OREGON CAREASSIST PROGRAM
FORMULARY BY CLASS
NON-PREFERRED PHARMACY FORMULARY
Effective 6/28/2022

P: 888-311-7632 **www.ramsellcorp.com** **F: 800-848-4241** **Version 1. 2022**

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, hydroxizine 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		
nitrofuran 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 - OPTHALMICS		
bacitracin-polymyxin-neomycin HC Opth Oint 0.5%		
dexamethasone (Opth)		
Opthalmic Steroid Combinations		e.g. gentamicin-prednisolone Ace Opth Susp e.g. loteprenol etabonate-tobramycin e.g. tobramycin-dexamethasone Opth Susp
Opthalmic Steroid Combinations		e.g. neomycin-polymyxin-HC Opth Susp, e.g. neomycin-polymyxin-dexamethason Opth Oint
prednisolone acetate (Opth)		

7. ANTIDEPRESSANTS		
All antidepressants		
alpha-2 receptor antagnoists		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		
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		
11. ANTIPROTOZOALS		
nitazoxanide	Alinia	
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		
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		

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		

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.