SUMMARY OF FORMULARY FOR PREFERRED NETWORK
OREGON CAREASSIST

Updated 12/1/20

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 **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	
velpatasvir/sofosbuvir	Epclusa	
sofosbuvir/velpatasvir/voxilaprevir	Vosevi	
ombitasvir/paritaprevir/ritonavir + dasabuvir	Viekira Pak	
elbasvir/grazoprevir	Zepatier	

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