

Generic Name	Brand Name	Restrictions/Examples
1. ANTIRETROVIRALS (ALL ARVS ARE INCLUDED)		
abacavir	Ziagen	
abacavir/lamivudine	Epzicom	
abacavir/lamivudine/zidovudine	Trizivir	
atazanavir	Reyataz	
atazanavir/cobicistat	Evotaz	
bictegravir-emtricitabine-tenofovir AF	Biktarvy	
cobicistat	Tybost	
darunavir (TMC-114)	Prezista	
darunavir/cobicistat	Prezcobix	
delavirdine	Rescriptor	
didanosine	Videx, Videx EC	
dolutegravir	Tivicay	
dolutegravir/lamivudine/abacavir	Triumeq	
efavirenz	Sustiva	
efavirenz/lamivudine/tenofovir DF	Symfy Lo	
elvitegravir	Vitekta	
elvitegravir, coicistat,emtricitabine, tenofovir	Stribild	
elvitegravir, coicistat,emtricitabine, tenofovir		
alafenamide	Genvoya®	
enfuvirtide	Fuzeon	
emtricitabine	Emtriva	
emtricitabine/rilpivirine/tenofovir	Complera	
emtricitabine/tenofovir/efavirenz	Atripla	
etravirine	Intelence	
fosamprenavir	Lexiva	
indinavir	Crixivan	
lamivudine (3TC)	Epivir	
maraviroc	Selzentry	
lopinavir/ritonavir	Kaletra	
nelfinavir	Viracept	
nevirapine	Viramune, Viramune XR	
raltegravir (RGV or MK-0518)	Isentress	
rilpivirine	Edurant	
ritonavir	Norvir	
saquinavir	Invirase	
stavudine (d4T)	Zerit	
tenofovir	Viread	
tenofovir/emtricitabine	Truvada	
tenofovir alafenamide/emtricitabine	Descovy	
tipranavir	Aptivus	
zidovudine (AZT)	Retrovir	
zidovudine/lamivudine (AZT/3TC)	Combivir	
2. ANTIBIOTICS		
Azithromycin For Susp 100 Mg/5ml		
Azithromycin For Susp 200 Mg/5ml		
Azithromycin Powd Pack For Susp 1 Gm		
Azithromycin Tab 250 Mg		
Azithromycin Tab 500 Mg		
Azithromycin Tab 600 Mg		

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2. ANTIBIOTICS CONTINUED		
Ciprofloxacin For Oral Susp 250 Mg/5ml		
Ciprofloxacin For Oral Susp 500 Mg/5ml		
Ciprofloxacin Hcl Tab 100 Mg (Base Equ)		
Ciprofloxacin Hcl Tab 250 Mg (Base Equ)		
Ciprofloxacin Hcl Tab 500 Mg (Base Equ)		
Ciprofloxacin Hcl Tab 750 Mg (Base Equ)		
Clarithromycin For Susp 125 Mg/5ml		
Clarithromycin For Susp 250 Mg/5ml		
Clarithromycin Tab 250 Mg		
Clarithromycin Tab 500 Mg		
Clindamycin Hcl Cap 150 Mg		
Clindamycin Hcl Cap 300 Mg		
Clindamycin Hcl Cap 75 Mg		
Erythromycin Base (Coated) Tbec		
Erythromycin Base CPEP		
Erythromycin Base Tabs		
Erythromycin Base Tbec		
Erythromycin Ethylsuccinate For Susp 2		
Erythromycin Ethylsuccinate For Susp 4		
Erythromycin Ethylsuccinate Tabs		
Erythromycin Stearate Tabs		
Ethambutol Hcl Tab 100 Mg		
Ethambutol Hcl Tab 400 Mg		
Isoniazid Syrup 50 Mg/5ml		
Isoniazid Tab 100 Mg		
Isoniazid Tab 300 Mg		
Levofloxacin Oral Soln 25 Mg/ML		
Levofloxacin Tab 250 Mg		
Levofloxacin Tab 500 Mg		
Levofloxacin Tab 750 Mg		
Moxifloxacin Hcl Tab 400 Mg (Base Equi		
Ofloxacin Tab 200 Mg		
Ofloxacin Tab 300 Mg		
Ofloxacin Tab 400 Mg		
Penicillin G		
Pyrazinamide Tabs		
Rifabutin Cap 150 Mg		
Rifampin Cap 150 Mg		
Rifampin Cap 300 Mg		
Sulfamethoxazole-Trimethoprim Susp 200		
Sulfamethoxazole-Trimethoprim Tab 400-		
Sulfamethoxazole-Trimethoprim Tab 800-		
3. ANTIFUNGAL AGENTS		
Fluconazole For Susp 10 Mg/ML		
Fluconazole For Susp 40 Mg/ML		
Fluconazole Tabs		
Itraconazole Cap 100 Mg		
Itraconazole Oral Soln 10 Mg/ML		
Ketoconazole Tab 200 Mg		

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4. ANTIVIRALS		
Acyclovir		
Acyclovir Topical		
Valganciclovir		
Cidofovir		
Foscarnet Sodium		
Ganciclovir		
Imiquimod Cream		
Immune Globulin (Human) Inj		
Valacyclovir Hcl		
5. ANTIPARASITIC AGENTS		
Atovaquone		
Dapsone Tab 100 Mg		
Dapsone Tab 25 Mg		
Pentamidine Isethionate		
Pyrimethamine Tab 25 Mg		
Sulfadiazine Tab 500 Mg		
6. HEMATOPOIETIC AGENTS		
Epoetin Alfa		
Filgrastim		
7. HEPATITIS TREATMENT		
All Hep C Drugs are Included		
Adefovir Dipivoxil		
Entecavir		
Hepatitis B Immune Globulin (Human)		
Interferon Alfa-2b		
Interferon Alfacon-1		
Interferon Alfa-N3		
Lamivudine Oral Soln 5 Mg/MI (Hbv)		
Lamivudine Tab 100 Mg (Hbv)		
Peginterferon Alfa-2a		
Ribavirin Cap 200 Mg		
Ribavirin Soln 40 Mg/MI		
Ribavirin Tab 200 Mg		
Telbivudine		
^ simprevir	Olysio	Dispensing of this Hep C drug will only be approved after the PA criteria is FULLY met. Requires a fully completed supplemental PA form and claim form with request. Please call Ramsell for supplemental form or access it at www.ramsellcorp.com *PA required ONLY for UN-INSURED patients or patients whose primary insurance denies covering the medication. For INSURED patients, copayments are allowed
^ sofosbuvir	Sovaldi	
^ ledipasvir/sofosbuvir	Harvoni	
^ ombitasvir/paritaprevir/ritonavir	Technivie	
^ ombitasvir/paritaprevir/ritonavir + dasabuvir	Viekira Pak Viekira XR	
^ Daclatasvir	Daklinza	
^ elbasvir/grazoprevir	Zepatier	
8. MISCELLANEOUS		
ALL Nicotine Replacement Therapies - Smoking Deterrents		e.g. Nicotine Inhaler, Nicotine Nasal Spray
varenicline	Chantix	
bupropion	Zyban	
condoms		



**OREGON CAREASSIST PROGRAM
CAREASSIST RESTRICTED FORMULARY
APPLICABLE TO RESTRICTED MEMBERS ONLY**



P: 888-311-7632

Effective 3.20.2018

www.ramsellcorp.com

F: 800-848-4241

Version 3.2018

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Program Dispensing Policies:

1. Prescription Coverage: The CAREAssist program will cover at full price a 30 day supply of any medication listed on the Restricted formulary for Restricted Members ONLY.
2. Prior Authorization: Drugs marked with “^” require a prior authorization. Additional information will be required.
3. ADAP mandates the use of DHHS guidelines for dispensing of Antiretroviral Agents in HIV-1 infected patients. Dosing outside of DHHS guidelines requires a Treatment Exception Request (T.E.R.).