Oregon Health Authority

P: 888-311-7632

OREGON CAREASSIST PROGRAM
FORMULARY BY CLASS
Effective 8/29/2013
www.ramsellcorp.com

Ramsell™

F: 800-848-4241 **Version 3 2013**

			Generic Name	Brand Name	Restrictions
			1. ANALGESICS		
			Oral Generic only		
C	A		codeine phosphate/sulfate		Oral Only
C	A		codeine/APAP	Tylenol #3, #4	
C	A		fentanyl		Patches Only
C	A		hydrocodone/APAP	Norco, Lortab	
C	A		hydrocodone/ibuprofen	Vicoprofen	
C	A		methadone		Not payable for detoxification treatment; oral generic form only; copy of original prescription required for approval.
C	A		Morphine sulfate (immediate release)		Oral Only
C	A		Morphine sulfate (sustained release)	Oramorph	Oral Only
C	A		oxycodone		Immediate release form only; oral only
C	A		oxycodone/APAP	Percocet	
C	A		oxycodone/ASA	Percodan	
C	A		Ibuprofen	Motrin	Prescription Strengths Only
C	A		Naproxen; Naproxen Sodium	Naprosyn	Prescription Strengths Only
			2. ANTIANXIETY AGENTS		
			Oral Generic only		
C	A		alprazolam		Extended release and dispersible tablets not covered.
C	M		buspirone	Buspar	
C	A		chlordiazepoxide		
C	M		clonazepam		
C	A		diazepam		Solution not covered.
C	M		flurazepam		
C	A		hydroxyzine HCL, pamoate	Vistaril, Atarax	
C	A		lorazepam		Solution not covered.
C	A		oxazepam		
C	A		temazepam		
			3. ANTIBIOTICS		
			Oral and Liquids only unless otherwised noted next to medication name.		
C	A		amoxicillin	Amoxil	Oral generic only
C	A		amoxicillin/potassium clavulanate	Augmentin	
C	A		ampicillin		
C	A		azithromycin	Zithromax	
C	A		ceftriaxone		IM Only
C	A		cephalexin	Keflex	
C	A		cefpodoxime	Vantin	
C	A		ciprofloxacin	Cipro	
C	A		clarithromycin	Biaxin	XL formulation not covered.
C	A		clindamycin		
C	A		dicloxacillin		
C	A		doxycycline		Delayed release and 20mg (periodontal dosage) not covered.
C	A		erythromycin		Oral only
C	M		ethambutol	Myambutol	
C	M		isoniazid		
C	A		levofloxacin	Levaquin	
C	A		moxifloxacin	Avelox	
C	A		ofloxacin	Floxin	
C	A		penicillin		Oral and intramuscular only
C	M		pyrazinamide		
C	M		rifabutin	Mycobutin	
C	M		rifampin	Rifadin	
C	A		tetracycline		
C	A		trimethoprim		
C	A		trimethoprim/sulfamethoxazole	Bactrim, Septra	
C	A		vancomycin oral		

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4. ANTIDEPRESSANTS					
C	M		citalopram	Celexa	
C	M		fluoxetine	Prozac	
C	M		paroxetine	Paxil Paxil CR	
C	M		sertraline	Zoloft	
C	M		amitriptyline		
C	M		bupropion (SR, XL, IR)	Wellbutrin Wellbutrin SR	
C	M		venlafaxine (IR, XR)		
C	M		mirtazapine		
C	M		trazodone		
5. ANTIDIABETIC AGENTS					
C	A		insulin, injection kits and glucose test strips		
C	M		Diabetic Supplies (needles, lancets, etc.)		
C	M	•	acarbose	Precose	
C	M	•	glimepiride	Amaryl	
C	M	•	glipizide	Glucotrol, Glucotrol XL, generic	
C	M	•	glyburide	DiaBeta, Micronase, generic	
C	M	•	metformin	Glucophage, Glucopahage XR, Fortamet	
C	M	•	metformin/rosiglitazone	Avandamet	
C	M	•	metformin/sitagliptin	Janumet	
C	M	•	metformin/repaglinide	PrandiMet	
C	M	•	pioglitazone	Actos	
C	M	•	repaglinide	Prandin	
C	M	•	rosiglitazone	Avandia	
C	M	•	sitagliptin	Januvia	
6. ANTIFUNGAL AGENTS					
C	A		clotrimazole	Lotrimin, Mycelex	Vaginal, troche and topical only
C	A		clotrimazole/betamethasone	Lotrisone Cream	
C	A		fluconazole	Diflucan	Oral only
C	M		itraconazole	Sporonox	
C	A		ketoconazole	Nizoral	Oral only
C	A		miconazole		Only topical cream or ointments covered. All vaginal products covered.
C	A		nystatin		Oral only
C	A		terconazole	Terazol	Vaginal only

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7. ANTIHYPERTENSIVES					
Beta Blockers					
C	M		Acebutolol	Sectral	Covered as of 6/22/2011
C	M		Atenolol	Tenormin	Covered as of 6/22/2011
C	M		Carvedilol	Coreg	Covered as of 6/22/2011
C	M		Metoprolol	Lopressor, Toprol XL, all formulations	Covered as of 6/22/2011 (tartrate and succinate) Oral Only
C	M		Propranolol	Inderal	Covered as of 6/22/2011. Oral Only
Calcium Channel Blockers					
C	M		Amlodipine	Norvasc	Covered as of 6/22/2011
C	M		Diltiazem	Cardizem, Cardizem CD,Cardizem SR, Cardia XT, Tiazac	Covered as of 6/22/2011. Oral Only
C	M		Felodipine	Plendil	Covered as of 6/22/2011
C	M		Nifedipine	Adalat, Adalat CC, Procardia,Procardia XL, all generics	Covered as of 6/22/2011
C	M		Verapamil	Calan, Calan SR, Covera, Isoptin, Verelan	Covered as of 6/22/2011. Oral Only
ACE -1 and others					
C	M		Benazepril	Lotensin	Covered as of 6/22/2011
C	M		Captopril	Capoten	Covered as of 6/22/2011
C	M		Enalapril	Vasotec	Covered as of 6/22/2011
C	M		Lisinopril	Prinivil, Zestril	Covered as of 6/22/2011
C	M		Losartan	Cozaar	Covered as of 6/22/2011
C	M		Quinapril	Accupril	Covered as of 6/22/2011
Diuretics					
C	M		Hydrocholothiazide		
C	M		Furosemide	Lasix	Covered as of 6/22/2011. Oral Only
C	M		Spironolactone	Aldactone	Covered as of 6/22/2011
Vasodilators					
C	M		Doxazosin	Cardura, Cardura XL	Covered as of 6/22/2011
C	M		Hydralazine		Covered as of 6/22/2011. Oral Only
8.. ANTIPARASITIC AGENTS					
C	A		aerosolized pentamidine	Nebupent	
C	A		atovaquone	Mepron	
C	M		dapsone		
C	M		pyrimethamine	Daraprim	
C	A		sulfa/pyrimethamine	Fansidar	
C	A		sulfadiazine	Microsulfon	
9. ANTIPSYCHOTICS					
C	M		haloperidol	Haldol	
C	M		olanzapine	Zyprexa Zyprexa Zydis	Covered for continuation of therapy only.
C	M		perphenazine		
C	M		quetiapine	Seroquel Seroquel XR	Covered for continuation of therapy only.
C	M		risperidone	Risperdal	
C	M		thiothixene	Navane	
C	M		ziprasidone	Geodon	Covered for continuation of therapy only.

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10. ANTIRETROVIRALS					
Brand ARVs preferred. Generics approved for copayments ONLY					
C	M	•	abacavir	Ziagen	
C	M	•	abacavir/lamivudine	Epzicom	
C	M	•	abacavir/lamivudine/zidovudine	Trizivir	
C	M	•	atazanavir	Reyataz	
C	M	•	darunavir (TMC-114)	Prezista	
C	M	•	delavirdine	Rescriptor	
C	M	•	didanosine	Videx, Videx EC	Brand only
C	M	•	dolutegravir	Tivicay	
C	M	•	efavirenz	Sustiva	
C	M	•	elvitegravir, coicistat,emtricitabine, tenofovir	Stribild	Covered as of 8/31/12
C	M	•	enfuvirtide	Fuzeon	
C	M	•	emtricitabine	Emtriva	
C	M	•	emtricitabine/rilpivirine/tenofovir	Complera	Covered as of 9/1/2011
C	M	•	emtricitabine/tenofovir/efavirenz	Atripla	
C	M	•	etravirine	Intelence	
C	M	•	fosamprenavir	Lexiva	
C	M	•	indinavir	Crixivan	
C	M	•	lamivudine (3TC)	Epivir	
C	M	•	maraviroc	Selzentry	
C	M	•	lopinavir/ritonavir	Kaletra	
C	M	•	nelfinavir	Viracept	
C	M	•	nevirapine	Viramune, Viramune XR	
C	M	•	raltegravir (RGV or MK-0518)	Isentress	
C	M	•	rilpivirine	Edurant	Covered as of 6/25/2011
C	M	•	ritonavir	Norvir	
C	M	•	saquinavir	Invirase	
C	M	•	stavudine (d4T)	Zerit	Brand only
C	M	•	tenofovir	Viread	
C	M	•	tenofovir/emtricitabine	Truvada	
C	M	•	tipranavir	Aptivus	
C	M	•	zidovudine (AZT)	Retrovir	Brand only
C	M	•	zidovudine/lamivudine (AZT/3TC)	Combivir	
11. ANTIVIRALS - OTHER					
C	A		acyclovir	Zovirax	
C	M		cidofovir	Vistide	
C	A		fomivirsen	Vitravene	
C	M		foscarnet	Foscavir	
C	M		ganciclovir	Cytovene	IV and Oral
C	A		imiquimod cream	Aldara	
C	A		immune globulin IM	IGIM	
C	A		oseltamivir	Tamiflu	
C	A		valacyclovir	Valtrex	Brand only
C	A		valganciclovir	Valcyte	
C	A		zanamivir	Relenza	

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12. HEMATOPOIETIC AGENTS					
C	**M**		epoetin-alpha	Procrit, Epogen	Restricted to treatment of ribavirin-related anemia and Hepatitis C diagnosis. **Aranesp not covered**
C	**M**		filgrastim (G-CSF)	Neupogen	Restricted to treatment of interferon-related neutropenia with a diagnosis of Hepatitis C or B. **Neulasta not covered.**
13. HEPATITIS TREATMENT					
^ Bridge Coverage - Continuation of therapy only, PA REQUIRED					
R	**M**	^●	adefovir dipivoxil	Hepsera	
R	**M**	^●	entecavir	Baraclude	
R	**M**	^	hepatitis B Immune Globulin	HBIG	
R	**M**	^●	interferon alfa-2a	Roferon-A	Restricted to use in treatment of Hepatitis B or C
R	**M**	^●	inteferon alfa-2b	Intron-A	Restricted to use in treatment of Hepatitis B or C
R	**M**	^●	interferon alfacon 1	Infergen	
R	**M**	^●	interferon alfa-N3	Alferon-N	
R	**M**	^●	lamivudine (3TC)	Epivir-HBV	
R	**M**	^●	pegylated interferons	Peg-Intron, Pegasys	Restricted to use in treatment of Hepatitis C - Vial only no Redipen coverage
R	**M**	^●	ribavirin	Rebetol, Copegus	
R	**M**	^●	ribavirin/interferon alfa 2B	Rebetron	
R	**M**	^●	telbivudine	Tyzeka	
14. MISCELLANEOUS					
R	**A**		leucovorin		Oral only
R	**M**	^●	varenicline	Chantix	Bridge Coverage with PA only if continuating therapy only
R	**M**	^●	bupropion	Zyban	Bridge Coverage with PA only if continuating therapy only
C	**M**		buprenorphine	Buprenex, Suboxone, Subutex	Available to Bridge and CAREAssist members as of 6/27/2011.
C	**M**		folic acid		1mg tablet, RX only
C	**M**		Vitamin D (ergocalciferol)		50,000 unit capsules
C	**M**		Syringes and Needles		
C	**M**		Cyancobalamin	Vitamin B-12	Injectible Only
C	**M**		Potassium Supplements		Oral, generic only
15. VACCINES					
Not covered for Bridge patients *Multi-dose vials are not covered*					
R	**A**	^	hemophilus influenza Type B vaccine	Hib	
R	**M**	^	hepatitis A vaccine	Havrix, Vaqta	single dose dispensing only
R	**M**	^	hepatitis B vaccine	Engerix B, Recombivix HB	single dose dispensing only
R	**M**	^	hepatitis A/Hepatitis B vaccine	Twinrix	
R	**M**	^	human papillomavirus/HPV	Gardasil, Cervarix	
R	**A**	^	influenza virus vaccine, split or whole virus		Vaccine is covered for all strains, injectible only
R	**M**	^	diphtheria & tetanus toxoids & pertussis vaccine		
R	**M**	^	diphtheria & tetanus		
R	**A**	^	pneumococcal vaccine	Pneumovax, Pnu-Immune	

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Program Dispensing Policies:

1. *Prescription Coverage*: The CAREAssist program will cover at full price any medication listed on the formulary, in the event that the member's insurance policy does not pay a portion of the cost. Medications not listed on the CAREAssist Formulary must be covered by the member's insurance policy in order for CAREAssist to assist with the copay.
2. *Brand Dispensing*: The CAREAssist program requires that pharmacies dispense generic brand medications if therapeutically equivalent to the brand drug. Brand name drugs will be covered for copayments only if covered by the primary. Brand Name ARVs prefferred, Generic ARVs covered for copayments ONLY
3. *Limited Coverage*: Medications listed as "Miscellaneous" may be available only for a limited time based on specific program initiatives.
4. *Vaccines* must be obtained through "no or low cost vaccine programs" whenever possible. Local county health departments and some nonprofit providers receive vaccines through the Oregon Immunization Program, targeting low income persons needing those medications. CAREAssist shall not pay for vaccines for the purpose of travel.
5. *OTC Medications*: Over the counter (OTC) medications listed on the formulary are available by prescription only.
6. *Day Supply*: Drugs marked with "●"are to be dispensed with a minimum 28 day supply for Bridge patients and 21 days for CAREAssist members.
7. *Prior Authorization*: Drugs marked with "^" require a prior authorization. Additional information will be required.
8. 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.).

If patient has no primary insurance or the primary insurance has denied the claim, the following applies:

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.