATE OIN	-	2
U-CORT CREAM	-	2
calcipotriene/betamethasone oint (TACLONEX equiv)	-	3
CAPEX SHAMPOO	-	3
clobetasol foam (OLUX equiv)	-	3
clobetasol lotion (CLOBEX LOTION equiv)	-	3
clobetasol shampoo (CLOBEX SHAMPOO equiv)	-	3
CLOCORTOLONE CREAM, CLODERM CREAM	-	3
CORDRAN TAPE	-	3
desoximetasone cream (TOPICORT CREAM equiv)	-	3
flurandrenolide cream (CORDRAN equiv)	-	3
flurandrenolide lotion (CORDRAN equiv)	-	3
hydrocortisone valerate cream	-	3
hydrocortisone valerate oint (WESTCORT equiv)	-	3
PANDEL CREAM	-	3
PRAMOSONE LOTION	-	3
TACLONEX SCALP SUSP	PA	3
triamcinolone spray (KENALOG equiv)	-	3
<b>ECZEMA AGENTS</b>		
DUPIXENT INJ (QL= 2 inj/ 28 days)	MSP-PA-QL	MSP
<b>EMOLLIENT/KERATOLYTIC AGENTS</b>		
urea cream ( )	-	1
urea lotion (KERALAC LOTION equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
<b>EMOLLIENTS</b>		
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	1
<b>ENZYMES - TOPICAL</b>		
SANTYL OINT (QL= 90gm/30 days)	QL	2
vasolex oint (XENADERM equiv)	-	2
XENADERM OINT	-	2
<b>HAIR GROWTH AGENTS</b>		
bimatoprost topical soln (LATISSE equiv)	-	EXC
finasteride tab (PROPECIA equiv)	-	EXC
LATISSE SOLN	-	EXC
<b>HAIR REDUCTION AGENTS</b>		
VANIQA CREAM	-	EXC
<b>IMMUNOMODULATING AGENTS - TOPICAL</b>		
imiquimod cream (ALDARA equiv)	-	2
ZYCLARA CREAM	-	EXC
<b>IMMUNOSUPPRESSIVE AGENTS - TOPICAL</b>		
pimecrolimus cream (ELIDEL equiv)	-	2
tacrolimus oint (PROTOPIC OINT equiv)	-	2
<b>KERATOLYTIC/ANTIMITOTIC AGENTS</b>		
PODOCON SOLN	-	2
podofilox soln (CONDYLOX equiv)	-	2
salicylic acid shampoo (SALEX equiv)	-	2
CONDYLOX GEL	-	3
<b>LOCAL ANESTHETICS - TOPICAL</b>		
lidocaine cream 3% (LIDAMANTLE equiv)	-	1
lidocaine cream 4%	OTC	1
lidocaine gel (XYLOCAINE equiv)	-	1
lidocaine oint (QL= 107gm/30 days)	QL	1
lidocaine soln (XYLOCAINE equiv)	-	1
lidocaine/prilocaine cream (EMLA equiv)	-	1
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	2
<b>MISC. DERMATOLOGICAL PRODUCTS</b>		
NUVAIL SOLN	-	EXC
<b>MISC. TOPICAL</b>		
aluminum chloride soln (DRYSOL equiv)	-	1
DRYSOL SOLN	-	1
<b>PIGMENTING-DEPIGMENTING AGENTS</b>		
hydroquinone cream (LUSTRA equiv)	-	EXC
NUQUIN HP GEL	-	EXC
TRI-LUMA CREAM	-	EXC
<b>ROSACEA AGENTS</b>		
metronidazole lotion (METROLOTION equiv)	-	1
azelaic acid gel (FINACEA equiv)	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary**  
**Category/Class**  
**Last Updated\* 1/1/2019**

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
FINACEA FOAM	-	2
FINACEA PLUS KIT	-	2
metronidazole cream (METROCREAM equiv)	-	2
metronidazole gel (METROGEL equiv)	-	2
DOXYCYCLINE CAP, ORACEA CAP	-	EXC
<b>SCABICIDES &amp; PEDICULICIDES</b>		
permethrin cream (ELIMITE CREAM equiv)	-	1
EURAX CREAM	-	2
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2
crotamiton lotion (EURAX equiv)	-	3
LINDANE LOTION	-	3
lindane shampoo	-	3
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	3
NATROBA SUSP (QL= 1 bottle/fill)	QL	3
SKLICE LOTION (QL= 1 tube/fill)	PA-QL	3
ULESFIA LOTION (QL= 4 bottles/fill)	QL	3
<b>WOUND CARE PRODUCTS</b>		
BIAFINE EMULSION	-	2
REGRANEX GEL (QL= 30gm/fill)	QL	2
<b>DIAGNOSTIC PRODUCTS</b>		
<b>DIAGNOSTIC DRUGS</b>		
GLUCAGEN INJ (QL= 1 kit/fill, 2 fills/30 days)	QL	2
<b>DIAGNOSTIC PRODUCTS, MISC.</b>		
FREESTYLE LITE TEST STRIP	OTC	DME
<b>DIAGNOSTIC TESTS</b>		
CLINISTIX TEST STRIP	OTC	DME
FREESTYLE INSULINX TEST STRIP	OTC	DME
FREESTYLE PRECISION NEO TEST STRIP	OTC	DME
FREESTYLE TEST STRIP	OTC	DME
KETO-DIASTIX TEST STRIP	OTC	DME
KETOSTIX	OTC	DME
PRECISION XTRA TEST STRIP	OTC	DME
TEST STRIP (all other test strips)	OTC-PA	DME
<b>DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS</b>		
<b>DIETARY MANAGEMENT PRODUCTS</b>		
L-METHYLFOLATE TAB	-	EXC
<b>DIGESTIVE AIDS</b>		
<b>DIGESTIVE ENZYMES</b>		
CREON CAP	-	2
<b>DIURETICS</b>		
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	2
acetazolamide tab	-	2
methazolamide tab (NEPTAZANE equiv)	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered	INF	<b>generic</b> =small letters	LD	<b>BRANDS</b> =CAPITAL LETTERS
MSP	Plan Exclusion	OTC	Infertility	PA	Limited Distribution
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	ST	Restricted to Specialist	VAC	Limited to two 15 day fills per month for first 3 months
¢	Smoking Cessation		Step Therapy		Vaccine Program
	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>DIURETICS Cont.</b>		
<b>DIURETIC COMBINATIONS</b>		
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2
<b>LOOP DIURETICS</b>		
bumetanide tab (BUMEX equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
torseamide tab (DEMADEX equiv)	-	1
ethacrynic tab (EDECIN equiv)	-	2
<b>POTASSIUM SPARING DIURETICS</b>		
amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
DYRENIUM CAP	-	2
<b>THIAZIDES AND THIAZIDE-LIKE DIURETICS</b>		
chlorothiazide tab (DIURIL equiv)	-	1
CHLOROTHIAZIDE TAB 250MG	-	1
CHLORTHALIDONE TAB	-	1
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
METHYCLOTHIAZIDE TAB	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
<b>ENDOCRINE AND METABOLIC AGENTS - MISC.</b>		
<b>BONE DENSITY REGULATORS</b>		
alendronate tab (FOSAMAX equiv)	-	1
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	1
ALENDRONATE TAB 40MG	-	2
calcitonin nasal spray (MIACALCIN equiv)	-	2
FORTICAL NASAL SPRAY	-	2
risedronate tab (ACTONEL equiv) (Step Therapy requires trial of alendronate.)	ST	2
FOSAMAX+D TAB	-	3
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	3
SKELID TAB	-	3
TYMLOS INJ	MSP-PA	MSP
<b>CALCIUM REGULATORS - MISC.</b>		
ALENDRONATE SOLN	-	3
etidronate disodium tab 200mg (DIDRONEL equiv)	-	3
<b>FERTILITY REGULATORS</b>		
CLOMIPHENE CITRATE TAB	-	1
clomiphene citrate tab (CLOMID equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.</b>		
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	MSP
<b>GROWTH HORMONES</b>		
NORDITROPIN INJ	MSP-PA	MSP
<b>HORMONE RECEPTOR MODULATORS</b>		
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older)	-	1
<b>INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)</b>		
INCRELEX INJ	MSP-PA	MSP
<b>LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
SYNAREL NASAL SOLN	-	2
<b>METABOLIC MODIFIERS</b>		
calcitriol cap (ROCALTROL equiv)	-	1
calcitriol soln (ROCALTROL SOLN equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1
levocarnitine tab (CARNITOR equiv)	-	1
doxercalciferol cap (HECTOROL equiv)	-	2
paricalcitol cap (ZEMPLAR equiv)	-	2
SENSIPAR TAB	-	2
CALCITRIOL INJ	MSP-PA	MSP
calcitriol inj (CALCIJEX equiv)	MSP-PA	MSP
KUVAN POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	MSP
KUVAN TAB (Only available through Walgreens 888-347-3416)	LD-PA	MSP
PALYNZIQ INJ (QL= 1 inj/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	MSP
sodium phenylbutyrate powder (BUPHENYL equiv)	MSP-PA	MSP
sodium phenylbutyrate tab (BUPHENYL equiv)	MSP-PA	MSP
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	MSP
<b>POSTERIOR PITUITARY HORMONES</b>		
desmopressin acetate tab (DDAVP equiv)	-	2
desmopressin nasal soln (DDAVP equiv)	-	2
STIMATE NASAL SOLN	-	2
DDAVP NASAL SOLN	-	3
<b>PROLACTIN INHIBITORS</b>		
cabergoline tab (DOSTINEX equiv)	-	1
<b>SOMATOSTATIC AGENTS</b>		
octreotide inj (SANDOSTATIN equiv)	MSP-PA	MSP
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 888-773-7376)	LD-PA-QL	MSP
<b>VASOPRESSIN RECEPTOR ANTAGONISTS</b>		
YYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP
<b>ESTROGENS</b>		
<b>ESTROGEN COMBINATIONS</b>		
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1
jjnteli tab (FEMHRT equiv)	-	2
PREMPHASE TAB, PREMPRO TAB	-	2
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>ESTROGENS Cont.</b>		
<b>ESTROGENS</b>		
estradiol patch (CLIMARA equiv) (QL= 1 patch/week)	QL	1
estradiol patch (VIVELLE-DOT equiv) (QL= 2 patches/week)	QL	1
estradiol tab (ESTRACE equiv)	-	1
ESTROPIPATE TAB	-	1
estropipate tab (OGEN equiv)	-	1
PREMARIN TAB	-	2
CENESTIN TAB	-	3

**FLUOROQUINOLONES**

<b>FLUOROQUINOLONES</b>		
ciprofloxacin tab (CIPRO equiv)	-	1
levofloxacin soln (LEVAQUIN equiv)	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
ofloxacin tab (FLOXIN equiv)	-	1
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	2
ciprofloxacin susp (CIPRO equiv)	-	2
moxifloxacin tab (AVELOX equiv)	-	2
CIPRO SUSP 5%	-	3
CIPROFLOXACIN 100MG TAB	-	3
CIPROFLOXACIN ER TAB	-	3
NOROXIN TAB	-	3

**GASTROINTESTINAL AGENTS - MISC.**

<b>FARNESOID X RECEPTOR (FXR) AGONISTS</b>		
OCALIVA TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF-¢	MSP

<b>GALLSTONE SOLUBILIZING AGENTS</b>		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1

<b>GASTROINTESTINAL ANTIALLERGY AGENTS</b>		
cromolyn conc (GASTROCROM equiv)	-	2

<b>GASTROINTESTINAL STIMULANTS</b>		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
METZOLV ODT	-	EXC

<b>INFLAMMATORY BOWEL AGENTS</b>		
balsalazide cap (COLAZAL equiv)	-	1
sulfasalazine EC tab (AZULFIDINE equiv)	-	1
sulfasalazine tab (AZULFIDINE equiv)	-	1
APRISO CAP	-	2
LIALDA TAB	-	2
mesalamine enema (ROWASA equiv)	-	2
mesalamine supp (CANASA equiv)	-	2
DIPENTUM CAP	-	3
CIMZIA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	MSP-PA-QL	MSP

**INTESTINAL ACIDIFIERS**

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>GASTROINTESTINAL AGENTS - MISC. Cont.</b>		
lactulose soln	-	1
<b>IRRITABLE BOWEL SYNDROME (IBS) AGENTS</b>		
LINZESS CAP	PA	2
alosetron tab (LOTROXEX equiv)	-	3
<b>PERIPHERAL OPIOID RECEPTOR ANTAGONISTS</b>		
MOVANTIK TAB	PA	2
SYMPROIC TAB	PA	2
<b>PHOSPHATE BINDER AGENTS</b>		
calcium acetate cap (PHOSLO equiv)	-	1
FOSRENOL POWDER PACK	-	2
lanthanum carbonate chew tab (FOSRENOL equiv)	-	2
SEVELAMER CARBONATE TAB	-	2
sevelamer powder pak (REVELA equiv)	-	2
sevelamer tab (REVELA TAB equiv)	-	2
<b>GENITOURINARY AGENTS - MISCELLANEOUS</b>		
<b>ALKALINIZERS</b>		
CYTRA-3 SYRUP	-	1
K/NA CITRATE SOLN CITRIC ACID	-	1
ORACIT SOLN	-	1
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1
sodium citrate/citric acid soln (BICITRA equiv)	-	1
tricitrates soln (POLYCITRA-LC equiv)	-	1
potassium citrate CR tab (UROKIT-K TAB equiv)	-	2
<b>CYSTINOSIS AGENTS</b>		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD-PA	MSP
<b>INTERSTITIAL CYSTITIS AGENTS</b>		
ELMIRON CAP	-	2
<b>PROSTATIC HYPERTROPHY AGENTS</b>		
alfuzosin SR tab (UROXATRAL equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
dutasteride cap (AVODART equiv)	-	2
dutasteride/tamsulosin cap (JALYN equiv)	-	2
<b>URINARY ANALGESICS</b>		
phenazopyridine tab (PYRIDIDIUM equiv)	-	1
<b>URINARY STONE AGENTS</b>		
LITHOSTAT TAB	-	3
<b>GOUT AGENTS</b>		
<b>GOUT AGENT COMBINATIONS</b>		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1
<b>GOUT AGENTS</b>		
allopurinol tab (ZYLOPRIM equiv)	-	1
MITIGARE CAP	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>GOUT AGENTS Cont.</b>		
ULORIC TAB (Step Therapy requires trial of allopurinol)	ST-¢	2
<b>URICOSURICS</b>		
probenecid tab (BENEMID equiv)	-	1
<b>HEMATOLOGICAL AGENTS - MISC.</b>		
<b>ANTHEMOPHILIC PRODUCTS</b>		
HEMLIBRA INJ	MSP-PA	MSP
<b>HEMATOALOGIC - TYROSINE KINASE INHIBITORS</b>		
TAVALISSE TAB (QL= 2 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	MSP
<b>HEMATORHEOLOGIC AGENTS</b>		
pentoxifylline ER tab (TRENTAL equiv)	-	1
<b>PLATELET AGGREGATION INHIBITORS</b>		
anagrelide cap (AGRYLIN equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
prasugrel tab (EFFIENT equiv)	-	1
ticlopidine tab (TICLID equiv)	-	1
aspirin/dipyridamole cap (AGGRENEX equiv)	-	2
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	2
BRILINTA TAB (Restricted to Cardiology Specialist)	RS	3
<b>HEMATOPOIETIC AGENTS</b>		
<b>AGENTS FOR GAUCHER DISEASE</b>		
miglustat cap (ZAVESCA equiv) (Only available through Accredo 888-773-7376 )	LD-PA	MSP
<b>AGENTS FOR SICKLE CELL ANEMIA</b>		
DROXIA CAP	-	2
<b>COBALAMINS</b>		
cyanocobalamin inj	-	1
NASCOBAL NASAL SPRAY	-	3
<b>FOLIC ACID/FOLATES</b>		
folic acid tab 1mg (Covered at \$0 for females only)	-	1
<b>HEMATOPOIETIC GROWTH FACTORS</b>		
FULPHILA INJ	MSP	MSP
GRANIX INJ	MSP	MSP
GRANIX INJ (Required through specialty pharmacy: GHC, UW Specialty or Walgreens Specialty)	MSP	MSP
LEUKINE INJ	MSP-PA	MSP
NEUMEGA INJ	MSP-PA	MSP
PROMACTA TAB	MSP-PA	MSP
RETACRIT INJ	MSP	MSP
ZARXIO INJ	MSP	MSP
<b>HEMATOPOIETIC MIXTURES</b>		
ferrex 150 forte cap	-	1
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1
folbee tab	-	1
multigen folic tab (CHROMAGEN FA equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>HEMATOPOIETIC AGENTS Cont.</b>		
multigen plus tab (CHROMAGEN FORTE equiv)	-	1
multigen tab (CHROMAGEN equiv)	-	1
tricon cap (TRINSICON equiv)	-	1
NEPHRON FA TAB	-	2
<b>IRON</b>		
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE SYRUP (Covered for members 1 year or younger)	OTC	\$0
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0
<b>HEMOSTATICS</b>		
<b>HEMOSTATICS - SYSTEMIC</b>		
tranexamic acid tab (LYSTEDA equiv)	-	2
AMICAR SOLN	-	3
<b>HYPNOTICS</b>		
<b>NON-BARBITURATE HYPNOTICS</b>		
zolpidem tab (AMBIEN equiv)	-	1
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS</b>		
<b>BARBITURATE HYPNOTICS</b>		
phenobarbital elixir	-	1
phenobarbital tab	-	1
SECONAL CAP	-	2
BUTISOL ELIXIR	-	3
BUTISOL TAB	-	3
<b>NON-BARBITURATE HYPNOTICS</b>		
estazolam tab (PROSOM equiv)	-	1
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1
FLURAZEPAM CAP	-	1
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 30mg (RESTORIL equiv)	-	1
triazolam tab (HALCION equiv)	-	1
zaleplon cap (SONATA equiv)	-	1
zolpidem ER tab (AMBIEN CR equiv) (Step Therapy requires trial of zolpidem IR)	ST	2
SOMNOTE CAP	-	3
temazepam cap 22.5mg (RESTORIL equiv)	-	3
temazepam cap 7.5mg (RESTORIL equiv)	-	3
EDLUAR SL TAB	-	EXC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	EXC
ZOLPIMIST SPRAY	-	EXC
<b>LAXATIVES</b>		
<b>LAXATIVE COMBINATIONS</b>		
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year)	QL	1
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1
CLENPIQ SOLN	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
----------	--------------	------

**LAXATIVES Cont.**

**LAXATIVES - MISCELLANEOUS**

lactulose soln	-	1
KRISTALOSE PACKET	-	3
lactulose pack (KRISTALOSE equiv)	-	3

**SALINE LAXATIVES**

OSMOPREP TAB	-	3
VISICOL TAB	-	3

**MACROLIDES**

**AZITHROMYCIN**

azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX POWDER PACK	-	3
ZMAX SUSP	-	3

**CLARITHROMYCIN**

clarithromycin susp (BIAXIN equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1
CLARITHROMYC SUSP	-	2
clarithromycin ER tab (BIAXIN XL equiv)	-	3

**ERYTHROMYCINS**

erythromycin DR cap (ERYC equiv)	-	2
erythromycin ethylsuccinate susp (ERYPED equiv)	-	2
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2
erythromycin stearate tab	-	2
erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE)	-	2
ERYPED SUSP	-	3
ERY-TAB	-	3
PCE TAB	-	3

**FIDAXOMICIN**

DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN)	QL-ST	2
---	-------	---

**MEDICAL DEVICES AND SUPPLIES**

**CONTRACEPTIVES**

CERVICAL CAP	-	\$0
DIAPHRAGM	-	\$0
FEMALE CONDOMS	OTC	\$0

**DIABETIC SUPPLIES**

FREESTYLE FREEDOM LITE METER	OTC	\$0
FREESTYLE INSULINX METER	OTC	\$0
FREESTYLE LITE METER	OTC	\$0
FREESTYLE PRECISION NEO METER	OTC	\$0
PRECISION XTRA METER	OTC	\$0
CALIBRATION LIQUID	OTC	1
V-GO INJ KIT (QL= 1 kit/day)	QL	2
DEXCOM G6 RECEIVER (QL= 1 receiver/year)	PA-QL	DME
DEXCOM G6 SENSOR (QL= 3 sensors/28 days)	PA-QL	DME
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days)	PA-QL	DME

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
----------	--------------	------

**MEDICAL DEVICES AND SUPPLIES Cont.**

FREESTYLE LANCETS	OTC	DME
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year)	PA-QL	DME
FREESTYLE LIBRE SENSOR (10-DAY) (QL= 3 sensors/30 days)	PA-QL	DME
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days)	PA-QL	DME
LANCETS	OTC	DME

**MISC. DEVICES**

ALCOHOL SWABS	OTC	DME
---------------	-----	-----

**PARENTERAL THERAPY SUPPLIES**

B-D INSULIN SYRINGE	--OTC	DME
B-D PEN NEEDLE	OTC	DME
NOVOFINE PEN NEEDLE	OTC	DME
NOVOTWIST PEN NEEDLE	OTC	DME

**RESPIRATORY THERAPY SUPPLIES**

AEROCHAMBER	OTC	DME
PEAK FLOW METER	OTC	DME

**MIGRAINE PRODUCTS**

**MIGRAINE COMBINATIONS**

ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	2
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	2
MIGERGOT SUPP	-	2
PRODRIN TAB	-	2
ergotamine/caffeine tab (CAFERGOT equiv)	-	3

**MIGRAINE PRODUCTS**

DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY (QL= 8 sprays/fill, 2 fills/30 days)	QL	3
--	----	---

**MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES**

AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	2
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2

**MIGRAINE PRODUCTS - NSAIDS**

CAMBIA POWDER PACKET	-	EXC
----------------------	---	-----

**SEROTONIN AGONISTS**

rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
eletriptan tab (RELPAK equiv) (QL= 6 tabs/fill, 2 fills/ 30 days)	QL	2
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	2
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	2
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	2
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	2
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
ZOMIG NASAL SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	3

**MINERALS & ELECTROLYTES**

**FLUORIDE**

FLUOR-A-DAY CHEW TAB	-	1
----------------------	---	---

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>MINERALS &amp; ELECTROLYTES Cont.</b>		
sodium fluoride chew tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger)	-	1
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger)	-	1
sodium fluoride lozenge (LOZI-FLUR equiv) (Covered at \$0 for members 5 years or younger)	-	1
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger)	-	1
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger)	-	1
FLUORABON SOLN (Covered at \$0 for members 5 years or younger)	-	2
<b>PHOSPHATE</b>		
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
K-PHOS TAB	-	2
<b>POTASSIUM</b>		
potassium bicarbonate effer tab (K-LYTE equiv)	-	1
potassium chloride effer tab (K-LYTE/CL equiv)	-	1
potassium chloride ER cap (MICRO-K equiv)	-	1
POTASSIUM CHLORIDE ER TAB	-	1
potassium chloride ER tab (KLOR-CON equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1
KLOR-CON M15 TAB	-	2
potassium chloride powder packet (KLOR-CON equiv)	-	2
potassium chloride soln	-	2
KLOR-CON POWDER PACKET 25MEQ	-	3
<b>ZINC</b>		
zinc sulfate cap	-	1
GALZIN CAP	-	2
<b>MISCELLANEOUS THERAPEUTIC CLASSES</b>		
<b>CHELATING AGENTS</b>		
trientine cap (SYPRINE equiv)	MSP-PA	MSP
<b>IMMUNOSUPPRESSIVE AGENTS</b>		
CYCLOSPORINE MODIFIED CAP	-	2
<b>SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS</b>		
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	MSP-PA-QL	MSP
BENLYSTA INJ (QL= 4 inj/28 day)	MSP-PA-QL	MSP
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<b>ANESTHETICS TOPICAL ORAL</b>		
lidocaine viscous soln	-	1
LIDOCAINE ORAL SOLN 4%	-	2
<b>ANTIALLERGY AGENTS - MOUTH/THROAT</b>		
APHTHASOL PASTE	-	2
<b>ANTI-INFECTIVES - THROAT</b>		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
ORAVIG TAB	-	3
<b>ANTISEPTICS - MOUTH/THROAT</b>		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
<b>DENTAL PRODUCTS</b>		

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>MOUTH/THROAT/DENTAL AGENTS Cont.</b>		
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger)	-	1
sodium fluoride gel (PREVIDENT equiv)	-	1
sodium fluoride paste (PREVIDENT equiv)	-	1
sodium fluoride rinse (PREVIDENT equiv)	-	1
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger)	-	2
PREVIDENT PASTE	-	2
<b>STERIODS - MOUTH/THROAT</b>		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
<b>THROAT PRODUCTS - MISC.</b>		
pilocarpine tab (SALAGEN equiv)	-	1
cevimeline cap (EVOXAC equiv)	-	2
<b>MULTIVITAMINS</b>		
<b>B-COMPLEX W/ FOLIC ACID</b>		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	-	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1
renaphro cap (NEPHROCAP equiv)	-	1
<b>MULTIPLE VITAMINS W/ MINERALS</b>		
multivitamin/minerals tab (STROVITE equiv)	-	1
<b>PED MULTI VITAMINS W/FL &amp; FE</b>		
pediatric multiple vitamins/fluoride/iron soln	-	1
<b>PED MV W/ FLUORIDE</b>		
pediatric multiple vitamins/fluoride soln	-	1
pediatric multiple vitamins/fluoride chew tab	-	3
QUFLORA PEDIATRIC CHEW TAB	-	3
<b>PRENATAL VITAMINS</b>		
PRENATAL VITAMINS (RX ONLY)	PA	2
<b>MUSCULOSKELETAL THERAPY AGENTS</b>		
<b>CENTRAL MUSCLE RELAXANTS</b>		
baclofen tab 10mg, 20mg	-	1
carisoprodol tab (SOMA equiv)	-	1
CHLORZOXAZONE TAB 500MG	-	1
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1
methocarbamol tab (ROBAXIN equiv)	-	1
orphenadrine citrate ER tab (NORFLEX equiv)	-	1
tizanidine tab (ZANAFLEX equiv)	-	1
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	3
metaxalone tab (SKELAXIN equiv)	-	3
METAXALONE TAB 400MG	-	3
tizanidine cap (ZANAFLEX equiv)	-	3
carisoprodol tab 250mg (SOMA equiv)	-	EXC
<b>DIRECT MUSCLE RELAXANTS</b>		

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>MUSCULOSKELETAL THERAPY AGENTS Cont.</b>		
dantrolene cap (DANTRIUM equiv)	-	2
<b>MUSCLE RELAXANT COMBINATIONS</b>		
ORPHENADRINE/ASPIRIN/CAFFEINE TAB	-	3
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	3
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL</b>		
<b>NASAL ANTIALLERGY</b>		
azelastine nasal spray 0.1% (ASTELIN equiv)	-	1
azelastine nasal spray 0.15% (ASTEPRO equiv)	-	2
olopatadine nasal spray (PATANASE equiv)	-	2
<b>NASAL ANTICHOLINERGICS</b>		
ipratropium nasal spray (ATROVENT equiv)	-	1
<b>NASAL ANTI-INFECTIVES</b>		
BACTROBAN NASAL OINT	-	3
<b>NASAL STEROIDS</b>		
FLONASE SENSIMIST	OTC	1
FLUNISOLIDE NASAL SPRAY (QL= 2 bottles/fill)	QL	1
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	1
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	1
rhinocort allergy nasal spray (RHINOCORT AQUA equiv) (QL= 2 bottles/fill)	OTC-QL	1
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1
mometasone nasal spray (NASONEX equiv) (Step Therapy requires trial of two: fluticasone, triamcinolone OTC, or budesonide)	ST	2
<b>NEUROMUSCULAR AGENTS</b>		
<b>ALS AGENTS</b>		
riluzole tab (RILUTEK equiv)	-	2
<b>OPHTHALMIC AGENTS</b>		
<b>ARTIFICIAL TEARS AND LUBRICANTS</b>		
LACRISERT OPHTH INSERT	-	2
<b>BETA-BLOCKERS - OPHTHALMIC</b>		
betaxolol ophth soln (BETOPTIC-S equiv)	-	1
CARTEOLOL OPHTH SOLN	-	1
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
timolol maleate ophth soln (TIMOPTIC equiv)	-	1
BETIMOL OPHTH SOLN	-	2
BETOPTIC-S OPHTH SOLN	-	2
COMBIGAN OPHTH SOLN	-	2
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	2
ISTALOL OPHTH SOLN	-	2
METIPRANOLOL OPHTH SOLN	-	2
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	2
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	2
TIMOLOL OPHTH GEL SOLN	-	2
TIMOPTIC OCUDOSE OPHTH SOLN	-	3

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
<b>CYCLOPLEGIC MYDRIATICS</b>		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPHTH SOLN	-	2
ISOPTO HOMATROPINE OPHTH SOLN 2%	-	2
ISOPTO HYOSCINE OPHTH SOLN	-	2
<b>MIOTICS</b>		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPHTH SOLN	-	2
PHOSPHOLINE OPHTH SOLN	-	2
PILOPINE HS OPHTH GEL	-	3
<b>OPHTHALMIC ADRENERGIC AGENTS</b>		
brimonidine ophth soln 0.2%	-	1
ALPHAGAN P OPHTH SOLN 0.1%	-	2
apraclonidine ophth soln (IOPIDINE equiv)	-	2
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2
IOPIDINE OPHTH SOLN 1%	-	2
SIMBRINZA OPHTH SUSP	-	2
<b>OPHTHALMIC ANTI-INFECTIVES</b>		
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1
ciprofloxacin ophth soln (CILOXAN equiv)	-	1
erythromycin ophth oint	-	1
GENTAK OPHTH OINT	-	1
gentamicin ophth oint (GARAMYCIN equiv)	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1
levofloxacin ophth soln (QUIXIN equiv)	-	1
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	1
ofloxacin ophth soln (OCUFLOX equiv)	-	1
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1
tobramycin ophth soln (TOBREX equiv)	-	1
AZASITE SOLN	-	2
BACITRACIN OPHTH OINT	-	2
CILOXAN OPHTH OINT	-	2
gatifloxacin ophth soln (ZYMAXID equiv) (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	2
TOBREX OPHTH OINT	-	2
trifluridine ophth soln (VIROPTIC equiv)	-	2
ZIRGAN OPHTH GEL	-	2
<b>OPHTHALMIC DECONGESTANTS</b>		
phenylephrine ophth soln (MYDFRIN equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
<b>OPHTHALMIC IMMUNOMODULATORS</b>		
RESTASIS OPHTH EMULSION (Restricted to Ophthalmology or Optometry Specialist)	RS	2
<b>OPHTHALMIC LOCAL ANESTHETICS</b>		
proparacaine ophth soln (ALCAINE equiv)	-	1
<b>OPHTHALMIC STEROIDS</b>		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1
dexamethasone ophth soln	-	1
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1
neomycin/polymyxin/hydrocortisone ophth soln (CORTISPORIN equiv)	-	1
prednisolone ophth soln (PRED FORTE equiv)	-	1
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1
ALREX OPHTH SUSP, LOTEMAX OPHTH SUSP	-	2
BLEPHAMIDE OPHTH SOLN	-	2
DUREZOL OPHTH EMULSION	-	2
LOTEMAX OPHTH GEL	-	2
LOTEMAX OPHTH OINT	-	2
MAXIDEX OPHTH SOLN	-	2
PRED FORTE OPHTH SUSP 1%	-	2
PRED MILD OPHTH SOLN	-	2
PRED-G OPHTH SOLN	-	2
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2
TOBRADEX OPHTH OINT	-	2
VEXOL OPHTH SUSP	-	2
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2
BLEPHAMIDE S.O.P. OPHTH OINT	-	3
FLAREX OPHTH SUSP	-	3
FML FORTE OPHTH SUSP	-	3
FML S.O.P. OPHTH OINT	-	3
TOBRADEX ST OPHTH SUSP	-	3
<b>OPHTHALMICS - MISC.</b>		
azelastine ophth soln (OPTIVAR equiv)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1
dorzolamide ophth soln (TRUSOPT equiv)	-	1
flurbiprofen ophth soln (OCUFEN equiv)	-	1
ketorolac ophth soln (ACULAR (LS) equiv)	-	1
ketotifen ophth soln (ZADITOR equiv) (OTC covered only)	OTC	1
olopatadine ophth soln 0.1% (PATANOL equiv)	-	1
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	QL	1
ALAMAST OPHTH SOLN	-	2
ALOCRIAL OPHTH SOLN	-	2
ALOMIDE OPHTH SOLN	-	2
AZOPT OPHTH SUSP	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
bromfenac ophth soln (BROMDAY equiv)	-	2
BROMFENAC OPHTH SOLN 0.09% (ONCE DAILY)	-	2
ILEVRO OPHTH SUSP	-	2
NEVANAC OPHTH SUSP	-	2
PROLENSA OPHTH SOLN	-	2
BEPREVE OPHTH SOLN	-	3
EMADINE OPHTH SOLN	-	3
epinastine ophth soln (ELESTAT equiv)	-	3
LASTACAPT OPHTH SOLN (QL= 3ml/30 days)	QL	3
CYSTARAN OPHTH SOLN (QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	MSP
<b>PROSTAGLANDINS - OPHTHALMIC</b>		
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	2
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2
TRAVATAN Z OPHTH SOLN (QL= 2.5ml/30 days)	QL	2
<b>OTIC AGENTS</b>		
<b>OTIC AGENTS - MISCELLANEOUS</b>		
acetic acid otic soln (VOSOL equiv)	-	1
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1
<b>OTIC ANTI-INFECTIVES</b>		
CIPROFLOXACIN OTIC SOLN	-	2
ofloxacin otic soln (FLOXIN equiv)	-	2
<b>OTIC COMBINATIONS</b>		
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
CIPRODEX OTIC SUSP	-	2
COLY-MYCIN S OTIC SUSP	-	2
CIPRO HC OTIC SUSP	-	3
<b>OTIC STEROIDS</b>		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1
fluocinolone otic oil (DERMOTIC equiv)	-	2
ACETASOL HC OTIC SOLN	-	3
<b>OXYTOCICS</b>		
<b>OXYTOCICS</b>		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	2
<b>PASSIVE IMMUNIZING AGENTS</b>		
<b>IMMUNE SERUMS</b>		
HIZENTRA INJ	MSP-PA	MSP
<b>PENICILLINS</b>		
<b>AMINOPENICILLINS</b>		
amoxicillin cap (TRIMOX equiv)	-	1
amoxicillin chew tab (AMOXIL equiv)	-	1
AMOXICILLIN CHEW TAB 250MG	-	1
amoxicillin susp (TRIMOX equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>PENICILLINS Cont.</b>		
amoxicillin tab (AMOXIL equiv)	-	1
ampicillin cap (PRINCIPEN equiv)	-	1
ampicillin susp (PRINCIPEN equiv)	-	1
<b>NATURAL PENICILLINS</b>		
penicillin vk soln (VEETIDS equiv)	-	1
penicillin vk tab (VEETIDS equiv)	-	1
<b>PENICILLIN COMBINATIONS</b>		
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	3
<b>PENICILLINASE-RESISTANT PENICILLINS</b>		
dicloxacillin cap (DYNAPEN equiv)	-	1
<b>PROGESTINS</b>		
<b>PROGESTINS</b>		
medroxyprogesterone tab (PROVERA equiv)	-	1
norethindrone tab (AYGESTIN equiv)	-	1
progesterone oil inj	-	1
progesterone cap (PROMETRIUM equiv)	-	2
megestrol ES susp (MEGACE ES equiv)	-	3
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
<b>AGENTS FOR CHEMICAL DEPENDENCY</b>		
disulfiram tab (ANTABUSE equiv)	-	1
acamprosate calcium DR tab (CAMPRAL equiv)	-	2
<b>ANTI-CATAPLECTIC AGENTS</b>		
XYREM SOLN (Only available through Xyrem Central Pharmacy 866-997-3688)	LD-PA	MSP
<b>ANTIDEMENTIA AGENTS</b>		
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	1
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	1
galantamine tab (RAZADYNE equiv)	¢	1
memantine tab (NAMENDA equiv)	-	1
rivastigmine cap (EXELON equiv)	-	1
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	2
EXELON SOLN	-	2
galantamine ER cap (RAZADYNE ER equiv)	-	2
GALANTAMINE SOLN	-	2
memantine ER cap (NAMENDA XR equiv)	-	2
memantine soln (NAMENDA equiv)	-	2
NAMENDA XR TITRATION PACK	-	2
NAMZARIC CAP (Step Therapy requires trial of donepezil and memantine)	ST	2
NAMZARIC STARTER PACK (Step Therapy requires trial of donepezil and memantine)	ST	2
rivastigmine patch (EXELON equiv)	-	2
<b>COMBINATION PSYCHOTHERAPEUTICS</b>		
chlordiazepoxide/amitriptyline tab (LIMBITROL equiv)	-	1
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.</b>		
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	2
<b>FIBROMYALGIA AGENTS</b>		
SAVELLA PAK	-	2
SAVELLA TAB (QL= 2 tabs/day)	QL	2
<b>MOVEMENT DISORDER DRUG THERAPY</b>		
tetrabenazine tab (XENAZINE equiv)	MSP-PA	MSP
<b>MULTIPLE SCLEROSIS AGENTS</b>		
AUBAGIO TAB	MSP	MSP
AVONEX INJ	MSP	MSP
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day)	MSP-PA-QL	MSP
EXTAVIA INJ	MSP	MSP
GILENYA CAP	MSP	MSP
glatiramer inj (COPAXONE equiv)	MSP	MSP
PLEGRIDY INJ	MSP	MSP
PLEGRIDY PEN INJ	MSP	MSP
REBIF INJ ( )	MSP	MSP
TECFIDERA CAP	MSP	MSP
TECFIDERA STARTER PACK	MSP	MSP
<b>PSEUDOBULBAR AFFECT (PBA) AGENTS</b>		
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	2
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
PIMOZIDE TAB	-	2
<b>SMOKING DETERRENENTS</b>		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX TAB (Limited to 180 days/plan year)	QL-SMKG	\$0
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTINE KIT	OTC-QL-SMKG	\$0
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0
<b>VASOMOTOR SYMPTOM AGENTS</b>		
paroxetine cap (BRISDELLE equiv)	-	EXC
<b>RESPIRATORY AGENTS - MISC.</b>		
<b>CYSTIC FIBROSIS AGENTS</b>		
KALYDECO PAK (QL= 2 packets/day)	MSP-PA-QL-SF	MSP
KALYDECO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	MSP
ORKAMBI GRANULES PACKET (QL= 2 packets/day)	MSP-PA-QL-SF	MSP
ORKAMBI TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP
PULMOZYME INH SOLN	MSP-PA	MSP
SYMDEKO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	MSP
<b>PULMONARY FIBROSIS AGENTS</b>		
ESBRIET CAP (QL= 9 caps/day)	MSP-PA-QL-SF	MSP
ESBRIET TAB 267MG (QL= 9 tabs/day)	MSP-PA-QL-SF	MSP

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>RESPIRATORY AGENTS - MISC. Cont.</b>		
ESBRIET TAB 801MG (QL= 3 tabs/day)	MSP-PA-QL-SF	MSP
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	MSP

**SULFONAMIDES**

**SULFONAMIDES**

SULFADIAZINE TAB	-	1
------------------	---	---

**TETRACYCLINES**

**TETRACYCLINES**

doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1
doxycycline hyclate tab (VIBRATAB equiv)	-	1
doxycycline monohydrate cap (MONODOX equiv)	-	1
doxycycline monohydrate cap 100mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 50mg (MONODOX equiv)	-	1
minocycline cap (MINOCIN equiv)	-	1
doxycycline monohydrate tab	-	2
doxycycline susp (VIBRAMYCIN equiv)	-	2
demeclocycline tab (DECLOMYCIN equiv)	-	3
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	3
ORAXYL CAP	-	3
tetracycline cap	-	3
VIBRAMYCIN SYRUP	-	3
doxycycline hyclate DR tab (DORYX equiv)	-	EXC
minocycline ER tab (SOLODYN equiv)	-	EXC
SOLODYN TAB	-	EXC

**THYROID AGENTS**

**ANTITHYROID AGENTS**

methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1

**THYROID HORMONES**

ARMOUR THYROID TAB, NATURE THROID TAB	-	1
liothyronine tab (CYTOMEL equiv)	-	1
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1
SYNTHROID TAB	-	1
THYROLAR TAB	-	2
TIROSINT CAP	-	3

**ULCER DRUGS**

**ANTISPASMODICS**

dicyclomine cap (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
hyoscyamine sulfate CR tab (LEVVID equiv)	-	1
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1
hyoscyamine sulfate soln (LEVSIN equiv)	-	1
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1
hyoscyamine tab (LEVSIN equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered	INF	<b>generic</b> =small letters	LD	<b>BRANDS</b> =CAPITAL LETTERS
MSP	Plan Exclusion	OTC	Infertility	PA	Limited Distribution
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	ST	Restricted to Specialist	VAC	Limited to two 15 day fills per month for first 3 months
¢	Smoking Cessation		Step Therapy		Vaccine Program
	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

**Last Updated\* 1/1/2019**

<b>DrugName</b>	<b>Special Code</b>	<b>Tier</b>
<b>ULCER DRUGS Cont.</b>		
BELLADONNA ALKALOID/OPIUM SUPP	-	2
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	2
dicyclomine soln (BENTYL equiv)	-	2
glycopyrrolate tab (ROBINUL equiv)	-	2
PROPANTHELINE TAB	-	2
CANTIL TAB	-	3
CUVPOSA SOLN	-	3
methscopolamine tab (PAMINE equiv)	-	3
pb-belladonna elixir (DONNATAL equiv)	-	3
SYMAX DUOTAB	-	3
<b>H-2 ANTAGONISTS</b>		
CIMETIDINE SOLN	-	1
cimetidine tab (TAGAMET equiv)	-	1
famotidine tab (PEPCID equiv)	-	1
nizatidine cap (AXID equiv)	-	1
ranitidine cap (ZANTAC equiv)	-	1
ranitidine syrup (ZANTAC equiv)	-	1
ranitidine tab (Rx Only) (ZANTAC equiv)	-	1
famotidine susp (PEPCID equiv)	-	2
nizatidine soln (AXID equiv)	-	3
<b>MISC. ANTI-ULCER</b>		
sucralfate tab (CARAFATE equiv)	-	1
CARAFATE SUSP	-	2
<b>PROTON PUMP INHIBITORS</b>		
esomeprazole cap (NEXIUM equiv) (Step Therapy requires trial of omeprazole)	ST	1
lansoprazole cap (PREVACID equiv)	OTC	1
omeprazole DR cap (PRILOSEC equiv)	-	1
pantoprazole EC tab (PROTONIX equiv)	-	1
PREVACID OTC CAP	OTC	1
rabeprazole EC tab (ACIPHEX equiv)	-	1
lansoprazole odt (PREVACID SOLUTAB equiv) (No Prior Authorization required for members 12 years and younger.)	PA	2
<b>ULCER DRUGS - PROSTAGLANDINS</b>		
misoprostol tab (CYTOTEC equiv)	-	1
<b>ULCER THERAPY COMBINATIONS</b>		
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	3
PYLERA CAP	-	3
<b>URINARY ANTI-INFECTIVES</b>		
<b>URINARY ANTI-INFECTIVE COMBINATIONS</b>		
UROQID #2 TAB	-	3
<b>URINARY ANTI-INFECTIVES</b>		
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1
methenamine hippurate tab (HIPREX equiv)	-	2
MONUROL GRANULE PACK	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>URINARY ANTI-INFECTIVES Cont.</b>		
nitrofurantoin susp (FURADANTIN equiv)	-	2
<b>URINARY ANTISPASMODICS</b>		
<b>BETA-3 ADRENERGIC AGONISTS</b>		
MYRBETRIQ TAB	-	2
<b>URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)</b>		
oxybutynin ER tab (DITROPAN XL equiv)	-	1
oxybutynin syrup	-	1
oxybutynin tab (DITROPAN equiv)	-	1
tolterodine tab (DETROL equiv)	¢	2
VESICARE TAB	¢	2
GELNIQUE	-	3
OXYTROL PATCH	PA	3
tropium chloride SR cap (SANCTURA XR equiv)	PA	3
tropium tab (SANCTURA equiv)	-	3
<b>URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)</b>		
tolterodine SR cap (DETROL LA equiv)	-	2
<b>URINARY ANTISPASMODICS</b>		
hyoscyamine tab (LEVSIN equiv)	-	1
<b>URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS</b>		
bethanechol tab (URECHOLINE equiv)	-	1
<b>VACCINES</b>		
<b>BACTERIAL VACCINES</b>		
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2
<b>VAGINAL PRODUCTS</b>		
<b>MISCELLANEOUS VAGINAL PRODUCTS</b>		
ACIDIC VAGINAL JELLY	-	2
FEM PH GEL	-	3
<b>SPERMICIDES</b>		
CONTRACEPTIVE FOAM	OTC	\$0
CONTRACEPTIVE GEL	OTC	\$0
TODAY SPONGE	OTC	\$0
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0
<b>VAGINAL ANTI-INFECTIVES</b>		
clindamycin vaginal cream (CLEOCIN equiv)	-	1
metronidazole vaginal gel (METROGEL equiv)	-	1
NYSTATIN VAGINAL TAB	-	1
terconazole cream (TERAZOL equiv)	-	1
TERCONAZOLE CREAM 8%	-	1
terconazole supp (TERAZOL equiv)	-	1
AVC VAGINAL CREAM	-	2
CLEOCIN VAGINAL SUPP	-	3
CLINDESSE VAGINAL CREAM	-	3
<b>VAGINAL ESTROGENS</b>		
estradiol cream (ESTRACE equiv)	-	1

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Category/Class**

Last Updated\* 1/1/2019

DrugName	Special Code	Tier
<b>VAGINAL PRODUCTS Cont.</b>		
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days (18 tabs on first fill))	QL	2
ESTRING (3 copays per Rx)	-	2
PREMARIN VAGINAL CREAM	-	2
FEMRING (3 copays per Rx)	-	3
<b>VAGINAL PROGESTINS</b>		
CRINONE GEL	-	EXC
ENDOMETRIN INSERT	-	EXC
<b>VASOPRESSORS</b>		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
EPINEPHRINE PEN INJ 0.15MG (MYLAN) (QL= 2 inj/fill)	QL	2
epinephrine pen inj 0.3mg (EPIPEN equiv) (QL= 2 inj/fill)	QL	2
<b>VASOPRESSORS</b>		
midodrine tab (PROAMATINE equiv)	-	1
<b>VITAMINS</b>		
<b>MISC. NUTRITIONAL FACTORS</b>		
PRENATAL CHEWABLE	-	1
PRENATAL VITAMIN (RX ONLY)	-	1
<b>OIL SOLUBLE VITAMINS</b>		
vitamin D cap 1000unit (Covered for members 65 years or older)	OTC	\$0
vitamin D cap 2000IU (Only covered for members 65 years old or older.)	OTC	\$0
VITAMIN D CAP 400IU (Only covered for members 65 years old or older.)	OTC	\$0
vitamin D cap 400unit (Covered for members 65 years or older)	OTC	\$0
vitamin D tab 2000IU (Only covered for members 65 years old or older.)	OTC	\$0
VITAMIN D TAB 400UNIT (Covered for members 65 years or older)	OTC	\$0
vitamin D cap (RX strength only)	-	1
phytonadione tab (MEPHYTON equiv)	-	2
<b>WATER SOLUBLE VITAMINS</b>		
niacin cap	OTC	1
niacin CR tab (SLO-NIACIN equiv)	OTC	1
niacin tab	OTC	1
NIACIN TR TAB	OTC	1
niacinamide tab	OTC	1
POTABA POWDER PACKET	-	2
POTABA TAB	-	2

**Note:** Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

\*\* OTC drugs are not a covered benefit.

EXC	<b>NC</b> =Not Covered Plan Exclusion	INF	<b>generic</b> =small letters Infertility	LD	<b>BRANDS</b> =CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	ST	Step Therapy	VAC	Vaccine Program
¢	RxCENTS				

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary**  
**Prior Authorization Drug List**  
**Last Updated\* 1/1/2019**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
abiraterone tab 250mg	MSP
ABSTRAL SL TAB	3
ACTEMRA ACTPEN INJ	MSP
ACTEMRA SC INJ	MSP
ACTIMMUNE INJ	MSP
adapalene cream	2
adapalene gel 0.3%	2
ADAPALENE LOTION	3
ADEMPAS TAB	MSP
AFINITOR DISPERZ	MSP
AFINITOR TAB	MSP
AIMOVIG INJ	2
ALECENSA CAP	MSP
ALFERON-N INJ	MSP
ALINIA SUSP	2
ALINIA TAB	2
ALUNBRIG TAB 30MG	MSP
ALUNBRIG TAB 90MG, 180MG	MSP
ANDRODERM PATCH	2
armodafinil tab	2
AZELEX CREAM	3
BENLYSTA AUTO-INJECTOR	MSP
BENLYSTA INJ	MSP
BENZNIDAZOLE TAB	2
BOSULIF TAB	MSP
budesonide ER tab	3
CABOMETYX TAB	MSP
CALCITRIOL INJ	MSP
CALQUENCE CAP	MSP
CAPRELSA TAB	MSP
CAYSTON INH SOLN	MSP
CIMZIA INJ	MSP
CIMZIA STARTER INJ KIT	MSP
clindamycin/benzoyl peroxide gel	3
clobazam tab	1
COMETRIQ KIT	MSP
CORLANOR TAB	3
COSENTYX INJ (1-PACK)	MSP
COSENTYX INJ (2-PACK)	MSP
COTELLIC TAB	MSP
CYSTAGON CAP	MSP
CYSTARAN OPHTH SOLN	MSP

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary cont.**  
**Prior Authorization Drug List**  
**Last Updated\* 1/1/2019**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
dalfampridine ER tab	MSP
DARAPRIM TAB	MSP
DESCOVY TAB	2
DEXCOM G6 RECEIVER	DME
DEXCOM G6 SENSOR	DME
DEXCOM G6 TRANSMITTER	DME
diclofenac gel	3
DIFFERIN LOTION 0.1%	3
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	3
DUPIXENT INJ	MSP
EMGALITY INJ	2
ENBREL INJ 25MG	MSP
ENBREL INJ 50MG	MSP
ENBREL MINI INJ	MSP
ENBREL SURECLICK INJ 50MG	MSP
ENTRESTO TAB	2
EPANED PREMIXED SOLN	3
EPANED SOLN	3
EPCLUSA TAB, SOFOSBUVIR/VELPATASVIR TAB	MSP
ERIVEDGE CAP	MSP
ESBRIET CAP	MSP
ESBRIET TAB 267MG	MSP
ESBRIET TAB 801MG	MSP
FANAPT TAB	3
FANAPT TITRATION PACK	3
FARYDAK CAP	MSP
fentanyl citrate lollipop	2
FENTORA TAB	3
FERRIPROX SOLN	MSP
FERRIPROX TAB	MSP
fondaparinux inj	2
FREESTYLE LIBRE RECEIVER	DME
FREESTYLE LIBRE SENSOR (10-DAY)	DME
FREESTYLE LIBRE SENSOR (14-DAY)	DME
FUZEON INJ	MSP
GILOTRIF TAB	MSP
HARVONI TAB, LEDIPASVIR/SOFOSBUVIR TAB	MSP
HEMLIBRA INJ	MSP
HIZENTRA INJ	MSP
HUMIRA INJ 10MG	MSP
HUMIRA INJ 20MG	MSP
HUMIRA INJ 40MG	MSP

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary cont.**  
**Prior Authorization Drug List**  
**Last Updated\* 1/1/2019**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	MSP
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	MSP
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	MSP
HUMIRA PEN INJ 40MG	MSP
HYCAMTIN CAP	MSP
IBRANCE CAP	MSP
ICLUSIG TAB	MSP
IDHIFA TAB	MSP
imatinib tab	MSP
IMBRUVICA CAP 140MG	MSP
IMBRUVICA CAP 70MG	MSP
IMBRUVICA TAB	MSP
INCRELEX INJ	MSP
INFERGEN INJ	MSP
INLYTA TAB	MSP
INTRON-A INJ	MSP
IRESSA TAB	MSP
itraconazole cap	2
itraconazole soln	3
JAKAFI TAB	MSP
JYNARQUE PAK	MSP
KALYDECO PAK	MSP
KALYDECO TAB	MSP
KEVZARA INJ	MSP
KINERET INJ	MSP
KISQALI PAK	MSP
KISQALI TAB	MSP
KORLYM TAB	MSP
KUVAN POWDER PACK	MSP
KUVAN TAB	MSP
lansoprazole odt	2
LAZANDA NASAL SPRAY	3
LENVIMA CAP	MSP
LETAIRIS TAB	MSP
LEUKINE INJ	MSP
LINZESS CAP	2
LONSURF TAB	MSP
LYNPARZA CAP	MSP
LYNPARZA TAB	MSP
LYRICA CAP	2
LYRICA SOLN	2
MAVYRET TAB	MSP

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary cont.  
Prior Authorization Drug List  
Last Updated\* 1/1/2019**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
MEKINIST TAB	MSP
METHITEST TAB	3
METHYLTESTOSTERONE CAP	3
miglustat cap	MSP
modafinil tab	2
MOVANTIK TAB	2
NERLYNX TAB	MSP
NEUMEGA INJ	MSP
NEXAVAR TAB	MSP
NINLARO CAP	MSP
NORDITROPIN INJ	MSP
NUDEXTA CAP	2
OCALIVA TAB	MSP
octreotide inj	MSP
ODACTRA SL TAB	3
ODOMZO CAP	MSP
OFEV CAP	MSP
OLUMIANT TAB	MSP
omega-3-acid ethyl esters cap	2
OPSUMIT TAB	MSP
ORENCIA CLICK INJ	MSP
ORENCIA SC INJ 125MG/ML	MSP
ORENCIA SC INJ 50MG/0.4ML	MSP
ORENCIA SC INJ 87.5MG/0.7ML	MSP
ORKAMBI GRANULES PACKET	MSP
ORKAMBI TAB	MSP
OTEZLA STARTER PACK	MSP
OTEZLA TAB	MSP
OXYTROL PATCH	3
paliperidone ER tab	2
PALYNZIQ INJ	MSP
PEGASYS INJ	MSP
PEGASYS INJ KIT	MSP
PEG-INTRON INJ	MSP
phenoxybenzamine cap	MSP
PRALUENT INJ	MSP
PRENATAL VITAMINS (RX ONLY)	2
PROMACTA TAB	MSP
PULMOZYME INH SOLN	MSP
QBRELIS SOLN	3
REPATHA INJ	MSP
REPATHA PUSHTRONEX INJ	MSP

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary cont.**  
**Prior Authorization Drug List**  
**Last Updated\* 1/1/2019**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
REVLIMID CAP	MSP
RUBRACA TAB	MSP
RYDAPT CAP	MSP
SABRIL TAB	MSP
SAPHRIS SL TAB	3
SIGNIFOR INJ	MSP
SKLICE LOTION	3
sodium phenylbutyrate powder	MSP
sodium phenylbutyrate tab	MSP
SOLOSEC GRANULES PACKET	3
SOMAVERT INJ	MSP
SPRYCEL TAB	MSP
STIVARGA TAB	MSP
STRENSIQ INJ	MSP
SUTENT CAP	MSP
SYMDEKO TAB	MSP
SYMPROIC TAB	2
TACLONEX SCALP SUSP	3
tadalafil tab (PAH)	MSP
tadalafil tab 2.5mg, 5mg	3
TAFINLAR CAP	MSP
TAGRISSO TAB	MSP
TARCEVA TAB	MSP
TARGRETIN GEL	MSP
TASIGNA CAP	MSP
TAVALISSE TAB	MSP
TEST STRIP (all other test strips)	DME
testosterone gel 1% 25mg	2
testosterone gel 1% 50mg	2
testosterone gel 1% pump	2
testosterone gel 1.62% 1.25gm	2
testosterone gel 1.62% 2.5gm	2
TESTOSTERONE GEL PUMP	2
testosterone gel pump 1.62%	2
tetrabenazine tab	MSP
THALOMID CAP	MSP
tobramycin neb soln	MSP
TRACLEER TAB 32MG	MSP
TRACLEER TAB 62.5MG, 125MG	MSP
tretinoin cap	MSP
trientine cap	MSP
trospium chloride SR cap	3

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary cont.**  
**Prior Authorization Drug List**  
**Last Updated\* 1/1/2019**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
TRUVADA TAB	2
TYKERB TAB	MSP
TYMLOS INJ	MSP
TYVASO INH SOLN	MSP
UCERIS RECTAL FOAM	3
UPTRAVI TAB	MSP
VALCHLOR GEL	MSP
VENCLEXTA STARTER PACK	MSP
VENCLEXTA TAB	MSP
VENTAVIS INH SOLN	MSP
VERZENIO TAB	MSP
vigabatrin powder pack	MSP
VOSEVI TAB	MSP
VOTRIENT TAB	MSP
XADAGO TAB	3
XALKORI CAP	MSP
XIFAXAN TAB 550MG	3
XTANDI CAP	MSP
XULTOPHY INJ	2
XYREM SOLN	MSP
ZEJULA CAP	MSP
ZELBORAF TAB	MSP
ZOLINZA CAP	MSP
ZORTRESS TAB	2
ZYDELIG TAB	MSP
ZYKADIA CAP	MSP

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary**  
**Last Updated\* 1/1/2019**  
**RxCents (Cost Savings Enabled by Tablet Splitting)**

Tablet splitting helps control prescription drug benefit costs and can provide significant savings for members. Participation in the program is voluntary. Through this program, members pay up to one-half of their usual copayment on a select group of prescription drugs. Drugs included in this program are based on the following criteria:

- The drug product is on the formulary.
- The drug product is recognized as an appropriate product to split by the Pharmacy & Therapeutics Committee.
- The drug is flat priced (i.e. various strengths of the medication must be comparably priced).
- The medication must have once-daily dosing.

An example of the savings that can be realized through this program is illustrated below:

	Product & Strength	Quantity	Member Copay	Member Annual Savings
Without Tablet Splitting	Drug A 40 mg tab	30	\$15.00	
With Tablet Splitting	Drug A 80 mg tab	15	\$7.50	\$90

As the example illustrates, tablet splitting allows members to receive the same dose in a fewer number of tablets; thus, the overall

**RxCents Program Medications**

BYSTOLIC TAB	eplerenone tab	galantamine tab	JANUVIA TAB
OCALIVA TAB	rasagiline tab	TEKTURNA TAB	tolterodine tab
ULORIC TAB	VESICARE TAB		

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary  
Last Updated\* 1/1/2019  
Over-the-Counter (OTC)**

- The following OTC drugs are a covered benefit with a prescription

**Over-the-Counter (OTC) Medications**

AEROCHAMBER	ALCOHOL SWABS	ammonium lactate cream	ammonium lactate lotion
ASPIRIN CHEW TAB 75MG	aspirin chew tab 81mg	aspirin ec tab 325mg	aspirin ec tab 81mg
aspirin tab 325mg	aspirin tab 81mg	B-D INSULIN SYRINGE	B-D PEN NEEDLE
benzoyl peroxide gel	CALIBRATION LIQUID	cetirizine chew tab	cetirizine syrup
cetirizine tab	CLINISTIX TEST STRIP	CONTRACEPTIVE FOAM	CONTRACEPTIVE GEL
DIFFERIN OTC GEL 0.1%	FEMALE CONDOMS	ferrous sulfate elixir	FERROUS SULFATE LIQUIII
ferrous sulfate soln	FERROUS SULFATE SYRUP	FLONASE SENSIMIST	FREESTYLE FREEDOM LITE METER
FREESTYLE INSULINX METER	FREESTYLE INSULINX TEST STRIP	FREESTYLE LANCETS	FREESTYLE LITE METER
FREESTYLE LITE TEST STRIP	FREESTYLE PRECISION NEO METER	FREESTYLE PRECISION NEO TEST STRIP	FREESTYLE TEST STRIP
guaifenesin/codeine syrup	IRON SUSP	KETO-DIASTIX TEST STRIF	KETOSTIX
ketotifen ophth soln	LANCETS	lansoprazole cap	levonorgestrel tab
lidocaine cream 4%	loratadine ODT	loratadine syrup	loratadine tab
meclizine chew tab	meclizine tab	NASACORT OTC NASAL SPRAY	niacin cap
niacin CR tab	niacin tab	NIACIN TR TAB	niacinamide tab
nicotine gum	NICOTINE KIT	nicotine lozenge	nicotine patch
NOVOFINE PEN NEEDLE	NOVOLIN INJ	NOVOTWIST PEN NEEDLE	PEAK FLOW METER
PRECISION XTRA METER	PRECISION XTRA TEST STRIP	PREVACID OTC CAP	rhinocort allergy nasal spray
TEST STRIP (all other test strips)	TODAY SPONGE	triamcinolone OTC nasal spray	vcf vaginal gel
vitamin D cap 1000unit	vitamin D cap 2000IU	VITAMIN D CAP 400IU	vitamin D cap 400unit
vitamin D tab 2000IU	VITAMIN D TAB 400UNIT		

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Last Updated\* 1/1/2019  
Mandatory Specialty Pharmacy (MSP)**

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

**Mandatory Specialty Pharmacy (MSP) Medications**

abiraterone tab 250mg	ACTEMRA ACTPEN INJ	ACTEMRA SC INJ	ACTIMMUNE INJ
ADEMPAS TAB	AFINITOR DISPERZ	AFINITOR TAB	ALECENSA CAP
ALFERON-N INJ	ALUNBRIG TAB 30MG	ALUNBRIG TAB 90MG, 180MG	APOKYN INJ
AUBAGIO TAB	AVONEX INJ	BENLYSTA	BENLYSTA INJ
bexarotene cap	BOSULIF TAB	AUTO-INJECTOR	calcitriol inj
CALQUENCE CAP	capecitabine tab	CABOMETYX TAB	CAYSTON INH SOLN
CIMZIA INJ	CIMZIA STARTER INJ KIT	CAPRELSA TAB	COSENTYX INJ (1-PACK)
COSENTYX INJ (2-PACK)	COTELLIC TAB	COMETRIQ KIT	CYSTARAN OPHTH SOLN
dalfampridine ER tab	DARAPRIM TAB	CYSTAGON CAP	ENBREL INJ 25MG
ENBREL INJ 50MG	ENBREL MINI INJ	DUPIXENT INJ	EPCLUSA TAB, SOFOSBUVIR/VELPATASVI R TAB
ERIVEDGE CAP	ESBRIET CAP	ENBREL SURECLICK INJ 50MG	ESBRIET TAB 801MG
etoposide cap	EXJADE TAB	ESBRIET TAB 267MG	FARYDAK CAP
FERRIPROX SOLN	FERRIPROX TAB	EXTAVIA INJ	FUZEON INJ
GILENYA CAP	GILOTRIF TAB	FULPHILA INJ	GRANIX INJ
HARVONI TAB,	HEMLIBRA INJ	glatiramer inj	HUMIRA INJ 10MG
LEDIPASVIR/SOFOSBUVIR TAB		HIZENTRA INJ	
HUMIRA INJ 20MG	HUMIRA INJ 40MG	HUMIRA INJ	HUMIRA INJ PEDIATRIC CROHNS STARTER PACK
		CROHNS/UC/HIDRADENITI STARTER PACK	
HUMIRA INJ	HUMIRA PEN INJ 40MG	HYCANTIN CAP	IBRANCE CAP
PSORIASIS/UVEITIS STARTER PACK			
ICLUSIG TAB	IDHIFA TAB	imatinib tab	IMBRUVICA CAP 140MG
IMBRUVICA CAP 70MG	IMBRUVICA TAB	INCRELEX INJ	INFERGEN INJ
INLYTA TAB	INTRON-A INJ	IRESSA TAB	JADENU SPRINKLE
JADENU TAB	JAKAFI TAB	JYNARQUE PAK	KALYDECO PAK
KALYDECO TAB	KEVZARA INJ	KINERET INJ	KISQALI PAK
KISQALI TAB	KORLYM TAB	KUVAN POWDER PACK	KUVAN TAB
LENVIMA CAP	LETAIRIS TAB	LEUKINE INJ	LONSURF TAB
LYNPARZA CAP	LYNPARZA TAB	LYSODREN TAB	MAVYRET TAB
MEKINIST TAB	MESNEX TAB	miglustat cap	MYLERAN TAB
NERLYNX TAB	NEUMEGA INJ	NEXAVAR TAB	nilutamide tab
NINLARO CAP	NORDITROPIN INJ	OICALIVA TAB	octreotide inj

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

ODOMZO CAP	OFEV CAP	OLUMIANT TAB	OPSUMIT TAB
ORENCIA CLICK INJ	ORENCIA SC INJ 125MG/ML	ORENCIA SC INJ 50MG/0.4ML	ORENCIA SC INJ 87.5MG/0.7ML
ORKAMBI GRANULES PACKET	ORKAMBI TAB	OTEZLA STARTER PACK	OTEZLA TAB
PALYNZIQ INJ	PEGASYS INJ	PEGASYS INJ KIT	PEG-INTRON INJ
phenoxybenzamine cap	PLEGRIDY INJ	PLEGRIDY PEN INJ	PRALUENT INJ
PROMACTA TAB	PULMOZYME INH SOLN	REBIF INJ	REPATHA INJ
REPATHA PUSHTRONEX INJ	RETACRIT INJ	REVLIMID CAP	RUBRACA TAB
RYDAPT CAP	SABRIL TAB	SIGNIFOR INJ	sodium phenylbutyrate powder
sodium phenylbutyrate tab	SOMAVERT INJ	SPRYCEL TAB	STIVARGA TAB
STRENSIQ INJ	SUTENT CAP	SYLATRON INJ	SYMDEKO TAB
tadalafil tab (PAH)	TAFINLAR CAP	TAGRISSO TAB	TARCEVA TAB
TARGRETIN GEL	TASIGNA CAP	TAVALISSE TAB	TECFIDERA CAP
TECFIDERA STARTER PACK	temozolomide cap	tetrabenazine tab	THALOMID CAP
TOBI PODHALER	tobramycin neb soln	TRACLEER TAB 32MG	TRACLEER TAB 62.5MG, 125MG
tretinoin cap	trientine cap	TYKERB TAB	TYMLOS INJ
TYVASO INH SOLN	UPTRAVI TAB	VALCHLOR GEL	VENCLEXTA STARTER PACK
VENCLEXTA TAB	VENTAVIS INH SOLN	VERZENIO TAB	vigabatrin powder pack
VOSEVI TAB	VOTRIENT TAB	XALKORI CAP	XTANDI CAP
XYREM SOLN	ZARXIO INJ	ZEJULA CAP	ZELBORAF TAB
ZOLINZA CAP	ZYDELIG TAB	ZYKADIA CAP	

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary**  
**Last Updated\* 1/1/2019**  
**Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

**Step Therapy (ST) Medications**

<b>Drug Name</b>	<b>Step Therapy Requirements</b>
amethyst tab	Step Therapy requires a trial of 2 preferred oral contraceptives
budesonide SR cap	Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
esomeprazole cap	Step Therapy requires trial of omeprazole
fluvoxamine ER cap	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
gatifloxacin ophth soln	Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA
LIVALO TAB	Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
LO LOESTRIN TAB	Step Therapy requires a trial of 2 preferred oral contraceptives
LO MINASTRIN 24 FE CHEW TAB	Step Therapy requires a trial of 2 preferred oral contraceptives
LOESTRIN 24 FE TAB	Step Therapy requires a trial of 2 preferred oral contraceptives
LONHALA MAGNAIR SOLN	Step Therapy requires trial of INCRUSE ELLIPTA INHALER
mibelas chew tab	Step Therapy requires a trial of 2 preferred oral contraceptives
mometasone nasal spray	Step Therapy requires trial of two: fluticasone, triamcinolone OTC, or budesonide
NAMZARIC CAP	Step Therapy requires trial of donepezil and memantine
NAMZARIC STARTER PACK	Step Therapy requires trial of donepezil and memantine
NATAZIA TAB	Step Therapy requires a trial of 2 preferred oral contraceptives
nevirapine ER tab	Step Therapy requires trial of nevirapine
NORINYL TAB 1-50	Step Therapy requires a trial of 2 preferred oral contraceptives
OGESTREL TAB	Step Therapy requires a trial of 2 preferred oral contraceptives
risedronate DR tab	Step Therapy requires trial of alendronate
risedronate tab	Step Therapy requires trial of alendronate.
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL
ULORIC TAB	Step Therapy requires trial of allopurinol
zolpidem ER tab	Step Therapy requires trial of zolpidem IR

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary  
Smoking Cessation Agents  
Last Updated\* 1/1/2019**

<b>Drug Name</b>	<b>Tier # for Drug Copay</b>
bupropion SR tab( Limited to 180 days/plan year)	\$0
CHANTIX PAK( Limited to 180 days/plan year)	\$0
CHANTIX TAB( Limited to 180 days/plan year)	\$0
nicotine gum( Limited to 180 days/plan year)	\$0
NICOTINE KIT	\$0
nicotine lozenge( Limited to 180 days/plan year)	\$0
nicotine patch( Limited to 180 days/plan year)	\$0
NICOTROL INHALER( Limited to 180 days/plan year)	\$0
NICOTROL NASAL SPRAY( Limited to 180 days/plan year)	\$0

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary**  
**Last Updated\* 1/1/2019**  
**Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
abiraterone tab 250mg	QL= 4 tab/day;
ABSTRAL SL TAB	QL= 120 tabs/30 days; Dosage limits may apply
ACTEMRA ACTPEN INJ	QL= 2 inj/28 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ADEMPAS TAB	QL= 3 tabs/day; Only available through Accredo 888-773-7376
AFINITOR DISPERZ	QL= 1 tab/day
AFINITOR TAB	QL= 1 tab/day
AIMOVIG INJ	QL= 1 pack/28 days
AKYNZEO CAP	QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
ALECENSA CAP	QL= 8 caps/day
ALINIA SUSP	QL= 60ml/3 days
ALINIA TAB	QL= 6 tabs/3 days
ALUNBRIG TAB 30MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306
ALUNBRIG TAB 90MG, 180MG	QL= 1 tab/day; Only available through Biologics 800-850-4306
ANDRODERM PATCH	QL= 1 patch/day
ANZEMET TAB	QL= 9 tabs/fill
aprepitant cap	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
aprepitant pak	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
aripiprazole ODT	QL= 2 tabs/day
armodafinil tab	QL= 1 tab/day
atorvastatin tab 10mg	QL= 1 tab/day
atorvastatin tab 20mg	QL= 1 tab/day
ATRIPLA TAB	QL= 1 tab/day
BAXDELA TAB	QL= 2 tabs/day; Restricted to Infectious Disease Specialist
BENLYSTA AUTO-INJECTOR	QL= 4 inj/28 day
BENLYSTA INJ	QL= 4 inj/28 day
bimatoprost ophth soln	QL= 2.5ml/30 days
budesonide ER tab	QL=1 tab/day
buprenorphine patch	QL= 4 patches/28 days; Dosage limits may apply
BUPRENORPHINE PATCH, BUTRANS PATCH	QL= 4 patches/28 days; Dosage limits may apply
bupropion SR tab	Limited to 180 days/plan year
bupropion XL tab	QL= 1 tab/day
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days; Dosage limits may apply
BYDUREON BCISE AUTO INJ	QL= 4 inj/28 days
BYDUREON INJ	QL= 4 inj/28 days
BYDUREON PEN INJ	QL= 4 inj/28 days
BYETTA INJ	QL= 1 pen/30 days
CABOMETYX TAB	QL= 1 tab/day
CALQUENCE CAP	QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
celecoxib cap	QL= 2 caps/day
CHANTIX PAK	Limited to 180 days/plan year
CHANTIX TAB	Limited to 180 days/plan year

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Last Updated\* 1/1/2019**  
**Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA STARTER INJ KIT	QL= 1 kit/plan year
COMPLERA TAB	QL= 1 tab/day
COSENTYX INJ (1-PACK)	QL= 1 inj/28 days
COSENTYX INJ (2-PACK)	QL= 2 inj/28 days
COTELLIC TAB	QL= 3 tabs/day
CYSTARAN OPHTH SOLN	QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416
dalfampridine ER tab	QL= 2 tabs/day
DARAPRIM TAB	QL= 3 tabs/day; Only available through Walgreens 888-347-3416
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year
DEXCOM G6 SENSOR	QL= 3 sensors/28 days
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days
diclofenac gel	QL= 300gm/30 days
diclofenac gel 1%	QL= 5 tubes/fill
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN
DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY	QL= 8 sprays/fill, 2 fills/30 days
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
DUPIXENT INJ	QL= 2 inj/ 28 days
eletriptan tab	QL= 6 tabs/fill, 2 fills/ 30 days
EMGALITY INJ	QL= 1 inj/28 days
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL MINI INJ	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
enoxaparin inj	QL= 17 days supply
entecavir tab	QL= 1 tab/day
ENTRESTO TAB	QL= 2 tabs/day
EPCLUSA TAB,	QL= 1 tab/day
SOFOSBUVIR/VELPATASVIR TAB	
EPINEPHRINE PEN INJ 0.15MG (MYLAN)	QL= 2 inj/fill
epinephrine pen inj 0.3mg	QL= 2 inj/fill
ESBRIET CAP	QL= 9 caps/day
ESBRIET TAB 267MG	QL= 9 tabs/day
ESBRIET TAB 801MG	QL= 3 tabs/day
estradiol patch	QL= 2 patches/week
estradiol vaginal tab, yuvafem vaginal tab	QL= 8 tabs/28 days (18 tabs on first fill)
eszopiclone tab	QL= 1 tab/day
ezetimibe/simvastatin tab	QL= 1 tab/day (10-80mg is Not Covered)

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Last Updated\* 1/1/2019**  
**Quantity Limit (QL)**

• The following drugs are covered on the formulary with a Quantity Limit.

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
FANAPT TAB	QL= 2 tabs/day
FANAPT TITRATION PACK	QL= 1 pack/plan year
FARXIGA TAB	QL= 1 tab/day
FARYDAK CAP	QL= 6 caps/21 days
fentanyl citrate lollipop	QL= 120 lozenges/30 days; Dosage limits may apply
FENTORA TAB	QL= 120 tabs/30 days; Dosage limits may apply
FLECTOR PATCH	QL= 30 patches/fill
FLUNISOLIDE NASAL SPRAY	QL= 2 bottles/fill
fluticasone nasal spray	QL= 2 bottles/fill
fluvastatin cap	QL= 1 cap/day
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year
FREESTYLE LIBRE SENSOR (10-DAY)	QL= 3 sensors/30 days
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days
GENVOYA TAB	QL= 1 tab/day
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 888-773-7376
GLUCAGEN HYPOKIT INJ	QL= 1 kit/fill, 2 fills/30 days
GLUCAGEN INJ	QL= 1 kit/fill, 2 fills/30 days
GLUCAGON INJ KIT	QL= 1 kit/fill, 2 fills/30 days
GLYXAMBI TAB	QL= 1 tab/day
granisetron tab	QL= 9 tabs/fill
GRANISOL SOLN	QL= 60ml/fill
GUAIFENESIN/CODEINE SYRUP	QL= 240ml/fill
HARVONI TAB,	QL= 1 tab/day
LEDIPASVIR/SOFOSBUVIR TAB	
HUMIRA INJ 10MG	QL= 2 syringes/28 days
HUMIRA INJ 20MG	QL= 2 syringes/28 days
HUMIRA INJ 40MG	QL= 2 syringes/28 days
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG	QL= 2 pens/28 days
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
HYDROCODONE/CHLORPHENIRAMINE/I SEUDOEPHEDRINE LIQUID	QL= 120ml/fill, 2 fills/month
ibandronate tab 150mg	QL= 1 tab/30 days
IBRANCE CAP	QL= 21 caps/28 days
IDHIFA TAB	QL= 1 tab/day
IMBRUVICA CAP 140MG	QL= 3 caps/day
IMBRUVICA CAP 70MG	QL= 1 cap/day
IMBRUVICA TAB	QL= 1 tab/day

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.



**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Last Updated\* 1/1/2019**  
**Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
INLYTA TAB	QL= 8 tabs/day
JAKAFI TAB	QL= 2 tabs/day
JANUMET TAB	QL= 2 tabs/day
JANUMET XR TAB	QL= 2 tabs/day
JANUVIA TAB	QL= 1 tab/day
JARDIANCE TAB	QL= 1 tab/day
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
JYNARQUE PAK	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KALYDECO PAK	QL= 2 packets/day
KALYDECO TAB	QL= 2 tabs/day
ketorolac tab	QL= 20 tabs/5 days
KEVZARA INJ	QL= 2 inj/28 days
KINERET INJ	QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644
KISQALI PAK	QL= 91 tabs/28 days
KISQALI TAB	QL= 63 tabs/28 days
LASTACRAFT OPHTH SOLN	QL= 3ml/30 days
latanoprost ophth soln	QL= 2.5ml/30 days
LAZANDA NASAL SPRAY	QL= 15 bottles/30 days; Dosage limits may apply
LENVIMA CAP	QL= 3 caps/day; Only available through Accredo 888-773-7376
LETAIRIS TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
lidocaine oint	QL= 107gm/30 days
lidocaine patch	QL= 3 patches/day
LUMIGAN OPHTH SOLN	QL= 2.5ml/30 days
LYNPARZA CAP	Only available through Biologics 800-850-4306, QL= 16 caps/day
LYNPARZA TAB	Only available through Biologics 800-850-4306, QL= 4 tabs/day
malathion lotion	QL= 2 bottles/fill
MAVYRET TAB	QL= 3 tabs/day
medroxyprogesterone inj	QL= 1 inj/90 days
methylegonovine tab	QL= 28 tabs/fill, 1 fill/365 days
modafinil tab	QL= 2 tabs/day
NALOXONE PREFILLED INJ	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NARCAN NASAL SPRAY	QL= 2 sprays/fill
NASACORT OTC NASAL SPRAY	QL= 2 bottles/fill
NATROBA SUSP	QL= 1 bottle/fill
NERLYNX TAB	QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	
nicotine lozenge	Limited to 180 days/plan year
nicotine patch	Limited to 180 days/plan year
NICOTROL INHALER	Limited to 180 days/plan year
NICOTROL NASAL SPRAY	Limited to 180 days/plan year

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Last Updated\* 1/1/2019**  
**Quantity Limit (QL)**

• The following drugs are covered on the formulary with a Quantity Limit.

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
NUCYNTA ER TAB	QL= 2 tabs/day; Dosage limits may apply
NUDEXTA CAP	QL= 2 caps/day
OICALIVA TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
ODEFSEY TAB	QL= 1 tab/day
OFEV CAP	QL= 2 caps/day
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days
OLUMIANT TAB	QL= 1 tab/day
OPSUMIT TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
ORENCIA CLICK INJ	QL= 4 inj/28 days
ORENCIA SC INJ 125MG/ML	QL= 4 inj/28 days
ORENCIA SC INJ 50MG/0.4ML	QL= 4 inj/28 days
ORENCIA SC INJ 87.5MG/0.7ML	QL= 4 inj/28 days
ORKAMBI GRANULES PACKET	QL= 2 packets/day
ORKAMBI TAB	QL= 4 tabs/day
oseltamivir cap	QL= 10 caps/fill
oseltamivir cap 30mg	QL= 20 caps/fill
oseltamivir susp	QL= 250ml/fill
OTEZLA STARTER PACK	QL= 2 tabs/day
OTEZLA TAB	QL= 2 tabs/day
OZEMPIC INJ	QL= 1 pack/28 days
PALYNZIQ INJ	QL= 1 inj/day; Only available through Diplomat Pharmacy 877-977-9118
peg 3350/electrolytes soln	Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year
PICATO GEL	QL= 1 box/fill
POTIGA TAB	QL= 3 tabs/day
PRALUENT INJ	QL= 2 inj/28 days
REGANEX GEL	QL= 30gm/fill
RELENZA DISKHALER	QL= 1 inhaler/fill
REPATHA INJ	QL= 2 inj/28 days
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
REVLIMID CAP	QL= 1 cap/day
rhinocort allergy nasal spray	QL= 2 bottles/fill
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
rosuvastatin tab 10mg	QL= 1 tab/day
rosuvastatin tab 20mg	QL= 1.5 tabs/day
rosuvastatin tab 40mg	QL= 1 tab/day
rosuvastatin tab 5mg	QL= 1 tab/day
RUBRACA TAB	QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779
SANCUSO PATCH	QL= 4 patches/fill
SANTYL OINT	QL= 90gm/30 days
SAPHRIS SL TAB	QL= 2 tabs/day
SAVELLA TAB	QL= 2 tabs/day
scopolamine patch	QL= 5 patches/fill

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Last Updated\* 1/1/2019**  
**Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
SIGNIFOR INJ	QL= 2 vials/day; Only available through Accredo 888-773-7376
sildenafil tab	QL=8 tabs/30 days
sildenafil tab 20mg	QL= 40 tabs/30 days
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKLICE LOTION	QL= 1 tube/fill
SOLOSEC GRANULES PACKET	QL= 1 packet/fill
SPINOSAD SUSP	QL= 1 bottle/fill
SPIRIVA RESPIMAT INHALER	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or
1.25MCG/ACT	FLUTICASONES/SALMETEROL
STIVARGA TAB	QL= 4 tabs/day
STRIBILD TAB	QL= 1 tab/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
sumatriptan inj	QL= 4 inj/fill, 2 fills/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 4 inj/fill, 2 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SYMDEKO TAB	QL= 2 tabs/day
SYNJARDY TAB	QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG	QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG	QL= 2 tabs/day
tadalafil tab 2.5mg, 5mg	QL= 1 tab/day; BPH Only, Additional criteria required
TAFINLAR CAP	QL= 4 caps/day
TAGRISSO TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
TAVALISSE TAB	QL= 2 tab/day; Only available through Biologics 800-850-4306
testosterone gel 1% 25mg	QL= 1 packet/day
testosterone gel 1% 50mg	QL= 2 packets/day
testosterone gel 1% pump	QL= 4 bottles/30 days
testosterone gel 1.62% 1.25gm	QL= 1 packet/day
testosterone gel 1.62% 2.5gm	QL= 2 packets/day
TESTOSTERONE GEL PUMP	QL= 4 bottles/30 days
testosterone gel pump 1.62%	QL= 2 bottles/30 days
TIVICAY TAB	QL= 2 tabs/day
TRACLEER TAB 32MG	QL=4 tabs/day; Only available through Walgreens 888-347-3416
TRACLEER TAB 62.5MG, 125MG	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
TRADJENTA TAB	QL= 1 tab/day
TRANSDERM-SCOP PATCH	QL= 5 patches/fill
TRAVATAN Z OPHTH SOLN	QL= 2.5ml/30 days
triamcinolone OTC nasal spray	QL= 2 bottles/fill
trilyte soln	Covered at \$0 for members 50-75 years, all other members covered at generic copay Limited to 2 fills/calendar year

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.

**GHC-SCW 4-Tier Complete Formulary Cont.**  
**Last Updated\* 1/1/2019**  
**Quantity Limit (QL)**

• The following drugs are covered on the formulary with a Quantity Limit.

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
TRIUMEQ TAB	QL= 1 tab/day
TYVASO INH SOLN	QL= 1 ampule/day; Only available through Accredo 888-773-7376
ULESFIA LOTION	QL= 4 bottles/fill
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 888-773-7376
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Accredo 888-773-7376
vancomycin cap	QL= 56 caps/fill
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VEMLIDY TAB	QL= 1 tab/day
VENTAVIS INH SOLN	QL= 9 ampules/day; Only available through Accredo 888-773-7376
VENTOLIN HFA INHALER	QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler
VERZENIO TAB	QL= 2 tabs/day
V-GO INJ KIT	QL= 1 kit/day
VICTOZA INJ	QL= 9ml/30 days
VIMPAT TAB	QL= 2 tabs/day
VIVOTIF CAP	QL= 4 caps/fill
VOSEVI TAB	QL= 1 tab/day
XADAGO TAB	QL= 1 tab/day
XALKORI CAP	QL= 2 caps/day
XIFAXAN TAB 200MG	QL= 9 tabs/3 days
XIGDUO XR TAB 2.5-1000MG, 5-1000MG	QL= 2 tabs/day
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG	QL= 1 tab/day
XTAMPZA ER CAP	QL= 120 caps/30 days; Dosage limits may apply
XTANDI CAP	QL= 4 caps/day
XULTOPHY INJ	QL= 15ml/30 days
ZEJULA CAP	QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
ZOMIG NASAL SPRAY	QL= 6 sprays/fill, 2 fills/30 days
ZYKADIA CAP	QL= 3 caps/day
ZYLET OPHTH SUSP	QL= 5ml/fill (10ml bottle is Not Covered)

\*\* OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.\*\* Products listed may not be all inclusive and are subject to change. We reserve the right to correct publishing errors.