

SUMMARY OF FORMULARY FOR PREFERRED NETWORK OREGON CAREASSIST

Effective 8.1.26

1. ALL PRESCRIPTION DRUGS covered.

- if covered by insurance, when filled at PREFERRED NETWORKS, with PA listed below.
- if insurance denies or if client has no insurance, when filled at PREFERRED NETWORKS, with Exclusions listed below.

2. Prior Authorization (PA) REQUIRED DRUGS

- A. Lenacapavir Sodium (Sunlenca™):** Sunlenca™ is accessible ONLY at CVS SPECIALITY Monroeville, *UNLESS covering copay*. Phone: 800-238-7828. Fax: 888-604-0385. A detailed supplemental form is required prior to drug access. The supplemental form including eligibility criteria and clinical requirements can be found at <https://www.ramsellcorp.com/pharmacies/or.aspx>
- B. Hepatitis C drugs** when insurance denies or if client has no insurance (coverage includes these medications ONLY). Treatment guidelines found at <https://hcvguidelines.org/>

Generic Name	Brand Name	Restriction
glecaprevir/pibrentasvir	Mavyret	Dispensing of these Hepatitis C medications 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 at 888-311-7685 for a supplemental form or access it at www.ramsellcorp.com
ledipasvir/sofosbuvir	Harvoni	
velpatasvir/sofosbuvir	Epclusa	
elbasvir/grazoprevir	Zepatier	<i>*PA required ONLY for patients whose primary insurance denies covering the medication. For INSURED patients, copayments are allowed.</i>

- C. Serostim: Coverage restricted to HIV Wasting (R64)**
- D. Egrifta: Coverage restricted to Protein-Caloric Malnutrition (E43, E44, E44.1 & E46)**
- E. Tadalafil (Adcirca™, Alyq™): Coverage restricted to treatment of Benign Prostatic Hyperplasia (BPH) and Pulmonary Arterial Hypertension (PAH) – PA by prescriber is required if covered by insurance**
- F. Sildenafil (Revatio™): Coverage restricted to treatment of Pulmonary Arterial Hypertension (PAH) – PA by prescriber is required if covered by insurance.**

3. FORMULARY EXCLUSIONS

These exclusions apply to patients whose primary insurance is not covering these medications (i.e., OCC3). For INSURED patients, copayments are allowed

G. Medications prescribed for:

1. Anorexia, weight loss, weight gain – **EXCLUDED**
 - Serostim & Egrifta are covered if PA requirements are met as stated above
2. Fertility purposes – **EXCLUDED**
3. Erectile dysfunction purposes – **EXCLUDED** (see **D.** above for BHP treatment)
4. Hair growth or cosmetic purposes – **EXCLUDED**
5. Prescription vitamins and mineral products – **EXCLUDED**

- Prenatal Vitamins, Fluoride, Niacin, Vitamin D analogs, and B vitamins are covered
- 6. Non-prescription drugs (OTCs) – **EXCLUDED**
 - Allergy medications with pseudoephedrine are covered
 - H2-receptor antagonists and Proton-pump inhibitors (PPIs) are covered
- 7. Nutritional/Dietary Supplements (including herbal supplements) – **EXCLUDED**
- 8. Durable Medical Equipment – **EXCLUDED**
 - Diabetic supplies are covered