



OREGON CAREASSIST PROGRAM
FORMULARY BY CLASS
NON-PREFERRED PHARMACY FORMULARY



P: 888-311-7632

www.ramsellcorp.com

F: 800-848-4241

Version 1. 2016

Generic Name	Brand Name	Restrictions/Examples
1. ANALGESICS - NSAIDS		
diclofenac		
etodolac		
fenoprofen		
flurbiprofen		
ibuprofen		
indomethacin		
ketoprofen		
ketorolac		
meclofenamate		
mefenamic acid		
meloxicam		
nabumetone		
naproxen; naproxen Sodium		
oxaprozin Tabs		
piroxicam Caps		
sulindac Tabs		
tolmetin		
2. ANALGESICS - OPIATE (ORAL AND TOPICAL)		
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		
3. ANESTHETICS - TOPICAL		
lidocaine HCl		

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



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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		



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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

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

24. STEROIDS - INHALED

bedesonide (Inhalation)

budesonide (Nasal)



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25. STEROIDS - ORAL

budesonide		
dexamethasone		
hydrocortisone		
methylprednisolone		
frn		
prednisolone sodium phosphate		
prednisone		

25. STEROID - TOPICAL

hydrocortisone (Rectal)		
hydrocortisone (Intrarectal)		
corticosteroids - Topical		

Program Dispensing Policies:

1. *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).
2. 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.

1. *Refill Percentage*: Refills may be obtained after 70% of the previously dispensed days supply has been used.
2. *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.