

**SUMMARY OF FORMULARY FOR PREFERRED NETWORK
OREGON CAREASSIST**

Updated 02/08/2019

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.** 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 for supplemental form or access it at www.ramsellcorp.com
sofosbuvir	Sovaldi	
ledipasvir/sofosbuvir	Harvoni	
velpatasvir/sofosbuvir	Epclusa	
sofosbuvir/velpatasvir/voxilaprevir	Vosevi	
ombitasvir/paritaprevir/ritonavir + dasabuvir	Viekira Pak	
elbasvir/grazoprevir	Zepatier	<i>*PA required ONLY for UN-INSURED patients or patients whose primary insurance denies covering the medication. For INSURED patients, copayments are allowed.</i>

- B.** Serostim: Coverage restricted to HIV Wasting (R64)
- C.** Egrifta: Coverage restricted to Protein-Caloric Malnutrition (E43, E44, E44.1 & E46)
- D.** Sildenafil and Tadalafil: Coverage restricted to treatment of Benign Prostatic Hyperplasia (BPH) ONLY – PA by prescriber to CAREAssist required for full-cost or 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

E. 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**
7. Nutritional/Dietary Supplements (including herbal supplements) – **EXCLUDED**
8. Durable Medical Equipment – **EXCLUDED**
 - Diabetic supplies are covered