

Generic Name	Brand Name	Restrictions/Examples
<b>1. ANALGESICS - NSAIDS</b>		
diclofenac		
etodolac		
fenoprofen		
flurbiprofen		
ibuprofen		
indomethacin		
ketoprofen		
ketorolac		
meclofenamate		
mefenamic acid		
meloxicam		
nabumetone		
naproxen; naproxen Sodium		
oxaprozin Tabs		
piroxicam Caps		
sulindac Tabs		
tolmetin		
<b>2. ANALGESICS - OPIATE (ORAL AND TOPICAL)</b>		
acetaminophen w-caffeine-dihydrocodeine		
aspirin-caffeine-dihydrocodeine		
codeine phosphate/sulfate		
codeine/APAP		
fentanyl		Patches, buccal tabs, SL tabs, film, Lpop
hydrocodone/APAP		
hydrocodone/ibuprofen		
hydromorphone		
levorphanol tartrate		
meperidine HCl		
methadone		
morphine sulfate		
oxycodone		
oxycodone/APAP	Percocet	
oxycodone/ASA	Percodan	
oxymorphone HCl		
pentazocine-acetaminopen		
pentazocine w/naloxone		
tapentadol HCl	Nucynta	
tramadol HCl		
tramadol-acetaminophen		
<b>3. ANESTHETICS - TOPICAL</b>		
lidocaine HCl		

● = Drug must be dispensed with a minimum 28 day supply

^ = Drug requires prior authorization

**4. ANTIANXIETY AGENTS**

**All antianxiety agents**

benzodiazepines		e.g. alprazolam, chlordiazepoxide, diazepam, lorazepam, oxazepam
miscellaneous antianxiety agents		e.g. buspirone, hydroxyzine HCl, hydroxyzine pamoate
flurazepam		
temazepam		
clonazepam		

**5. ANTIBIOTICS**

**All Antibiotics**

aminoglycosides		e.g. amikacin, streptomycin
aminopenicillins		e.g. amoxicillin, ampicillin
anti TB combinations		e.g. rifampin/isoniazid,
anti-infective agents - Misc.		e.g. trimethoprim, vancomycin
anti-infective misc. - Combinations		e.g. trimethoprim/sulfamethoxazole, erythromycin sulfisoxazole
antimycobacterial agents		e.g. capreomycin, ethionamide, rifapentine, ethambutol, isoniazid, pyrazinamide, rifabutin, rifampin
azithromycins		
cephalosporins - 1st generation		e.g. cephalexin, cefadroxil
cephalosporins - 2nd generation		e.g. cefaclor, cefprozil, cefuroxime
cephalosporins - 3rd generation		e.g. cefpodoxime, cefdinir, cefditoren, cefixime, ceftibuten, ceftriaxone
clarithromycins		e.g. clarithromycin, fidaxomycin
erythromycins		
fluoroquinolones		e.g. ciprofloxacin, levofloxacin, moxifloxacin, ofloxacin, gemifloxacin, norfloxacin
ketolides		e.g. telithromycin
lincosamides		e.g. clindamycin
linezolid		
nitrofurans derivatives		e.g. Nitrofurantoin
ophthalmic anti-infectives		e.g. azithromycin, bacitracin, ciprofloxacin, gentamicin
penicillins		e.g. dicloxacillin, amoxicillin/potassium clavulanate, penicillin
tetracyclines		e.g. doxycycline, demeclocycline, minocycline, tetracycline

**6. ANTIBIOTICS - OPHTHALMICS**

bacitracin-polymyxin-neomycin HC Oph Oint 0.5%		
dexamethasone (Oph)		
Ophthalmic Steroid Combinations		e.g. gentamicin-prednisolone Ace Oph Susp e.g. loteprenol etabonate-tobramycin e.g. tobramycin-dexamethasone Oph Susp
Ophthalmic Steroid Combinations		e.g. neomycin-polymyxin-HC Oph Susp, e.g. neomycin-polymyxin-dexamethason Oph Oint
prednisolone acetate (Oph)		

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**7. ANTIDEPRESSANTS**

**All antidepressants**

alpha-2 receptor antagoists		e.g. mirtazapine
serotonin modulators		e.g. trazodone
SSRI's		e.g. citalopram, fluoxetine, paroxetine, sertraline
SNRI's		e.g. venlafaxine
tricyclic agents		e.g. amitriptyline
antidepressants-misc.		e.g. bupropion

**8. ANTIEMETICS**

promethazine		
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**9. ANTIFUNGAL AGENTS**

clotrimazole	Lotrimin, Mycelex	Vaginal, troche and topical only
clotrimazole/betamethasone	Lotrisone Cream	
miconazole		Only topical cream or ointments covered. All vaginal products covered.
nystatin		Oral only
terconazole	Terazol	Vaginal only

**10. ANTIPARASITICS - ORAL, TOPICAL**

permethrin cream		
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**11. ANTIPROTOZOALS**

nitazoxanide	Alinia	
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**12. ANTIPSYCHOTICS**

Antimanic Agents		e.g. lithium
Antipsychotics/Misc.	Geodon	e.g. ziprasidone
Benzisoxazoles	Risperdal	e.g. risperidone
Butyrophenones	Haldol	e.g. haloperidol
Dibenzodiazepines	Zyprexa Zyprexa Zydis	e.g. olanzapine
Phenothiazines		e.g. perphenazine
Thioxanthenes	Navane	e.g. thiothixene
valproic acid		e.g. divalproex

**13. ANTIVIRALS - OTHER**

oseltamivir	Tamiflu	
zanamivir	Relenza	

**14. ANTITUSSIVES - NON-NARCOTIC**

guaifenesin-codeine		
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**15. BRONCHODILATORS, INHALED/ORAL (ACUTE USE)**

albuterol sulfate		
levalbuterol HCl		

**16. DENTAL AIDS/MISCELLANEOUS**

chlorhexidine gluconate (Mouth-Throat)  
soln

**17. DIURETICS**

furosemide

**18. GI AGENTS**

bisacodyl-Peg 3350-pot chloride - sod  
bicarb - sod chloride

loperamide

metoclopramide

sulfasalazine

**19. HORMONES**

progesterone

Vaginal gel, suppository, insert

**20. MIGRAINE PRODUCTS**

selective serotonin agonists 5-HT

e.g. almotriptan, eletriptan, sumatriptan, etc.

sumatriptan-naproxen sodium

acetaminophen-isometheptene-  
dichloralphenazone

ergotamine w/caffeine

**21. MISCELLANEOUS**

leucovorin

Oral only

naloxone

Evzio, Narcan

**22. PROTON PUMP INHIBITORS**

dexlansoprazole

esomeprazole magnesium

lansoprazole

omeprazole

omeprazole Magnesium

pantoprazole Sodium

rabeprazole Sodium

omeprazole-sodium bicarbonate

**23. SKELETAL MUSCLE RELAXANTS**

Centrally acting muscle relaxants

    baclofen

    carisoprodol

    chlorzoxazone

    cyclobenzaprine HCl

    metaxalone

    methocarbamol

    orphenadrine Citrate

    tizanidine HCl

cyclobenzaprine HCl (Bulk)

dantrolene sodium

carisoprodol w/aspirin & codeine Tab 200-  
325-16mg



**OREGON CAREASSIST PROGRAM  
FORMULARY BY CLASS  
NON-PREFERRED PHARMACY FORMULARY  
Effective 10.1.2024**



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**Version 1. 2024**

**24. STEROIDS - INHALED**

bedesonide (Inhalation)		
budesonide (Nasal)		

**25. STEROIDS - ORAL**

budesonide		
dexamethasone		
hydrocortisone		
methylprednisolone		
prednisolone		
prednisolone sodium phosphate		
prednisone		

**25. STEROID - TOPICAL**

hydrocortisone (Rectal)		
hydrocortisone (Intrarectal)		
corticosteroids - Topical		

**26. ANTIRETROVIRALS**

Lenacapavir Sodium	Sunlenca	Drug accessible ONLY at CVS SPECIALITY Monroeville. Phone: 800-238-7828 Fax: 888-604-0385. Supplemental form needed. See detail PA criteria
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**Program Dispensing Policies:**

- Prescription Coverage:* The CAREAssist program will cover the copay for medications listed on the non-preferred pharmacy formulary for insured members when receiving medications at the NON-PREFERRED NETWORK (formerly referred to as out-of-network pharmacies).
- The non-preferred pharmacy formulary is a limited list of medications (primarily acute medications) available for CAREAssist insured members at non-preferred pharmacies.

**If patient has no primary insurance or the primary insurance has denied the claim, the member must receive services at a preferred pharmacy to receive services from the CAREAssist program.**

- Refill Percentage:* Refills may be obtained after 70% of the previously dispensed days supply has been used.
- Quantity Limits:* An authorization request will be required when quantity exceeds 120 for DEA class II and quantity exceeds 240 for DEA class III drugs. Submit original prescription with the request.