SUMMARY OF FORMULARY FOR PREFERRED NETWORK
OREGON CAREASSIST

Effective 10.1.24

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. 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 **PA required ONLY for UN-INSURED patients or patients whose primary insurance denies covering the medication. For INSURED patients, copayments are allowed.*
ledipasvir/sofosbuvir	Harvoni	
velpatasvir/sofosbuvir	Epclusa	
elbasvir/grazoprevir	Zepatier	

   - **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 only to **UN-INSURED** patients or 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