

Search Tip:

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar or using the CTRL+F search function from your keyboard. 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 3-Tier Complete Formulary
Alphabetical Index
Last Updated 11/1/2023**

Drug Name	Special Code	Tier	Category
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
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tab/day;)	MSP-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABRYSVO INJ	VAC	EXC	VACCINES
ABSORICA CAP	-	EXC	DERMATOLOGICALS
acamprosate calcium DR tab (CAMPRAL equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	1	ANTIDIABETICS
ACCU-CHEK AVIVA PLUS METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
ACCU-CHEK GUIDE CARE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE ME KIT	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
ACCU-CHEK NANO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK SMARTVIEW TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
ACCU-CHEK TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
acebutolol cap (SECTRAL equiv)	-	1	BETA BLOCKERS
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	-	1	OTIC AGENTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	2	DIURETICS
acetazolamide tab	-	1	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
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
ACTHIB INJ, HIBERIX INJ	VAC	EXC	VACCINES
ACTIMMUNE INJ	LD-PA	MSP	ANTINEOPLASTICS
acyclovir cap (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir oint (ZOVIRAX equiv)	-	1	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	1	ANTIVIRALS
ADACEL/BOOSTRIX INJ	VAC	EXC	TOXOIDS
ADALIMUMAB-ADAZ INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ PFS INJ (QL= 2 inj/28 days;)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
adapalene cream (DIFFERIN equiv)	-	2	DERMATOLOGICALS
adapalene gel 0.3% (DIFFERIN equiv)	-	2	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	2	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	2	DERMATOLOGICALS
ADBRY INJ (QL= 4 inj/28 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
ADDERALL XR CAP (QL= 2 caps/day)	QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
adefovir dipivoxil tab (HEPSERA equiv)	-	2	ANTIVIRALS
ADEMPAS TAB (QL= 3 tabs/day)	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
AIMOVIJ INJ (QL= 1 pack/28 days)	PA-QL	2	MIGRAINE PRODUCTS
AJOVY 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
albendazole tab (ALBENZA equiv)	-	2	ANTHELMINTICS
albuterol neb soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL NEBULIZER SOLN	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	2	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 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
alfuzosin SR tab (UROXATRAL equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS - MISC.
aliskiren tab (TEKTURNA equiv)	-	2	ANTIHYPERTENSIVES
allopurinol tab (ZYLOPRIM equiv)	-	1	GOUT AGENTS
ALOCRILOPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALOMIDOPHTH SOLN	-	2	OPHTHALMIC AGENTS
alprazolam ER tab (XANAX XR equiv)	-	2	ANTIANKXIETY AGENTS
alprazolam tab (XANAX equiv)	-	1	ANTIANKXIETY AGENTS
ALREXOPHTH SUSP	-	2	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

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

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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
ALUNBRIG TAB 30MG (QL= 4 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day)	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
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
amethyst tab (LYBREL equiv) (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0	CONTRACEPTIVES
amiloride tab (MIDAMOR equiv)	-	1	DIURETICS
AMILORIDE/HCTZ TAB	-	1	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1	DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	2	HEMOSTATICS
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 TAB equiv)	-	2	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	2	ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	1	DERMATOLOGICALS
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	2	DERMATOLOGICALS
amoxapine tab (AMOXAPINE equiv)	-	1	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	1	PENICILLINS
AMOXICILLIN CHEW TAB	-	1	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	1	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1	PENICILLINS
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
anagrelide cap (AGRYLIN equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
anastrozole tab (ARIMIDEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANORO ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
APRACLONIDINE OPHTH SOLN	-	2	OPHTHALMIC 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
APTIVUS CAP	-	2	ANTIVIRALS
APTIVUS SOLN	-	2	ANTIVIRALS
AREXVY INJ	VAC	EXC	VACCINES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
arformoterol tartrate neb soln (BROVANA equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARIKAYCE SUSP (QL= 1 vial/day)	LD-PA-QL	MSP	AMINOGLYCOSIDES
aripiprazole soln (ABILIFY equiv)	-	2	ANTIpsychOTICS/ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	1	ANTIpsychOTICS/ANTIMANIC AGENTS
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ARMOUR THYROID TAB, NATURE THROID TAB	-	1	THYROID AGENTS
ARNUIITY ELLIPTA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day)	QL	2	ANTIpsychOTICS/ANTIMANIC AGENTS
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	\$0	CONTRACEPTIVES
ASMANEX HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
aspirin chew tab 81mg (Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 81mg (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.
ASTAMED MYO CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
atazanavir cap (REYATAZ equiv)	-	2	ANTIVIRALS
atenolol tab (TENORMIN equiv)	-	1	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1	ANTIHYPERTENSIVES
atomoxetine cap (STRATTERA equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
atorvastatin tab (LIPITOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	1	ANTIMALARIALS
atropine ophth oint	-	1	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1	OPHTHALMIC AGENTS
ATROVENT HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AUSTEDO TAB (QL= 4 tabs/day)	MSP-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB 6MG (QL= 3 tabs/day)	MSP-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days)	MSP-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVANDIA TAB	-	2	ANTIDIABETICS
AVAR	-	EXC	DERMATOLOGICALS
AVAR GEL	-	2	DERMATOLOGICALS
AVONEX INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AYVAKIT TAB (QL= 1 tab/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AZASITE SOLN	-	2	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	1	ASSORTED CLASSES

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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) (OTC covered only)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	1	OPHTHALMIC AGENTS
azithromycin susp (ZITHROMAX equiv)	-	1	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	1	MACROLIDES
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 (BACLOFEN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
balsalazide cap (COLAZAL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
BALVERSA TAB 3MG (QL= 3 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 4MG (QL= 2 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 5MG (QL= 1 tab/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	2	ANTIDIABETICS
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	2	FLUOROQUINOLONES
BCG INJ	VAC	EXC	VACCINES
BD ECLIPSE NEEDLE/25G X	OTC	DME	MEDICAL DEVICES AND SUPPLIES
BD HYPO NEEDLE MIS 18Gx1.5"	-	DME	MEDICAL DEVICES AND SUPPLIES
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
benazepril tab (LOTENSIN equiv)	-	1	ANTIHYPERTENSIVES
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 (Restricted to Infectious Disease Specialist)	RS	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
BERINERT INJ	LD-PA	MSP	HEMATOLOGICAL AGENTS - MISC.
betaine powder for oral solution (CYSTADANE equiv)	LD	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
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)	-	2	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate lotion	-	1	DERMATOLOGICALS
betamethasone dipropionate oint	-	1	DERMATOLOGICALS
betamethasone valerate cream	-	1	DERMATOLOGICALS
betamethasone valerate lotion	-	1	DERMATOLOGICALS
betamethasone valerate oint	-	1	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
BETAXOLOL OPHTH SOLN	-	1	OPHTHALMIC AGENTS
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
bexarotene gel (TARGRETIN equiv)	MSP-PA	MSP	DERMATOLOGICALS
BEYFORTUS INJ	VAC	EXC	PASSIVE IMMUNIZING AND TREATMENT AGENTS
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
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
BOSULIF TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRAFTOVI CAP 75MG (QL= 6 caps/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BREO ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREZTRI AEROSPHERE INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2%	-	1	OPHTHALMIC AGENTS
brimonidine tartrate gel (MIRVASO equiv)	-	EXC	DERMATOLOGICALS
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	2	OPHTHALMIC AGENTS
brimonidine/timolol ophth soln (COMBIGAN equiv)	-	2	OPHTHALMIC AGENTS
brinzolamide ophth susp (AZOPT equiv)	-	2	OPHTHALMIC AGENTS
bromfenac ophth soln (BROMDAY equiv)	-	2	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	2	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	2	ANTIPARKINSON AGENTS
BRUKINSA CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
budesonide inh susp (PULMICORT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide nasal spray (RHINOCORT AQUA equiv) (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
budesonide SR cap (ENTOCORT EC equiv)	-	2	CORTICOSTEROIDS
bumetanide tab (BUMEX equiv)	-	1	DIURETICS
buprenorphine SL tab (SUBUTEX equiv)	-	1	ANALGESICS - OPIOID
buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv)	-	1	ANALGESICS - OPIOID
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1	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.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
bupropion tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion XL tab (WELLBUTRIN XL equiv) (QL= 1 tab/day)	QL	1	ANTIDEPRESSANTS
bupirone tab (BUSPAR equiv)	-	1	ANTIANKXIETY 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; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
BYDUREON INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
BYLVAY CAP 1200MCG (QL= 5 caps/day)	LD-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
BYLVAY CAP 400MCG (QL= 15 caps/day)	LD-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day)	LD-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day)	LD-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
cabergoline tab (DOSTINEX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
CABLIVI INJ KIT (QL= 1 vial/day)	LD-PA-QL	MSP	HEMATOLOGICAL 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
calcitonin nasal spray (MIACALCIN equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol soln (ROCALTROL SOLN equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES
CALQUENCE CAP (QL= 2 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CALQUENCE TAB (QL= 2 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAMBIA POWDER	-	EXC	MIGRAINE PRODUCTS
CAMZYOS CAP (QL= 1 cap/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
candesartan tab (ATACAND equiv)	-	1	ANTIHYPERTENSIVES
capecitabine tab (XELODA equiv)	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPRELSA TAB	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
captopril tab (CAPOTEN equiv)	-	2	ANTIHYPERTENSIVES
carbamazepine chew tab (TEGRETOL equiv)	-	1	ANTICONSULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	2	ANTICONSULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	2	ANTICONSULSANTS
carbamazepine susp (TEGRETOL equiv)	-	1	ANTICONSULSANTS
carbamazepine tab (TEGRETOL equiv)	-	1	ANTICONSULSANTS
carbidopa tab (LODOSYN equiv)	-	2	ANTIPARKINSON AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA ODT	-	1	ANTIPARKINSON AND RELATED THERAPY 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
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	2	ANTIPARKINSON AND RELATED THERAPY AGENTS
CARETOUCH MIS	OTC	DME	MEDICAL DEVICES AND SUPPLIES
carglumic acid tab (CARBAGLU equiv)	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
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	LD-PA	MSP	ANTI-INFECTIVE AGENTS - MISC.
cefadroxil cap (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	1	CEPHALOSPORINS
CEFADROXIL TAB	-	1	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	1	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	1	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	1	CEPHALOSPORINS
cefepodoxime proxetil susp (VANTIN equiv)	-	2	CEPHALOSPORINS
cefepodoxime proxetil tab (VANTIN equiv)	-	2	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	1	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	1	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	1	CEPHALOSPORINS
celecoxib cap (CELEBREX equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
cephalexin cap (KEFLEX equiv)	-	1	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	1	CEPHALOSPORINS
CERVICAL CAP	-	\$0	MEDICAL DEVICES AND SUPPLIES
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
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	1	ANTI-ANXIETY AGENTS
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	-	1	DIURETICS
chlorothiazide tab (DIURIL equiv)	-	1	DIURETICS
chlorpromazine tab (THORAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
chlorthalidone tab	-	1	DIURETICS
chlorzoxazone tab 500mg	-	2	MUSCULOSKELETAL THERAPY AGENTS
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
CIBINQO TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	DERMATOLOGICALS
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/ANTISPASMODICS/ANTICHOLINEF CS
cimetidine soln (CIMETIDINE equiv)	-	1	ULCER DRUGS
cimetidine tab (TAGAMET HB 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.
cinacalcet tab (SENSIPAR equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
CINRYZE INJ (QL= 16 vials/28 days)	LD-PA-QL	MSP	HEMATOLOGICAL AGENTS - MISC.
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
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	2	OTIC AGENTS
citalopram soln (CELEXA equiv)	-	1	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	1	ANTIDEPRESSANTS
CLARINEX SYRUP	-	EXC	ANTIHISTAMINES
CLARITHROMYC SUSP	-	2	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
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)	-	2	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	1	VAGINAL PRODUCTS
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	2	VAGINAL AND RELATED PRODUCTS
CLINISTIX TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
clobazam susp (ONFI equiv) (Members age 9 or older require Prior Authorization)	PA	2	ANTICONVULSANTS
clobazam tab (ONFI equiv)	-	1	ANTICONVULSANTS
clobetasol lotion (CLOBEX equiv)	-	2	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	1	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol propionate soln (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol shampoo (CLOBEX SHAMPOO equiv)	-	2	DERMATOLOGICALS
CLOBEX LOTION	-	EXC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
CLOMID TAB	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
CLOMIPHENE TAB	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
clonazepam tab (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonidine ER tab (KAPVAY equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
clonidine patch (CATAPRES-TTS equiv)	-	2	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	1	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
clotrimazole troches (MYCELEX TROCHES equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1	DERMATOLOGICALS
clozapine tab (CLOZARIL equiv)	-	2	ANTIPTSYCHOTICS/ANTIMANIC AGENTS
codeine sulfate tab (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
colchicine tab (COLCRYS equiv)	-	2	GOUT AGENTS
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 tab (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
COLY-MYCIN S OTIC SUSP	-	2	OTIC AGENTS
COMBIVENT RESPIMAT INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
COMETRIQ KIT	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COMIRNATY INJ 30MCG/0.3ML	VAC	EXC	VACCINES
COMPLERA TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
CONCEPT DHA CAP	PA	2	MULTIVITAMINS
CONTRACEPTIVE FOAM	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE GEL	OTC	\$0	VAGINAL PRODUCTS
COPIKTRA CAP (QL= 2 caps/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CORLANOR TAB	PA	2	CARDIOVASCULAR AGENTS - MISC.
CORTISONE ACETATE TAB	-	2	CORTICOSTEROIDS
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COVID-19 VACCINE INJ 5-11Y (PFIZER)	VAC	EXC	VACCINES
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	VAC	EXC	VACCINES
COVID-19 VACCINE INJ 6M-4Y (PFIZER)	VAC	EXC	VACCINES
CREON CAP	-	2	DIGESTIVE AIDS
CRINONE GEL	-	EXC	VAGINAL PRODUCTS
CRIVIVAN CAP	-	2	ANTIVIRALS
cromolyn conc (GASTROCROM equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
cromolyn ophth soln (CROLOM equiv)	-	1	OPHTHALMIC AGENTS
CROMOLYN SODIUM OPHTH SOLN	-	1	OPHTHALMIC AGENTS
cryselle tab	-	\$0	CONTRACEPTIVES
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EXC	DIAGNOSTIC PRODUCTS
CUE HEALTH MONITOR	OTC	EXC	DIAGNOSTIC PRODUCTS
cyanocobalamin inj	-	1	HEMATOPOIETIC AGENTS
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1	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	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclosporine cap (SANDIMMUNE equiv)	-	2	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	1	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	2	ASSORTED CLASSES
cyclosporine ophth emulsion (RESTASIS equiv) (Restricted to Ophthalmology or Optometry Specialist)	RS	2	OPHTHALMIC AGENTS
cyproheptadine syrup	-	1	ANTIHISTAMINES
cyproheptadine tab	-	1	ANTIHISTAMINES
CYSTADROPS SOLN (QL= 4 bottles/28 days)	LD-PA-QL	MSP	OPHTHALMIC AGENTS
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days)	LD-PA-QL	MSP	OPHTHALMIC AGENTS
CYTRA K CRYSTALS	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
CYTRA-3 SYRUP	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	2	ANTICOAGULANTS
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist)	QL-RS	2	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.
darifenacin SR tab (ENABLEX equiv)	-	2	URINARY ANTISPASMODICS
darunavir tab (PREZISTA equiv)	-	2	ANTIVIRALS
deferasirox granules packet (JADENU equiv)	MSP	MSP	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (EXJADE equiv)	MSP	MSP	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab 180mg (JADENU equiv)	MSP	MSP	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab 90mg, 360mg (JADENU equiv)	MSP	MSP	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferiprone tab (FERRIPROX equiv)	LD-PA	MSP	ANTIDOTES AND SPECIFIC ANTAGONISTS
DELSTRIGO TAB	-	2	ANTIVIRALS
DENGVAIXIA SUSP	VAC	EXC	VACCINES
DEPLIN CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	2	CORTICOSTEROIDS
DEPO-PROVERA INJ (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
DESCOVY TAB (DESCOVY TAB (HIV pre-exposure prophylaxis) with a PA at \$0 and DESCOVY TAB (HIV treatment) with a PA at tier 2)	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.
desonide cream (DESOWEN equiv)	-	2	DERMATOLOGICALS
desonide lotion	-	2	DERMATOLOGICALS
desonide oint (DESOWEN equiv)	-	2	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
desoximetasone cream 0.025% (TOPICORT CREAM equiv)	-	2	DERMATOLOGICALS
desoximetasone gel (TOPICORT equiv)	-	2	DERMATOLOGICALS
desoximetasone oint 0.25% (TOPICORT equiv)	-	2	DERMATOLOGICALS
desvenlafaxine ER tab (PRISTIQ equiv)	-	1	ANTIDEPRESSANTS
DEXAMETHASONE CONC	-	1	CORTICOSTEROIDS
dexamethasone elixir	-	1	CORTICOSTEROIDS
DEXAMETHASONE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
dexamethasone sodium phosphate inj	-	1	CORTICOSTEROIDS
DEXAMETHASONE SOLN	-	1	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	1	CORTICOSTEROIDS
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME	MEDICAL DEVICES AND SUPPLIES
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dexmethylphenidate tab (FOCALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DIACOMIT CAP	LD-PA	MSP	ANTICONVULSANTS
DIACOMIT POWDER PACK	LD-PA	MSP	ANTICONVULSANTS
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 (QL= 2 packs/fill)	QL	1	ANTICONVULSANTS
diazepam conc (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	1	ANTI-ANXIETY AGENTS
diazepam tab (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS
diclofenac gel (SOLARAZE equiv) (QL= 300 gm/30 days)	QL	2	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1	DERMATOLOGICALS
diclofenac gel 1% OTC	OTC	1	DERMATOLOGICALS
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	EXC	MIGRAINE PRODUCTS
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 soln 1.5% (PENNSAID equiv) (QL= 3 bottles/fill)	QL	2	DERMATOLOGICALS
dicloxacin cap (DYNAPEN equiv)	-	1	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	2	ULCER DRUGS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
dicyclomine tab (BENTYL equiv)	-	1	ULCER DRUGS
didanosine DR cap (VIDEX EC equiv)	-	2	ANTIVIRALS
DIDANOSINE DR CAP, VIDEX EC CAP	-	2	ANTIVIRALS
DIFFERIN OTC GEL 0.1%	OTC	1	DERMATOLOGICALS
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2	MACROLIDES
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2	MACROLIDES
diffunisal tab (DOLOBID equiv)	-	1	ANALGESICS - NONNARCOTIC
difluprednate ophth emulsion (DUREZOL equiv)	-	2	OPHTHALMIC AGENTS
digoxin soln (LANOXIN equiv)	-	1	CARDIOTONICS
DIGOXIN SOLN 0.05MG/ML	-	1	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	1	CARDIOTONICS
DILANTIN CAP 30MG	PA	2	ANTICONVULSANTS
diltiazem ER cap (CARDIZEM CD equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
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
dimethyl fumarate DR cap (TECFIDERA equiv)	MSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	MSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1	ANTIIDIARRHEALS
DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	EXC	TOXOIDS
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)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DOPTELET TAB (QL= 2 tabs/day)	LD-PA-QL	MSP	HEMATOPOIETIC AGENTS
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
DOVATO TAB	-	2	ANTIVIRALS
doxazosin tab (CARDURA equiv)	-	1	ANTIHYPERTENSIVES
doxepin cap (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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 tab 20mg, 100mg (VIBRATAB equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate tab	-	2	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	2	TETRACYCLINES
D-PENAMINE TAB	-	2	ASSORTED CLASSES
dronabinol cap (MARINOL equiv)	-	2	ANTIEMETICS
drosiprone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	\$0	CONTRACEPTIVES
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
DUPIXENT PEN INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
dutasteride cap (AVODART equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
econazole cream (SPECTAZOLE equiv)	-	1	DERMATOLOGICALS
EDLUAR SL TAB	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
EDURANT TAB	-	2	ANTIVIRALS
EFAVIRENZ CAP	-	2	ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	2	ANTIVIRALS
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv) (QL= 1 tab/day)	QL	2	ANTIVIRALS
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	2	ANTIVIRALS
EGRIFTA INJ	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
eletriptan tab (RELPAK equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
ELIGEN B12 TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ELIQUIS TAB, ELIQUIS STARTER PACK	-	2	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	\$0	CONTRACEPTIVES
ELMIRON CAP	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
EMCYT CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2	MIGRAINE PRODUCTS
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year)	PA-QL	2	MIGRAINE PRODUCTS
EMPAVELI INJ (QL= 160ml/28 days)	LD-PA-QL	MSP	HEMATOLOGICAL AGENTS - MISC.
emtricitabine cap (EMTRIVA equiv)	-	2	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	2	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab 200-300mg (TRUVADA equiv)	-	\$0	ANTIVIRALS
EMTRIVA SOLN	-	2	ANTIVIRALS
enalapril tab (VASOTEC equiv)	-	1	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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
ENDARI POWDER PACK (QL= 6 packets/day)	MSP-PA-QL	MSP	HEMATOPOIETIC AGENTS
ENDOMETRIN INSERT	-	EXC	VAGINAL PRODUCTS
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	EXC	VACCINES
enoxaparin inj (LOVENOX equiv)	-	2	ANTICOAGULANTS
enpresse tab (TRI-LEVELLEN equiv)	-	\$0	CONTRACEPTIVES
ENSPRYNG INJ (QL= 1 inj/28 days)	MSP-PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSES
entacapone tab (COMTAN equiv)	-	2	ANTIPARKINSON AGENTS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	2	ANTIVIRALS
ENTRESTO TAB (QL= 2 tabs/day)	QL	2	CARDIOVASCULAR AGENTS - MISC.
EPIDIOLEX SOLN	MSP-PA	MSP	ANTICONVULSANTS
EPIFOAM AEROSOL	-	2	DERMATOLOGICALS
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	2	VASOPRESSORS
EPIQUIN MICRO CREAM	-	EXC	DERMATOLOGICALS
EPIVIR HBV SOLN	-	2	ANTIVIRALS
eplerenone tab (INSPRA equiv)	-	1	ANTIHYPERTENSIVES
ergotamine/cafeine tab (CAFERGOT equiv)	-	2	MIGRAINE PRODUCTS
ERIVEDGE CAP	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB (QL= 4 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB 240MG (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab (TARCEVA equiv)	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERY PAD	-	2	DERMATOLOGICALS
erythromycin DR cap (ERYC equiv)	-	2	MACROLIDES
ERYTHROMYCIN EC CAP	-	2	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv)	-	2	MACROLIDES
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2	MACROLIDES
erythromycin gel	-	2	DERMATOLOGICALS
erythromycin ophth oint (Covered at \$0 for members 1 year or younger)	-	1	OPHTHALMIC AGENTS
erythromycin pad	-	1	DERMATOLOGICALS
erythromycin soln	-	1	DERMATOLOGICALS
erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE)	-	2	MACROLIDES
escitalopram soln (LEXAPRO equiv)	-	2	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	1	ANTIDEPRESSANTS
esomeprazole cap (NEXIUM equiv)	OTC	1	ULCER DRUGS
estazolam tab (PROSOM equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER 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

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	2	ESTROGENS
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1	ESTROGENS
ESTRING (3 copays per Rx)	-	2	VAGINAL PRODUCTS
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEF 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
etodolac cap (LODINE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ETOPOSIDE CAP	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
etravirine tab (INTELENCE equiv)	-	2	ANTIVIRALS
EULEXIN CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab (ZORTRESS equiv)	PA	2	MISCELLANEOUS THERAPEUTIC CLASSE
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	PA-MSP-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EVOTAZ TAB	-	2	ANTIVIRALS
EVRYSDI SOLN (QL= 6.67ml/day)	LD-PA-QL	MSP	NEUROMUSCULAR AGENTS
exemestane tab (AROMASIN equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXKIVITY CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXTAVIA INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ezetimibe tab (ZETIA equiv)	-	1	ANTHYPERLIPIDEMICS
FALESSA TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
famciclovir tab (FAMVIR equiv)	-	2	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	2	ULCER DRUGS
famotidine tab (PEPCID equiv)	-	1	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
FARXIGA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST-¢	2	GOUT AGENTS
felbamate susp (FELBATOL equiv)	-	2	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	2	ANTICONVULSANTS
felodipine ER tab (PLENDIL equiv)	-	1	CALCIUM CHANNEL BLOCKERS
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$0	MEDICAL DEVICES AND SUPPLIES
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	1	ANTHYPERLIPIDEMICS
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1	ANTHYPERLIPIDEMICS
fenofibric acid DR cap (TRILIPIX equiv)	-	1	ANTHYPERLIPIDEMICS
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days; Dosage limits may apply)	PA-QL	2	ANALGESICS - OPIOID
fentanyl patch (DURAGESIC equiv) (Dosage limits may apply)	-	2	ANALGESICS - OPIOID
ferrex 150 forte cap	-	1	HEMATOPOIETIC AGENTS
FERRIPROX SOLN	LD-PA	MSP	ANTIDOTES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	2	URINARY ANTISPASMODICS
FIASP FLEXTOUCH INJ	-	2	ANTIDIABETICS
FIASP INJ	-	2	ANTIDIABETICS
FIASP PENFILL INJ	-	2	ANTIDIABETICS
FILSPARI TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	GENITOURINARY AGENTS - MISCELLANEOUS
FINACEA FOAM	-	2	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
finasteride tab (PROPECIA equiv)	-	EXC	DERMATOLOGICALS
fingolimod hcl cap 0.5mg (GILENYA equiv)	MSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FINTEPLA SOLN (QL= 12ml/day)	LD-PA-QL	MSP	ANTICONVULSANTS
FIRDAPSE TAB	LD-PA	MSP	ANTIMYASTHENIC/CHOLINERGIC AGENTS
FIRVANQ SOLN	-	1	ANTI-INFECTIVE AGENTS - MISC.
FIRVANQ SOLN 50MG/ML	-	1	ANTI-INFECTIVE AGENTS - MISC.
flecainide tab (TAMBOCOR equiv)	-	1	ANTIARRHYTHMICS
FLONASE SENSIMIST NASAL SPRAY	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
fluocinolone acetonide cream	-	1	DERMATOLOGICALS
fluocinolone acetonide oil (DERMA-SMOOTH 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 cream 0.1% (VANOS CREAM equiv)	-	1	DERMATOLOGICALS
fluocinonide emollient cream	-	2	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
FLUORIDEX SENSITIVITY PASTE	-	1	MOUTH/THROAT/DENTAL AGENTS
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1	OPHTHALMIC AGENTS
fluorouracil cream (EFUDEX CREAM equiv)	-	1	DERMATOLOGICALS
FLUOROURACIL SOLN	-	2	DERMATOLOGICALS
fluoxetine cap (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine soln (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine tab (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluphenazine tab (PROLIXIN equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FLURAZEPAM CAP	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
FLURBIPROFEN OPHTH SOLN	-	2	OPHTHALMIC AGENTS
FLURBIPROFEN TAB	-	1	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
flurbiprofen tab (ANSAID equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
FLUTAMIDE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
flutamide cap (EULEXIN equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1	DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	1	DERMATOLOGICALS
FLUTICASONE/SALMETEROL INHALER (AIRDUO equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvastatin cap (LESCOL equiv) (QL= 2 caps/day)	QL	2	ANTIHYPERTENSIVES
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires a trial of 2 of the following: citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine, or paroxetine)	ST	2	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	1	ANTIDEPRESSANTS
FOLBEE PLUS CZ TAB	-	1	MULTIVITAMINS
folbee tab	-	1	HEMATOPOIETIC AGENTS
folic acid tab 1mg (Covered at \$0 for females only)	-	1	HEMATOPOIETIC AGENTS
folic acid tab 400mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
folic acid tab 800mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
fondaparinux inj (ARIXTRA equiv)	-	2	ANTICOAGULANTS
FORTICAL NASAL SPRAY	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosamprenavir tab (LEXIVA equiv)	-	2	ANTIVIRALS
fosfomycin tromethamine powder pack (MONUROL equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
fosinopril tab (MONOPRIL equiv)	-	1	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1	ANTIHYPERTENSIVES
FOSRENOL POWDER PACK	-	2	GASTROINTESTINAL AGENTS - MISC.
FOTIVDA CAP (QL= 21 caps/28 days)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FRAGMIN INJ	-	2	ANTICOAGULANTS
FREESTYLE LANCETS	OTC	DME	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME	MEDICAL DEVICES AND SUPPLIES
FULPHILA INJ	MSP	MSP	HEMATOPOIETIC AGENTS
FUROSEMIDE SOLN	-	1	DIURETICS
furosemide soln (LASIX equiv)	-	1	DIURETICS
furosemide tab (LASIX equiv)	-	1	DIURETICS
FUZEON INJ	-	2	ANTIVIRALS
gabapentin cap (NEURONTIN equiv) (QL= 9 caps/day)	QL	1	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	2	ANTICONVULSANTS
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	1	ANTICONVULSANTS
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	1	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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.
GALZIN CAP	-	2	MINERALS & ELECTROLYTES
gatifloxacin ophth soln (ZYMAXID equiv) (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	2	OPHTHALMIC AGENTS
GAVILYTE-C SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year)	QL	1	LAXATIVES
GAVRETO CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
gefitinib tab (IRESSA equiv)	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
gemfibrozil tab (LOPID equiv)	-	1	ANTIHYPERTENSIVES
GENTAK OPTH OINT	-	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 0.25MG	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILOTRIF TAB (QL= 1 tab/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glatiramer inj (COPAXONE equiv)	MSP	1	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 (rdna) for inj kit (GLUCAGON equiv) (QL= 1 kit/fill, 2 fills/30 days)	QL	2	ANTIDIABETICS
GLUCAGON EMR INJ (QL= 2 inj/fill)	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
GLYGEST PAK	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
GLYXAMBI TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
GOLYTELY SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year)	QL	1	LAXATIVES
granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill)	QL	1	ANTIEMETICS
griseofulvin micro tab (GRIFULVIN V equiv)	-	2	ANTIFUNGALS
griseofulvin susp (GRIFULVIN equiv)	-	2	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	2	ANTIFUNGALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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
guanfacine ER tab (INTUNIV equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
guanfacine IR tab (TENEX equiv)	-	1	ANTIHYPERTENSIVES
GVOKE INJ (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
GVOKE INJ KIT (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
GVOKE PFS INJ (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
HADLIMA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HAEGARDA INJ	LD-PA	MSP	HEMATOLOGICAL AGENTS - MISC.
halobetasol propionate cream (ULTRAVATE equiv)	-	2	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv)	-	2	DERMATOLOGICALS
haloperidol lactate conc (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
haloperidol tab (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
HEMLIBRA INJ	MSP-PA	MSP	HEMATOLOGICAL AGENTS - MISC.
HEXALEN CAP	-	2	ANTINEOPLASTICS
HIZENTRA INJ	MSP-PA	MSP	PASSIVE IMMUNIZING AGENTS
HOMATROPINE OPTH SOLN	-	2	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 80MG (QL= 2 syringes/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 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 PEDIATRIC UC 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 bitartrate ER cap (ZOHYDRO equiv) (QL= 2 caps/day)	QL	2	ANALGESICS - OPIOID
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/homatropine syrup (HYCODAN equiv)	-	1	COUGH/COLD/ALLERGY
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

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
hydrocortisone supp (ANUSOL HC equiv)	-	2	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	1	CORTICOSTEROIDS
hydrocortisone valerate cream	PA	2	DERMATOLOGICALS
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
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTIAXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTIAXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTIAXIETY AGENTS
HYFTOR GEL (QL= 10 grams/30 days)	LD-PA-QL	MSP	DERMATOLOGICALS
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 tab (LEVSIN equiv)	-	1	ULCER DRUGS
HYPO NEEDDLE MIS 18GX1.5	OTC	DME	MEDICAL DEVICES AND SUPPLIES
HYPODERMIC NEEDLES	OTC	DME	MEDICAL DEVICES AND SUPPLIES
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
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
icatibant inj (FIRAZYR equiv)	MSP-PA	MSP	HEMATOLOGICAL AGENTS - MISC.
ICLUSIG TAB (QL= 1 tab/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
icosapent ethyl cap (VASCEPA equiv)	PA	2	ANTIHYPERTENSIVES
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	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 SUSP (QL= 6ml/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 420MG, 560MG (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMCIVREE INJ (QL= 1 inj/day)	LD-PA-QL	MSP	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
imipramine tab (TOFRANIL equiv)	-	1	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	1	DERMATOLOGICALS
IMOVAX INJ	VAC	EXC	VACCINES
INCRELEX INJ	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
indapamide tab (LOZOL equiv)	-	1	DIURETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
indomethacin cap (INDOCIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
INGREZZA CAP (QL= 1 cap/day)	LD-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INGREZZA PACK 40-80MG (QL= 1 pack/28 days)	LD-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INQOVI TAB (QL= 5 tabs/28 days)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	2	ANTIDIABETICS
INSULIN ASPART INJ (NOVOLOG equiv)	-	2	ANTIDIABETICS
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	2	ANTIDIABETICS
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	2	ANTIDIABETICS
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	2	ANTIDIABETICS
INSULIN SYRINGE	OTC	DME	MEDICAL DEVICES AND SUPPLIES
INTELENCE TAB	-	2	ANTIVIRALS
INTRON-A INJ	MSP-PA	MSP	ANTINEOPLASTICS
INVIRASE CAP	-	2	ANTIVIRALS
INVIRASE TAB	-	2	ANTIVIRALS
IOPIDINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
IPOL INJ	VAC	EXC	VACCINES
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
ISENTRESS (HD) TAB	-	2	ANTIVIRALS
ISENTRESS CHEW TAB	-	2	ANTIVIRALS
ISENTRESS POWDER PACK	-	2	ANTIVIRALS
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	\$0	CONTRACEPTIVES
ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	2	MIGRAINE PRODUCTS
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	2	MIGRAINE PRODUCTS
ISONIAZID TAB	-	1	ANTIMYCOBACTERIAL AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
isosorbide dinitrate SL tab	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate ER tab (IMDUR equiv)	-	1	ANTIANGINAL AGENTS
ISOSORBIDE MONONITRATE TAB	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	1	ANTIANGINAL AGENTS
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ISTURISA TAB 10MG (QL= 6 tabs/day)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
ISTURISA TAB 1MG (QL= 8 tabs/day)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
ISTURISA TAB 5MG (QL= 2 tabs/day)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
itraconazole cap (SPORANOX equiv)	-	2	ANTIFUNGALS
ivermectin tab (STROMEKTOL equiv)	-	2	ANTHELMINTICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	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
JAYPIRCA TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JENTADUETO TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
jinteli tab (FEMHRT equiv)	-	1	ESTROGENS
JUBLIA SOLN	-	EXC	DERMATOLOGICALS
JULUCA TAB	-	2	ANTIVIRALS
JYNARQUE PAK (QL= 2 tabs/day)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
JYNARQUE TAB (QL= 2 tabs/day)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
KALYDECO PAK (QL= 2 packets/day)	LD-PA-QL	MSP	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day)	LD-PA-QL	MSP	RESPIRATORY AGENTS - MISC.
kelnor tab (DEMULEN equiv)	-	\$0	CONTRACEPTIVES
KERYDIN SOLN	-	EXC	DERMATOLOGICALS
KESIMPTA INJ	MSP-PA	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL 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
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	1	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)	LD-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	EXC	TOXOIDS
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	EXC	TOXOIDS
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
KLOXXADO NASAL SPRAY	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
KORLYM TAB (QL= 4 tabs/day)	LD-PA-QL	MSP	ANTIDIABETICS
KOSELUGO CAP (QL= 4 caps/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO CAP 10MG (QL= 8 caps/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KRAZATI TAB (QL= 6 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KRINTAFEL TAB	-	2	ANTIMALARIALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
K-TAB	-	1	MINERALS & ELECTROLYTES
labetalol tab (NORMODYNE equiv)	-	1	BETA BLOCKERS
LAC-HYDRIN LOTION 5%	OTC	1	DERMATOLOGICALS
lacosamide oral solution (VIMPAT equiv)	-	1	ANTICONVULSANTS
lacosamide tab (VIMPAT equiv)	-	1	ANTICONVULSANTS
lactulose soln	-	1	GASTROINTESTINAL AGENTS - MISC.
LAGEVRIO CAP (QL= 40 caps/fill)	QL	\$0	ANTIVIRALS
lamivudine soln (EPIVIR equiv)	-	2	ANTIVIRALS
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 tab (LAMICTAL equiv)	-	1	ANTICONVULSANTS
LAMPIT TAB	PA	2	ANTI-INFECTIVE AGENTS - MISC.
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/ANTISPASMODICS/ANTICHOLINEF CS
lanthanum carbonate chew tab (FOSRENOL equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
lapatinib ditosylate tab (TYKERB equiv)	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
LATISSE SOLN	-	EXC	DERMATOLOGICALS
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0	CONTRACEPTIVES
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTIVIRALS
leflunomide tab (ARAVA equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day)	PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSE
LENVIMA CAP (QL= 3 caps/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
letrozole tab (FEMARA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	1	ANTINEOPLASTICS
LEUKERAN TAB	-	2	ANTINEOPLASTICS
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levabuterol neb soln (XOPENEX equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
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	-	1	OPHTHALMIC AGENTS
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.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
levocetirizine soln (XYZAL equiv)	-	2	ANTIHISTAMINES
levocetirizine tab (XYZAL equiv)	-	2	ANTIHISTAMINES
levofloxacin ophth soln (QUIXIN equiv)	-	1	OPHTHALMIC AGENTS
LEVOFLOXACIN OPHTH SOLN 0.5%	-	1	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
LEVOFLOXACIN SOLN 25MG/ML	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	\$0	CONTRACEPTIVES
levonorgestrel/ethinyl estradiol tab (LOSEASONIQUE equiv)	-	\$0	CONTRACEPTIVES
levonorgestrel/ethinyl estradiol tab (QUARTETTE equiv)	-	\$0	CONTRACEPTIVES
levothyroxine tab (SYNTHROID equiv)	-	1	THYROID AGENTS
LEXIVA SUSP	-	2	ANTIVIRALS
lidocaine cream	OTC	1	DERMATOLOGICALS
lidocaine cream 3% (LIDAMANTLE equiv)	-	1	DERMATOLOGICALS
lidocaine cream 4%	OTC	1	DERMATOLOGICALS
lidocaine gel (GLYDO equiv)	-	1	DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
LIDOCAINE GEL	-	2	DERMATOLOGICALS
lidocaine oint (QL= 107gm/30 days)	QL	1	DERMATOLOGICALS
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	2	DERMATOLOGICALS
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	QL	2	DERMATOLOGICALS
lidocaine rectal cream	OTC	1	ANORECTAL AGENTS
lidocaine soln (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	2	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
linezolid susp (ZYVOX equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
linezolid tab (ZYVOX equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
LINZESS CAP	-	2	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	1	THYROID AGENTS
lisdexamfetamine dimesylate cap (VYVANSE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
lisdexamfetamine dimesylate chew tab (VYVANSE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1	ANTIHYPERTENSIVES
lithium carbonate cap (ESKALITH ER equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate tab	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LIVMARLI SOLN (QL= 90ml/30 days)	LD-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
LIVTENCITY TAB (QL= 4 tabs/day)	LD-PA-QL	MSP	ANTIVIRALS
L-METHYLFOLATE TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LOKELMA PAK	PA	2	MISCELLANEOUS THERAPEUTIC CLASSE
LONHALA MAGNAIR SOLN (Step Therapy requires trial of INCRUSE ELLIPTA INHALER)	ST	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LONSURF TAB	PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
lopinavir/ritonavir soln (KALETRA equiv)	-	2	ANTIVIRALS
lopinavir/ritonavir tab (KALETRA equiv)	-	2	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
loratadine ODT (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
loratadine syrup (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
loratadine tab (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
lorazepam conc (ATIVAN equiv)	-	1	ANTIANSIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	1	ANTIANSIETY AGENTS
LORBRENA TAB 100MG (QL= 1 tab/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
losartan tab (COZAAR equiv)	-	1	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1	ANTIHYPERTENSIVES
LOTEMAX OPHTH GEL	-	2	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	2	OPHTHALMIC AGENTS
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	2	OPHTHALMIC AGENTS
loteprednol ophth susp (LOTEMAX equiv)	-	2	OPHTHALMIC AGENTS
lovastatin tab (MEVACOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
loxapine cap (LOXITANE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
LUMAKRAS TAB (QL= 8 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMAKRAS TAB 320MG (QL= 3 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
lurasidone hcl tab (LATUDA equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LUVIRA CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LYNPARZA TAB (QL= 4 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYSODREN TAB	LD	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYTGOBI THERAPY PACK (QL= 5 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
malathion lotion (OVIDE equiv)	QL	2	DERMATOLOGICALS
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$0	MEDICAL DEVICES AND SUPPLIES
MAPROTILINE TAB	-	1	ANTIDEPRESSANTS
maraviroc tab (SELZENTRY equiv)	-	2	ANTIVIRALS
MARPLAN TAB	-	2	ANTIDEPRESSANTS
MASK	OTC	DME	MEDICAL DEVICES AND SUPPLIES
MATULANE CAP	-	2	ANTINEOPLASTICS
MAVYRET PAK (QL= 5 packs/day)	MSP-PA-QL	MSP	ANTIVIRALS
MAVYRET TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP	ANTIVIRALS
MAXIDEX OPHTH SOLN	-	2	OPHTHALMIC AGENTS
MAYZENT TAB	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAYZENT TAB STARTER PACK	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
meclizine chew tab (BONINE equiv)	OTC	1	ANTIEMETICS
meclizine tab (ANTIVERT equiv)	OTC	1	ANTIEMETICS
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	1	PROGESTINS
mefloquine tab (LARIAM equiv)	-	2	ANTIMALARIALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
megestrol susp (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 2MG (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKTOVI TAB (QL= 6 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam tab (MOBIC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
MELPHALAN TAB	-	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.
mercaptopurine tab (PURINETHOL equiv)	-	2	ANTINEOPLASTICS
mesalamine DR cap (DELZICOL equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
mesalamine DR tab (LIALDA equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (APRISO equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
mesalamine supp (CANASA equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
MESNEX TAB	MSP	MSP	ANTINEOPLASTICS
METANX CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
METAPROTERENOL SYRUP	-	1	ANTIASTHMATIC AND BRONCHODILATOR 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	ANTI-INFECTIVE AGENTS - MISC.
methenamine mandelate tab	-	1	ANTI-INFECTIVE AGENTS - MISC.
methimazole tab (TAPAZOLE equiv)	-	1	THYROID AGENTS
methocarbamol tab (ROBAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
methotrexate inj	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	1	ANTINEOPLASTICS
METHOXSALEN CAP	-	2	DERMATOLOGICALS
methoxsalen cap (OXSORALEN ULTRA equiv)	-	2	DERMATOLOGICALS
methsuximide cap (CELONTIN equiv)	-	2	ANTICONVULSANTS
METHYLDOPA TAB	-	1	ANTIHYPERTENSIVES
methylidopa tab (ALDOMET equiv)	-	1	ANTIHYPERTENSIVES
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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 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
methylphenidate tab (RITALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprednisolone dose pack (MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprenisolone sod succinate inj (SOLU-MEDROL equiv)	-	1	CORTICOSTEROIDS
METIPRANOLOL OPTH 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
METOSOLV ODT	-	EXC	GASTROINTESTINAL AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	1	DERMATOLOGICALS
metronidazole gel (METROGEL equiv)	-	2	DERMATOLOGICALS
metronidazole gel 0.75% (METROGEL equiv)	-	1	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	2	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
metronidazole vaginal gel (METROGEL equiv)	-	1	VAGINAL PRODUCTS
mexiletine hcl cap	-	2	ANTIARRHYTHMICS
midazolam hcl syrup	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
midodrine tab (PROAMATINE equiv)	-	1	VASOPRESSORS
mifepristone tab (MIFIPREX equiv)	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
MIFIPREX TAB	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
miglustat cap (ZAVESCA equiv)	LD-PA	MSP	HEMATOPOIETIC AGENTS
minocycline cap (MINOCIN equiv)	-	1	TETRACYCLINES
MINOLIRA TAB	-	EXC	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	1	ANTIHYPERTENSIVES
mirtazapine ODT (REMERON equiv)	-	1	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	1	ANTIDEPRESSANTS
MIRVASO GEL	-	EXC	DERMATOLOGICALS
misoprostol tab (CYTOTEC equiv)	-	1	ULCER DRUGS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MODERNA COVID-19 VACCINE	VAC	EXC	VACCINES
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
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
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
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
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	-	1	HEMATOPOIETIC AGENTS
MULTIGEN PLUS TAB	-	1	HEMATOPOIETIC AGENTS
MULTIGEN TAB	-	1	HEMATOPOIETIC AGENTS
MULTIVITAMIN/FLOURIDE CHEW 0.25MG	-	1	MULTIVITAMINS
MULTIVITAMIN/FLOURIDE CHEW 1MG	-	1	MULTIVITAMINS
MULTIVITAMIN/FLUORIDE CHEW TAB	-	1	MULTIVITAMINS
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
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	2	ESTROGENS
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
naloxone hcl nasal spray (NARCAN equiv)	OTC	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone inj	-	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone prefilled inj	-	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	--QL	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	1	ANTIDOTES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
NAMENDA XR TITRATION PACK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
naproxen EC tab (NAPROSYN EC equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	EXC	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
NATACYN OPHTH SUSP (QL= 15ml/fill)	QL	2	OPHTHALMIC AGENTS
nateglinide tab (STARLIX equiv)	-	2	ANTIDIABETICS
NAYZILAM SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	2	ANTICONVULSANTS
nebivolol hcl tab (BYSTOLIC equiv)	¢	2	BETA BLOCKERS
NEBUSAL NEB SOLN	-	2	COUGH/COLD/ALLERGY
NEEDLE (DISP) 18 G	-	DME	MEDICAL DEVICES AND SUPPLIES
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/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
NEPHRON FA TAB	-	2	HEMATOPOIETIC AGENTS
NERLYNX TAB (QL= 6 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NEVANAC OPHTH SUSP	-	2	OPHTHALMIC AGENTS
NEVIRAPINE ER TAB	-	2	ANTIVIRALS
nevirapine ER tab (VIRAMUNE XR equiv)	-	2	ANTIVIRALS
NEVIRAPINE SUSP	-	2	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	1	ANTIVIRALS
NEXLETOL TAB (QL= 1 tab/day)	PA-QL	2	ANTIHYPERTENSIVES
niacin cap	OTC	1	VITAMINS
niacin CR tab (SLO-NIACIN equiv)	OTC	1	VITAMINS
niacin ER tab (NIASPAN equiv)	-	1	ANTIHYPERTENSIVES
niacin tab	OTC	1	VITAMINS
NIACIN TR TAB	OTC	1	VITAMINS
niacinamide tab	OTC	1	VITAMINS
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.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
nifedipine ER tab (ADALAT CC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nilutamide tab (NILANDRON equiv)	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NINLARO CAP	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS - MISC.
NITRO-BID OINT	-	2	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap 50mg, 100mg	-	1	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
NITROGLYCERIN ER CAP	-	1	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	1	ANTIANGINAL AGENTS
NIVESTYM INJ	MSP	MSP	HEMATOPOIETIC AGENTS
NIZATIDINE CAP	-	1	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINER CS
nizatidine cap (AXID equiv)	-	1	ULCER DRUGS
NORDITROPIN INJ	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv)	-	\$0	CONTRACEPTIVES
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (NORA-QD equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	1	PROGESTINS
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	\$0	CONTRACEPTIVES
NORPACE CR CAP	-	2	ANTIARRHYTHMICS
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	\$0	CONTRACEPTIVES
nortrel tab (OVCON 35 equiv)	-	\$0	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	1	ANTIDEPRESSANTS
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1	ANTIDEPRESSANTS
NORTRIPTYLINE SOLN	-	2	ANTIDEPRESSANTS
NORVIR CAP	-	2	ANTIVIRALS
NORVIR POWDER PACK	-	2	ANTIVIRALS
NORVIR SOLN	-	2	ANTIVIRALS
NOVOFINE PEN NEEDLE	OTC	DME	MEDICAL DEVICES AND SUPPLIES
NOVOLIN 70/30 INJ	OTC	2	ANTIDIABETICS
NOVOLIN MIX FLEXPEN INJ	OTC	2	ANTIDIABETICS
NOVOLIN N FLEXPEN INJ	OTC	2	ANTIDIABETICS
NOVOLIN N INJ	OTC	2	ANTIDIABETICS
NOVOLIN R FLEXPEN INJ	OTC	2	ANTIDIABETICS
NOVOLIN R INJ	OTC	2	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	2	ANTIDIABETICS
NOVOLOG 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
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1	THYROID AGENTS
NUBEQA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NUCYNTA ER TAB (QL= 2 tabs/day; Dosage limits may apply)	QL	2	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NULYTELY SOLN (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1	LAXATIVES
NUQUIN HP GEL	-	EXC	DERMATOLOGICALS
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/triamcinolone cream	-	1	DERMATOLOGICALS
nystatin/triamcinolone oint	-	1	DERMATOLOGICALS
NYVEPRIA INJ	MSP	MSP	HEMATOPOIETIC AGENTS
OCALIVA TAB (QL= 1 tab/day)	LD-PA-QL-SF-¢	MSP	GASTROINTESTINAL AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
OCTREOTIDE INJ 100MCG	-	2	ENDOCRINE AND METABOLIC AGENTS - 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)	-	1	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	1	FLUOROQUINOLONES
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.
OLLIZAC POWDER	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
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)	OTC	1	OPHTHALMIC AGENTS
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-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)	-	1	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	1	ULCER DRUGS
OMNIPOD 5 INTRO KIT (QL= 1 kit/year)	QL	DME	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	DME	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	DME	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	DME	MEDICAL DEVICES AND SUPPLIES
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	DME	MEDICAL DEVICES AND SUPPLIES
OMNITROPE INJ	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
ondansetron ODT (ZOFRAN equiv)	-	1	ANTIEMETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
ondansetron soln (ZOFTRAN equiv)	-	1	ANTIEMETICS
ONDANSETRON TAB	-	1	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	1	ANTIEMETICS
ONETOUCH METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
ONETOUCH VERIO FLEX METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO IQ METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO REFLECT METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO TEST STRIP	OTC	DME	DIAGNOSTIC PRODUCTS
OPSUMIT TAB (QL= 1 tab/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
OPVEE NASAL SPRAY	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
ORACIT SOLN	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
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
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
ORGOVYX TAB (QL= 30 tabs/28 days)	PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	2	ESTROGENS
ORILISSA TAB 150MG (QL= 1 tab/day)	PA-QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORILISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORKAMBI GRANULES PACKET (QL= 2 packets/day)	LD-PA-QL	MSP	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day)	LD-PA-QL	MSP	RESPIRATORY AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
ORSERDU TAB (QL= 3 tabs/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORSERDU TAB 345MG (QL= 1 tab/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1	ANTIVIRALS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1	ANTIVIRALS
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	2	ANTIVIRALS
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
oxaprozin tab (DAYPRO equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	2	ANTIANKXIETY AGENTS
OXBRYTA TAB (QL= 3 tabs/day)	LD-PA-QL	MSP	HEMATOPOIETIC AGENTS
OXBRYTA TAB FOR ORAL SUSP (QL= 5 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	MSP	HEMATOPOIETIC AGENTS
oxcarbazepine susp (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
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

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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 (PERCOET equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
OXYCODONE/ASPIRIN TAB (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
OXYTROL PATCH (OTC)	OTC	1	URINARY ANTISPASMODICS
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
paliperidone ER tab (INVEGA equiv) (QL= 2 tabs/day)	QL	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PALYNZIQ INJ (QL= 1 inj/day)	LD-PA-QL-SF	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
pantoprazole EC tab (PROTONIX equiv)	-	1	ULCER DRUGS
paricalcitol cap (ZEMPLAR equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
paroxetine cap (BRISDELLE equiv)	-	EXC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
paroxetine ER tab (PAXIL CR equiv)	-	2	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	1	ANTIDEPRESSANTS
PATADAY ER OPHTH SOLN 0.7%	-	1	OPHTHALMIC AGENTS
PAXLOVID TAB (QL= 20 tabs/fill)	QL	\$0	ANTIVIRALS
PAXLOVID TAB (QL= 30 tabs/fill)	QL	\$0	ANTIVIRALS
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PEAK FLOW METER	OTC	DME	MEDICAL DEVICES AND SUPPLIES
PEDIARIX INJ	VAC	EXC	TOXOIDS
pediatric multiple vitamins/fluoride chew tab	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	1	MULTIVITAMINS
PEDVAXHIB INJ	VAC	EXC	VACCINES
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0	LAXATIVES
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year)	QL	1	LAXATIVES
peg 3350/electrolytes soln (NULYTELY equiv) (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1	LAXATIVES
PEGANONE TAB	-	2	ANTICONSULTANTS
PEGASYS INJ	MSP-PA	MSP	ANTIVIRALS
PEMAZYRE TAB (QL= 1 tab/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
penicillamine tab (DEPEN TITRATAB equiv)	-	2	MISCELLANEOUS THERAPEUTIC CLASSES
penicillin vk tab (VEETIDS equiv)	-	1	PENICILLINS
PENTACEL INJ	VAC	EXC	TOXOIDS
pentamidine neb soln (NEBUPENT equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
pentazocine/acetaminophen tab (TALACEN equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
pentoxifylline ER tab (TRENAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
pepcid chewable	-	1	ULCER DRUGS
PERINDOPRIL TAB	-	1	ANTIHYPERTENSIVES
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	1	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
perphenazine tab (TRILAFON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PHEBURANE ORAL PELLETS	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
phenazopyridine tab (PYRIDIUM equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 95mg (AZO equiv)	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 97.5mg (AZO equiv)	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 99.5mg (AZO equiv)	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
PHENELZINE SULFATE TAB	-	1	ANTIDEPRESSANTS
phenelzine tab (NARDIL equiv)	-	1	ANTIDEPRESSANTS
phenobarbital elixir	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
phenobarbital tab	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER 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
PHEXXI GEL (QL= 1 box/fill)	QL	\$0	VAGINAL AND RELATED PRODUCTS
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1	MINERALS & ELECTROLYTES
phytonadione tab (MEPHYTON equiv)	-	2	VITAMINS
PIFELTRO TAB	-	2	ANTIVIRALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older)	-	2	DERMATOLOGICALS
PIMOZIDE TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pindolol tab (VISKEN equiv)	-	1	BETA BLOCKERS
pioglitazone tab (ACTOS equiv)	-	1	ANTIDIABETICS
PIQRAY TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	MSP-PA-QL-SF	MSP	RESPIRATORY AGENTS - MISC.
piroxicam cap (FELDENE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
PLEGRIDY INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLEGRIDY PEN INJ	MSP	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PODIAPN CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
PODOCON SOLN	-	2	DERMATOLOGICALS
PODOFILOX SOLN	-	2	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	2	DERMATOLOGICALS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1	OPHTHALMIC AGENTS
POMALYST CAP (QL= 21 caps/28 days)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
POT/CHLORIDE EFFER TAB	-	1	MINERALS & ELECTROLYTES
POTABA POWDER PACKET	-	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 (K-TAB 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 CHLORIDE TAB ER	-	1	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
potassium iodide oral soln (SSKI equiv)	-	2	COUGH/COLD/ALLERGY
potassium phosphate monobasic tab (K-PHOS equiv)	-	2	MINERALS & ELECTROLYTES
POTIGA TAB (QL= 3 tabs/day)	QL	2	ANTICONVULSANTS
PRAMASONE OINT	-	2	DERMATOLOGICALS
pramipexole tab (MIRAPEX equiv)	-	1	ANTIPARKINSON AGENTS
PRAMOSONE CREAM 1-1%	-	2	DERMATOLOGICALS
PRAMOSONE E CREAM	-	2	DERMATOLOGICALS
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1	ANORECTAL AGENTS
PRASCION RA CREAM	-	2	DERMATOLOGICALS
prasugrel tab (EFFIENT equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
pravastatin tab (PRAVACHOL equiv)	-	\$0	ANTIHYPERLIPIDEMICS
praziquantel tab (BILTRICIDE equiv)	-	2	ANTHELMINTICS
prazosin cap (MINIPRESS equiv)	-	1	ANTIHYPERTENSIVES
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 OIN	-	2	DERMATOLOGICALS
PREDNISOLONE OPHTH SUSP	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
prednisolone soln	-	1	CORTICOSTEROIDS
prednisolone soln (PEDIAPRED equiv)	-	1	CORTICOSTEROIDS
PREDNISON SOLN	-	2	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	1	CORTICOSTEROIDS
pregabalin 25mg, 50mg, 75mg, 100mg (LYRICA equiv) (QL= 5 caps/day)	QL	1	ANTICONVULSANTS
pregabalin cap 150mg (LYRICA equiv) (QL= 4 caps/day)	QL	1	ANTICONVULSANTS
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	1	ANTICONVULSANTS
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	1	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	2	ANTICONVULSANTS
PREHEVBRIO SUSP	VAC	EXC	VACCINES
PREMARIN TAB	-	2	ESTROGENS
PREMARIN VAGINAL CREAM	-	2	VAGINAL PRODUCTS
PREMPHASE TAB, PREMPRO TAB	-	2	ESTROGENS
PRENATAL 19 CHEW TAB	-	1	MULTIVITAMINS
PRENATAL VITAMIN (RX ONLY)	-	1	VITAMINS
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	2	ANTIMYCOBACTERIAL AGENTS
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
PREVIDENT SOLN	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVNAR 20 INJ	VAC	EXC	VACCINES
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	MSP-PA-QL	MSP	ANTIVIRALS
PREZCOBIX TAB	-	2	ANTIVIRALS
PREZISTA SUSP	-	2	ANTIVIRALS
PREZISTA TAB	-	2	ANTIVIRALS
PRIFTIN TAB	-	2	ANTIMYCOBACTERIAL AGENTS
primaquine tab (PRIMAQUINE equiv)	-	1	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	1	ANTICONVULSANTS
PRIORIX INJ	VAC	EXC	VACCINES
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
progesterone cap (PROMETRIUM equiv)	-	1	PROGESTINS
progesterone oil inj	-	1	PROGESTINS
PROLENSA OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PROMACTA POWDER	MSP-PA	MSP	HEMATOPOIETIC AGENTS
PROMACTA TAB	MSP-PA	MSP	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	1	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
PROMETHEGAN SUPP	-	2	ANTIHISTAMINES
propafenone ER cap (RYTHMOL SR equiv)	-	2	ANTIARRHYTHMICS
propafenone tab (RYTHMOL equiv)	-	1	ANTIARRHYTHMICS
PROPANTHELINE TAB	-	2	ULCER DRUGS
proparacaine ophth soln (ALCAINE equiv)	-	1	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	1	BETA BLOCKERS
propranolol oral soln 20mg/5ml (PROPRANOLOL equiv)	-	1	BETA BLOCKERS
PROPRANOLOL SOLN	-	1	BETA BLOCKERS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
propylthiouracil tab	-	1	THYROID AGENTS
PULMOZYME INH SOLN	MSP-PA	MSP	RESPIRATORY AGENTS - MISC.
pyrazinamide tab	-	1	ANTIMYCOBACTERIAL AGENTS
pyridostigmine CR tab (MESTINON equiv)	-	2	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	1	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day)	LD-PA-QL	MSP	ANTIMALARIALS
PYRUKYND TAB (QL= 2 tabs/day)	LD-PA-QL	MSP	HEMATOLOGICAL AGENTS - MISC.
PYRUKYND TAPER PACK (QL= 1 tab/day)	LD-PA-QL	MSP	HEMATOLOGICAL AGENTS - MISC.
QINLOCK TAB (QL= 3 tabs/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
QSYMIA CAP	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
quetiapine tab (SEROQUEL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
quinapril tab (ACCUPRIL equiv)	-	1	ANTIHYPERTENSIVES
QUINAPRIL/HCTZ TAB	-	1	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	2	ANTIARRHYTHMICS
quinidine sulfate tab	-	1	ANTIARRHYTHMICS
RABAVERT INJ	VAC	EXC	VACCINES
rabeprazole EC tab (ACIPHEX equiv)	-	1	ULCER DRUGS
RADICAVA ORS STARTER KIT (QL= 70ml/365 days)	LD-PA-QL	MSP	NEUROMUSCULAR AGENTS
RADICAVA ORS SUSP (QL= 50mL/28 days)	LD-PA-QL	MSP	NEUROMUSCULAR AGENTS
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	QL	2	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ramipril cap (ALTACE equiv)	-	1	ANTIHYPERTENSIVES
ranolazine tab (RANEXA equiv)	-	2	ANTIANGINAL AGENTS
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
RELYVRIO PAK (QL= 2 packets/day)	LD-PA-QL	MSP	NEUROMUSCULAR AGENTS
renaphro cap (NEPHROCAP equiv)	-	1	MULTIVITAMINS
RENOVA CREAM	-	EXC	DERMATOLOGICALS
repaglinide tab (PRANDIN equiv)	-	1	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2	ANTIHYPERLIPIDEMICS
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2	ANTIHYPERLIPIDEMICS
RESCRIPTOR TAB	-	2	ANTIVIRALS
RETACRIT INJ	MSP	MSP	HEMATOPOIETIC AGENTS
RETEVMO CAP (QL= 4 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REVLIMID CAP (QL= 1 cap/day)	PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSE!
REYATAZ POWDER PACK	-	2	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	2	MIGRAINE PRODUCTS
REZLIDHIA CAP (QL= 2 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REZUROCK TAB (QL= 1 tab/day)	LD-PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSES
RHOFADE CREAM	-	EXC	DERMATOLOGICALS
RHOPRESSA OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ribavirin cap (REBETOL equiv)	-	2	ANTIVIRALS
RIBAVIRIN CAP	--MSP	MSP	ANTIVIRALS
RIBAVIRIN TAB	-	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
RINVOQ ER TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
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
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
ROCKLATAN OPHTH SOLN	-	2	OPHTHALMIC AGENTS
roflumilast tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ropinirole ER tab (REQUIP XL equiv)	-	2	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	1	ANTIPARKINSON AGENTS
rosuvastatin tab (CRESTOR equiv)	-	\$0	ANTIHYPERTENSIVES
ROTARIX SUSP	VAC	EXC	VACCINES
ROTATEQ INJ	VAC	EXC	VACCINES
ROZLYTREK CAP (QL= 3 caps/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUBRACA TAB (QL= 4 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUCONEST INJ	LD-PA	MSP	HEMATOLOGICAL AGENTS - MISC.
rufinamide susp (BANZEL equiv)	PA	2	ANTICONSULTANTS
rufinamide tab (BANZEL TAB equiv)	PA	2	ANTICONSULTANTS
RUKOBIA ER TAB	PA	2	ANTIVIRALS
RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
RYDAPT CAP (QL= 56 caps/28 days)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
salicylic acid shampoo (SALEX equiv)	-	2	DERMATOLOGICALS
salsalate tab (DISALCID equiv)	-	2	ANALGESICS - NONNARCOTIC

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
SANDIMMUNE SOLN 100MG/ML (QL= 150 mL/30 days)	QL	2	ASSORTED CLASSES
SANTYL OINT (QL= 90gm/30 days)	QL	2	DERMATOLOGICALS
sapropterin dihydrochloride powder packet (KUVAN equiv)	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
sapropterin dihydrochloride soluble tab (KUVAN equiv)	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
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	2	ANTIEMETICS
SECONAL CAP	-	2	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
selegiline cap (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selenium sulfide lotion	OTC	1	DERMATOLOGICALS
selenium sulfide lotion 2.5% (SELSUN equiv)	-	1	DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	2	DERMATOLOGICALS
SELZENTRY SOLN	-	2	ANTIVIRALS
SELZENTRY TAB	-	2	ANTIVIRALS
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	2	ANTIDIABETICS
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	2	ANTIDIABETICS
SEREVENT DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
sertraline conc (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sevelamer powder pak (REVELA equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (REVELA TAB equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
SHINGRIX INJ	VAC	EXC	VACCINES
SIGNIFOR INJ (QL= 2 vials/day)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
sildenafil susp (REVATIO equiv) (Members age 9 or older require Prior Authorization)	PA	2	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab (VIAGRA equiv) (QL=8 tabs/30 days)	QL	1	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab 20mg (REVATIO equiv) (QL= 40 tabs/30 days)	QL	1	CARDIOVASCULAR AGENTS - MISC.
silodosin cap (RAPAFLO equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1	DERMATOLOGICALS
SIMBRINZA OPHTH SUSP	-	2	OPHTHALMIC AGENTS
SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 100MG (QL=1 inj/28 days)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0	ANTIHYPERTENSIVES
sirolimus soln (RAPAMUNE equiv)	-	2	MISCELLANEOUS THERAPEUTIC CLASSES
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.
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	MSP-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	MSP-PA-QL	MSP	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 75MG/0.83ML (QL= 2 inj/84 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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 paste (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride rinse (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
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 OXYBATE SOLN	LD-PA	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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 lotion (KLARON equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	2	DERMATOLOGICALS
sodium/magnesium/potassium soln (SUPREP equiv) (QL= 2 fills/calendar year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0	LAXATIVES
SOFOBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTIVIRALS
solifenacin tab (VESICARE equiv)	-	1	URINARY ANTISPASMODICS
SOLIQUA INJ (QL= 15ml/25 days)	QL	2	ANTIDIABETICS
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	2	CORTICOSTEROIDS
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	2	CORTICOSTEROIDS
SOLU-MEDROL INJ 2GM	-	2	CORTICOSTEROIDS
SOMAVERT INJ	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
sorafenib tosylate tab (NEXAVAR equiv)	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
sotalol AF tab (BETAPACE AF equiv)	-	1	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	1	BETA BLOCKERS
SPACER MASK	OTC	DME	MEDICAL DEVICES AND SUPPLIES
SPIKEVAX COVID-19 VACCINE	VAC	EXC	VACCINES
SPIKEVAX INJ 50MCG/0.5ML	VAC	EXC	VACCINES
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/MILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL))	QL-ST	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone tab (ALDACTONE equiv)	-	1	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1	DIURETICS
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	\$0	CONTRACEPTIVES
SPRYCEL TAB	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SPS SUSP	-	1	MISCELLANEOUS THERAPEUTIC CLASSES
STAVUDINE CAP	-	2	ANTIVIRALS
stavudine cap (ZERIT equiv)	-	2	ANTIVIRALS
STELARA INJ (QL= 1 inj/84 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
STIMATE NASAL SOLN	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
STIOLTO INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
STRENSIQ INJ	LD-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIBILD TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
sucrafate susp (CARAFATE equiv)	-	2	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFICS
sucrafate 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
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	2	DERMATOLOGICALS
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 (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
sunitinib malate cap (SUTENT equiv)	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SUNOSI TAB (QL= 1 tab/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
SYMBICORT INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SYMDEKO TAB (QL= 2 tabs/day)	LD-PA-QL	MSP	RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	EXC	ANTIVIRALS
SYMJEPI INJ (QL= 2 inj/fill)	QL	2	VASOPRESSORS
SYMPROIC TAB	PA	2	GASTROINTESTINAL AGENTS - MISC.
SYM TUZA TAB	-	2	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
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	-	EXC	THYROID AGENTS
SYRINGE (DISPOSABLE) 3 ML	-	DME	MEDICAL DEVICES AND SUPPLIES
SYRINGE LUER-LOK	OTC	DME	MEDICAL DEVICES AND SUPPLIES
TABLOID TAB	-	2	ANTINEOPLASTICS
TABRECTA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tacrolimus cap (PROGRAF equiv)	-	1	ASSORTED CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	1	DERMATOLOGICALS
tadalafil tab (CIALIS equiv) (QL= 8 tabs/30 days)	QL	1	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab (PAH) (ADCIRCA equiv) (QL= 2 tabs/day)	MSP-QL	1	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day)	QL	1	CARDIOVASCULAR AGENTS - MISC.
TADLIQ SUSP (Members age 9 years or older require Prior Authorization)	MSP-PA	MSP	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP (QL= 4 caps/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAGRISSE TAB (QL= 1 tab/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAKHZYRO INJ (QL= 2 inj/28 days)	LD-PA-QL	MSP	HEMATOLOGICAL AGENTS - MISC.
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days)	LD-PA-QL	MSP	HEMATOLOGICAL AGENTS - MISC.
TALTZ INJ (QL= 1 inj/28 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day)	MSP-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
TASIGNA CAP	MSP-PA-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tavorole soln (KERYDIN equiv)	-	EXC	DERMATOLOGICALS
TAVALISSE TAB (QL= 2 tabs/day)	LD-PA-QL-SF	MSP	HEMATOLOGICAL AGENTS - MISC.
TAVNEOS CAP (QL= 6 caps/day)	LD-PA-QL	MSP	HEMATOLOGICAL AGENTS - MISC.
tazarotene cream 0.1% (TAZORAC equiv)	-	2	DERMATOLOGICALS
TAZVERIK TAB (QL= 8 tabs/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TB SYRINGE	OTC	DME	MEDICAL DEVICES AND SUPPLIES
telmisartan tab (MICARDIS equiv)	-	1	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
temozolomide cap (TEMODAR equiv)	MSP	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	2	ANTIVIRALS
TEPMETKO TAB (QL= 2 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

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

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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
terazosin cap (HYTRIN equiv)	-	1	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv)	-	1	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
TERCONAZOLE CREAM 0.8%	-	1	VAGINAL PRODUCTS
terconazole supp (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
teriflunomide tab (AUBAGIO equiv)	MSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TEST STRIP (all other test strips)	OTC-PA	DME	DIAGNOSTIC PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1	ANDROGENS-ANABOLIC
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	2	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 (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 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	1	ANDROGENS-ANABOLIC
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
tetrabenazine tab (XENAZINE equiv)	MSP-PA	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
THALOMID CAP	MSP-PA	MSP	ASSORTED CLASSES
theophylline ER tab (UNIPHYL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline er tab (THEOPHYLLINE ER equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THEOPHYLLINE TAB ER	-	2	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
TIBSOVO TAB (QL= 2 tabs/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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
tinidazole tab (TINDAMAX equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
tiopronin tab (THIOLA equiv)	MSP-PA	MSP	GENITOURINARY AGENTS - MISCELLANEOUS
TIVICAY PD TAB	-	2	ANTIVIRALS
TIVICAY TAB	-	2	ANTIVIRALS
tizanidine tab (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER	LD-PA	MSP	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	2	OPHTHALMIC AGENTS
tobramycin neb soln (TOBI equiv)	MSP-PA	MSP	AMINOGLYCOSIDES
tobramycin ophth soln (TOBREX equiv)	-	1	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1	OPHTHALMIC AGENTS
TOBEX OPHTH OINT	-	2	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	\$0	VAGINAL PRODUCTS
TOLAZAMIDE TAB	-	1	ANTIDIABETICS
TOLBUTAMIDE TAB	-	2	ANTIDIABETICS
tolterodine SR cap (DETROL LA equiv)	-	2	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	1	URINARY ANTISPASMODICS
topiramate sprinkle cap (TOPAMAX equiv)	-	1	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	1	ANTICONVULSANTS
toremifene tab (FARESTON equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
torseamide tab (DEMADEX equiv)	-	1	DIURETICS
TOUJEO MAX SOLOSTAR INJ	-	2	ANTIDIABETICS
TOUJEO SOLOSTAR INJ	-	2	ANTIDIABETICS
TRACLEER TAB 32MG (QL= 4 tabs/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
TRADJENTA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
tramadol tab (ULTRAM equiv) (Dosage limits may apply)	-	1	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv)	-	1	ANALGESICS - OPIOID
trandolapril tab (MAVIK equiv)	-	1	ANTIHYPERTENSIVES
tranexamic acid tab (LYSTEDA equiv)	-	2	HEMOSTATICS
tranylcypromine tab (PARNATE equiv)	-	2	ANTIDEPRESSANTS
travoprost ophth soln (TRAVATAN Z equiv) (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	1	ANTIDEPRESSANTS
TRELEGY ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TREMFYA INJ (QL= 1 inj/56 days)	MSP-PA-QL	MSP	DERMATOLOGICALS
TRESIBA FLEXTOUCH INJ	-	2	ANTIDIABETICS
TRESIBA INJ	-	2	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	MSP	MSP	ANTINEOPLASTICS
tretinoin cream	-	2	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv)	-	2	DERMATOLOGICALS
triamcinolone acetonide inj (KENALOG equiv)	-	1	CORTICOSTEROIDS
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)	-	2	DERMATOLOGICALS
triamterene cap (DYRENIUM equiv)	-	2	DIURETICS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1	DIURETICS
triazolam tab (HALCION equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
tricitrates soln (POLYCITRA-LC equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
tricon cap (TRINICON equiv)	-	1	HEMATOPOIETIC AGENTS
trientine cap (SYPRINE equiv)	MSP-PA	MSP	MISCELLANEOUS THERAPEUTIC CLASSES
trifluoperazine tab (STELAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
TRIFLURIDINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
trihexyphenidyl elixir (ARTANE equiv)	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
TRIHEXYPHENIDYL SOLN	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	2	ANTIDIABETICS
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
TRIKAFTA TAB (QL= 84 tabs/28 days)	PA-QL	MSP	RESPIRATORY AGENTS - MISC.
TRIKAFTA THERAPY PACK	LD-PA-QL	MSP	RESPIRATORY AGENTS - MISC.
tri-legest tab (ESTROSTEP FE equiv)	-	\$0	CONTRACEPTIVES
TRI-LUMA CREAM	-	EXC	DERMATOLOGICALS
trimethobenzamide cap (TIGAN equiv)	-	1	ANTIEMETICS
TRIMETHOPRIM TAB	-	1	ANTI-INFECTIVE AGENTS - MISC.
trimethoprim tab (PROLOPRIM equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0	CONTRACEPTIVES
TRIUMEQ PD TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
TRIUMEQ TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
TRIZIVIR TAB	-	2	ANTIVIRALS
tropicamide ophth soln (MYDRIACYL equiv)	-	1	OPHTHALMIC AGENTS
tropium chloride SR cap (SANCTURA XR equiv)	-	2	URINARY ANTISPASMODICS
tropium tab (SANCTURA equiv)	-	1	URINARY ANTISPASMODICS
TRULANCE TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
TUKYSA TAB (QL= 4 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TURALIO CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYBLUME TAB	-	\$0	CONTRACEPTIVES
TYMLOS INJ	MSP-PA	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYVASO DPI POWDER (QL= 4 cartridges/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/2 days)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
TYVASO INH SOLN (QL= 1 ampule/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	2	MIGRAINE PRODUCTS
UPTRAVI TAB (QL= 2 tabs/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
urea cream ()	-	1	DERMATOLOGICALS
urea lotion (KERALAC LOTION equiv)	-	1	DERMATOLOGICALS
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)	LD-PA-QL	MSP	DERMATOLOGICALS
valganciclovir soln (VALCYTE equiv)	-	2	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	2	ANTIVIRALS
valproic acid cap (DEPAKENE equiv)	-	1	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
valproic acid syrup (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valsartan tab (DIOVAN equiv)	-	1	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1	ANTIHYPERTENSIVES
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	1	ANTI-INFECTIVE AGENTS - MISC.
VANIQA CREAM	-	EXC	DERMATOLOGICALS
varденаfil tab (LEVITRA equiv)	-	EXC	CARDIOVASCULAR AGENTS - MISC.
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab (VARENICLINE equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
vasoalex oint (XENADERM equiv)	-	2	DERMATOLOGICALS
VAXNEUVANCE INJ	VAC	EXC	VACCINES
VELIVET PAK	-	\$0	CONTRACEPTIVES
velivet tab (CYCLESSA equiv)	-	\$0	CONTRACEPTIVES
VELTASSA POWDER	PA	2	ASSORTED CLASSES
VEMLIDY TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
VENCLEXTA STARTER PACK	MSP-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB	MSP-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)	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	1	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
verapamil SR cap (VERELAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VERAPAMIL SR CAP 360mg	-	1	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist)	QL-RS	2	CARDIOVASCULAR AGENTS - MISC.
VERZENIO TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
V-GO INJ KIT (QL= 1 kit/day)	QL	DME	MEDICAL DEVICES AND SUPPLIES
VICTOZA INJ (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
VIDEX SOLN	-	2	ANTIVIRALS
vienna tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0	CONTRACEPTIVES
vigabatrin powder pack (SABRIL POWDER equiv)	LD-PA	MSP	ANTICONVULSANTS
vigabatrin tab (SABRIL equiv)	LD-PA	MSP	ANTICONVULSANTS
vigadrone powder pack	LD-PA	MSP	ANTICONVULSANTS
VIJOICE TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSES
VIJOICE TAB 250MG (QL= 2 tabs/day)	MSP-PA-QL	MSP	MISCELLANEOUS THERAPEUTIC CLASSES
vilazodone hcl tab (VIIBRYD equiv) (QL= 1 tab/day; Step Therapy requires a trial of 1 of the following: citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine, or paroxetine)	QL-ST	2	ANTIDEPRESSANTS
VIMOVO TAB	-	EXC	ANALGESICS - ANTI-INFLAMMATORY
viorele tab, kariva tab (MIRCETTE equiv)	-	\$0	CONTRACEPTIVES
VIRACEPT TAB	-	2	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
VIREAD TAB	-	2	ANTIVIRALS
vitamin D cap (RX strength only)	-	1	VITAMINS
VITRAKVI CAP 100MG (QL= 2 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI CAP 25MG (QL= 6 caps/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI SOLN (QL= 10ml/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2	VACCINES
VIZIMPRO TAB (QL= 1 tab/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VONJO CAP (QL= 4 caps/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
voriconazole tab (VFEND equiv)	-	2	ANTIFUNGALS
VOSEVI TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANTIVIRALS
VOTRIENT TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VOXZOGO INJ (QL= 1 vial/day)	LD-PA-QL	MSP	ENDOCRINE AND METABOLIC AGENTS - MISC.
VYNDAMAX CAP (QL= 1 cap/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
VYNDAQEL CAP (QL= 4 caps/day)	LD-PA-QL	MSP	CARDIOVASCULAR AGENTS - MISC.
warfarin tab (COUMADIN equiv)	-	1	ANTICOAGULANTS
WEGOVY INJ	EXC	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
WEGOVY INJ 1.7MG/0.75ML	EXC	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
WEGOVY INJ 2.4MG/0.75ML	EXC	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
WELIREG TAB (QL= 3 tabs/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XACIATO GEL (QL= 1 applicator/fill)	QL	2	VAGINAL AND RELATED PRODUCTS
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XAQUIL XR TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
XARELTO STARTER PACK	-	2	ANTICOAGULANTS
XARELTO SUSP	-	2	ANTICOAGULANTS
XARELTO TAB	-	2	ANTICOAGULANTS
XCOPRI PAK 100-150MG (QL= 2 tabs/day)	QL	2	ANTICONVULSANTS
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	2	ANTICONVULSANTS
XCOPRI PAK 50-200MG (QL= 2 tabs/day)	QL	2	ANTICONVULSANTS
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day)	QL	2	ANTICONVULSANTS
XCOPRI TAB 50MG, 100MG (QL= 1 tab/day)	QL	2	ANTICONVULSANTS
XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day)	QL	2	ANTICONVULSANTS
XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day)	QL	2	ANTICONVULSANTS
XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day)	QL	2	ANTICONVULSANTS
XELJANZ SOLN (QL= 10ml/day)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ XR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP	ANALGESICS - ANTI-INFLAMMATORY
XENADERM OINT	-	2	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist)	QL-RS	2	ANTI-INFECTIVE AGENTS - MISC.
XERESE CREAM	-	EXC	DERMATOLOGICALS
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
XOSPATA TAB (QL= 3 tabs/day)	LD-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XPOVIO PAK (QL= 32 tabs/28 days)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTAMPZA ER CAP (QL= 120 caps/30 days; Dosage limits may apply)	QL	2	ANALGESICS - OPIOID
XULTOPHY INJ (QL= 15ml/30 days)	QL	2	ANTIDIABETICS
XYZBAC TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
zafemy patch (XULANE equiv)	-	\$0	CONTRACEPTIVES
zafirlukast tab (ACCOLATE equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv) (QL= 2 caps/day)	QL	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ZARXIO INJ	MSP	MSP	HEMATOPOIETIC AGENTS
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
ZEJULA CAP (QL= 3 caps/day)	PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEJULA TAB (QL= 1 tab/day)	LD-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELBORAF TAB (QL= 8 tabs/day)	MSP-PA-QL	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEPOSIA CAP (QL= 1 cap/day)	MSP-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZEPOSIA STARTER PACK (QL= 1 cap/day)	MSP-PA-QL	MSP	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
zidovudine cap (RETROVIR equiv)	-	2	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	2	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	2	ANTIVIRALS
ZIMHI SOLN	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
ziprasidone cap (GEODON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZIRGAN OPHTH GEL	-	2	OPHTHALMIC AGENTS
ZOLINZA CAP	MSP-PA-SF	MSP	ANTINEOPLASTICS
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) (QL= 1 tab/day)	QL	2	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
zolpidem tab (AMBIEN equiv)	-	1	HYPNOTICS
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ZOLPIDEM TARTRATE SL TAB 1.75MG	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ZOLPIDEM TARTRATE SL TAB 3.5MG	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ZOLPIMIST SPRAY	-	EXC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
zonisamide cap (ZONEGRAN equiv)	-	1	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

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

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 3-Tier Complete Formulary Cont.
Alphabetical Index
Last Updated 11/1/2023

Drug Name	Special Code	Tier	Category
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	2	HEMATOLOGICAL AGENTS - MISC.
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	2	DERMATOLOGICALS
ZTALMY SUSP (QL= 1100ml/30 days)	LD-PA-QL	MSP	ANTICONVULSANTS
ZUBSOLV SL TAB	-	2	ANALGESICS - OPIOID
ZUPLENZ SL FILM	-	EXC	ANTIEMETICS
ZYCLARA CREAM	-	EXC	DERMATOLOGICALS
ZYDELIG TAB	LD-PA	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYKADIA CAP (QL= 3 caps/day)	MSP-PA-QL-SF	MSP	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYKADIA TAB (QL= 3 tabs/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	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	1
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1
dextroamphetamine tab (DEXEDRINE equiv)	-	1
lisdexamfetamine dimesylate cap (VYVANSE equiv)	-	1
lisdexamfetamine dimesylate chew tab (VYVANSE equiv)	-	1
ADDERALL XR CAP (QL= 2 caps/day)	QL	2
dextroamphetamine ER cap (DEXEDRINE equiv)	-	2
ANALECTICS		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	2
ANOREXIANTS NON-AMPHETAMINE		
phentermine cap (ADIPEX equiv)	-	EXC
phentermine tab (ADIPEX equiv)	-	EXC
QSYMIA CAP	-	EXC
ANTI-OBESITY AGENTS		
WEGOVY INJ	EXC	EXC
WEGOVY INJ 1.7MG/0.75ML	EXC	EXC
WEGOVY INJ 2.4MG/0.75ML	EXC	EXC
IMCIVREE INJ (QL= 1 inj/day)	LD-PA-QL	MSP
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine cap (STRATTERA equiv)	-	1
guanfacine ER tab (INTUNIV equiv)	-	1
clonidine ER tab (KAPVAY equiv)	-	2
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB (QL= 1 tab/day)	PA-QL	2
STIMULANTS - MISC.		
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	QL	1
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
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	QL	1
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	2
methylphenidate ER cap (RITALIN LA equiv)	-	2
METHYLPHENIDATE ER TAB	-	2
methylphenidate ER tab (CONCERTA equiv)	-	2
methylphenidate soln (METHYLIN equiv)	-	2
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
neomycin tab	-	1
ARIKAYCE SUSP (QL= 1 vial/day)	LD-PA-QL	MSP
TOBI PODHALER	LD-PA	MSP
tobramycin neb soln (TOBI equiv)	MSP-PA	MSP
ANALGESICS - ANTI-INFLAMMATORY		

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ANTIRHEUMATIC - ENZYME INHIBITORS		
OLUMIANT TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
RINVOQ ER TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
XELJANZ SOLN (QL= 10ml/day)	MSP-PA-QL	MSP
XELJANZ TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP
XELJANZ XR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMUMAB-ADAZ INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
ADALIMUMAB-ADAZ PFS INJ (QL= 2 inj/28 days;)	MSP-PA-QL	MSP
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (QL= 2 inj/28 days)	MSP-PA-QL	MSP
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP
HADLIMA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP
HADLIMA PUSH INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	MSP
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 80MG (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 PEDIATRIC UC 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
SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days)	MSP-PA-QL	MSP
SIMPONI INJ 100MG (QL=1 inj/28 days)	MSP-PA-QL	MSP
GOLD COMPOUNDS		
RIDAURA CAP	-	2
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (QL= 1 inj/day)	LD-PA-QL	MSP
INTERLEUKIN-6 RECEPTOR INHIBITORS		
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
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap (CELEBREX equiv)	-	1
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	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	generic = small letters	LD	BRANDS = CAPITAL LETTERS Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	INF	PA	Prior Authorization
QL	Quantity Limit	OTC	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	RDX	ST	Step Therapy
VAC	Vaccine Program	SMKG		
		¢		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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ibuprofen tab	-	1
ibuprofen tab (RX only)	-	1
indomethacin cap (INDOCIN equiv)	-	1
indomethacin CR cap (INDOCIN SR equiv)	-	1
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	1
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	1
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	1
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1
meloxicam tab (MOBIC equiv)	-	1
nabumetone tab (RELAFEN equiv)	-	1
naproxen tab (NAPROSYN equiv)	-	1
piroxicam cap (FELDENE equiv)	-	1
sulindac tab (CLINORIL equiv)	-	1
naproxen EC tab (NAPROSYN EC equiv)	-	2
naproxen sodium tab (ANAPROX equiv)	-	2
oxaprozin tab (DAYPRO equiv)	-	2
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	EXC
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 81mg (Covered for females (no age restriction))	OTC	\$0
aspirin ec tab 81mg (Covered for females (no age restriction))	OTC	\$0
diflunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	2

ANALGESICS - OPIOID

OPIOID AGONISTS

CODEINE SULFATE TAB (Dosage limits may apply)	-	1
hydromorphone tab (DILAUDID equiv) (Dosage limits may apply)	-	1
METHADONE SOLN (Dosage limits may apply)	-	1
methadone tab (DOLOPHINE equiv) (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.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
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
hydrocodone bitartrate ER cap (ZOHYDRO equiv) (QL= 2 caps/day)	QL	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

OPIOID COMBINATIONS

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 (Dosage limits may apply)	-	1
pentazocine/acetaminophen tab (TALACEN equiv) (Dosage limits may apply)	-	1
tramadol/acetaminophen tab (ULTRACET equiv)	-	1
OXYCODONE/ACETAMINOPHEN SOLN (Dosage limits may apply)	-	2

OPIOID PARTIAL AGONISTS

buprenorphine SL tab (SUBUTEX equiv)	-	1
buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv)	-	1
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days; Dosage limits may apply)	QL	2
ZUBSOLV SL TAB	-	2

ANDROGENS-ANABOLIC

ANDROGENS

testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	1
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2
danazol cap (DANOCRINE equiv)	-	2
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	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 (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 PUMP (QL= 4 bottles/30 days)	PA-QL	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.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	2
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
hydrocortisone enema (CORTENEMA equiv)	-	2
RECTAL COMBINATIONS		
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	2
PROCTOFOAM HC FOAM	-	2
RECTAL LOCAL ANESTHETICS		
lidocaine rectal cream	OTC	1
RECTAL STEROIDS		
proctosol HC cream (ANUSOL HC equiv)	-	1
hydrocortisone supp (ANUSOL HC equiv)	-	2
ANTHELMINTICS		
ANTHELMINTICS		
albendazole tab (ALBENZA equiv)	-	2
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	2
ivermectin tab (STROMECTOL equiv)	-	2
praziquantel tab (BILTRICIDE equiv)	-	2
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
ranolazine tab (RANEXA equiv)	-	2
NITRATES		
isosorbide dinitrate SL tab	-	1
isosorbide dinitrate tab (ISORDIL equiv)	-	1
isosorbide mononitrate ER tab (IMDUR equiv)	-	1
ISOSORBIDE MONONITRATE TAB	-	1
isosorbide mononitrate tab (MONOKET equiv)	-	1
NITROGLYCERIN ER CAP	-	1
nitroglycerin patch (NITRO-DUR equiv)	-	1
nitroglycerin SL tab (NITROSTAT equiv)	-	1
NITRO-BID OINT	-	2
ANTIANKXIETY AGENTS		
ANTIANKXIETY AGENTS - MISC.		
bupirone tab (BUSPAR equiv)	-	1
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
hydroxyzine syrup (ATARAX equiv)	-	1
hydroxyzine tab (ATARAX equiv)	-	1
BENZODIAZEPINES		
alprazolam tab (XANAX equiv)	-	1
chlordiazepoxide cap (LIBRIUM equiv)	-	1
diazepam conc (VALIUM equiv)	-	1
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	1
diazepam tab (VALIUM 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

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

ANTIANKXIETY AGENTS Cont.

lorazepam conc (ATIVAN equiv)	-	1
lorazepam tab (ATIVAN equiv)	-	1
alprazolam ER tab (XANAX XR equiv)	-	2
oxazepam cap (SERAX equiv)	-	2

ANTIARRHYTHMICS

ANTIARRHYTHMICS TYPE I-A

disopyramide cap (NORPACE equiv)	-	1
quinidine sulfate tab	-	1
disopyramide ER cap (NORPACE CR equiv)	-	2
NORPACE CR CAP	-	2
quinidine gluconate CR tab	-	2

ANTIARRHYTHMICS TYPE I-B

mexiletine hcl cap	-	2
--------------------	---	---

ANTIARRHYTHMICS TYPE I-C

flecainide tab (TAMBOCOR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1
propafenone ER cap (RYTHMOL SR equiv)	-	2

ANTIARRHYTHMICS TYPE III

amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	2
MULTAQ TAB	-	2

ANTIASTHMATIC AND BRONCHODILATOR AGENTS

BRONCHODILATORS - ANTICHOLINERGICS

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 (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL))	QL-ST	2

LEUKOTRIENE MODULATORS

montelukast chew tab (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
montelukast granule pack (SINGULAIR equiv)	-	2
zafirlukast tab (ACCOLATE equiv)	-	2

SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS

roflumilast tab	-	1
-----------------	---	---

STEROID INHALANTS

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

SYMPATHOMIMETICS

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
albuterol neb soln	-	1
ALBUTEROL NEBULIZER SOLN	-	1
albuterol sulfate syrup	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
FLUTICASONE/SALMETEROL INHALER (AIRDUO equiv)	-	1
METAPROTERENOL SYRUP	-	1
VENTOLIN HFA INHALER (QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler)	QL	1
ADVAIR DISKUS INHALER	-	2
ADVAIR HFA INHALER	-	2
albuterol sulfate tab	-	2
ALBUTEROL TAB ER	-	2
ANORO ELLIPTA INHALER	-	2
arformoterol tartrate neb soln (BROVANA equiv)	-	2
BREO ELLIPTA INHALER	-	2
BREZTRI AEROSPHERE INHALER	-	2
COMBIVENT RESPIMAT INHALER	-	2
DULERA INHALER	-	2
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler)	QL	2
levalbuterol neb soln (XOPENEX equiv)	-	2
SEREVENT DISKUS INHALER	-	2
STIOLTO INHALER	-	2
SYMBICORT INHALER	-	2
terbutaline sulfate tab (BRETHINE equiv)	-	2
TRELEGY ELLIPTA INHALER	-	2
XANTHINES		
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
ELIXOPHYLLIN ELIXIR	-	2
theophylline er tab (THEOPHYLLINE ER equiv)	-	2
THEOPHYLLINE TAB ER	-	2
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	1
DIRECT FACTOR XA INHIBITORS		
ELIQUIS TAB, ELIQUIS STARTER PACK	-	2
XARELTO STARTER PACK	-	2
XARELTO SUSP	-	2
XARELTO TAB	-	2
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin inj (LOVENOX equiv)	-	2
fondaparinux inj (ARIXTRA equiv)	-	2
FRAGMIN INJ	-	2
THROMBIN INHIBITORS		
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	2
ANTICONVULSANTS		

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	generic = small letters	LD	BRANDS = CAPITAL LETTERS
MSP	NC/3P = Not Covered, Third Party Reviewer	INF	PA	
QL	Plan Exclusion	OTC	RS	
SF	Mandatory Specialty Pharmacy Program	RDX	ST	
VAC	Quantity Limit	SMKG		
	Limited to two 15 day fills per month for first 3 months	¢		
	Vaccine Program			

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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam tab (ONFI equiv)	-	1
clonazepam tab (KLONOPIN equiv)	-	1
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 2 packs/fill)	QL	1
clobazam susp (ONFI equiv) (Members age 9 or older require Prior Authorization)	PA	2
NAYZILAM SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	2
ANTICONVULSANTS - MISC.		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine susp (TEGRETOL equiv)	-	1
carbamazepine tab (TEGRETOL equiv)	-	1
gabapentin cap (NEURONTIN equiv) (QL= 9 caps/day)	QL	1
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	1
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	1
lacosamide oral solution (VIMPAT equiv)	-	1
lacosamide tab (VIMPAT 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
pregabalin 25mg, 50mg, 75mg, 100mg (LYRICA equiv) (QL= 5 caps/day)	QL	1
pregabalin cap 150mg (LYRICA equiv) (QL= 4 caps/day)	QL	1
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	1
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	1
primidone tab (MYSOLINE equiv)	-	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
carbamazepine ER cap (CARBATROL equiv)	-	2
carbamazepine ER tab (TEGRETOL XR equiv)	-	2
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	2
POTIGA TAB (QL= 3 tabs/day)	QL	2
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	2
rufinamide susp (BANZEL equiv)	PA	2
rufinamide tab (BANZEL TAB equiv)	PA	2
DIACOMIT CAP	LD-PA	MSP
DIACOMIT POWDER PACK	LD-PA	MSP
EPIDIOLEX SOLN	MSP-PA	MSP
FINTEPLA SOLN (QL= 12ml/day)	LD-PA-QL	MSP
ZTALMY SUSP (QL= 1100ml/30 days)	LD-PA-QL	MSP
CARBAMATES		
felbamate susp (FELBATOL equiv)	-	2
felbamate tab (FELBATOL equiv)	-	2
XCOPRI PAK 100-150MG (QL= 2 tabs/day)	QL	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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	2
XCOPRI PAK 50-200MG (QL= 2 tabs/day)	QL	2
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day)	QL	2
XCOPRI TAB 50MG, 100MG (QL= 1 tab/day)	QL	2
XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day)	QL	2
XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day)	QL	2
XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day)	QL	2
GABA MODULATORS		
tiagabine tab (GABITRIL equiv)	-	2
vigabatrin powder pack (SABRIL POWDER equiv)	LD-PA	MSP
vigabatrin tab (SABRIL equiv)	LD-PA	MSP
vigadrone powder pack	LD-PA	MSP
HYDANTOINS		
phenytoin cap (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	PA	2
PEGANONE TAB	-	2
phenytoin chew tab (DILANTIN equiv)	-	2
SUCCINIMIDES		
ethosuximide soln (ZARONTIN equiv)	-	1
ethosuximide cap (ZARONTIN equiv)	-	2
methsuximide cap (CELONTIN equiv)	-	2
VALPROIC ACID		
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
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
ANTIDEPRESSANTS - MISC.		
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
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
PHENELZINE SULFATE TAB	-	1
phenelzine tab (NARDIL equiv)	-	1
MARPLAN TAB	-	2
tranylcypromine tab (PARNATE equiv)	-	2
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
escitalopram tab (LEXAPRO equiv)	-	1
fluoxetine cap (PROZAC equiv)	-	1
fluoxetine soln (PROZAC equiv)	-	1
fluoxetine tab (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 a trial of 2 of the following: citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine, or paroxetine)	ST	2
paroxetine ER tab (PAXIL CR equiv)	-	2

SEROTONIN MODULATORS

NEFAZODONE TAB	-	1
nefazodone tab 50mg, 250mg	-	1
trazodone tab (DESYREL equiv)	-	1
vilazodone hcl tab (VIIBRYD equiv) (QL= 1 tab/day; Step Therapy requires a trial of 1 of the following: citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine, or paroxetine)	QL-ST	2

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

desvenlafaxine ER tab (PRISTIQ equiv)	-	1
duloxetine EC cap (CYMBALTA equiv)	-	1
venlafaxine ER cap (EFFEXOR XR equiv)	-	1
venlafaxine tab (EFFEXOR equiv)	-	1

TRICYCLIC AGENTS

amitriptyline tab (ELAVIL equiv)	-	1
amoxapine tab (AMOXAPINE equiv)	-	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
desipramine tab (NORPRAMIN equiv)	-	2
NORTRIPTYLINE SOLN	-	2

ANTIDIABETICS

ALPHA-GLUCOSIDASE INHIBITORS

acarbose tab (PRECOSE equiv)	-	1
------------------------------	---	---

ANTIDIABETIC COMBINATIONS

glipizide/metformin tab (METAGLIP equiv)	-	1
glyburide/metformin tab (GLUCOVANCE equiv)	-	1
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
SOLIQUA INJ (QL= 15ml/25 days)	QL	2
SYNJARDY TAB (QL= 2 tabs/day)	QL	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	generic = small letters	LD	BRANDS = CAPITAL LETTERS
MSP	NC/3P = Not Covered, Third Party Reviewer	INF	PA	
QL	Plan Exclusion	OTC	RS	
SF	Mandatory Specialty Pharmacy Program	RDX	ST	
VAC	Quantity Limit	SMKG		
	Limited to two 15 day fills per month for first 3 months	¢		
	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
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
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	2
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (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)	QL	2
BIGUANIDES		
metformin tab (GLUCOPHAGE equiv)	-	1
metformin XL tab (GLUCOPHAGE XR equiv)	-	1
metformin ER osmotic tab (FORTAMET equiv)	-	EXC
metformin ER osmotic tab (GLUMETZA equiv)	-	EXC
DIABETIC OTHER		
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	2
GLUCAGEN HYPOKIT INJ (QL= 1 kit/fill, 2 fills/30 days)	QL	2
glucagon (rdna) for inj kit (GLUCAGON equiv) (QL= 1 kit/fill, 2 fills/30 days)	QL	2
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	2
GVOKE INJ (QL= 2 inj/fill)	QL	2
GVOKE INJ KIT (QL= 2 inj/fill)	QL	2
GVOKE PFS INJ (QL= 2 inj/fill)	QL	2
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	2
KORLYM TAB (QL= 4 tabs/day)	LD-PA-QL	MSP
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
JANUVIA TAB (QL= 1 tab/day)	QL-¢	2
TRADJENTA TAB (QL= 1 tab/day)	QL	2
INCRETIN MIMETIC AGENTS		
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
BYDUREON INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
BYDUREON PEN INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
VICTOZA INJ (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
INSULIN		
FIASP FLEXTOUCH INJ	-	2
FIASP INJ	-	2
FIASP PENFILL INJ	-	2
HUMULIN R INJ U-500	-	2
HUMULIN R U-500 KWIKPEN INJ	-	2
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	2
INSULIN ASPART INJ (NOVOLOG equiv)	-	2
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	2
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	2
LEVEMIR FLEXTOUCH INJ	-	2
LEVEMIR INJ	-	2
NOVOLIN 70/30 INJ	OTC	2
NOVOLIN MIX FLEXPEN INJ	OTC	2
NOVOLIN N FLEXPEN INJ	OTC	2
NOVOLIN N INJ	OTC	2
NOVOLIN R FLEXPEN INJ	OTC	2
NOVOLIN R INJ	OTC	2
NOVOLOG FLEXPEN INJ	-	2
NOVOLOG INJ	-	2
NOVOLOG MIX FLEXPEN INJ	-	2
NOVOLOG MIX INJ	-	2
NOVOLOG PENFILL INJ	-	2
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	2
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	2
TOUJEO MAX SOLOSTAR INJ	-	2
TOUJEO SOLOSTAR INJ	-	2
TRESIBA FLEXTOUCH INJ	-	2
TRESIBA INJ	-	2
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv)	-	1
AVANDIA TAB	-	2
MEGLITINIDE ANALOGUES		
repaglinide tab (PRANDIN equiv)	-	1
nateglinide tab (STARLIX equiv)	-	2
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB (QL= 1 tab/day)	QL	2
JARDIANCE TAB (QL= 1 tab/day)	QL	2
SULFONYLUREAS		
glimepiride 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	-	1
TOLBUTAMIDE TAB	-	2
ANTIDIARRHEALS		
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
ANTIDOTES		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	2
FERRIPROX SOLN	LD-PA	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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

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

ANTIDOTES Cont.

OPIOID ANTAGONISTS

naltrexone tab (REVIA equiv)	-	1
------------------------------	---	---

ANTIDOTES AND SPECIFIC ANTAGONISTS

ANTIDOTES - CHELATING AGENTS

deferasirox granules packet (JADENU equiv)	MSP	MSP
deferasirox tab (EXJADE equiv)	MSP	MSP
deferasirox tab 180mg (JADENU equiv)	MSP	MSP
deferasirox tab 90mg, 360mg (JADENU equiv)	MSP	MSP
deferiprone tab (FERRIPROX equiv)	LD-PA	MSP

OPIOID ANTAGONISTS

naloxone hcl nasal spray (NARCAN equiv)	OTC	1
naloxone inj	-	1
naloxone prefilled inj	-	1
KLOXXADO NASAL SPRAY	-	2
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	2
OPVEE NASAL SPRAY	-	2
ZIMHI SOLN	-	2

ANTIEMETICS

5-HT3 RECEPTOR ANTAGONISTS

granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill)	QL	1
ondansetron ODT (ZOFTRAN equiv)	-	1
ondansetron soln (ZOFTRAN equiv)	-	1
ONDANSETRON TAB	-	1
ondansetron tab (ZOFTRAN equiv)	-	1
ZUPLENZ SL FILM	-	EXC

ANTIEMETICS - ANTICHOLINERGIC

meclizine chew tab (BONINE equiv)	OTC	1
meclizine tab (ANTIVERT equiv)	OTC	1
trimethobenzamide cap (TIGAN equiv)	-	1
scopolamine patch (TRANSDERM-SCOP equiv) (QL= 5 patches/fill)	QL	2

ANTIEMETICS - MISCELLANEOUS

AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
dronabinol cap (MARINOL equiv)	-	2

SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS

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

ANTIFUNGALS

ANTIFUNGALS

nystatin powder	-	1
nystatin tab	-	1
terbinafine tab (LAMISIL equiv)	-	1
flucytosine cap (ANCOBON equiv)	-	2
griseofulvin micro tab (GRIFULVIN V 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.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIFUNGALS Cont.		
griseofulvin susp (GRIFULVIN equiv)	-	2
griseofulvin tab (GRIS-PEG equiv)	-	2
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
ketoconazole tab (NIZORAL equiv)	-	1
itraconazole cap (SPORANOX equiv)	-	2
voriconazole tab (VFEND equiv)	-	2
ANTIHISTAMINES		
ANTIHISTAMINES - NON-SEDATING		
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
levocetirizine soln (XYZAL equiv)	-	2
levocetirizine tab (XYZAL equiv)	-	2
CLARINEX SYRUP	-	EXC
DES Loratadine ODT	-	EXC
desloratadine tab (CLARINEX equiv)	-	EXC
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine syrup	-	1
promethazine tab (PHENERGAN equiv)	-	1
promethazine supp (PHENERGAN equiv)	-	2
PROMETHEGAN SUPP	-	2
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
ANTIHYPERLIPIDEMICS		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB (QL= 1 tab/day)	PA-QL	2
ANTIHYPERLIPIDEMICS - MISC.		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1
icosapent ethyl cap (VASCEPA equiv)	PA	2
BILE ACID SEQUESTRANTS		
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
FIBRIC ACID DERIVATIVES		

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	1
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1
fenofibric acid DR cap (TRILIPIX equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab (LIPITOR equiv)	-	\$0
lovastatin tab (MEVACOR equiv)	-	\$0
pravastatin tab (PRAVACHOL equiv)	-	\$0
rosuvastatin tab (CRESTOR equiv)	-	\$0
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0
fluvastatin cap (LESCOL equiv) (QL= 2 caps/day)	QL	2
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	1
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv)	-	1
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2
ANTIHYPERTENSIVES		
ACE INHIBITORS		
benazepril tab (LOTENSIN equiv)	-	1
enalapril tab (VASOTEC equiv)	-	1
fosinopril tab (MONOPRIL equiv)	-	1
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1
PERINDOPRIL TAB	-	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
AGENTS FOR PHEOCHROMOCYTOMA		
phenoxybenzamine cap (DIBENZYLININE equiv)	MSP-PA	MSP
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan tab (ATACAND equiv)	-	1
irbesartan tab (AVAPRO equiv)	-	1
losartan tab (COZAAR equiv)	-	1
olmesartan tab (BENICAR equiv)	-	1
telmisartan tab (MICARDIS equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1
METHYLDOPA 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1
terazosin cap (HYTRIN equiv)	-	1
clonidine patch (CATAPRES-TTS equiv)	-	2
ANTIHYPERTENSIVE COMBINATIONS		
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	-	1
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	1
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	1
QUINAPRIL/HCTZ TAB	-	1
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
amlodipine/olmesartan tab (AZOR TAB equiv)	-	2
amlodipine/valsartan tab (EXFORGE equiv)	-	2
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	2
DIRECT RENIN INHIBITORS		
aliskiren tab (TEKTURNA equiv)	-	2
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPIRA equiv)	-	1
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole tab (FLAGYL equiv)	-	1
tinidazole tab (TINDAMAX equiv)	-	1
TRIMETHOPRIM TAB	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
pentamidine neb soln (NEBUPENT equiv)	-	2
ANTI-INFECTIVE MISC. - COMBINATIONS		
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
ANTIPROTOZOAL AGENTS		
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2
atovaquone susp (MEPRON 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
LAMPIT TAB	PA	2
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	2
GLYCOPEPTIDES		
FIRVANQ SOLN	-	1
FIRVANQ SOLN 50MG/ML	-	1
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	1
LEPROSTATICS		
dapsone tab	-	1
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	2
MONOBACTAMS		
CAYSTON INH SOLN	LD-PA	MSP
OXAZOLIDINONES		
linezolid susp (ZYVOX equiv)	-	2
linezolid tab (ZYVOX equiv)	-	2
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2
PLEUROMUTILINS		
XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist)	QL-RS	2
URINARY ANTI-INFECTIVES		
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap 50mg, 100mg	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1
fosfomycin tromethamine powder pack (MONUROL equiv)	-	2
methenamine hippurate tab (HIPREX equiv)	-	2
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	1
ANTIMALARIALS		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
primaquine tab (PRIMAQUINE equiv)	-	1
KRINTAFEL TAB	-	2
mefloquine tab (LARIAM equiv)	-	2
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day)	LD-PA-QL	MSP
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine tab (MESTINON equiv)	-	1
pyridostigmine CR tab (MESTINON equiv)	-	2
FIRDAPSE TAB	LD-PA	MSP
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	2
ANTIMYCOBACTERIAL AGENTS		

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS Cont.		
ISONIAZID TAB	-	1
pyrazinamide tab	-	1
ethambutol tab (MYAMBUTOL equiv)	-	2
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	2
PRIFTIN TAB	-	2
rifabutin cap (MYCOBUTIN equiv)	-	2
rifampin cap (RIFADIN equiv)	-	2

ANTINEOPLASTICS

ALKYLATING AGENTS

HEXALEN CAP	-	2
LEUKERAN TAB	-	2

ANTIMETABOLITES

methotrexate tab (TREXALL equiv)	-	1
mercaptapurine tab (PURINETHOL equiv)	-	2
TABLOID TAB	-	2

ANTINEOPLASTIC ENZYME INHIBITORS

ZOLINZA CAP	MSP-PA-SF	MSP
-------------	-----------	-----

ANTINEOPLASTICS MISC.

hydroxyurea cap (HYDREA equiv)	-	1
MATULANE CAP	-	2
ACTIMMUNE INJ	LD-PA	MSP
ALFERON-N INJ	MSP-PA	MSP
INTRON-A INJ	MSP-PA	MSP
tretinoin cap (VESANOID equiv)	MSP	MSP

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

leucovorin tab	-	1
MESNEX TAB	MSP	MSP

TOPOISOMERASE I INHIBITORS

HYCAMTIN CAP	MSP-PA	MSP
--------------	--------	-----

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

ALKYLATING AGENTS

cyclophosphamide cap	-	2
CYCLOPHOSPHAMIDE TAB	-	2
GLEOSTINE/LOMUSTINE CAP	-	2
MELPHALAN TAB	-	2
MYLERAN TAB	MSP	MSP
temozolomide cap (TEMODAR equiv)	MSP	MSP

ANTIMETABOLITES

METHOTREXATE INJ	-	1
capecitabine tab (XELODA equiv)	MSP	MSP

ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS

INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	MSP
LENVIMA CAP (QL= 3 caps/day)	MSP-PA-QL	MSP

ANTINEOPLASTIC - ANTI-HER2 AGENTS

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
TUKYSA TAB (QL= 4 tabs/day)	LD-PA-QL-SF	MSP
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA STARTER PACK	MSP-PA	MSP
VENCLEXTA TAB	MSP-PA	MSP
ANTINEOPLASTIC - EGFR INHIBITORS		
erlotinib tab (TARCEVA equiv)	MSP-PA-SF	MSP
EXKIVITY CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP
gefitinib tab (IRESSA equiv)	LD-PA	MSP
GILOTRIF TAB (QL= 1 tab/day)	LD-PA-QL	MSP
TAGRISSE TAB (QL= 1 tab/day)	LD-PA-QL-SF	MSP
VIZIMPRO TAB (QL= 1 tab/day)	MSP-PA-QL-SF	MSP
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP	MSP-PA-SF	MSP
ODOMZO CAP	MSP-PA-SF	MSP
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
anastrozole tab (ARIMIDEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
exemestane tab (AROMASIN equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
bicalutamide tab (CASODEX equiv)	-	1
letrozole tab (FEMARA equiv)	-	1
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
EULEXIN CAP	-	2
FLUTAMIDE CAP	-	2
flutamide cap (EULEXIN equiv)	-	2
toremifene tab (FARESTON equiv)	-	2
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tab/day;)	MSP-QL	MSP
ERLEADA TAB (QL= 4 tabs/day)	MSP-PA-QL	MSP
ERLEADA TAB 240MG (QL= 1 tab/day)	MSP-PA-QL	MSP
LYSODREN TAB	LD	MSP
nilutamide tab (NILANDRON equiv)	MSP	MSP
NUBEQA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP
ORGOVYX TAB (QL= 30 tabs/28 days)	PA-QL	MSP
ORSERDU TAB (QL= 3 tabs/day)	LD-PA-QL	MSP
ORSERDU TAB 345MG (QL= 1 tab/day)	LD-PA-QL	MSP
ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS		
WELIREG TAB (QL= 3 tabs/day)	LD-PA-QL	MSP
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP (QL= 21 caps/28 days)	MSP-PA-QL	MSP
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS		
AYVAKIT TAB (QL= 1 tab/day)	LD-PA-QL-SF	MSP
ANTINEOPLASTIC - XPO1 INHIBITORS		

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
XPOVIO PAK (QL= 32 tabs/28 days)	MSP-PA-QL-SF	MSP
ANTINEOPLASTIC COMBINATIONS		
INQOVI TAB (QL= 5 tabs/28 days)	MSP-PA-QL	MSP
KISQALI PAK (QL= 91 tabs/28 days)	MSP-PA-QL	MSP
LONSURF TAB	PA	MSP
ANTINEOPLASTIC ENZYME INHIBITORS		
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	MSP
ALUNBRIG TAB 30MG (QL= 4 tabs/day)	LD-PA-QL-SF	MSP
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day)	LD-PA-QL-SF	MSP
BALVERSA TAB 3MG (QL= 3 tabs/day)	LD-PA-QL-SF	MSP
BALVERSA TAB 4MG (QL= 2 tabs/day)	LD-PA-QL-SF	MSP
BALVERSA TAB 5MG (QL= 1 tab/day)	LD-PA-QL-SF	MSP
BOSULIF TAB	MSP-PA-SF	MSP
BRAFTOVI CAP 75MG (QL= 6 caps/day)	LD-PA-QL	MSP
BRUKINSA CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	MSP
CALQUENCE CAP (QL= 2 caps/day)	LD-PA-QL-SF	MSP
CALQUENCE TAB (QL= 2 tabs/day)	LD-PA-QL-SF	MSP
CAPRELSA TAB	LD-PA	MSP
COMETRIQ KIT	LD-PA	MSP
COPIKTRA CAP (QL= 2 caps/day)	LD-PA-QL	MSP
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	MSP-PA-QL	MSP
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	MSP-PA-QL-SF	MSP
FOTIVDA CAP (QL= 21 caps/28 days)	LD-PA-QL	MSP
GAVRETO CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP
ICLUSIG TAB (QL= 1 tab/day)	LD-PA-QL-SF	MSP
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
imatinib tab (GLEEVEC equiv)	MSP	MSP
IMBRUVICA CAP 140MG (QL= 3 caps/day)	MSP-PA-QL	MSP
IMBRUVICA CAP 70MG (QL= 1 cap/day)	MSP-PA-QL	MSP
IMBRUVICA SUSP (QL= 6ml/day)	LD-PA-QL	MSP
IMBRUVICA TAB 420MG, 560MG (QL= 1 tab/day)	MSP-PA-QL	MSP
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	MSP
JAYPIRCA TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP
KISQALI TAB (QL= 63 tabs/28 days)	MSP-PA-QL	MSP
KOSELUGO CAP (QL= 4 caps/day)	LD-PA-QL	MSP
KOSELUGO CAP 10MG (QL= 8 caps/day)	LD-PA-QL	MSP
KRAZATI TAB (QL= 6 tabs/day)	LD-PA-QL-SF	MSP
lapatinib ditosylate tab (TYKERB equiv)	MSP-PA	MSP
LORBRENA TAB 100MG (QL= 1 tab/day)	MSP-PA-QL-SF	MSP
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	MSP
LUMAKRAS TAB (QL= 8 tabs/day)	LD-PA-QL-SF	MSP
LUMAKRAS TAB 320MG (QL= 3 tabs/day)	LD-PA-QL-SF	MSP
LYNPARZA TAB (QL= 4 tabs/day)	LD-PA-QL-SF	MSP
LYTGOBI THERAPY PACK (QL= 5 tabs/day)	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	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	MSP-PA-QL	MSP
MEKINIST TAB 2MG (QL= 1 tab/day)	MSP-PA-QL	MSP
MEKTOVI TAB (QL= 6 tabs/day)	MSP-PA-QL	MSP
NERLYNX TAB (QL= 6 tabs/day)	LD-PA-QL-SF	MSP
NINLARO CAP	LD-PA	MSP
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP
PEMAZYRE TAB (QL= 1 tab/day)	LD-PA-QL	MSP
PIQRAY TAB	MSP-PA-SF	MSP
QINLOCK TAB (QL= 3 tabs/day)	LD-PA-QL	MSP
RETEVMO CAP (QL= 4 caps/day)	MSP-PA-QL-SF	MSP
REZLIDHIA CAP (QL= 2 caps/day)	LD-PA-QL-SF	MSP
ROZLYTREK CAP (QL= 3 caps/day)	MSP-PA-QL	MSP
RUBRACA TAB (QL= 4 tabs/day)	LD-PA-QL-SF	MSP
RYDAPT CAP (QL= 56 caps/28 days)	MSP-PA-QL	MSP
sorafenib tosylate tab (NEXAVAR equiv)	MSP-PA-SF	MSP
SPRYCEL TAB	MSP-PA-SF	MSP
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP
sunitinib malate cap (SUTENT equiv)	MSP-PA-SF	MSP
TABRECTA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP
TAFINLAR CAP (QL= 4 caps/day)	MSP-PA-QL	MSP
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	MSP
TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day)	MSP-PA-QL-SF	MSP
TASIGNA CAP	MSP-PA-SF	MSP
TAZVERIK TAB (QL= 8 tabs/day)	LD-PA-QL	MSP
TEPMETKO TAB (QL= 2 tabs/day)	LD-PA-QL-SF	MSP
TIBSOVO TAB (QL= 2 tabs/day)	LD-PA-QL	MSP
TURALIO CAP (QL= 4 caps/day)	LD-PA-QL-SF	MSP
VERZENIO TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP
VITRAKVI CAP 100MG (QL= 2 caps/day)	LD-PA-QL-SF	MSP
VITRAKVI CAP 25MG (QL= 6 caps/day)	LD-PA-QL-SF	MSP
VITRAKVI SOLN (QL= 10ml/day)	LD-PA-QL-SF	MSP
VONJO CAP (QL= 4 caps/day)	LD-PA-QL	MSP
VOTRIENT TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	MSP
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	MSP
XOSPATA TAB (QL= 3 tabs/day)	LD-PA-QL-SF	MSP
ZEJULA CAP (QL= 3 caps/day)	PA-QL	MSP
ZEJULA TAB (QL= 1 tab/day)	LD-PA-QL	MSP
ZELBORAF TAB (QL= 8 tabs/day)	MSP-PA-QL	MSP
ZYDELIG TAB	LD-PA	MSP
ZYKADIA CAP (QL= 3 caps/day)	MSP-PA-QL-SF	MSP
ZYKADIA TAB (QL= 3 tabs/day)	MSP-PA-QL-SF	MSP
ANTINEOPLASTICS MISC.		
bexarotene cap (TARGRETIN equiv)	MSP-SF	MSP
MITOTIC INHIBITORS		
ETOPOSIDE CAP	MSP	MSP

ANTIPARKINSON AGENTS

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	2
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	2
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
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
ropinirole ER tab (REQUIP XL equiv)	-	2
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
rasagiline tab (AZILECT equiv)	¢	2
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS		
trihexyphenidyl elixir (ARTANE equiv)	-	1
TRIHEXYPHENIDYL SOLN	-	1
ANTIPARKINSON DOPAMINERGICS		
CARBIDOPA/LEVODOPA ODT	-	1
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	2
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
ANTIPSYCHOTICS - MISC.		
lurasidone hcl tab (LATUDA equiv)	-	1
ziprasidone cap (GEODON equiv)	-	1
BENZISOXAZOLES		
risperidone soln (RISPERDAL equiv)	-	1
risperidone tab (RISPERDAL equiv)	-	1
paliperidone ER tab (INVEGA equiv) (QL= 2 tabs/day)	QL	2
RISPERIDONE ODT	-	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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
risperidone ODT (RISPERDAL M equiv)	-	2
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1
DIBENZAPINES		
loxapine cap (LOXITANE equiv)	-	1
olanzapine ODT (ZYPREXA equiv)	-	1
olanzapine tab (ZYPREXA equiv)	-	1
quetiapine tab (SEROQUEL equiv)	-	1
quetiapine XR tab (SEROQUEL XR equiv)	-	1
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day)	QL	2
clozapine tab (CLOZARIL equiv)	-	2
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
aripiprazole soln (ABILIFY equiv)	-	2
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	1
ANTIVIRALS		
ANTIRETROVIRALS		
emtricitabine/tenofovir disoproxil fumarate tab 200-300mg (TRUVADA equiv)	-	\$0
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
BIKTARVY TAB	-	2
CIMDUO TAB	-	2
COMPLERA TAB (QL= 1 tab/day)	QL	2
CRIXIVAN CAP	-	2
darunavir tab (PREZISTA equiv)	-	2
DELSTRIGO TAB	-	2
DESCOVY TAB (DESCOVY TAB (HIV pre-exposure prophylaxis) with a PA at \$0 and DESCOVY TAB (HIV treatment) with a PA at tier 2)	PA	2
didanosine DR cap (VIDEX EC 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
DIDANOSINE DR CAP, VIDEX EC CAP	-	2
DOVATO TAB	-	2
EDURANT TAB	-	2
EFAVIRENZ CAP	-	2
efavirenz tab (SUSTIVA equiv)	-	2
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv) (QL= 1 tab/day)	QL	2
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	2
emtricitabine cap (EMTRIVA equiv)	-	2
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	2
EMTRIVA SOLN	-	2
etravirine tab (INTELENCE equiv)	-	2
EVOTAZ TAB	-	2
fosamprenavir tab (LEXIVA equiv)	-	2
FUZEON INJ	-	2
GENVOYA TAB (QL= 1 tab/day)	QL	2
INTELENCE TAB	-	2
INVIRASE CAP	-	2
INVIRASE TAB	-	2
ISENTRESS (HD) TAB	-	2
ISENTRESS CHEW TAB	-	2
ISENTRESS POWDER PACK	-	2
JULUCA 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
lopinavir/ritonavir tab (KALETRA equiv)	-	2
maraviroc tab (SELZENTRY equiv)	-	2
NEVIRAPINE ER TAB	-	2
nevirapine ER tab (VIRAMUNE XR equiv)	-	2
NEVIRAPINE SUSP	-	2
NORVIR CAP	-	2
NORVIR POWDER PACK	-	2
NORVIR SOLN	-	2
ODEFSEY TAB (QL= 1 tab/day)	QL	2
PIFELTRO TAB	-	2
PREZCOBIX TAB	-	2
PREZISTA SUSP	-	2
PREZISTA TAB	-	2
RESCRIPTOR TAB	-	2
REYATAZ POWDER PACK	-	2
ritonavir tab (NORVIR equiv)	-	2
RUKOBIA ER TAB	PA	2
SELZENTRY SOLN	-	2
SELZENTRY TAB	-	2
STAVUDINE 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
stavudine cap (ZERIT equiv)	-	2
STRIBILD TAB (QL= 1 tab/day)	QL	2
SYMTUZA TAB	-	2
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	2
TIVICAY PD TAB	-	2
TIVICAY TAB	-	2
TRIUMEQ PD TAB (QL= 1 tab/day)	QL	2
TRIUMEQ TAB (QL= 1 tab/day)	QL	2
TRIZIVIR TAB	-	2
VIDEX SOLN	-	2
VIRACEPT TAB	-	2
VIREAD TAB	-	2
zidovudine cap (RETROVIR equiv)	-	2
zidovudine syrup (RETROVIR equiv)	-	2
zidovudine tab (RETROVIR equiv)	-	2
SYMFI (LO) TAB	-	EXC
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB (QL= 20 tabs/fill)	QL	\$0
PAXLOVID TAB (QL= 30 tabs/fill)	QL	\$0
CMV AGENTS		
valganciclovir soln (VALCYTE equiv)	-	2
valganciclovir tab (VALCYTE equiv)	-	2
LIVTENCITY TAB (QL= 4 tabs/day)	LD-PA-QL	MSP
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	MSP-PA-QL	MSP
HEPATITIS AGENTS		
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
REBETOL SOLN	-	2
ribavirin cap (REBETOL equiv)	-	2
RIBAVIRIN TAB	-	2
VEMLIDY TAB (QL= 1 tab/day)	QL	2
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
MAVYRET PAK (QL= 5 packs/day)	MSP-PA-QL	MSP
MAVYRET TAB (QL= 3 tabs/day)	MSP-PA-QL	MSP
PEGASYS INJ	MSP-PA	MSP
RIBAVIRIN CAP	MSP	MSP
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
VOSEVI TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
HERPES AGENTS		
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

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
INFLUENZA AGENTS		
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	2
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2
MISC. ANTIVIRALS		
LAGEVRIO CAP (QL= 40 caps/fill)	QL	\$0
ASSORTED CLASSES		
CHELATING AGENTS		
D-PENAMINE TAB	-	2
IMMUNOMODULATORS		
THALOMID CAP	MSP-PA	MSP
IMMUNOSUPPRESSIVE AGENTS		
azathioprine tab (IMURAN equiv)	-	1
cyclosporine modified cap (NEORAL equiv)	-	1
mycophenolate mofetil cap (CELLCEPT equiv)	-	1
mycophenolate mofetil tab (CELLCEPT equiv)	-	1
tacrolimus cap (PROGRAF equiv)	-	1
cyclosporine cap (SANDIMMUNE equiv)	-	2
cyclosporine modified soln (NEORAL equiv)	-	2
mycophenolate DR tab (MYFORTIC equiv)	-	2
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	2
SANDIMMUNE SOLN 100MG/ML (QL= 150 mL/30 days)	QL	2
sirolimus tab (RAPAMUNE equiv)	-	2
POTASSIUM REMOVING RESINS		
sodium polystyrene susp (SPS equiv)	-	1
sodium polystyrene powder (KAYEXALATE equiv)	-	2
VELTASSA POWDER	PA	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
nebivolol hcl tab (BYSTOLIC equiv)	¢	2
BETA BLOCKERS NON-SELECTIVE		
pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
propranolol oral soln 20mg/5ml (PROPRANOLOL 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
BETA BLOCKERS Cont.		
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

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
felodipine ER tab (PLENDIL equiv)	-	1
isradipine cap (DYNACIRC equiv)	-	1
nifedipine cap (PROCARDIA equiv)	-	1
nifedipine ER tab (ADALAT CC equiv)	-	1
verapamil SR cap (VERELAN equiv)	-	1
VERAPAMIL SR CAP 360mg	-	1
verapamil tab (CALAN equiv)	-	1
diltiazem ER tab (CARDIZEM LA equiv)	-	2

CARDIOTONICS

CARDIAC GLYCOSIDES		
digoxin soln (LANOXIN equiv)	-	1
DIGOXIN SOLN 0.05MG/ML	-	1
digoxin tab (LANOXIN equiv)	-	1

CARDIOVASCULAR AGENTS - MISC.

CARDIAC MYOSIN INHIBITORS		
CAMZYOS CAP (QL= 1 cap/day)	LD-PA-QL	MSP

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
ENTRESTO TAB (QL= 2 tabs/day)	QL	2

IMPOTENCE AGENTS		
sildenafil tab (VIAGRA equiv) (QL=8 tabs/30 days)	QL	1
tadalafil tab (CIALIS equiv) (QL= 8 tabs/30 days)	QL	1
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day)	QL	1
LEVITRA TAB	-	EXC
vardeafil tab (LEVITRA equiv)	-	EXC

PROSTAGLANDIN VASODILATORS		
TYVASO DPI POWDER (QL= 4 cartridges/day)	LD-PA-QL	MSP
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/28 days)	LD-PA-QL	MSP
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days)	LD-PA-QL	MSP
TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days)	LD-PA-QL	MSP
TYVASO INH SOLN (QL= 1 ampule/day)	LD-PA-QL	MSP
VENTAVIS INH SOLN (QL= 9 ampules/day)	LD-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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

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

CARDIOVASCULAR AGENTS - MISC. Cont.

PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS

ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day)	LD-PA-QL	MSP
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day)	LD-PA-QL	MSP
OPSUMIT TAB (QL= 1 tab/day)	LD-PA-QL	MSP
TRACLEER TAB 32MG (QL= 4 tabs/day)	LD-PA-QL	MSP

PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS

sildenafil tab 20mg (REVATIO equiv) (QL= 40 tabs/30 days)	QL	1
tadalafil tab (PAH) (ADCIRCA equiv) (QL= 2 tabs/day)	MSP-QL	1
sildenafil susp (REVATIO equiv) (Members age 9 or older require Prior Authorization)	PA	2
TADLIQ SUSP (Members age 9 years or older require Prior Authorization)	MSP-PA	MSP

PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST

UPTRAVI TAB (QL= 2 tabs/day)	LD-PA-QL	MSP
------------------------------	----------	-----

PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR

ADEMPAS TAB (QL= 3 tabs/day)	LD-PA-QL	MSP
------------------------------	----------	-----

SINUS NODE INHIBITORS

CORLANOR TAB	PA	2
--------------	----	---

TRANSTHYRETIN STABILIZERS

VYNDAMAX CAP (QL= 1 cap/day)	LD-PA-QL	MSP
VYNDAQEL CAP (QL= 4 caps/day)	LD-PA-QL	MSP

VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)

VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist)	QL-RS	2
--	-------	---

CEPHALOSPORINS

CEPHALOSPORINS - 1ST GENERATION

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

CEPHALOSPORINS - 2ND GENERATION

cefprozil susp (CEFZIL equiv)	-	1
cefprozil tab (CEFZIL equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1

CEPHALOSPORINS - 3RD GENERATION

cefdinir cap (OMNICEF equiv)	-	1
cefdinir susp (OMNICEF equiv)	-	1
cefepodoxime proxetil susp (VANTIN equiv)	-	2
cefepodoxime proxetil tab (VANTIN equiv)	-	2

CONTRACEPTIVES

COMBINATION CONTRACEPTIVES - ORAL

amethyst tab (LYBREL equiv) (Step Therapy requires a trial of 2 preferred oral contraceptives)	ST	\$0
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	\$0
cryselle tab	-	\$0
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	\$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.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RDX Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0
levonorgestrel/ethinyl estradiol tab (LOSEASONIQUE equiv)	-	\$0
levonorgestrel/ethinyl estradiol tab (QUARTETTE equiv)	-	\$0
norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv)	-	\$0
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	\$0
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	\$0
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	\$0
nortrel tab (OVCON 35 equiv)	-	\$0
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	\$0
tri-legest tab (ESTROSTEP FE equiv)	-	\$0
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0
TYBLUME TAB	-	\$0
VELIVET PAK	-	\$0
velivet tab (CYCLESSA equiv)	-	\$0
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0
viorele tab, kariva tab (MIRCETTE equiv)	-	\$0
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
zafemy patch (XULANE equiv)	-	\$0
COMBINATION CONTRACEPTIVES - VAGINAL		
NUVARING	-	\$0
EMERGENCY CONTRACEPTIVES		
ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA INJ (QL= 1 inj/90 days)	QL	\$0
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	\$0

CORTICOSTEROIDS

GLUCOCORTICOSTEROIDS

DEXAMETHASONE CONC	-	1
dexamethasone elixir	-	1
dexamethasone sodium phosphate inj	-	1
DEXAMETHASONE SOLN	-	1
dexamethasone tab (DECADRON equiv)	-	1
hydrocortisone tab (CORTEF equiv)	-	1
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	1
methylprednisolone dose pack (MEDROL equiv)	-	1
methylprednisolone tab (MEDROL equiv)	-	1
methylprednisolone sod succinate inj (SOLU-MEDROL 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	generic = small letters	LD	BRANDS = CAPITAL LETTERS
MSP	NC/3P = Not Covered, Third Party Reviewer	INF	PA	
QL	Plan Exclusion	OTC	RS	
SF	Mandatory Specialty Pharmacy Program	RDX	ST	
VAC	Quantity Limit	SMKG		
	Limited to two 15 day fills per month for first 3 months	¢		
	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier																														
CORTICOSTEROIDS Cont.																																
prednisolone soln	-	1																														
prednisolone soln (PEDIAPRED equiv)	-	1																														
prednisone tab (DELTASONE equiv)	-	1																														
triamcinolone acetonide inj (KENALOG equiv)	-	1																														
budesonide SR cap (ENTOCORT EC equiv)	-	2																														
CORTISONE ACETATE TAB	-	2																														
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	2																														
PREDNISONE SOLN	-	2																														
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	2																														
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	2																														
SOLU-MEDROL INJ 2GM	-	2																														
RAYOS TAB	-	EXC																														
MINERALOCORTICIDS																																
fludrocortisone tab (FLORINEF equiv)	-	1																														
COUGH/COLD/ALLERGY																																
ANTITUSSIVES																																
benzonatate cap (TESSALON equiv)	-	1																														
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1																														
COUGH/COLD/ALLERGY COMBINATIONS																																
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	1																														
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1																														
promethazine DM syrup	-	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																														
EXPECTORANTS																																
potassium iodide oral soln (SSKI equiv)	-	2																														
MISC. RESPIRATORY INHALANTS																																
sodium chloride neb soln (HYPER-SAL equiv)	-	1																														
NEBUSAL NEB SOLN	-	2																														
MUCOLYTICS																																
acetylcysteine soln (MUCOMYST equiv)	-	1																														
DERMATOLOGICALS																																
ACNE PRODUCTS																																
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																														
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.																																
** OTC drugs are not a covered benefit.																																
<table border="1"> <tr> <td>EXC</td> <td>NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion</td> <td>INF</td> <td>Infertility</td> <td>LD</td> <td>Limited Distribution</td> </tr> <tr> <td>MSP</td> <td>Mandatory Specialty Pharmacy Program</td> <td>OTC</td> <td>Over-the-Counter</td> <td>PA</td> <td>Prior Authorization</td> </tr> <tr> <td>QL</td> <td>Quantity Limit</td> <td>RDX</td> <td>Restricted to Diagnosis</td> <td>RS</td> <td>Restricted to Specialist</td> </tr> <tr> <td>SF</td> <td>Limited to two 15 day fills per month for first 3 months</td> <td>SMKG</td> <td>Smoking Cessation</td> <td>ST</td> <td>Step Therapy</td> </tr> <tr> <td>VAC</td> <td>Vaccine Program</td> <td>¢</td> <td>RxCENTS</td> <td></td> <td></td> </tr> </table>			EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis	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		
EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution																											
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization																											
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
erythromycin soln	-	1
adapalene cream (DIFFERIN equiv)	-	2
adapalene gel 0.3% (DIFFERIN equiv)	-	2
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	2
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	2
amnestem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	2
AVAR GEL	-	2
ERY PAD	-	2
erythromycin gel	-	2
PRASCION RA CREAM	-	2
sodium sulfacetamide lotion (KLARON equiv)	-	2
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	2
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH 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 susp (SUMAXIN equiv)	-	2
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	2
tretinoin cream	-	2
tretinoin gel (RETIN-A GEL equiv)	-	2
ABSORICA CAP	-	EXC
AVAR	-	EXC
clindamycin foam (EVOCLIN equiv)	-	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
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
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1
econazole cream (SPECTAZOLE equiv)	-	1
ketconazole cream (NIZORAL CREAM equiv)	-	1
ketconazole shampoo (NIZORAL SHAMPOO equiv)	-	1
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
nystatin/triamcinolone cream	-	1
nystatin/triamcinolone oint	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	2
JUBLIA SOLN	-	EXC
KERYDIN SOLN	-	EXC

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
tavorole soln (KERYDIN equiv)	-	EXC
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1
diclofenac gel 1% OTC	OTC	1
diclofenac soln 1.5% (PENNSAID equiv) (QL= 3 bottles/fill)	QL	2
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
fluorouracil cream (EFUDEX CREAM equiv)	-	1
diclofenac gel (SOLARAZE equiv) (QL= 300 gm/30 days)	QL	2
FLUOROURACIL SOLN	-	2
bexarotene gel (TARGRETIN equiv)	MSP-PA	MSP
VALCHLOR GEL (QL= 4 tubes/30 days)	LD-PA-QL	MSP
ANTIPSORIATICS		
acitretin cap (SORIATANE equiv)	-	2
calcipotriene cream (DOVONEX CREAM equiv)	-	2
calcipotriene oint	-	2
calcipotriene soln (DOVONEX SOLN equiv)	-	2
METHOXSALEN CAP	-	2
methoxsalen cap (OXSORALEN ULTRA equiv)	-	2
tazarotene cream 0.1% (TAZORAC equiv)	-	2
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	2
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	MSP-PA-QL	MSP
SKYRIZI INJ 75MG/0.83ML (QL= 2 inj/84 days)	MSP-PA-QL	MSP
STELARA INJ (QL= 1 inj/84 days)	MSP-PA-QL	MSP
TALTZ INJ (QL= 1 inj/28 days)	MSP-PA-QL	MSP
TREMFYA INJ (QL= 1 inj/56 days)	MSP-PA-QL	MSP
ANTISEBORRHEIC PRODUCTS		
selenium sulfide lotion	OTC	1
selenium sulfide lotion 2.5% (SELSUN equiv)	-	1
selenium sulfide shampoo (SELSEB equiv)	-	2
sodium sulfacetamide wash (OVACE WASH equiv)	-	2
ANTIVIRALS - TOPICAL		
acyclovir oint (ZOVIRAX equiv)	-	1
XERESE CREAM	-	EXC
BURN PRODUCTS		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
SULFAMYLON CREAM	-	2
CORTICOSTEROIDS - TOPICAL		
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
betamethasone augmented gel	-	1
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1
betamethasone dipropionate lotion	-	1
betamethasone dipropionate oint	-	1
betamethasone valerate cream	-	1
betamethasone valerate lotion	-	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	generic = small letters	LD	BRANDS = CAPITAL LETTERS
MSP	NC/3P = Not Covered, Third Party Reviewer	INF	PA	Limited Distribution
QL	Plan Exclusion	OTC	RS	Prior Authorization
SF	Mandatory Specialty Pharmacy Program	RDX	ST	Restricted to Specialist
VAC	Quantity Limit	SMKG		Step Therapy
	Limited to two 15 day fills per month for first 3 months	¢		
	Vaccine Program			

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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
betamethasone valerate oint	-	1
clobetasol propionate cream (TEMOVATE equiv)	-	1
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1
clobetasol propionate gel (TEMOVATE GEL equiv)	-	1
clobetasol propionate oint (TEMOVATE equiv)	-	1
clobetasol propionate soln (TEMOVATE equiv)	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oint	-	1
fluocinonide cream 0.05% (LIDEX equiv)	-	1
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	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
betamethasone augmented oint (DIPROLENE OINT equiv)	-	2
clobetasol lotion (CLOBEX equiv)	-	2
clobetasol shampoo (CLOBEX SHAMPOO equiv)	-	2
desonide cream (DESOWEN equiv)	-	2
desonide lotion	-	2
desonide oint (DESOWEN equiv)	-	2
desoximetasone cream 0.025% (TOPICORT CREAM equiv)	-	2
desoximetasone gel (TOPICORT equiv)	-	2
desoximetasone oint 0.25% (TOPICORT equiv)	-	2
EPIFOAM AEROSOL	-	2
fluocinolone acetonide oil (DERMA-SMOOTH equiv)	-	2
fluocinolone acetonide soln	-	2
fluocinonide emollient cream	-	2
halobetasol propionate cream (ULTRAVATE equiv)	-	2
halobetasol propionate oint (ULTRAVATE equiv)	-	2
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	2
hydrocortisone valerate cream	PA	2
PRAMASONE OINT	-	2
PRAMOSONE CREAM 1-1%	-	2
PRAMOSONE E CREAM	-	2
PREDNICARBATE CREAM	-	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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
PREDNICARBATE OIN	-	2
triamcinolone spray (KENALOG equiv)	-	2
CLOBEX LOTION	-	EXC
ECZEMA AGENTS		
ADBRY INJ (QL= 4 inj/28 days)	MSP-PA-QL	MSP
CIBINQO TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
DUPIXENT INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
DUPIXENT PEN INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
EMOLLIENT/KERATOLYTIC AGENTS		
urea cream ()	-	1
urea lotion (KERALAC LOTION equiv)	-	1
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	1
LAC-HYDRIN LOTION 5%	OTC	1
ENZYMES - TOPICAL		
SANTYL OINT (QL= 90gm/30 days)	QL	2
vasolex oint (XENADERM equiv)	-	2
XENADERM OINT	-	2
HAIR GROWTH AGENTS		
bimatoprost topical soln (LATISSE equiv)	-	EXC
finasteride tab (PROPECIA equiv)	-	EXC
LATISSE SOLN	-	EXC
HAIR REDUCTION AGENTS		
VANIQA CREAM	-	EXC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	1
ZYCLARA CREAM	-	EXC
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
tacrolimus oint (PROTOPIC OINT equiv)	-	1
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older)	-	2
HYFTOR GEL (QL= 10 grams/30 days)	LD-PA-QL	MSP
KERATOLYTIC/ANTIMITOTIC AGENTS		
PODOCON SOLN	-	2
PODOFILOX SOLN	-	2
podofilox soln (CONDYLOX equiv)	-	2
salicylic acid shampoo (SALEX equiv)	-	2
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream	OTC	1
lidocaine cream 3% (LIDAMANTLE equiv)	-	1
lidocaine cream 4%	OTC	1
lidocaine gel (GLYDO equiv)	-	1
lidocaine gel (XYLOCAINE equiv)	-	1
lidocaine oint (QL= 107gm/30 days)	QL	1
lidocaine soln (XYLOCAINE 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
lidocaine/prilocaine cream (EMLA equiv)	-	1
LIDOCAINE GEL	-	2
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	2
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	QL	2
MISC. DERMATOLOGICAL PRODUCTS		
NUVAIL SOLN	-	EXC
MISC. TOPICAL		
DRYSOL SOLN	-	1
PIGMENTING-DEPIGMENTING AGENTS		
EPIQUIN MICRO CREAM	-	EXC
hydroquinone cream (LUSTRA equiv)	-	EXC
NUQUIN HP GEL	-	EXC
TRI-LUMA CREAM	-	EXC
ROSACEA AGENTS		
metronidazole cream (METROCREAM equiv)	-	1
metronidazole gel 0.75% (METROGEL equiv)	-	1
azelaic acid gel (FINACEA equiv)	-	2
FINACEA FOAM	-	2
metronidazole gel (METROGEL equiv)	-	2
metronidazole lotion (METROLOTION equiv)	-	2
brimonidine tartrate gel (MIRVASO equiv)	-	EXC
DOXYCYCLINE CAP, ORACEA CAP	-	EXC
MIRVASO GEL	-	EXC
RHOFADE CREAM	-	EXC
SCABICIDES & PEDICULICIDES		
permethrin cream (ELIMITE CREAM equiv)	-	1
malathion lotion (OVIDE equiv)	QL	2
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2
WOUND CARE PRODUCTS		
BIAFINE EMULSION	-	2
REGRANEX GEL (QL= 30gm/fill)	QL	2
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS		
GLUCAGEN INJ (QL= 1 kit/fill, 2 fills/30 days)	QL	2
DIAGNOSTIC TESTS		
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC	DME
ACCU-CHEK GUIDE TEST STRIP	OTC	DME
ACCU-CHEK SMARTVIEW TEST STRIP	OTC	DME
ACCU-CHEK TEST STRIP	OTC	DME
CLINISTIX TEST STRIP	OTC	DME
KETO-DIASTIX TEST STRIP	OTC	DME
KETOSTIX	OTC	DME
ONETOUCH TEST STRIP	OTC	DME
ONETOUCH VERIO TEST STRIP	OTC	DME
TEST STRIP (all other test strips)	OTC-PA	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	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
DIAGNOSTIC PRODUCTS Cont.		
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EXC
CUE HEALTH MONITOR	OTC	EXC

DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS

DIETARY MANAGEMENT PRODUCTS

ASTAMED MYO CAP	-	EXC
DEPLIN CAP	-	EXC
ELIGEN B12 TAB	-	EXC
FALESSA TAB	-	EXC
GLYGEST PAK	-	EXC
L-METHYLFOLATE TAB	-	EXC
LUVIRA CAP	-	EXC
METANX CAP	-	EXC
OLLIZAC POWDER	-	EXC
PODIAPN CAP	-	EXC
XAQUIL XR TAB	-	EXC
XYZBAC TAB	-	EXC

DIGESTIVE AIDS

DIGESTIVE ENZYMES

CREON CAP	-	2
-----------	---	---

DIURETICS

CARBONIC ANHYDRASE INHIBITORS

acetazolamide tab	-	1
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	2
methazolamide tab (NEPTAZANE equiv)	-	2

DIURETIC COMBINATIONS

AMILORIDE/HCTZ TAB	-	1
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1

LOOP DIURETICS

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

POTASSIUM SPARING DIURETICS

amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
triamterene cap (DYRENIUM equiv)	-	2

THIAZIDES AND THIAZIDE-LIKE DIURETICS

CHLOROTHIAZIDE TAB	-	1
chlorothiazide tab (DIURIL equiv)	-	1
chlorthalidone 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	generic = small letters	LD	BRANDS = CAPITAL LETTERS
MSP	NC/3P = Not Covered, Third Party Reviewer	INF	PA	Limited Distribution
QL	Plan Exclusion	OTC	RS	Prior Authorization
SF	Mandatory Specialty Pharmacy Program	RDX	ST	Restricted to Specialist
VAC	Quantity Limit	SMKG		Step Therapy
	Limited to two 15 day fills per month for first 3 months	¢		
	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
DIURETICS Cont.		
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ADRENAL STEROID INHIBITORS		
ISTURISA TAB 10MG (QL= 6 tabs/day)	LD-PA-QL	MSP
ISTURISA TAB 1MG (QL= 8 tabs/day)	LD-PA-QL	MSP
ISTURISA TAB 5MG (QL= 2 tabs/day)	LD-PA-QL	MSP
BONE DENSITY REGULATORS		
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
TYMLOS INJ	MSP-PA	MSP
FERTILITY REGULATORS		
CLOMID TAB	-	2
CLOMIPHENE TAB	-	2
GNRH/LHRH ANTAGONISTS		
ORILISSA TAB 150MG (QL= 1 tab/day)	PA-QL	2
ORILISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	2
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ	LD-PA	MSP
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	EXC
GROWTH HORMONES		
NORDITROPIN INJ	MSP-PA	MSP
OMNITROPE INJ	MSP-PA	MSP
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older)	-	1
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ	LD-PA	MSP
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL NASAL SOLN	-	2
METABOLIC MODIFIERS		
calcitriol cap (ROCALTROL equiv)	-	1
calcitriol soln (ROCALTROL SOLN equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1
levocarnitine tab (CARNITOR equiv)	-	1
cinacalcet tab (SENSIPAR equiv)	-	2
doxercalciferol cap (HECTOROL 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
paricalcitol cap (ZEMPLAR equiv)	-	2
betaine powder for oral solution (CYSTADANE equiv)	LD	MSP
carglumic acid tab (CARBAGLU equiv)	LD-PA	MSP
PALYNZIQ INJ (QL= 1 inj/day)	LD-PA-QL-SF	MSP
PHEBURANE ORAL PELLETS	MSP-PA	MSP
sapropterin dihydrochloride powder packet (KUVAN equiv)	MSP-PA	MSP
sapropterin dihydrochloride soluble tab (KUVAN equiv)	MSP-PA	MSP
sodium phenylbutyrate powder (BUPHENYL equiv)	MSP-PA	MSP
sodium phenylbutyrate tab (BUPHENYL equiv)	MSP-PA	MSP
STRENSIQ INJ	LD-PA	MSP
NATRIURETIC PEPTIDES		
VOXZOGO INJ (QL= 1 vial/day)	LD-PA-QL	MSP
POSTERIOR PITUITARY HORMONES		
desmopressin acetate tab (DDAVP equiv)	-	2
STIMATE NASAL SOLN	-	2
PROGESTERONE RECEPTOR ANTAGONISTS		
mifepristone tab (MIFIPREX equiv)	-	EXC
MIFIPREX TAB	-	EXC
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	1
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	-	2
OCTREOTIDE INJ 100MCG	-	2
SIGNIFOR INJ (QL= 2 vials/day)	LD-PA-QL	MSP
VASOPRESSIN RECEPTOR ANTAGONISTS		
JYNARQUE PAK (QL= 2 tabs/day)	LD-PA-QL	MSP
JYNARQUE TAB (QL= 2 tabs/day)	LD-PA-QL	MSP
ESTROGENS		
ESTROGEN COMBINATIONS		
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1
jinteli tab (FEMHRT equiv)	-	1
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	2
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	2
PREMPHASE TAB, PREMPRO TAB	-	2
ESTROGENS		
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
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	2
PREMARIN TAB	-	2
FLUOROQUINOLONES		
FLUOROQUINOLONES		
ciprofloxacin tab (CIPRO 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
levofloxacin soln (LEVAQUIN equiv)	-	1
LEVOFLOXACIN SOLN 25MG/ML	-	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
GASTROINTESTINAL AGENTS - MISC.		
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB	-	2
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB (QL= 1 tab/day)	LD-PA-QL-SF-¢	MSP
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	2
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	PA-QL	2
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
METZOZLV ODT	-	EXC
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS		
BYLVAY CAP 1200MCG (QL= 5 caps/day)	LD-PA-QL	MSP
BYLVAY CAP 400MCG (QL= 15 caps/day)	LD-PA-QL	MSP
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day)	LD-PA-QL	MSP
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day)	LD-PA-QL	MSP
LIVMARLI SOLN (QL= 90ml/30 days)	LD-PA-QL	MSP
INFLAMMATORY BOWEL AGENTS		
balsalazide cap (COLAZAL equiv)	-	1
sulfasalazine EC tab (AZULFIDINE equiv)	-	1
sulfasalazine tab (AZULFIDINE equiv)	-	1
mesalamine DR cap (DELZICOL equiv)	-	2
mesalamine DR tab (LIALDA equiv)	-	2
mesalamine enema (ROWASA equiv)	-	2
mesalamine ER cap (APRISO equiv)	-	2
mesalamine supp (CANASA equiv)	-	2
CIMZIA INJ (QL= 2 inj/28 days)	MSP-PA-QL	MSP
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	MSP-PA-QL	MSP
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	MSP-PA-QL	MSP
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	MSP-PA-QL	MSP
INTESTINAL ACIDIFIERS		
lactulose soln	-	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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
LINZESS CAP	-	2
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB	PA	2
SYMPROIC TAB	PA	2
PHOSPHATE BINDER AGENTS		
calcium acetate cap (PHOSLO equiv)	-	1
FOSRENOL POWDER PACK	-	2
lanthanum carbonate chew tab (FOSRENOL equiv)	-	2
sevelamer powder pak (REVELA equiv)	-	2
sevelamer tab (REVELA TAB equiv)	-	2
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		
CYTRA K CRYSTALS	-	1
CYTRA-3 SYRUP	-	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 (UROCIT-K TAB equiv)	-	2
IGA NEPHROPATHY (IGAN) AGENTS		
FILSPARI TAB (QI= 1 tab/day)	MSP-PA-QL	MSP
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	2
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin SR tab (UROXATRAL equiv)	-	1
dutasteride cap (AVODART equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
silodosin cap (RAPAFLO equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
URINARY ANALGESICS		
phenazopyridine tab (PYRIDIDIUM equiv)	-	1
phenazopyridine tab 95mg (AZO equiv)	OTC	1
phenazopyridine tab 97.5mg (AZO equiv)	OTC	1
phenazopyridine tab 99.5mg (AZO equiv)	OTC	1
URINARY STONE AGENTS		
tiopronin tab (THIOLA equiv)	MSP-PA	MSP
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1
GOUT AGENTS		
allopurinol tab (ZYLOPRIM equiv)	-	1
colchicine tab (COLCRYS 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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
GOUT AGENTS Cont.		
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST-¢	2
URICOSURICS		
probenecid tab (BENEMID equiv)	-	1
HEMATOLOGICAL AGENTS - MISC.		
ANTHEMOPHILIC PRODUCTS		
HEMLIBRA INJ	MSP-PA	MSP
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant inj (FIRAZYR equiv)	MSP-PA	MSP
COMPLEMENT INHIBITORS		
BERINERT INJ	LD-PA	MSP
CINRYZE INJ (QL= 16 vials/28 days)	LD-PA-QL	MSP
EMPAVELI INJ (QL= 160ml/28 days)	LD-PA-QL	MSP
HAEGARDA INJ	LD-PA	MSP
RUCONEST INJ	LD-PA	MSP
TAVNEOS CAP (QL= 6 caps/day)	LD-PA-QL	MSP
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB (QL= 2 tabs/day)	LD-PA-QL-SF	MSP
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	1
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO INJ (QL= 2 inj/28 days)	LD-PA-QL	MSP
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days)	LD-PA-QL	MSP
PLATELET AGGREGATION INHIBITORS		
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
aspirin/dipyridamole cap (AGGRENOX equiv)	-	2
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	2
CABLIVI INJ KIT (QL= 1 vial/day)	LD-PA-QL	MSP
PYRUVATE KINASE ACTIVATORS		
PYRUKYND TAB (QL= 2 tabs/day)	LD-PA-QL	MSP
PYRUKYND TAPER PACK (QL= 1 tab/day)	LD-PA-QL	MSP
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
miglustat cap (ZAVESCA equiv)	LD-PA	MSP
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	2
AGENTS FOR SICKLE CELL DISEASE		
ENDARI POWDER PACK (QL= 6 packets/day)	MSP-PA-QL	MSP
OXBRYTA TAB (QL= 3 tabs/day)	LD-PA-QL	MSP
OXBRYTA TAB FOR ORAL SUSP (QL= 5 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	MSP
COBALAMINS		

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
cyanocobalamin inj	-	1
FOLIC ACID/FOLATES		
folic acid tab 400mcg (Covered for females only)	OTC	\$0
folic acid tab 800mcg (Covered for females only)	OTC	\$0
folic acid tab 1mg (Covered at \$0 for females only)	-	1
HEMATOPOIETIC GROWTH FACTORS		
DOPTELET TAB (QL= 2 tabs/day)	LD-PA-QL	MSP
FULPHILA INJ	MSP	MSP
NIVESTYM INJ	MSP	MSP
NYVEPRIA INJ	MSP	MSP
PROMACTA POWDER	MSP-PA	MSP
PROMACTA TAB	MSP-PA	MSP
RETACRIT INJ	MSP	MSP
ZARXIO INJ	MSP	MSP
HEMATOPOIETIC MIXTURES		
ferrex 150 forte cap	-	1
folbee tab	-	1
MULTIGEN FOLIC TAB	-	1
MULTIGEN PLUS TAB	-	1
MULTIGEN TAB	-	1
tricon cap (TRINSICON equiv)	-	1
NEPHRON FA TAB	-	2
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid soln (AMICAR equiv)	-	2
tranexamic acid tab (LYSTEDA equiv)	-	2
HYPNOTICS		
NON-BARBITURATE HYPNOTICS		
zolpidem tab (AMBIEN equiv)	-	1
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	1
phenobarbital tab	-	1
SECONAL CAP	-	2
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	1
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1
FLURAZEPAM CAP	-	1
midazolam hcl syrup	-	1
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	1
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 30mg (RESTORIL equiv)	-	1
triazolam tab (HALCION equiv)	-	1
zaleplon cap (SONATA equiv) (QL= 2 caps/day)	QL	1
zolpidem ER tab (AMBIEN CR equiv) (QL= 1 tab/day)	QL	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 NC/3P = Not Covered, Third Party Reviewer 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	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
EDLUAR SL TAB	-	EXC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	EXC
ZOLPIDEM TARTRATE SL TAB 1.75MG	-	EXC
ZOLPIDEM TARTRATE SL TAB 3.5MG	-	EXC
ZOLPIMIST SPRAY	-	EXC
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	QL	2
LAXATIVES		
LAXATIVE COMBINATIONS		
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0
sodium/magnesium/potassium soln (SUPREP equiv) (QL= 2 fills/calendar year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0
GAVILYTE-C SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year)	QL	1
GOLYTELY SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year)	QL	1
NULYTELY SOLN (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year)	QL	1
peg 3350/electrolytes soln (NULYTELY equiv) (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1
LAXATIVES - MISCELLANEOUS		
lactulose soln	-	1
MACROLIDES		
AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
CLARITHROMYCIN		
clarithromycin tab (BIAXIN equiv)	-	1
CLARITHROMYC SUSP	-	2
ERYTHROMYCINS		
erythromycin DR cap (ERYC equiv)	-	2
ERYTHROMYCIN EC CAP	-	2
erythromycin ethylsuccinate susp (ERYPED equiv)	-	2
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2
erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE)	-	2
FIDAXOMICIN		
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CERVICAL CAP	-	\$0
DIAPHRAGM	-	\$0
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$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	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$0
DIABETIC SUPPLIES		
ACCU-CHEK AVIVA PLUS METER	OTC	\$0
ACCU-CHEK GUIDE CARE METER	OTC	\$0
ACCU-CHEK GUIDE ME KIT	OTC	\$0
ACCU-CHEK NANO METER	OTC	\$0
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	\$0
ONETOUCH METER	OTC	\$0
ONETOUCH VERIO FLEX METER	OTC	\$0
ONETOUCH VERIO IQ METER	OTC	\$0
ONETOUCH VERIO METER	OTC	\$0
ONETOUCH VERIO REFLECT METER	OTC	\$0
CALIBRATION LIQUID	OTC	1
DEXCOM G6 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME
FREESTYLE LANCETS	OTC	DME
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	DME
LANCETS	OTC	DME
OMNIPOD 5 INTRO KIT (QL= 1 kit/year)	QL	DME
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	DME
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	DME
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	DME
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	DME
V-GO INJ KIT (QL= 1 kit/day)	QL	DME
MISC. DEVICES		
ALCOHOL SWABS	OTC	DME
PARENTERAL THERAPY SUPPLIES		
BD ECLIPSE NEEEDLE/25G X	OTC	DME
BD HYPO NEEDLE MIS 18Gx1.5"	-	DME
B-D INSULIN SYRINGE	--OTC	DME
B-D PEN NEEDLE	OTC	DME
CARETOUCH MIS	OTC	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	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
HYPO NEEDDLE MIS 18GX1.5	OTC	DME
HYPODERMIC NEEDLES	OTC	DME
INSULIN SYRINGE	OTC	DME
NEEDLE (DISP) 18 G	-	DME
NOVOFINE PEN NEEDLE	OTC	DME
NOVOTWIST PEN NEEDLE	OTC	DME
SYRINGE (DISPOSABLE) 3 ML	-	DME
SYRINGE LUER-LOK	OTC	DME
TB SYRINGE	OTC	DME
RESPIRATORY AIDS		
MASK	OTC	DME
RESPIRATORY THERAPY SUPPLIES		
AEROCHAMBER	OTC	DME
PEAK FLOW METER	OTC	DME
SPACER MASK	OTC	DME
MIGRAINE PRODUCTS		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	2
MIGRAINE COMBINATIONS		
ergotamine/cafeine tab (CAFERGOT equiv)	-	2
ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	2
isometheptene/cafeine/acetaminophen tab (PRODRIN equiv)	-	2
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES		
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	2
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	2
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year)	PA-QL	2
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	2
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POWDER	-	EXC
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	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= 9 tabs/fill, 2 fills/30 days)	QL	2
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	2
SUMATRIPTAN INJ (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

MINERALS & ELECTROLYTES

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
FLUORIDE		
sodium fluoride chew tab (LURIDE 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
PHOSPHATE		
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
potassium phosphate monobasic tab (K-PHOS equiv)	-	2
POTASSIUM		
K-TAB	-	1
POT/CHLORIDE EFFER TAB	-	1
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 (K-TAB equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1
POTASSIUM CHLORIDE TAB ER	-	1
potassium chloride powder packet (KLOR-CON equiv)	-	2
potassium chloride soln	-	2
ZINC		
GALZIN CAP	-	2

MISCELLANEOUS THERAPEUTIC CLASSES

CHELATING AGENTS		
penicillamine tab (DEPEN TITRATAB equiv)	-	2
trientine cap (SYPRINE equiv)	MSP-PA	MSP
IMMUNOMODULATORS		
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day)	PA-QL	MSP
REVLIMID CAP (QL= 1 cap/day)	PA-QL	MSP
REZUROCK TAB (QL= 1 tab/day)	LD-PA-QL	MSP
IMMUNOSUPPRESSIVE AGENTS		
everolimus tab (ZORTRESS equiv)	PA	2
sirolimus soln (RAPAMUNE equiv)	-	2
ENSPRYNG INJ (QL= 1 inj/28 days)	MSP-PA-QL	MSP
PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS		
VIJOICE TAB (QL= 1 tab/day)	MSP-PA-QL	MSP
VIJOICE TAB 250MG (QL= 2 tabs/day)	MSP-PA-QL	MSP
POTASSIUM REMOVING AGENTS		
SPS SUSP	-	1
LOKELMA PAK	PA	2
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	MSP-PA-QL	MSP
BENLYSTA INJ (QL= 4 inj/28 day)	MSP-PA-QL	MSP

MOUTH/THROAT/DENTAL AGENTS

ANESTHETICS TOPICAL ORAL		
---------------------------------	--	--

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	1
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
DENTAL PRODUCTS		
FLUORIDEX SENSITIVITY PASTE	-	1
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
PREVIDENT SOLN	-	2
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
THROAT PRODUCTS - MISC.		
pilocarpine tab (SALAGEN equiv)	-	1
cevimeline cap (EVOXAC equiv)	-	2
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	-	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1
renaphro cap (NEPHROCAP equiv)	-	1
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	1
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	1
PED MV W/ FLUORIDE		
MULTIVITAMIN/FLOURIDE CHEW 0.25MG	-	1
MULTIVITAMIN/FLOURIDE CHEW 1MG	-	1
MULTIVITAMIN/FLUORIDE CHEW TAB	-	1
pediatric multiple vitamins/fluoride chew tab	-	1
pediatric multiple vitamins/fluoride soln	-	1
PRENATAL VITAMINS		
PRENATAL 19 CHEW TAB	-	1
CONCEPT DHA CAP	PA	2

MUSCULOSKELETAL THERAPY AGENTS

CENTRAL MUSCLE RELAXANTS

baclofen tab (BACLOFEN 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	generic = small letters	LD	BRANDS = CAPITAL LETTERS
MSP	NC/3P = Not Covered, Third Party Reviewer	INF	PA	Limited Distribution
QL	Plan Exclusion	OTC	RS	Prior Authorization
SF	Mandatory Specialty Pharmacy Program	RDX	ST	Restricted to Specialist
VAC	Quantity Limit	SMKG		Step Therapy
	Limited to two 15 day fills per month for first 3 months	¢		
	Vaccine Program			

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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
carisoprodol tab (SOMA equiv)	-	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
chlorzoxazone tab 500mg	-	2
carisoprodol tab 250mg (SOMA equiv)	-	EXC

DIRECT MUSCLE RELAXANTS

dantrolene cap (DANTRIUM equiv)	-	2
---------------------------------	---	---

NASAL AGENTS - SYSTEMIC AND TOPICAL

NASAL AGENTS - MISC.

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

NASAL ANTIALLERGY

azelastine nasal spray 0.1% (ASTELIN equiv)	-	1
azelastine nasal spray 0.15% (ASTEPRO equiv) (OTC covered only)	OTC	1
olopatadine nasal spray (PATANASE equiv)	-	2

NASAL ANTICHOLINERGICS

ipratropium nasal spray (ATROVENT equiv)	-	1
--	---	---

NASAL STEROIDS

budesonide nasal spray (RHINOCORT AQUA equiv) (QL= 2 bottles/fill)	OTC-QL	1
FLONASE SENSIMIST NASAL SPRAY	OTC	1
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	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

NEUROMUSCULAR AGENTS

ALS AGENTS

riluzole tab (RILUTEK equiv)	-	2
RADICAVA ORS STARTER KIT (QL= 70ml/365 days)	LD-PA-QL	MSP
RADICAVA ORS SUSP (QL= 50mL/28 days)	LD-PA-QL	MSP
RELYVRIO PAK (QL= 2 packets/day)	LD-PA-QL	MSP

SPINAL MUSCULAR ATROPHY AGENTS (SMA)

EVRYSDI SOLN (QL= 6.67ml/day)	LD-PA-QL	MSP
-------------------------------	----------	-----

OPHTHALMIC AGENTS

BETA-BLOCKERS - OPHTHALMIC

BETAXOLOL OPHTH SOLN	-	1
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	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
timolol maleate ophth soln (TIMOPTIC equiv)	-	1
BETIMOL OPHTH 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.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF Infertility	LD Limited Distribution
EXC	OTC Over-the-Counter	PA Prior Authorization
MSP Mandatory Specialty Pharmacy Program	RDX Restricted to Diagnosis	RS Restricted to Specialist
QL Quantity Limit	SMKG Smoking Cessation	ST Step Therapy
SF Limited to two 15 day fills per month for first 3 months	¢	
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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
BETOPTIC-S OPHTH SOLN	-	2
brimonidine/timolol ophth soln (COMBIGAN equiv)	-	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
CYCLOPLEGIC MYDRIATICS		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
phenylephrine ophth soln (MYDFRIN equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPHTH SOLN	-	2
HOMATROPINE OPHTH SOLN	-	2
MIOTICS		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPHTH SOLN	-	2
OPHTHALMIC ADRENERGIC AGENTS		
brimonidine ophth soln 0.2%	-	1
APRACLONIDINE OPHTH SOLN	-	2
apraclonidine ophth soln (IOPIDINE equiv)	-	2
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	2
IOPIDINE OPHTH SOLN	-	2
SIMBRINZA OPHTH SUSP	-	2
OPHTHALMIC ANTI-INFECTIVES		
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 (Covered at \$0 for members 1 year or younger)	-	1
GENTAK OPHTH OINT	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1
levofloxacin ophth soln (QUIXIN equiv)	-	1
LEVOFLOXACIN OPHTH SOLN 0.5%	-	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

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
NATACYN OPHTH SUSP (QL= 15ml/fill)	QL	2
TOBREX OPHTH OINT	-	2
TRIFLURIDINE OPHTH SOLN	-	2
ZIRGAN OPHTH GEL	-	2
OPHTHALMIC IMMUNOMODULATORS		
cyclosporine ophth emulsion (RESTASIS equiv) (Restricted to Ophthalmology or Optometry Specialist)	RS	2
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA OPHTH SOLN	-	2
ROCKLATAN OPHTH SOLN	-	2
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	1
OPHTHALMIC STEROIDS		
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	-	1
PREDNISOLONE OPHTH SUSP	-	1
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	1
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1
ALREX OPHTH SUSP	-	2
BLEPHAMIDE OPHTH SOLN	-	2
difluprednate ophth emulsion (DUREZOL equiv)	-	2
LOTEMAX OPHTH GEL	-	2
LOTEMAX OPHTH OINT	-	2
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	2
loteprednol ophth susp (LOTEMAX equiv)	-	2
MAXIDEX OPHTH SOLN	-	2
PRED FORTE OPHTH SUSP 1%	-	2
PRED MILD OPHTH SOLN	-	2
PRED-G OPHTH SOLN	-	2
TOBRADEX OPHTH OINT	-	2
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2
OPHTHALMICS - MISC.		
azelastine ophth soln (OPTIVAR equiv)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1
CROMOLYN SODIUM OPHTH SOLN	-	1
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1
dorzolamide ophth soln (TRUSOPT 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)	OTC	1
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-QL	1
PATADAY ER OPHTH SOLN 0.7%	-	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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

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

OPHTHALMIC AGENTS Cont.

ALOCRILOPHTH SOLN	-	2
ALOMIDOPHTH SOLN	-	2
brinzolamide ophth susp (AZOPT equiv)	-	2
bromfenac ophth soln (BROMDAY equiv)	-	2
FLURBIPROFENOPHTH SOLN	-	2
ILEVROOPHTH SUSP	-	2
NEVANACOPHTH SUSP	-	2
PROLENSAOPHTH SOLN	-	2
CYSTADROPS SOLN (QL= 4 bottles/28 days)	LD-PA-QL	MSP
CYSTARANOPHTH SOLN (QL= 4 bottles/28 days)	LD-PA-QL	MSP

PROSTAGLANDINS - OPHTHALMIC

latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	2
LUMIGANOPHTH SOLN (QL= 2.5ml/30 days)	QL	2
travoprost ophth soln (TRAVATAN Z equiv) (QL= 2.5ml/30 days)	QL	2

OTIC AGENTS

OTIC AGENTS - MISCELLANEOUS

acetic acid otic soln (VOSOL equiv)	-	1
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1

OTIC ANTI-INFECTIVES

ofloxacin otic soln (FLOXIN equiv)	-	1
CIPROFLOXACIN OTIC SOLN	-	2

OTIC COMBINATIONS

neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	2
COLY-MYCIN S OTIC SUSP	-	2

OTIC STEROIDS

ACETASOL HC OTIC SOLN	-	1
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1
fluocinolone otic oil (DERMOTIC equiv)	-	2

OXYTOCICS

OXYTOCICS

methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	2
---	----	---

PASSIVE IMMUNIZING AGENTS

IMMUNE SERUMS

HIZENTRA INJ	MSP-PA	MSP
--------------	--------	-----

PASSIVE IMMUNIZING AND TREATMENT AGENTS

IMMUNE SERUMS

HIZENTRA INJ	MSP-PA	MSP
--------------	--------	-----

MONOCLONAL ANTIBODIES

BEYFORTUS INJ	VAC	EXC
---------------	-----	-----

PENICILLINS

AMINOPENICILLINS

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	generic = small letters	LD	BRANDS = CAPITAL LETTERS
MSP	NC/3P = Not Covered, Third Party Reviewer	INF	PA	Limited Distribution
QL	Plan Exclusion	OTC	RS	Prior Authorization
SF	Mandatory Specialty Pharmacy Program	RDX	ST	Restricted to Specialist
VAC	Quantity Limit	SMKG		Step Therapy
	Limited to two 15 day fills per month for first 3 months	¢		
	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
PENICILLINS Cont.		
amoxicillin cap (TRIMOX equiv)	-	1
AMOXICILLIN CHEW TAB	-	1
amoxicillin susp (TRIMOX equiv)	-	1
amoxicillin tab (AMOXIL equiv)	-	1
NATURAL PENICILLINS		
penicillin vk tab (VEETIDS equiv)	-	1
PENICILLIN COMBINATIONS		
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin cap (DYNAPEN equiv)	-	1
PROGESTINS		
PROGESTINS		
medroxyprogesterone tab (PROVERA equiv)	-	1
norethindrone tab (AYGESTIN equiv)	-	1
progesterone cap (PROMETRIUM equiv)	-	1
progesterone oil inj	-	1
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
disulfiram tab (ANTABUSE equiv)	-	1
acamprosate calcium DR tab (CAMPRAL equiv)	-	2
ANTI-CATAPLECTIC AGENTS		
SODIUM OXYBATE SOLN	LD-PA	MSP
ANTIDEMENTIA AGENTS		
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)	QL	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
rivastigmine patch (EXELON equiv)	-	2
COMBINATION PSYCHOTHERAPEUTICS		
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	2
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	2
SAVELLA TAB (QL= 2 tabs/day)	QL	2
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB (Ql= 4 tabs/day)	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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
AUSTEDO XR TAB (QL= 2 tabs/day)	MSP-PA-QL	MSP
AUSTEDO XR TAB 6MG (QL= 3 tabs/day)	MSP-PA-QL	MSP
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days)	MSP-PA-QL	MSP
INGREZZA CAP (QL= 1 cap/day)	LD-PA-QL	MSP
INGREZZA PACK 40-80MG (QL= 1 pack/28 days)	LD-PA-QL	MSP
tetrabenazine tab (XENAZINE equiv)	MSP-PA	MSP
MULTIPLE SCLEROSIS AGENTS		
dimethyl fumarate DR cap (TECFIDERA equiv)	MSP	1
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	MSP	1
fingolimod hcl cap 0.5mg (GILENYA equiv)	MSP	1
glatiramer inj (COPAXONE equiv)	MSP	1
teriflunomide tab (AUBAGIO equiv)	MSP	1
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist)	QL-RS	2
AVONEX INJ	MSP	MSP
EXTAVIA INJ	MSP	MSP
GILENYA CAP 0.25MG	MSP	MSP
KESIMPTA INJ	MSP-PA	MSP
MAYZENT TAB	MSP	MSP
MAYZENT TAB STARTER PACK	MSP	MSP
PLEGRIDY INJ	MSP	MSP
PLEGRIDY PEN INJ	MSP	MSP
REBIF INJ ()	MSP	MSP
ZEPOSIA CAP (QL= 1 cap/day)	MSP-PA-QL	MSP
ZEPOSIA STARTER PACK (QL= 1 cap/day)	MSP-PA-QL	MSP
PSEUDOBULBAR AFFECT (PBA) AGENTS		
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	2
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
PIMOZIDE TAB	-	2
SMOKING DETERRENTS		
bupropion SR tab (ZYBAN equiv) (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
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	\$0
varenicline tartrate tab (VARENICLINE equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
VASOMOTOR SYMPTOM AGENTS		
paroxetine cap (BRISDELLE equiv)	-	EXC
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
KALYDECO PAK (QL= 2 packets/day)	LD-PA-QL	MSP
KALYDECO TAB (QL= 2 tabs/day)	LD-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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
RESPIRATORY AGENTS - MISC. Cont.		
ORKAMBI GRANULES PACKET (QL= 2 packets/day)	LD-PA-QL	MSP
ORKAMBI TAB (QL= 4 tabs/day)	LD-PA-QL	MSP
PULMOZYME INH SOLN	MSP-PA	MSP
SYMDEKO TAB (QL= 2 tabs/day)	LD-PA-QL	MSP
TRIKAFTA TAB (QL= 84 tabs/28 days)	PA-QL	MSP
TRIKAFTA THERAPY PACK	LD-PA-QL	MSP
PULMONARY FIBROSIS AGENTS		
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	MSP
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	MSP-PA-QL-SF	MSP
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	MSP-PA-QL-SF	MSP
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	MSP-PA-QL-SF	MSP
TETRACYCLINES		
TETRACYCLINES		
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1
doxycycline hyclate tab 20mg, 100mg (VIBRATAB equiv)	-	1
doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv)	-	1
minocycline cap (MINOCIN equiv)	-	1
doxycycline monohydrate tab	-	2
doxycycline susp (VIBRAMYCIN equiv)	-	2
MINOLIRA TAB	-	EXC
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
THYROID HORMONES		
ARMOUR THYROID TAB, NATURE THROID TAB	-	1
levothyroxine tab (SYNTHROID equiv)	-	1
liothyronine tab (CYTOMEL equiv)	-	1
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1
THYROLAR TAB	-	2
SYNTHROID TAB	-	EXC
TOXOIDS		
TOXOID COMBINATIONS		
ADACEL/BOOSTRIX INJ	VAC	EXC
DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	EXC
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	EXC
KINRIX PEF SYRINGE, QUADRACEL PEF SYRINGE	VAC	EXC
PEDIARIX INJ	VAC	EXC
PENTACEL INJ	VAC	EXC
ULCER DRUGS		
ANTISPASMODICS		
dicyclomine cap (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
hyoscyamine sulfate CR tab (LEVBIID equiv)	-	1
hyoscyamine sulfate elixir (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	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1
hyoscyamine sulfate soln (LEVSIN equiv)	-	1
hyoscyamine tab (LEVSIN equiv)	-	1
BELLADONNA ALKALOID/OPIUM SUPP	-	2
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	2
dicyclomine soln (BENTYL equiv)	-	2
glycopyrrolate tab (ROBINUL equiv)	-	2
PROPANTHELINE TAB	-	2
H-2 ANTAGONISTS		
cimetidine soln (CIMETIDINE equiv)	-	1
cimetidine tab (TAGAMET HB equiv)	-	1
nizatidine cap (AXID equiv)	-	1
famotidine susp (PEPCID equiv)	-	2
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	1
PROTON PUMP INHIBITORS		
esomeprazole cap (NEXIUM equiv)	OTC	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
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	1
ULCER THERAPY COMBINATIONS		
pepcid chewable	-	1
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
H-2 ANTAGONISTS		
CIMETIDINE SOLN	-	1
famotidine tab (PEPCID equiv)	-	1
NIZATIDINE CAP	-	1
MISC. ANTI-ULCER		
sucralfate susp (CARAFATE equiv)	-	2
PROTON PUMP INHIBITORS		
lansoprazole odt (PREVACID SOLUTAB equiv) (No Prior Authorization required for members 12 years and younger.)	PA	2
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)		
tropium chloride SR cap (SANCTURA XR equiv)	-	2
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
oxybutynin ER tab (DITROPAN XL equiv)	-	1
oxybutynin syrup	-	1
oxybutynin tab (DITROPAN equiv)	-	1
OXYTROL PATCH (OTC)	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	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
URINARY ANTISPASMODICS Cont.		
solifenacin tab (VESICARE equiv)	-	1
tolterodine tab (DETROL equiv)	-	1
tropium tab (SANCTURA equiv)	-	1
darifenacin SR tab (ENABLEX equiv)	-	2
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	2
tolterodine SR cap (DETROL LA equiv)	-	2
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
MYRBETRIQ TAB	-	2
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	1

VACCINES

BACTERIAL VACCINES		
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2
ACTHIB INJ, HIBERIX INJ	VAC	EXC
BCG INJ	VAC	EXC
PEDVAXHIB INJ	VAC	EXC
PREVNAR 20 INJ	VAC	EXC
VAXNEUVANCE INJ	VAC	EXC
VIRAL VACCINES		
ABRYVO INJ	VAC	EXC
AREXVY INJ	VAC	EXC
COMIRNATY INJ 30MCG/0.3ML	VAC	EXC
COVID-19 VACCINE INJ 5-11Y (PFIZER)	VAC	EXC
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	VAC	EXC
COVID-19 VACCINE INJ 6M-4Y (PFIZER)	VAC	EXC
DENG VAXIA SUSP	VAC	EXC
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	EXC
IMOVAX INJ	VAC	EXC
IPOL INJ	VAC	EXC
MODERNA COVID-19 VACCINE	VAC	EXC
PREHEVBRIO SUSP	VAC	EXC
PRIORIX INJ	VAC	EXC
RABAVERT INJ	VAC	EXC
ROTARIX SUSP	VAC	EXC
ROTATEQ INJ	VAC	EXC
SHINGRIX INJ	VAC	EXC
SPIKEVAX COVID-19 VACCINE	VAC	EXC
SPIKEVAX INJ 50MCG/0.5ML	VAC	EXC

VAGINAL AND RELATED PRODUCTS

VAGINAL ANTI-INFECTIVES		
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	2
XACIATO GEL (QL= 1 applicator/fill)	QL	2
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL (QL= 1 box/fill)	QL	\$0

VAGINAL PRODUCTS

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Category/Class**

Last Updated* 11/1/2023

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
SPERMICIDES		
CONTRACEPTIVE FOAM	OTC	\$0
CONTRACEPTIVE GEL	OTC	\$0
TODAY SPONGE	OTC	\$0
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	1
metronidazole vaginal gel (METROGEL equiv)	-	1
terconazole cream (TERAZOL equiv)	-	1
TERCONAZOLE CREAM 0.8%	-	1
terconazole supp (TERAZOL equiv)	-	1
VAGINAL ESTROGENS		
estradiol cream (ESTRACE equiv)	-	1
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
VAGINAL PROGESTINS		
CRINONE GEL	-	EXC
ENDOMETRIN INSERT	-	EXC
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	2
SYMJEPI INJ (QL= 2 inj/fill)	QL	2
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	1
VITAMINS		
MISC. NUTRITIONAL FACTORS		
PRENATAL VITAMIN (RX ONLY)	-	1
OIL SOLUBLE VITAMINS		
vitamin D cap (RX strength only)	-	1
phytonadione tab (MEPHYTON equiv)	-	2
WATER SOLUBLE VITAMINS		
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

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 NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	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 3-Tier Complete Formulary
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ACTEMRA ACTPEN INJ	MSP
ACTEMRA SC INJ	MSP
ACTIMMUNE INJ	MSP
ADALIMUMAB-ADAZ INJ	MSP
ADALIMUMAB-ADAZ PFS INJ	MSP
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	MSP
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	MSP
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	MSP
ADBRY INJ	MSP
ADEMPAS TAB	MSP
AIMOVIG INJ	2
AJOVY INJ	2
ALECENSA CAP	MSP
ALFERON-N INJ	MSP
ALINIA SUSP	2
ALUNBRIG TAB 30MG	MSP
ALUNBRIG TAB 90MG, 180MG	MSP
ambrisentan tab	MSP
ANDRODERM PATCH	2
ARIKAYCE SUSP	MSP
AUSTEDO TAB	MSP
AUSTEDO XR TAB	MSP
AUSTEDO XR TAB 6MG	MSP
AUSTEDO XR TAB TITRATION KIT	MSP
AYVAKIT TAB	MSP
BALVERSA TAB 3MG	MSP
BALVERSA TAB 4MG	MSP
BALVERSA TAB 5MG	MSP
BENLYSTA AUTO-INJECTOR	MSP
BENLYSTA INJ	MSP
BERINERT INJ	MSP
bexarotene gel	MSP
bosentan tab	MSP
BOSULIF TAB	MSP
BRAFTOVI CAP 75MG	MSP
BRUKINSA CAP	MSP
BYLVAY CAP 1200MCG	MSP
BYLVAY CAP 400MCG	MSP
BYLVAY SPRINKLE CAP 200MCG	MSP
BYLVAY SPRINKLE CAP 600MCG	MSP
CABLIVI INJ KIT	MSP
CABOMETYX 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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
CALQUENCE CAP	MSP
CALQUENCE TAB	MSP
CAMZYOS CAP	MSP
CAPRELSA TAB	MSP
carglumic acid tab	MSP
CAYSTON INH SOLN	MSP
CIBINQO TAB	MSP
CIMZIA INJ	MSP
CIMZIA STARTER INJ KIT	MSP
CINRYZE INJ	MSP
clobazam susp	2
COMETRIQ KIT	MSP
CONCEPT DHA CAP	2
COPIKTRA CAP	MSP
CORLANOR TAB	2
COTELLIC TAB	MSP
CYSTADROPS SOLN	MSP
CYSTARAN OPHTH SOLN	MSP
deferiprone tab	MSP
DESCOVY TAB	2
DIACOMIT CAP	MSP
DIACOMIT POWDER PACK	MSP
DILANTIN CAP 30MG	2
DOPTELET TAB	MSP
DUPIXENT INJ	MSP
DUPIXENT PEN INJ	MSP
EMGALITY INJ	2
EMGALITY INJ 100MG/ML	2
EMPAVELI INJ	MSP
ENBREL INJ 25MG	MSP
ENBREL INJ 50MG	MSP
ENBREL MINI INJ	MSP
ENBREL SURECLICK INJ 50MG	MSP
ENDARI POWDER PACK	MSP
ENSPRYNG INJ	MSP
EPIDIOLEX SOLN	MSP
ERIVEDGE CAP	MSP
ERLEADA TAB	MSP
ERLEADA TAB 240MG	MSP
erlotinib tab	MSP
everolimus tab	MSP
everolimus tab for oral susp	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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
EVRYSDI SOLN	MSP
EXKIVITY CAP	MSP
fentanyl citrate lollipop	2
FERRIPROX SOLN	MSP
FILSPARI TAB	MSP
FINTEPLA SOLN	MSP
FIRDAPSE TAB	MSP
FOTIVDA CAP	MSP
GAVRETO CAP	MSP
gefitinib tab	MSP
GILOTRIF TAB	MSP
HADLIMA INJ	MSP
HADLIMA INJ 40MG/0.8ML	MSP
HADLIMA PUSH INJ	MSP
HADLIMA PUSH INJ 40MG/0.8ML	MSP
HAEGARDA INJ	MSP
HEMLIBRA INJ	MSP
HIZENTRA INJ	MSP
HUMIRA INJ 10MG	MSP
HUMIRA INJ 20MG	MSP
HUMIRA INJ 40MG	MSP
HUMIRA INJ 80MG	MSP
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	MSP
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	MSP
HUMIRA INJ PEDIATRIC UC STARTER PACK	MSP
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	MSP
HUMIRA PEN INJ 40MG	MSP
HYCAMTIN CAP	MSP
hydrocortisone valerate cream	2
HYFTOR GEL	MSP
icatibant inj	MSP
ICLUSIG TAB	MSP
icosapent ethyl cap	2
IDHIFA TAB	MSP
IMBRUVICA CAP 140MG	MSP
IMBRUVICA CAP 70MG	MSP
IMBRUVICA SUSP	MSP
IMBRUVICA TAB 420MG, 560MG	MSP
IMCIVREE INJ	MSP
INCRELEX INJ	MSP
INGREZZA CAP	MSP
INGREZZA PACK 40-80MG	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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
INLYTA TAB	MSP
INQOVI TAB	MSP
INTRON-A INJ	MSP
ISTURISA TAB 10MG	MSP
ISTURISA TAB 1MG	MSP
ISTURISA TAB 5MG	MSP
JAKAFI TAB	MSP
JAYPIRCA TAB	MSP
JYNARQUE PAK	MSP
JYNARQUE TAB	MSP
KALYDECO PAK	MSP
KALYDECO TAB	MSP
KESIMPTA INJ	MSP
KEVZARA INJ	MSP
KINERET INJ	MSP
KISQALI PAK	MSP
KISQALI TAB	MSP
KORLYM TAB	MSP
KOSELUGO CAP	MSP
KOSELUGO CAP 10MG	MSP
KRAZATI TAB	MSP
LAMPIT TAB	2
lansoprazole odt	2
lapatinib ditosylate tab	MSP
LEDIPASVIR/SOFOSBUVIR TAB	MSP
lenalidomide cap	MSP
LENVIMA CAP	MSP
LIVMARLI SOLN	MSP
LIVTENCITY TAB	MSP
LOKELMA PAK	2
LONSURF TAB	MSP
LORBRENA TAB 100MG	MSP
LORBRENA TAB 25MG	MSP
lubiprostone cap	2
LUMAKRAS TAB	MSP
LUMAKRAS TAB 320MG	MSP
LYNPARZA TAB	MSP
LYTGOBI THERAPY PACK	MSP
MAVYRET PAK	MSP
MAVYRET TAB	MSP
MEKINIST TAB 0.5MG	MSP
MEKINIST TAB 2MG	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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
MEKTOVI TAB	MSP
miglustat cap	MSP
MOVANTIK TAB	2
MYFEMBREE TAB	2
NERLYNX TAB	MSP
NEXLETOL TAB	2
NINLARO CAP	MSP
nitazoxanide tab	2
NORDITROPIN INJ	MSP
NUBEQA TAB	MSP
NUDEXTA CAP	2
OCALIVA TAB	MSP
ODOMZO CAP	MSP
OFEV CAP	MSP
OLUMIANT TAB	MSP
OMNITROPE INJ	MSP
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
ORGOVYX TAB	MSP
ORIAHNN CAP	2
ORILISSA TAB 150MG	2
ORILISSA TAB 200MG	2
ORKAMBI GRANULES PACKET	MSP
ORKAMBI TAB	MSP
ORSERDU TAB	MSP
ORSERDU TAB 345MG	MSP
OTEZLA STARTER PACK	MSP
OTEZLA TAB	MSP
OXBRYTA TAB	MSP
OXBRYTA TAB FOR ORAL SUSP	MSP
PALYNZIQ INJ	MSP
pazopanib tab	MSP
PEGASYS INJ	MSP
PEMAZYRE TAB	MSP
PHEBURANE ORAL PELLETS	MSP
phenoxybenzamine cap	MSP
PIQRAY TAB	MSP
pirfenidone cap	MSP
pirfenidone tab 267mg	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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
pirfenidone tab 801mg	MSP
POMALYST CAP	MSP
PREVYMIS TAB	MSP
PROMACTA POWDER	MSP
PROMACTA TAB	MSP
PULMOZYME INH SOLN	MSP
pyrimethamine tab	MSP
PYRUKYND TAB	MSP
PYRUKYND TAPER PACK	MSP
QINLOCK TAB	MSP
RADICAVA ORS STARTER KIT	MSP
RADICAVA ORS SUSP	MSP
RELYVRIO PAK	MSP
REPATHA INJ	2
REPATHA PUSHTRONEX INJ	2
RETEVMO CAP	MSP
REVLIMID CAP	MSP
REYVOW TAB	2
REZLIDHIA CAP	MSP
REZUROCK TAB	MSP
RINVOQ ER TAB	MSP
ROZLYTREK CAP	MSP
RUBRACA TAB	MSP
RUCONEST INJ	MSP
rufinamide susp	2
rufinamide tab	2
RUKOBIA ER TAB	2
RYDAPT CAP	MSP
sapropterin dihydrochloride powder packet	MSP
sapropterin dihydrochloride soluble tab	MSP
SIGNIFOR INJ	MSP
sildenafil susp	2
SIMPONI AUTO-INJECTOR 100MG	MSP
SIMPONI INJ 100MG	MSP
SKYRIZI INJ 150MG/ML	MSP
SKYRIZI INJ 180 MG/1.2ML	MSP
SKYRIZI INJ 360MG/2.4ML	MSP
SKYRIZI INJ 75MG/0.83ML	MSP
SODIUM OXYBATE SOLN	MSP
sodium phenylbutyrate powder	MSP
sodium phenylbutyrate tab	MSP
SOFOSBUVIR/VELPATASVIR 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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
SOMAVERT INJ	MSP
sorafenib tosylate tab	MSP
SPRYCEL TAB	MSP
STELARA INJ	MSP
STIVARGA TAB	MSP
STRENSIQ INJ	MSP
sunitinib malate cap	MSP
SUNOSI TAB	2
SYMDEKO TAB	MSP
SYMPROIC TAB	2
TABRECTA TAB	MSP
TADLIQ SUSP	MSP
TAFINLAR CAP	MSP
TAGRISSO TAB	MSP
TAKHZYRO INJ	MSP
TAKHZYRO INJ 150MG/ML	MSP
TALTZ INJ	MSP
TALZENNA CAP 0.25MG	MSP
TALZENNA CAP 0.5MG, 0.75MG, 1MG	MSP
TASIGNA CAP	MSP
TAVALISSE TAB	MSP
TAVNEOS CAP	MSP
TAZVERIK TAB	MSP
TEPMETKO 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 PUMP	2
testosterone gel pump 1.62%	1
testosterone soln	2
tetrabenazine tab	MSP
THALOMID CAP	MSP
TIBSOVO TAB	MSP
tiopronin tab	MSP
TOBI PODHALER	MSP
tobramycin neb soln	MSP
TRACLEER TAB 32MG	MSP
TREMFYA INJ	MSP
trientine cap	MSP
TRIKAFTA TAB	MSP
TRIKAFTA THERAPY PACK	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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
TUKYSA TAB	MSP
TURALIO CAP	MSP
TYMLOS INJ	MSP
TYVASO DPI POWDER	MSP
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	MSP
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	MSP
TYVASO DPI POWDER TITRATION KIT 16-32MCG	MSP
TYVASO INH SOLN	MSP
UBRELVY TAB	2
UPTRAVI TAB	MSP
VALCHLOR GEL	MSP
VELTASSA POWDER	2
VENCLEXTA STARTER PACK	MSP
VENCLEXTA TAB	MSP
VENTAVIS INH SOLN	MSP
VERZENIO TAB	MSP
vigabatrin powder pack	MSP
vigabatrin tab	MSP
vigadrone powder pack	MSP
VIJOICE TAB	MSP
VIJOICE TAB 250MG	MSP
VITRAKVI CAP 100MG	MSP
VITRAKVI CAP 25MG	MSP
VITRAKVI SOLN	MSP
VIZIMPRO TAB	MSP
VONJO CAP	MSP
VOSEVI TAB	MSP
VOTRIENT TAB	MSP
VOXZOGO INJ	MSP
VYNDAMAX CAP	MSP
VYNDAQEL CAP	MSP
WELIREG TAB	MSP
XALKORI CAP	MSP
XELJANZ SOLN	MSP
XELJANZ TAB	MSP
XELJANZ XR TAB	MSP
XOSPATA TAB	MSP
XPOVIO PAK	MSP
ZEJULA CAP	MSP
ZEJULA TAB	MSP
ZELBORAF TAB	MSP
ZEPOSIA 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 3-Tier Complete Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2023

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ZEPOSIA STARTER PACK	MSP
ZOLINZA CAP	MSP
ZORYVE CREAM	2
ZTALMY SUSP	MSP
ZYDELIG TAB	MSP
ZYKADIA CAP	MSP
ZYKADIA 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 3-Tier Complete Formulary
Last Updated* 11/1/2023
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

febuxostat tab
 rasagiline tab

JANUVIA TAB

nebivolol hcl tab

OCALIVA 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 3-Tier Complete Formulary
Last Updated* 11/1/2023
Over-the-Counter (OTC)

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

Over-the-Counter (OTC) Medications

ACCU-CHEK AVIVA PLUS METER	ACCU-CHEK AVIVA PLUS TEST STRIP	ACCU-CHEK GUIDE CARE METER	ACCU-CHEK GUIDE ME KIT
ACCU-CHEK GUIDE TEST STRIP	ACCU-CHEK NANO METER	ACCU-CHEK SMARTVIEW TEST STRIP	ACCU-CHEK TEST STRIP
AEROCHAMBER aspirin chew tab 81mg	ALCOHOL SWABS aspirin ec tab 81mg	ammonium lactate cream azelastine nasal spray 0.15%	ammonium lactate lotion BD ECLIPSE NEEEDLE/25C X
B-D INSULIN SYRINGE CALIBRATION LIQUID cetirizine tab diclofenac gel 1% OTC FLONASE SENSIMIST NASAL SPRAY guaifenesin/codeine syrup	B-D PEN NEEDLE CARETOUCH MIS CLINISTIX TEST STRIP DIFFERIN OTC GEL 0.1% folic acid tab 400mcg	benzoyl peroxide gel cetirizine chew tab CONTRACEPTIVE FOAM esomeprazole cap folic acid tab 800mcg	budesonide nasal spray cetirizine syrup CONTRACEPTIVE GEL FEMALE CONDOMS FREESTYLE LANCETS
KETO-DIASTIX TEST STRIF LANCETS lidocaine cream 4% loratadine tab meclizine tab niacin tab NICOTINE KIT NOVOLIN 70/30 INJ NOVOLIN R FLEXPEN INJ olopatadine ophth soln 0.2%	HYPO NEEDDLE MIS 18GX1.5 KETOSTIX lansoprazole cap lidocaine rectal cream MALE CONDOMS naloxone hcl nasal spray NIACIN TR TAB nicotine lozenge NOVOLIN MIX FLEXPEN IN. NOVOLIN R INJ ONETOUCH METER	HYPODERMIC NEEDLES ketotifen ophth soln levonorgestrel tab loratadine ODT MASK niacin cap niacinamide tab nicotine patch NOVOLIN N FLEXPEN INJ NOVOTWIST PEN NEEDLE ONETOUCH TEST STRIP	INSULIN SYRINGE LAC-HYDRIN LOTION 5% lidocaine cream loratadine syrup meclizine chew tab niacin CR tab nicotine gum NOVOFINE PEN NEEDLE NOVOLIN N INJ olopatadine ophth soln 0.1% ONETOUCH VERIO FLEX METER
ONETOUCH VERIO IQ METER OXYTROL PATCH (OTC) phenazopyridine tab 99.5mg SYRINGE LUER-LOK	ONETOUCH VERIO METER PEAK FLOW METER PREVACID OTC CAP TB SYRINGE	ONETOUCH VERIO REFLECT METER phenazopyridine tab 95mg selenium sulfide lotion TEST STRIP (all other test strips)	ONETOUCH VERIO TEST STRIP phenazopyridine tab 97.5mg SPACER MASK TODAY SPONGE
triamcinolone OTC nasal spray			

** 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 3-Tier Complete Formulary
Last Updated* 11/1/2023
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
ADALIMUMAB-ADAZ INJ	ADALIMUMAB-ADAZ PFS INJ	ADALIMUMAB-FKJP AUTO-INJECTOR KIT	ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	ADBRY INJ	ADEMPAS TAB	ALECENSA CAP
ALFERON-N INJ	ALUNBRIG TAB 30MG	ALUNBRIG TAB 90MG, 180MG	ambrisentan tab
ARIKAYCE SUSP	AUSTEDO TAB	AUSTEDO XR TAB	AUSTEDO XR TAB 6MG
AUSTEDO XR TAB TITRATION KIT	AVONEX INJ	AYVAKIT TAB	BALVERSA TAB 3MG
BALVERSA TAB 4MG	BALVERSA TAB 5MG	BENLYSTA AUTO-INJECTOI	BENLYSTA INJ
BERINERT INJ	betaine powder for oral solution	bexarotene cap	bexarotene gel
bosentan tab	BOSULIF TAB	BRAFTOVI CAP 75MG	BRUKINSA CAP
BYLVAY CAP 1200MCG	BYLVAY CAP 400MCG	BYLVAY SPRINKLE CAP 200MCG	BYLVAY SPRINKLE CAP 600MCG
CABLIVI INJ KIT	CABOMETYX TAB	CALQUENCE CAP	CALQUENCE TAB
CAMZYOS CAP	capecitabine tab	CAPRELSA TAB	carglumic acid tab
CAYSTON INH SOLN	CIBINQO TAB	CIMZIA INJ	CIMZIA STARTER INJ KIT
CINRYZE INJ	COMETRIQ KIT	COPIKTRA CAP	COTELLIC TAB
CYSTADROPS SOLN	CYSTARAN OPHTH SOLN	deferasirox granules packet	deferasirox tab
deferasirox tab 180mg	deferasirox tab 90mg, 360mg	deferiprone tab	DIACOMIT CAP
DIACOMIT POWDER PACK	dimethyl fumarate DR cap	dimethyl fumarate DR starter pack	DOPTELET TAB
DUPIXENT INJ	DUPIXENT PEN INJ	EMPAVELI INJ	ENBREL INJ 25MG
ENBREL INJ 50MG	ENBREL MINI INJ	ENBREL SURECLICK INJ 50MG	ENDARI POWDER PACK
ENSPRYNG INJ	EPIDIOLEX SOLN	ERIVEDGE CAP	ERLEADA TAB
ERLEADA TAB 240MG	erlotinib tab	ETOPOSIDE CAP	everolimus tab
everolimus tab for oral susp	EVRYSDI SOLN	EXKIVITY CAP	EXTAVIA INJ
FERRIPROX SOLN	FILSPARI TAB	figolimod hcl cap 0.5mg	FINTEPLA SOLN
FIRDAPSE TAB	FOTIVDA CAP	FULPHILA INJ	GAVRETO CAP
gefitinib tab	GILENYA CAP 0.25MG	GILOTRIF TAB	glatiramer inj
HADLIMA INJ	HADLIMA INJ 40MG/0.8ML	HADLIMA PUSH INJ	HADLIMA PUSH INJ 40MG/0.8ML
HAEGARDA INJ	HEMLIBRA INJ	HIZENTRA INJ	HUMIRA INJ 10MG
HUMIRA INJ 20MG	HUMIRA INJ 40MG	HUMIRA INJ 80MG	

** 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.

HUMIRA INJ CROHNS/UC/HIDRADENITI STARTER PACK HUMIRA PEN INJ 40MG ICLUSIG TAB IMBRUVICA CAP 70MG	HUMIRA INJ PEDIATRIC CROHNS STARTER PACK HYCAMTIN CAP IDHIFA TAB IMBRUVICA SUSP	HUMIRA INJ PEDIATRIC UC STARTER PACK HYFTOR GEL imatinib tab IMBRUVICA TAB 420MG, 560MG INGREZZA PACK 40-80MG ISTURISA TAB 10MG JAYPIRCA TAB KALYDECO TAB KISQALI PAK KOSELUGO CAP 10MG LENVIMA CAP	HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK icatibant inj IMBRUVICA CAP 140MG IMCIVREE INJ INLYTA TAB ISTURISA TAB 1MG JYNARQUE PAK KESIMPTA INJ KISQALI TAB KRAZATI TAB LIVMARLI SOLN
INCRELEX INJ INQOVI TAB ISTURISA TAB 5MG JYNARQUE TAB KEVZARA INJ KORLYM TAB lapatinib ditosylate tab	INGREZZA CAP INTRON-A INJ JAKAFI TAB KALYDECO PAK KINERET INJ KOSELUGO CAP LEDIPASVIR/SOFOSBUVIR TAB LORBRENA TAB 100MG LYNPARZA TAB MAVYRET TAB	LORBRENA TAB 25MG LYSODREN TAB MAYZENT TAB MEKTOVI TAB NERLYNX TAB NORDITROPIN INJ ODOMZO CAP OPSUMIT TAB ORENCIA SC INJ 87.5MG/0.7ML ORSERDU TAB 345MG OXBRYTA TAB FOR ORAL SUSP PEMAZYRE TAB	LUMAKRAS TAB LYTGOBI THERAPY PACK MAYZENT TAB STARTER PACK MESNEX TAB nilutamide tab NUBEQA TAB OFEV CAP ORENCIA CLICK INJ ORKAMBI GRANULES PACKET OTEZLA STARTER PACK PALYNZIQ INJ
LIVTENCITY TAB LUMAKRAS TAB 320MG MAVYRET PAK	MEKINIST TAB 0.5MG miglustat cap NINLARO CAP NYVEPRIA INJ OLUMIANT TAB ORENCIA SC INJ 125MG/MI	MEKINIST TAB 2MG MYLERAN TAB NIVESTYM INJ OCALIVA TAB OMNITROPE INJ ORENCIA SC INJ 50MG/0.4ML ORSERDU TAB OXBRYTA TAB	ORKAMBI TAB OTEZLA TAB pazopanib tab
phenoxybenzamine cap pirfenidone tab 801mg PREVYMIS TAB pyrimethamine tab RADICAVA ORS STARTER KIT RETACRIT INJ RIBAVIRIN CAP RUCONEST INJ	PIQRAY TAB PLEGRIDY INJ PROMACTA POWDER PYRUKYND TAB RADICAVA ORS SUSP	pirfenidone cap PLEGRIDY PEN INJ PROMACTA TAB PYRUKYND TAPER PACK REBIF INJ	PHEBURANE ORAL PELLETS pirfenidone tab 267mg POMALYST CAP PULMOZYME INH SOLN QINLOCK TAB RELYVRIO PAK
SIGNIFOR INJ	RETEVMO CAP RINVOQ ER TAB RYDAPT CAP	REZLIDHIA CAP ROZLYTREK CAP sapropterin dihydrochloride powder packet SIMPONI INJ 100MG	REZUROCK TAB RUBRACA TAB sapropterin dihydrochloride soluble tab SKYRIZI INJ 150MG/ML
SKYRIZI INJ 180 MG/1.2ML sodium phenylbutyrate powder sorafenib tosylate tab STRENSIQ INJ tadalafil tab (PAH) TAKHZYRO INJ	SIMPONI AUTO-INJECTOR 100MG SKYRIZI INJ 360MG/2.4ML sodium phenylbutyrate tab SPRYCEL TAB sunitinib malate cap TADLIQ SUSP TAKHZYRO INJ 150MG/ML	SKYRIZI INJ 75MG/0.83ML SOFOSBUVIR/VELPATASVI R TAB STELARA INJ SYMDEKO TAB TAFINLAR CAP TALTZ INJ	SODIUM OXYBATE SOLN SOMAVERT INJ STIVARGA TAB TABRECTA TAB TAGRISSO TAB TALZENNA CAP 0.25MG

** 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.

TALZENNA CAP 0.5MG,
0.75MG, 1MG
TAZVERIK TAB
tetrabenazine tab
TOBI PODHALER
tretinoin cap
TURALIO CAP

TASIGNA CAP
temozolomide cap
THALOMID CAP
tobramycin neb soln
trientine cap
TYMLOS INJ

TAVALISSE TAB
TEPMETKO TAB
TIBSOVO TAB
TRACLEER TAB 32MG
TRIKAFTA THERAPY PACK
TYVASO DPI POWDER

TAVNEOS CAP
teriflunomide tab
tiopronin tab
TREMIFYA INJ
TUKYSA TAB
TYVASO DPI POWDER
MAINTENANCE KIT
32-48MCG
UPTRAVI TAB

TYVASO DPI POWDER
TITRATION KIT 16-32-48MC
VALCHLOR GEL

TYVASO DPI POWDER
TITRATION KIT 16-32MCG
VENCLEXTA STARTER
PACK

TYVASO INH SOLN

VENTAVIS INH SOLN

VERZENIO TAB
VIJOICE TAB
VITRAKVI SOLN
VOTRIENT TAB
WELIREG TAB
XELJANZ XR TAB
ZEJULA TAB
ZOLINZA CAP
ZYKADIA TAB

vigabatrin powder pack
VIJOICE TAB 250MG
VIZIMPRO TAB
VOXZOGO INJ
XALKORI CAP
XOSPATA TAB
ZELBORAF TAB
ZTALMY SUSP

VENCLEXTA TAB

vigabatrin tab
VITRAKVI CAP 100MG
VONJO CAP
VYNDAMAX CAP
XELJANZ SOLN
XPOVIO PAK
ZEPOSIA CAP
ZYDELIG TAB

vigadrone powder pack
VITRAKVI CAP 25MG
VOSEVI TAB
VYNDAQEL CAP
XELJANZ TAB
ZARXIO INJ
ZEPOSIA STARTER PACK
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 3-Tier Complete Formulary
Last Updated* 11/1/2023
Step Therapy (ST)

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

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
amethyst tab	Step Therapy requires a trial of 2 preferred oral contraceptives
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYC SOLN, or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYC SOLN, or FIRVANQ SOLN
febuxostat tab	Step Therapy requires trial of allopurinol
fluvoxamine ER cap	Step Therapy requires a trial of 2 of the following: citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine, or paroxetine
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
gatifloxacin ophth soln	Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA
LONHALA MAGNAIR SOLN	Step Therapy requires trial of INCRUSE ELLIPTA INHALER
mometasone nasal spray	Step Therapy requires trial of two: fluticasone, triamcinolone OTC, or budesonide
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 (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL)
vilazodone hcl tab	QL= 1 tab/day; Step Therapy requires a trial of 1 of the following: citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine, or paroxetine

** 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 3-Tier Complete Formulary
Smoking Cessation Agents
Last Updated* 11/1/2023**

Drug Name	Tier # for Drug Copay
bupropion SR 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
VARENICLINE TAB(Limited to 180 days/plan year)	\$0
varenicline tartrate tab(Limited to 180 days/plan year)	\$0
varenicline tartrate tab starter pack(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 3-Tier Complete Formulary
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
abiraterone tab 250mg	QL= 4 tab/day;
ACTEMRA ACTPEN INJ	QL= 2 inj/28 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ADALIMUMAB-ADAZ INJ	QL= 2 inj/28 days
ADALIMUMAB-ADAZ PFS INJ	QL= 2 inj/28 days;
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	QL= 2 inj/28 days
ADBRY INJ	QL= 4 inj/28 days
ADDERALL XR CAP	QL= 2 caps/day
ADEMPAS TAB	QL= 3 tabs/day
AIMOVI INJ	QL= 1 pack/28 days
AJOVY 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
ALUNBRIG TAB 30MG	QL= 4 tabs/day
ALUNBRIG TAB 90MG, 180MG	QL= 1 tab/day
ambrisentan tab	QL= 1 tab/day
ANDRODERM PATCH	QL= 1 patch/day
aprepitant cap	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
aprepitant pak	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
ARIKAYCE SUSP	QL= 1 vial/day
armodafinil tab	QL= 1 tab/day
asenapine maleate SL tab	QL= 2 tabs/day
AUSTEDO TAB	QL= 4 tabs/day
AUSTEDO XR TAB	QL= 2 tabs/day
AUSTEDO XR TAB 6MG	QL= 3 tabs/day
AUSTEDO XR TAB TITRATION KIT	QL= 1 pack/28 days
AYVAKIT TAB	QL= 1 tab/day
BALVERSA TAB 3MG	QL= 3 tabs/day
BALVERSA TAB 4MG	QL= 2 tabs/day
BALVERSA TAB 5MG	QL= 1 tab/day
BAQSIMI NASAL POWDER	QL= 2 inhalations/fill
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
bosentan tab	QL= 2 tabs/day
BRAFTOVI CAP 75MG	QL= 6 caps/day
BRUKINSA CAP	QL= 4 caps/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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
budesonide nasal spray	QL= 2 bottles/fill
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; Diagnosis Restricted – Type 2 Diabetes (E11)
BYDUREON INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
BYDUREON PEN INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
BYLVAY CAP 1200MCG	QL= 5 caps/day
BYLVAY CAP 400MCG	QL= 15 caps/day
BYLVAY SPRINKLE CAP 200MCG	QL= 8 caps/day
BYLVAY SPRINKLE CAP 600MCG	QL= 4 caps/day
CABLIVI INJ KIT	QL= 1 vial/day
CABOMETYX TAB	QL= 1 tab/day
CALQUENCE CAP	QL= 2 caps/day
CALQUENCE TAB	QL= 2 tabs/day
CAMZYOS CAP	QL= 1 cap/day
CIBINQO TAB	QL= 1 tab/day
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA STARTER INJ KIT	QL= 1 kit/plan year
CINRYZE INJ	QL= 16 vials/28 days
clindamycin vaginal cream	QL=1 tube/fill
CLINDESSE VAGINAL CREAM	QL= 1 applicator/fill
COMPLERA TAB	QL= 1 tab/day
COPIKTRA CAP	QL= 2 caps/day
COTELLIC TAB	QL= 3 tabs/day
CYSTADROPS SOLN	QL= 4 bottles/28 days
CYSTARAN OPHTH SOLN	QL= 4 bottles/28 days
dalfampridine ER tab	QL= 2 tabs/day; Restricted to Neurology Specialist
DEPO-PROVERA INJ	QL= 1 inj/90 days
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	QL= 2 packs/fill
diclofenac gel	QL= 300 gm/30 days

** 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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
diclofenac gel 1%	QL= 5 tubes/fill
diclofenac soln 1.5%	QL= 3 bottles/fill
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day
DOPTELET TAB	QL= 2 tabs/day
DUPIXENT INJ	QL= 2 inj/28 days
DUPIXENT PEN INJ	QL= 2 inj/28 days
efavirenz/emtricitabine/tenofovir df tab	QL= 1 tab/day
eletriptan tab	QL= 9 tabs/fill, 2 fills/30 days
EMGALITY INJ	QL= 1 inj/28 days
EMGALITY INJ 100MG/ML	QL= 3 inj/fill, 6 fills/year
EMPAVELI INJ	QL= 160ml/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
ENDARI POWDER PACK	QL= 6 packets/day
ENSPRYNG INJ	QL= 1 inj/28 days
entecavir tab	QL= 1 tab/day
ENTRESTO TAB	QL= 2 tabs/day
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill
ERLEADA TAB	QL= 4 tabs/day
ERLEADA TAB 240MG	QL= 1 tab/day
estradiol patch	QL= 1 patch/week
estradiol vaginal tab, yuvafem vaginal tab	QL= 8 tabs/28 days (18 tabs on first fill)
estradiol valerate inj	QL= 5ml/fill
eszopiclone tab	QL= 1 tab/day
everolimus tab	QL= 1 tab/day
everolimus tab for oral susp	QL= 1 tab/day
EVRYSDI SOLN	QL= 6.67ml/day
EXKIVITY CAP	QL= 4 caps/day
FARXIGA TAB	QL= 1 tab/day
FEMALE CONDOMS	QL= 12 condoms/fill
fentanyl citrate lollipop	QL= 120 lozenges/30 days; Dosage limits may apply
FILSPARI TAB	QL= 1 tab/day
FINTEPLA SOLN	QL= 12ml/day
fluticasone nasal spray	QL= 2 bottles/fill
fluvastatin cap	QL= 2 caps/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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
FOTIVDA CAP	QL= 21 caps/28 days
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
gabapentin cap	QL= 9 caps/day
gabapentin soln	QL= 72 mls/day
gabapentin tab 600mg	QL= 6 tabs/day
gabapentin tab 800mg	QL= 4.5 tabs/day
GAVILYTE-C SOLN	Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year
GAVRETO CAP	QL= 4 caps/day
GENVOYA TAB	QL= 1 tab/day
GILOTRIF TAB	QL= 1 tab/day
GLUCAGEN HYPOKIT INJ	QL= 1 kit/fill, 2 fills/30 days
GLUCAGEN INJ	QL= 1 kit/fill, 2 fills/30 days
glucagon (rdna) for inj kit	QL= 1 kit/fill, 2 fills/30 days
GLUCAGON EMR INJ	QL= 2 inj/fill
GLYXAMBI TAB	QL= 1 tab/day
GOLYTELY SOLN	Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year
granisetron tab	QL= 14 tabs/fill
guaifenesin/codeine syrup	QL= 240ml/fill
GVOKE INJ	QL= 2 inj/fill
GVOKE INJ KIT	QL= 2 inj/fill
GVOKE PFS INJ	QL= 2 inj/fill
HADLIMA INJ	QL= 2 inj/28 days
HADLIMA INJ 40MG/0.8ML	QL= 2 inj/28 days
HADLIMA PUSH INJ	QL= 2 inj/28 days
HADLIMA PUSH INJ 40MG/0.8ML	QL= 2 inj/28 days
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 80MG	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

** 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 3-Tier Complete Formulary Cont.

Last Updated* 11/1/2023

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
HUMIRA INJ PEDIATRIC UC 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 bitartrate ER cap	QL= 2 caps/day
HYFTOR GEL	QL= 10 grams/30 days
ibandronate tab 150mg	QL= 1 tab/30 days
ICLUSIG TAB	QL= 1 tab/day
IDHIFA TAB	QL= 1 tab/day
IMBRUVICA CAP 140MG	QL= 3 caps/day
IMBRUVICA CAP 70MG	QL= 1 cap/day
IMBRUVICA SUSP	QL= 6ml/day
IMBRUVICA TAB 420MG, 560MG	QL= 1 tab/day
IMCIVREE INJ	QL= 1 inj/day
INGREZZA CAP	QL= 1 cap/day
INGREZZA PACK 40-80MG	QL= 1 pack/28 days
INLYTA TAB	QL= 8 tabs/day
INQOVI TAB	QL= 5 tabs/28 days
ISTURISA TAB 10MG	QL= 6 tabs/day
ISTURISA TAB 1MG	QL= 8 tabs/day
ISTURISA TAB 5MG	QL= 2 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
JAYPIRCA TAB	QL= 2 tabs/day
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
JYNARQUE PAK	QL= 2 tabs/day
JYNARQUE TAB	QL= 2 tabs/day
KALYDECO PAK	QL= 2 packets/day
KALYDECO TAB	QL= 2 tabs/day
ketorolac inj 15mg/ml	QL= 20ml/5 days
ketorolac inj 30mg/ml	QL= 20ml/5 days
ketorolac inj 60mg/2ml	QL= 20ml/5 days
ketorolac tab	QL= 20 tabs/5 days
KEVZARA INJ	QL= 2 inj/28 days
KINERET INJ	QL= 1 inj/day
KISQALI PAK	QL= 91 tabs/28 days
KISQALI TAB	QL= 63 tabs/28 days
KORLYM TAB	QL= 4 tabs/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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
KOSELUGO CAP	QL= 4 caps/day
KOSELUGO CAP 10MG	QL= 8 caps/day
KRAZATI TAB	QL= 6 tabs/day
LAGEVRIO CAP	QL= 40 caps/fill
latanoprost ophth soln	QL= 2.5ml/30 days
LEDIPASVIR/SOFOSBUVIR TAB	QL= 1 tab/day
lenalidomide cap	QL= 1 cap/day
LENVIMA CAP	QL= 3 caps/day
LEVALBUTEROL INHALER, XOPENEX HF INHALER	QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler
lidocaine oint	QL= 107gm/30 days
lidocaine patch	QL= 3 patches/day
lidocaine patch 5%	QL= 3 patches/day
LIVMARLI SOLN	QL= 90ml/30 days
LIVTENCITY TAB	QL= 4 tabs/day
LORBRENA TAB 100MG	QL= 1 tab/day
LORBRENA TAB 25MG	QL= 3 tabs/day
lubiprostone cap	QL= 2 caps/day
LUMAKRAS TAB	QL= 8 tabs/day
LUMAKRAS TAB 320MG	QL= 3 tabs/day
LUMIGAN OPHTH SOLN	QL= 2.5ml/30 days
LYNPARZA TAB	QL= 4 tabs/day
LYTGOBI THERAPY PACK	QL= 5 tabs/day
malathion lotion	
MALE CONDOMS	QL= 12 condoms/fill
MAVYRET PAK	QL= 5 packs/day
MAVYRET TAB	QL= 3 tabs/day
medroxyprogesterone inj	QL= 1 inj/90 days
MEKINIST TAB 0.5MG	QL= 3 tabs/day
MEKINIST TAB 2MG	QL= 1 tab/day
MEKTOVI TAB	QL= 6 tabs/day
methylergonovine tab	QL= 28 tabs/fill, 1 fill/365 days
modafinil tab	QL= 2 tabs/day
MOUNJARO INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
MYFEMBREE TAB	QL= 1 tab/day
NALOXONE PREFILLED INJ	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NATACYN OPHTH SUSP	QL= 15ml/fill
NAYZILAM SPRAY	QL= 2 packs/fill; Restricted to Neurology Specialist
NERLYNX TAB	QL= 6 tabs/day
NEXLETOL TAB	QL= 1 tab/day
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	

** 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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
nitazoxanide tab	QL= 6 tabs/3 days
NUBEQA TAB	QL= 4 tabs/day
NUCYNTA ER TAB	QL= 2 tabs/day; Dosage limits may apply
NUDEXTA CAP	QL= 2 caps/day
NULYTELY SOLN	Covered at \$0 for members 45-75 years, all other members covered at generic copay Limited to 2 fills/calendar year
OCALIVA TAB	QL= 1 tab/day
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
OMNIPOD 5 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 PACK PODS	QL= 10 pods/month
OMNIPOD DASH INTRO KIT	QL= 1 kit/year
OMNIPOD DASH PODS	QL= 10 pods/month
OMNIPOD STARTER KIT	QL= 1 kit/year
OPSUMIT TAB	QL= 1 tab/day
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
ORGOVYX TAB	QL= 30 tabs/28 days
ORIAHNN CAP	QL= 2 caps/day
ORILISSA TAB 150MG	QL= 1 tab/day
ORILISSA TAB 200MG	QL= 2 tabs/day
ORKAMBI GRANULES PACKET	QL= 2 packets/day
ORKAMBI TAB	QL= 4 tabs/day
ORSERDU TAB	QL= 3 tabs/day
ORSERDU TAB 345MG	QL= 1 tab/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
OXBRYTA TAB	QL= 3 tabs/day
OXBRYTA TAB FOR ORAL SUSP	QL= 5 tabs/day; Only available through Accredo 800-803-2523
OZEMPIC INJ	QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
paliperidone ER tab	QL= 2 tabs/day
PALYNZIQ INJ	QL= 1 inj/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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
PAXLOVID TAB	QL= 20 tabs/fill
pazopanib tab	QL= 4 tabs/day
peg 3350 soln (100 gram Moviprep equiv)	QL= 2 fills/year; \$0 for members 45-75 years, all other members covered at generic copay
peg 3350/electrolytes soln	Covered at \$0 for members 45-75 years, all other members covered at generic copay Limited to 2 fills/calendar year
PEMAZYRE TAB	QL= 1 tab/day
PHEXXI GEL	QL= 1 box/fill
pirfenidone cap	QL= 9 caps/day
pirfenidone tab 267mg	QL= 9 tabs/day
pirfenidone tab 801mg	QL= 3 tabs/day
POMALYST CAP	QL= 21 caps/28 days
POTIGA TAB	QL= 3 tabs/day
pregabalin 25mg, 50mg, 75mg, 100mg	QL= 5 caps/day
pregabalin cap 150mg	QL= 4 caps/day
pregabalin cap 225mg	QL= 2 caps/day
pregabalin cap 300mg	QL= 2 caps/day
pregabalin soln	QL= 30ml/day
PRETOMANID TAB	QL= 1 tab/day; Restricted to Infectious Disease Specialist
PREVYMIS TAB	QL= 1 tab/day; Limit 200 tabs/365 days
pyrimethamine tab	QL= 3 tabs/day
PYRUKYND TAB	QL= 2 tabs/day
PYRUKYND TAPER PACK	QL= 1 tab/day
QINLOCK TAB	QL= 3 tabs/day
RADICAVA ORS STARTER KIT	QL= 70ml/365 days
RADICAVA ORS SUSP	QL= 50mL/28 days
ramelteon tab	QL= 1 tab/day
REGANEX GEL	QL= 30gm/fill
RELENZA DISKHALER	QL= 1 inhaler/fill
RELYVRIO PAK	QL= 2 packets/day
REPATHA INJ	QL= 2 inj/28 days
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
RETEVMO CAP	QL= 4 caps/day
REVLIMID CAP	QL= 1 cap/day
REYVOW TAB	QL= 8 tabs/30 days, 6 fills/year
REZLIDHIA CAP	QL= 2 caps/day
REZUROCK TAB	QL= 1 tab/day
RINVOQ ER TAB	QL= 1 tab/day
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
ROZLYTREK CAP	QL= 3 caps/day
RUBRACA TAB	QL= 4 tabs/day
RYBELSUS TAB	QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11)

** 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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
RYDAPT CAP	QL= 56 caps/28 days
SANDIMMUNE SOLN 100MG/ML	QL= 150 mL/30 days
SANTYL OINT	QL= 90gm/30 days
SAVELLA TAB	QL= 2 tabs/day
scopolamine patch	QL= 5 patches/fill
SIGNIFOR INJ	QL= 2 vials/day
sildenafil tab	QL=8 tabs/30 days
sildenafil tab 20mg	QL= 40 tabs/30 days
SIMPONI AUTO-INJECTOR 100MG	QL=1 inj/28 days
SIMPONI INJ 100MG	QL=1 inj/28 days
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKYRIZI INJ 150MG/ML	QL= 1 inj/84 days
SKYRIZI INJ 180 MG/1.2ML	QL= 1 inj/56 days
SKYRIZI INJ 360MG/2.4ML	QL= 1 inj/56 days
SKYRIZI INJ 75MG/0.83ML	QL= 2 inj/84 days
sodium/magnesium/potassium soln	QL= 2 fills/calendar year; \$0 for members 45-75 years, all other members covered at generic copay
SOFOSBUVIR/VELPATASVIR TAB	QL= 1 tab/day
SOLQUA INJ	QL= 15ml/25 days
SOLU-CORTEF INJ	QL= 1 vial/fill
SOLU-CORTEF INJ 100MG	QL= 2 vials/fill
SPINOSAD SUSP	QL= 1 bottle/fill
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL)
STELARA INJ	QL= 1 inj/84 days
STIVARGA TAB	QL= 4 tabs/day
STRIBILD TAB	QL= 1 tab/day
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
SUNOSI TAB	QL= 1 tab/day
SYMDEKO TAB	QL= 2 tabs/day
SYMJEPI INJ	QL= 2 inj/fill
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
TABRECTA TAB	QL= 4 tabs/day
tadalafil tab	QL= 8 tabs/30 days

** 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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
tadalafil tab (PAH)	QL= 2 tabs/day
tadalafil tab 2.5mg, 5mg	QL= 1 tab/day
TAFINLAR CAP	QL= 4 caps/day
TAGRISSO TAB	QL= 1 tab/day
TAKHZYRO INJ	QL= 2 inj/28 days
TAKHZYRO INJ 150MG/ML	QL= 2 inj/28 days
TALTZ INJ	QL= 1 inj/28 days
TALZENNA CAP 0.25MG	QL= 3 caps/day
TALZENNA CAP 0.5MG, 0.75MG, 1MG	QL= 1 cap/day
TAVALISSE TAB	QL= 2 tabs/day
TAVNEOS CAP	QL= 6 caps/day
TAZVERIK TAB	QL= 8 tabs/day
TEPMETKO TAB	QL= 2 tabs/day
TESTOSTERONE ENANTHATE INJ 200MG/ML	QL= 5ml/fill
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 PUMP	QL= 4 bottles/30 days
testosterone gel pump 1.62%	QL= 2 bottles/30 days
testosterone soln	QL= 2 bottles/30 days
TIBSOVO TAB	QL= 2 tabs/day
TRACLEER TAB 32MG	QL= 4 tabs/day
TRADJENTA TAB	QL= 1 tab/day
travoprost ophth soln	QL= 2.5ml/30 days
TREMFYA INJ	QL= 1 inj/56 days
triamcinolone OTC nasal spray	QL= 2 bottles/fill
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG	QL= 1 tab/day
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG	QL= 2 tabs/day
TRIKAFTA TAB	QL= 84 tabs/28 days
TRIKAFTA THERAPY PACK	
TRIUMEQ PD TAB	QL= 1 tab/day
TRIUMEQ TAB	QL= 1 tab/day
TRULICITY INJ	QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
TUKYSA TAB	QL= 4 tabs/day
TURALIO CAP	QL= 4 caps/day
TYVASO DPI POWDER	QL= 4 cartridges/day
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	QL= 224 cartridges/28 days
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	QL= 252 cartridges/28 days

** 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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TYVASO DPI POWDER TITRATION KIT 16-32MCG	QL= 196 cartridges/28 days
TYVASO INH SOLN	QL= 1 ampule/day
UBRELVY TAB	QL= 10 tabs/30 days, 6 fills/year
UPTRAVI TAB	QL= 2 tabs/day
VALCHLOR GEL	QL= 4 tubes/30 days
vancomycin cap	QL= 56 caps/fill
VARENICLINE TAB	Limited to 180 days/plan year
varenicline tartrate tab	Limited to 180 days/plan year
varenicline tartrate tab starter pack	Limited to 180 days/plan year
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
VENTOLIN HFA INHALER	QL= 1 inhaler/fill, 2 fills/30 days; Member pays 1 copay per inhaler
VERQUVO TAB	QL= 1 tab/day; Restricted to Cardiology Specialist
VERZENIO TAB	QL= 2 tabs/day
V-GO INJ KIT	QL= 1 kit/day
VICTOZA INJ	QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11)
VIJOICE TAB	QL= 1 tab/day
VIJOICE TAB 250MG	QL= 2 tabs/day
vilazodone hcl tab	QL= 1 tab/day; Step Therapy requires a trial of 1 of the following: citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine, or paroxetine
VITRAKVI CAP 100MG	QL= 2 caps/day
VITRAKVI CAP 25MG	QL= 6 caps/day
VITRAKVI SOLN	QL= 10ml/day
VIVOTIF CAP	QL= 4 caps/fill
VIZIMPRO TAB	QL= 1 tab/day
VONJO CAP	QL= 4 caps/day
VOSEVI TAB	QL= 1 tab/day
VOTRIENT TAB	QL= 4 tabs/day
VOXZOGO INJ	QL= 1 vial/day
VYNDAMAX CAP	QL= 1 cap/day
VYNDAQEL CAP	QL= 4 caps/day
WELIREG TAB	QL= 3 tabs/day
XACIATO GEL	QL= 1 applicator/fill
XALKORI CAP	QL= 2 caps/day
XCOPRI PAK 100-150MG	QL= 2 tabs/day
XCOPRI PAK 150-200MG	QL= 2 tabs/day
XCOPRI PAK 50-200MG	QL= 2 tabs/day
XCOPRI TAB 150MG, 200MG	QL= 2 tabs/day
XCOPRI TAB 50MG, 100MG	QL= 1 tab/day
XCOPRI TITRATION PAK 12.5-25MG	QL= 1 tab/day
XCOPRI TITRATION PAK 150-200MG	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 3-Tier Complete Formulary Cont.
Last Updated* 11/1/2023
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
XCOPRI TITRATION PAK 50-100MG	QL= 1 tab/day
XELJANZ SOLN	QL= 10ml/day
XELJANZ TAB	QL= 2 tabs/day
XELJANZ XR TAB	QL= 1 tab/day
XENLETA TAB	QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist
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
XOSPATA TAB	QL= 3 tabs/day
XPOVIO PAK	QL= 32 tabs/28 days
XTAMPZA ER CAP	QL= 120 caps/30 days; Dosage limits may apply
XULTOPHY INJ	QL= 15ml/30 days
zaleplon cap	QL= 2 caps/day
ZEGALOGUE INJ	QL= 2 inj/fill
ZEJULA CAP	QL= 3 caps/day
ZEJULA TAB	QL= 1 tab/day
ZELBORAF TAB	QL= 8 tabs/day
ZEPOSIA CAP	QL= 1 cap/day
ZEPOSIA STARTER PACK	QL= 1 cap/day
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
zolpidem ER tab	QL= 1 tab/day
ZORYVE CREAM	QL= 60 grams/30 days
ZTALMY SUSP	QL= 1100ml/30 days
ZYKADIA CAP	QL= 3 caps/day
ZYKADIA TAB	QL= 3 tabs/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.