

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred
Allergy/Cold	Anaphylaxis Rescue	EPINEPHRINE EPINEPHRINE (EPIPEN 2-PAK™) EPINEPHRINE (EPIPEN JR 2-PAK™) AUTO INJECT AUTO INJECT AUTO INJECT
Allergy/Cold	Antihistamines, Second Generation	CETIRIZINE HCL CETIRIZINE HCL LORATADINE LORATADINE LORATADINE SOLUTION *** TABLET SOLUTION *** TAB RAPDIS *** TABLET
Allergy/Cold	Cough and Cold	CODEINE PHOSPHATE/GUAIFENESIN * CODEINE PHOSPHATE/GUAIFENESIN * CODEINE PHOSPHATE/GUAIFENESIN * GUAIFENESIN ‡ GUAIFENESIN ‡ GUAIFENESIN ‡ GUAIFENESIN ‡ GUAIFENESIN ‡ GUAIFENESIN ‡ GUAIFENESIN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ GUAIFENESIN/DEXTROMETHORPHAN ‡ PSEUDOEPHEDRINE HCL ‡ PSEUDOEPHEDRINE HCL ‡ LIQUID SYRUP TABLET GRAN PACK LIQUID SYRUP TAB ER 12H TABLET TABLET ER CAPSULE DROPS ELIXIR GRAN PACK LIQUID LIQUID PKT SYRUP TAB ER 12H TABLET CAPSULE TABLET
Allergy/Cold	Nasal Allergy Inhalers	FLUTICASONE PROPIONATE * SPRAY SUSP
Analgesics	Analgesics, Topical	CAPSAICIN CREAM (G)
Analgesics	Gout	ALLOPURINOL PROBENECID/COLCHICINE TABLET TABLET
Analgesics	Muscle Relaxants, Oral	BACLOFEN CYCLOBENZAPRINE HCL TIZANIDINE HCL TABLET TABLET *** TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred	
Analgesics	Non-Steroidal Anti-Inflammatory Drugs	DICLOFENAC POTASSIUM	TABLET
		DICLOFENAC SODIUM	TABLET DR
		ETODOLAC	TABLET
		FLURBIPROFEN	TABLET
		IBUPROFEN	CAPSULE
		IBUPROFEN	DROPS SUSP
		IBUPROFEN	ORAL SUSP
		IBUPROFEN	TAB CHEW
		IBUPROFEN	TABLET
		INDOMETHACIN	CAPSULE
		KETOPROFEN	CAPSULE
		KETOROLAC TROMETHAMINE **	TABLET
		MELOXICAM	TABLET
		NABUMETONE	TABLET
		NAPROXEN	TABLET
		NAPROXEN	TABLET DR
		NAPROXEN SODIUM	TABLET
OXAPROZIN	TABLET		
SALSALATE	TABLET		
SULINDAC	TABLET		
Analgesics	Opioids, Long-Acting	FENTANYL **	PATCH TD72
		MORPHINE SULFATE **	TABLET ER
Analgesics	Opioids, Short-Acting	ACETAMINOPHEN WITH CODEINE *	ORAL SUSP
		ACETAMINOPHEN WITH CODEINE *	SOLUTION
		ACETAMINOPHEN WITH CODEINE *	TABLET
		BUTORPHANOL TARTRATE **	SPRAY
		CODEINE SULFATE *	TABLET
		HYDROCODONE/ACETAMINOPHEN **	SOLUTION
		HYDROCODONE/ACETAMINOPHEN **	TABLET
		HYDROMORPHONE HCL **	SUPP.RECT
		HYDROMORPHONE HCL **	TABLET
		MORPHINE SULFATE **	SOLUTION
		MORPHINE SULFATE **	SUPP.RECT
		MORPHINE SULFATE **	TABLET
		OPIUM/BELLADONNA ALKALOIDS **	SUPP.RECT
		OXYCODONE HCL **	SOLUTION
		OXYCODONE HCL **	TABLET
		OXYCODONE HCL/ACETAMINOPHEN **	TABLET
TRAMADOL HCL **	TABLET		
Analgesics	Triptans, Nasal	SUMATRIPTAN **	SPRAY
Analgesics	Triptans, Oral	NARATRIPTAN HCL **	TABLET
		SUMATRIPTAN SUCCINATE **	TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred
Analgesics	Triptans, Subcutaneous	SUMATRIPTAN SUCCINATE ** SUMATRIPTAN SUCCINATE ** SUMATRIPTAN SUCCINATE ** CARTRIDGE PEN INJCTR VIAL
Antibiotics	Amoxicillin and Clavulanate, Oral	AMOXICILLIN/POTASSIUM CLAV AMOXICILLIN/POTASSIUM CLAV AMOXICILLIN/POTASSIUM CLAV SUSP RECON TAB CHEW TABLET
Antibiotics	Cephalosporins (1st Gen), Oral	CEPHALEXIN CEPHALEXIN CAPSULE *** SUSP RECON
Antibiotics	Cephalosporins (2nd Gen), Oral	CEFPROZIL CEFPROZIL CEFUROXIME AXETIL CEFUROXIME AXETIL SUSP RECON TABLET SUSP RECON TABLET
Antibiotics	Cephalosporins (3rd Gen), Oral	CEFDINIR CEFDINIR CAPSULE SUSP RECON
Antibiotics	Clostridium Difficile Antibiotics	METRONIDAZOLE METRONIDAZOLE VANCOMYCIN HCL VANCOMYCIN HCL CAPSULE TABLET CAPSULE VIAL
Antibiotics	Fluroquinolones, Oral	CIPROFLOXACIN CIPROFLOXACIN HCL LEVOFLOXACIN LEVOFLOXACIN SUS MC REC TABLET SOLUTION TABLET
Antibiotics	Macrolides, Oral	AZITHROMYCIN AZITHROMYCIN CLARITHROMYCIN SUSP RECON TABLET TABLET
Antibiotics	Oxazolidinones, Oral	LINEZOLID LINEZOLID SUSP RECON TABLET
Antibiotics	Tetracyclines, Oral	DOXYCYCLINE HYCLATE DOXYCYCLINE HYCLATE DOXYCYCLINE MONOHYDRATE DOXYCYCLINE MONOHYDRATE TETRACYCLINE HCL CAPSULE TABLET *** CAPSULE *** SUSP RECON CAPSULE
Antifungal	Antifungals, Oral	CLOTRIMAZOLE FLUCONAZOLE FLUCONAZOLE NYSTATIN NYSTATIN TROCHE SUSP RECON TABLET ORAL SUSP TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred
Antivirals	Hepatitis B	LAMIVUDINE * LAMIVUDINE * TENOFIVIR DISOPROXIL FUMARATE *
		SOLUTION TABLET TABLET
Antivirals	Hepatitis C, Direct-Acting Antivirals	ELBASVIR/GRAZOPREXIL (ZEPATIER™) * GLECAPREXIL/PIBRENTASVIR (MAVYRET™) * SOFOSBUVIR/VELPATASVIR (VOSEVI™) * SOFOSBUVIR/VELPATASVIR (EPCLUSA™) *
		TABLET TABLET TABLET TABLET
Antivirals	Hepatitis C, Other Agents	PEGINTERFERON ALFA-2A * PEGINTERFERON ALFA-2A * PEGINTERFERON ALFA-2A * PEGINTERFERON ALFA-2B * RIBAVIRIN * RIBAVIRIN *
		PEN INJCTR SYRINGE VIAL KIT CAPSULE TABLET
Antivirals	Herpes Simplex	ACYCLOVIR ACYCLOVIR ACYCLOVIR
		CAPSULE ORAL SUSP TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

† Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List

Effective: January 1, 2018

System	Class	Preferred	
Antivirals	HIV	ABACAVIR SULFATE	SOLUTION
		ABACAVIR SULFATE	TABLET
		ABACAVIR SULFATE/LAMIVUDINE	TABLET
		ABACAVIR/DOLUTEGRAVIR/LAMIVUDI	TABLET
		ABACAVIR/LAMIVUDINE/ZIDOVUDINE	TABLET
		ATAZANAVIR SULFATE	CAPSULE
		ATAZANAVIR SULFATE	POWD PACK
		ATAZANAVIR SULFATE/COBICISTAT (EVOTAZ™)	TABLET
		COBICISTAT	TABLET
		DARUNAVIR ETHANOLATE	ORAL SUSP
		DARUNAVIR ETHANOLATE	TABLET
		DARUNAVIR/COBICISTAT (PREZCOBIX™)	TABLET
		DELAVIRDINE MESYLATE	TAB DISPER
		DELAVIRDINE MESYLATE	TABLET
		DIDANOSINE	CAPSULE DR
		DIDANOSINE	SOLN RECON
		DOLUTEGRAVIR SODIUM	TABLET
		EFAVIRENZ	CAPSULE
		EFAVIRENZ	TABLET
		EFAVIRENZ/EMTRICITAB/TENOFOVIR	TABLET
		ELVITEG/COB/EMTRI/TENOF ALAFEN (GENVOYA™)	TABLET
		ELVITEG/COB/EMTRI/TENOFO DISOP	TABLET
		EMTRICITA/RILPIVIRINE/TENOF DF	TABLET
		EMTRICITAB/RILPIVIRI/TENOF ALA (ODEFSEY™)	TABLET
		EMTRICITABINE	CAPSULE
		EMTRICITABINE	SOLUTION
		EMTRICITABINE/TENOFOV ALAFENAM (DESCOVY™)	TABLET
		EMTRICITABINE/TENOFOVIR (TDF)	TABLET
		ENFUVRTIDE	VIAL
		ETRAVIRINE	TABLET
		FOSAMPRENAVIR CALCIUM	ORAL SUSP
		FOSAMPRENAVIR CALCIUM	TABLET
		INDINAVIR SULFATE	CAPSULE
		LAMIVUDINE	SOLUTION
		LAMIVUDINE	TABLET
		LAMIVUDINE/ZIDOVUDINE	TABLET
		LOPINAVIR/RITONAVIR	SOLUTION
		LOPINAVIR/RITONAVIR	TABLET
		MARAVIROC	SOLUTION
		MARAVIROC	TABLET
		NELFINAVIR MESYLATE	TABLET
		NEVIRAPINE	ORAL SUSP
NEVIRAPINE	TAB ER 24H		
NEVIRAPINE	TABLET		
RALTEGRAVIR POTASSIUM	POWD PACK		
RALTEGRAVIR POTASSIUM	TAB CHEW		
RALTEGRAVIR POTASSIUM	TABLET		
RILPIVIRINE HCL	TABLET		
RITONAVIR	SOLUTION		
RITONAVIR (NORVIR™)	TABLET		

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred	
Antivirals	HIV	SAQUINAVIR MESYLATE SAQUINAVIR MESYLATE STAVUDINE STAVUDINE TIPRANAVIR TIPRANAVIR/VITAMIN E TPGS ZIDOVUDINE ZIDOVUDINE ZIDOVUDINE ZIDOVUDINE	CAPSULE TABLET CAPSULE SOLN RECON CAPSULE SOLUTION CAPSULE SYRUP TABLET VIAL
Antivirals	Influenza	OSELTAMIVIR PHOSPHATE * OSELTAMIVIR PHOSPHATE *	CAPSULE SUSP RECON
Cardiovascular	ACEIs, ARBs and DRIs	BENAZEPRIL HCL ENALAPRIL MALEATE IRBESARTAN LISINOPRIL LOSARTAN POTASSIUM OLMESARTAN MEDOXOMIL RAMIPRIL TELMISARTAN VALSARTAN	TABLET TABLET TABLET TABLET TABLET TABLET CAPSULE TABLET TABLET
Cardiovascular	Antianginals	ISOSORBIDE DINITRATE ISOSORBIDE DINITRATE ISOSORBIDE MONONITRATE NITROGLYCERIN NITROGLYCERIN NITROGLYCERIN	CAPSULE ER TABLET TABLET CAPSULE ER PATCH TD24 TAB SUBL
Cardiovascular	Anticoagulants, Oral and SQ	APIXABAN (ELIQUIS™) DABIGATRAN ETEXILATE MESYLATE (PRADAXA™) DALTEPARIN SODIUM, PORCINE EDOXABAN TOSYLATE ENOXAPARIN SODIUM ENOXAPARIN SODIUM RIVAROXABAN (XARELTO™) RIVAROXABAN (XARELTO™) WARFARIN SODIUM	TABLET CAPSULE SYRINGE TABLET SYRINGE VIAL TAB DS PK TABLET TABLET
Cardiovascular	Beta-Blockers, Oral	ACEBUTOLOL HCL ATENOLOL CARVEDILOL LABETALOL HCL METOPROLOL SUCCINATE METOPROLOL TARTRATE PROPRANOLOL HCL	CAPSULE TABLET TABLET TABLET TAB ER 24H TABLET TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

† Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List

Effective: January 1, 2018

System	Class	Preferred
Cardiovascular	Calcium Channel Blockers - Dihydropyridine, Oral	AMLODIPINE BESYLATE TABLET NICARDIPINE HCL CAPSULE NIFEDIPINE TAB ER 24 NIFEDIPINE TABLET ER
Cardiovascular	Calcium Channel Blockers - Non-Dihydropyridine, Oral	DILTIAZEM HCL CAP ER 12H DILTIAZEM HCL CAP ER 24H DILTIAZEM HCL CAP ER DEG DILTIAZEM HCL CAP SA 24H DILTIAZEM HCL TABLET VERAPAMIL HCL CAP24H PEL VERAPAMIL HCL TABLET VERAPAMIL HCL TABLET ER
Cardiovascular	Combination Antihypertensives	AMLODIPINE BES/OLMESARTAN MED TABLET BENAZEPRIL/HYDROCHLOROTHIAZIDE TABLET ENALAPRIL/HYDROCHLOROTHIAZIDE TABLET LISINOPRIL/HYDROCHLOROTHIAZIDE TABLET LOSARTAN/HYDROCHLOROTHIAZIDE TABLET METOPROLOL SU/HYDROCHLOROTHIAZ TAB ER 24H OLMESARTAN/AMLODIPIN/HCTHIAZID TABLET OLMESARTAN/HYDROCHLOROTHIAZIDE TABLET TELMISARTAN/HYDROCHLOROTHIAZID TABLET
Cardiovascular	Diuretics, Oral	AMILORIDE HCL TABLET AMILORIDE/HYDROCHLOROTHIAZIDE TABLET BUMETANIDE TABLET FUROSEMIDE SOLUTION *** FUROSEMIDE TABLET HYDROCHLOROTHIAZIDE CAPSULE HYDROCHLOROTHIAZIDE TABLET INDAPAMIDE TABLET SPIRONOLACT/HYDROCHLOROTHIAZID TABLET SPIRONOLACTONE TABLET TORSEMIDE TABLET TRIAMTERENE CAPSULE TRIAMTERENE/HYDROCHLOROTHIAZID CAPSULE
Cardiovascular	Other Dyslipidemia Drugs	CHOLESTYRAMINE (WITH SUGAR) POWD PACK CHOLESTYRAMINE (WITH SUGAR) POWDER CHOLESTYRAMINE/ASPARTAME POWD PACK CHOLESTYRAMINE/ASPARTAME POWDER FENOFIBRATE TABLET *** GEMFIBROZIL TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred
Cardiovascular	Platelet Inhibitors	ASPIRIN ASPIRIN ASPIRIN ASPIRIN/DIPYRIDAMOLE CILOSTAZOL CLOPIDOGREL BISULFATE DIPYRIDAMOLE TAB CHEW TABLET TABLET DR CPMP 12HR TABLET TABLET TABLET
Cardiovascular	Statins & Combos (High Potency)	ATORVASTATIN CALCIUM SIMVASTATIN TABLET TABLET
Cardiovascular	Statins & Combos (Low-Medium Potency)	LOVASTATIN PRAVASTATIN SODIUM TABLET TABLET
Dermatologicals	Antibiotics, Topical	BACITRACIN BACITRACIN ZINC BACITRACIN ZINC/POLYMYXIN B BACITRACIN/POLYMYXIN B SULFATE GENTAMICIN SULFATE MUPIROCIN NEOMYCIN/BACITRACIN/POLYMYXINB OINT. (G) *** OINT. (G) OINT. (G) OINT. (G) CREAM (G) OINT. (G) OINT. (G)
Dermatologicals	Antifungals, Topical	MICONAZOLE NITRATE NYSTATIN NYSTATIN CREAM (G) CREAM (G) OINT. (G)
Dermatologicals	Antiparasitics, Topical	PERMETHRIN PERMETHRIN PERMETHRIN PIPERONYL BUTOX/PYRETHR/PERMET PIPERONYL BUTOXIDE/PYRETHRINS PIPERONYL BUTOXIDE/PYRETHRINS PIPERONYL BUTOXIDE/PYRETHRINS PIPERONYL BUTOXIDE/PYRETHRINS COMBO. PKG CREAM (G) LIQUID KIT GEL (GRAM) KIT LIQUID SHAMPOO
Dermatologicals	Antipsoriatics, Topical	CALCIPOTRIENE * CALCIPOTRIENE * CALCIPOTRIENE/BETAMETHASONE * TAZAROTENE * TAZAROTENE * CREAM (G) SOLUTION OINT. (G) CREAM (G) GEL (GRAM)

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

† Age restrictions apply



Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List

Effective: January 1, 2018

System	Class	Preferred	
Dermatologicals	Steroids, Topical	ALCLOMETASONE DIPROPIONATE	CREAM (G)
		ALCLOMETASONE DIPROPIONATE	OINT. (G)
		BETAMETHASONE DIPROPIONATE	CREAM (G)
		BETAMETHASONE DIPROPIONATE	LOTION
		BETAMETHASONE DIPROPIONATE	OINT. (G)
		BETAMETHASONE VALERATE	CREAM (G)
		BETAMETHASONE VALERATE	OINT. (G)
		CLOBETASOL PROPIONATE	CREAM (G)
		CLOBETASOL PROPIONATE	OINT. (G)
		DESONIDE	CREAM (G)
		DESONIDE	OINT. (G)
		FLUOCINOLONE ACETONIDE	CREAM (G)
		FLUOCINOLONE ACETONIDE	SOLUTION
		FLUOCINONIDE	CREAM (G)
		FLUOCINONIDE	SOLUTION
		FLUOCINONIDE/EMOLLIENT BASE	CREAM (G)
		HYDROCORTISONE	CREAM (G) ***
		HYDROCORTISONE	CREAM PACK ***
		HYDROCORTISONE	OINT. (G)
		HYDROCORTISONE ACETATE	CREAM (G)
HYDROCORTISONE BUTYRATE	SOLUTION		
TRIAMCINOLONE ACETONIDE	CREAM (G)		
TRIAMCINOLONE ACETONIDE	OINT. (G)		
Endocrine	Androgens, Topical & Parenteral	TESTOSTERONE ‡	GEL (GRAM)
		TESTOSTERONE ‡	GEL MD PMP
		TESTOSTERONE ‡	GEL PACKET
		TESTOSTERONE CYPIONATE ‡	VIAL
		TESTOSTERONE ENANTHATE ‡	VIAL
Endocrine	Bone Metabolism Drugs	ALENDRONATE SODIUM	TABLET
		IBANDRONATE SODIUM	TABLET
		RISEDRONATE SODIUM	TABLET
Endocrine	Diabetes, DPP-4 Inhibitors	SITAGLIPTIN PHOS/METFORMIN HCL (JANUMET™) *	TABLET
		SITAGLIPTIN PHOSPHATE (JANUVIA™) *	TABLET
Endocrine	Diabetes, GLP-1 Receptor Agonists	EXENATIDE *	PEN INJECTR

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred	
Endocrine	Diabetes, Insulins	INSULIN ASPART INSULIN ASPART INSULIN ASPART INSULIN ASPART PROT/INSULN ASP INSULIN ASPART PROT/INSULN ASP INSULIN DETEMIR * INSULIN GLARGINE,HUM.REC.ANLOG INSULIN LISPRO INSULIN LISPRO PROTAMIN/LISPRO INSULIN NPH HUM/REG INSULIN HM INSULIN NPH HUM/REG INSULIN HM * INSULIN NPH HUMAN ISOPHANE INSULIN REGULAR, HUMAN INSULIN ZINC HUMAN RECOMBINANT LANTUS SOLOSTAR™ - BRAND ONLY *	CARTRIDGE INSULN PEN VIAL INSULN PEN VIAL INSULN PEN VIAL VIAL VIAL VIAL VIAL INSULN PEN VIAL VIAL VIAL INSULN PEN
Endocrine	Diabetes, Miscellaneous Antidiabetic Agents	METFORMIN HCL METFORMIN HCL	TAB ER 24H TABLET
Endocrine	Diabetes, Sulfonylureas	GLIMEPIRIDE GLIPIZIDE GLYBURIDE	TABLET TABLET TABLET
Endocrine	Diabetes, Thiazolidinediones	PIOGLITAZONE HCL	TABLET
Endocrine	Estrogen Replacement, Oral	ESTRADIOL ‡ ESTROPIPATE ‡	TABLET TABLET
Endocrine	Estrogen Replacement, Topical	ESTRADIOL ‡ ESTRADIOL ‡	PATCH TDSW PATCH TDWK
Endocrine	Estrogen Replacement, Vaginal	ESTRADIOL ESTROGENS, CONJUGATED	TABLET CREAM/APPL
Endocrine	Growth Hormones	SOMATROPIN (GENOTROPIN™) * SOMATROPIN (GENOTROPIN™) * SOMATROPIN (NORDITROPIN FLEXPRO™) * SOMATROPIN (NUTROPIN AQ NUSPIN™) *	CARTRIDGE SYRINGE PEN INJECTR PEN INJECTR
Endocrine	Progestational Agents	HYDROXYPROGESTERONE CAPROAT/PF (MAKENA™) * HYDROXYPROGESTERONE CAPROATE (MAKENA™) * MEDROXYPROGESTERONE ACETATE MEDROXYPROGESTERONE ACETATE NORETHINDRONE ACETATE PROGESTERONE, MICRONIZED	VIAL VIAL TABLET VIAL TABLET CAPSULE
Endocrine	Vitamin D Analogs	CALCITRIOL CALCITRIOL CALCITRIOL	AMPUL CAPSULE SOLUTION

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred
Gastrointestinal	Antacid, H2 Antagonists	FAMOTIDINE RANITIDINE HCL RANITIDINE HCL TABLET SYRUP TABLET
Gastrointestinal	Antacid, Proton Pump Inhibitors	OMEPRAZOLE ** PANTOPRAZOLE SODIUM ** CAPSULE DR TABLET DR
Gastrointestinal	Antidiarrheals	LOPERAMIDE HCL LOPERAMIDE HCL LOPERAMIDE HCL CAPSULE LIQUID TABLET
Gastrointestinal	Antiemetics, Conventional	METOCLOPRAMIDE HCL METOCLOPRAMIDE HCL PHOSPHORATED CARBO(DEXT-FRUCT) PROCHLORPERAZINE PROCHLORPERAZINE MALEATE PROMETHAZINE HCL PROMETHAZINE HCL PROMETHAZINE HCL SOLUTION TABLET SOLUTION SUPP.RECT TABLET SUPP.RECT SYRUP TABLET
Gastrointestinal	Antiemetics, Newer	ONDANSETRON ONDANSETRON HCL ONDANSETRON HCL TAB RAPDIS SOLUTION TABLET
Gastrointestinal	Bile Therapy	URSODIOL URSODIOL CAPSULE TABLET
Gastrointestinal	Inflammatory Bowel Disease	BALSALAZIDE DISODIUM BUDESONIDE MESALAMINE MESALAMINE MESALAMINE MESALAMINE (LIALDA ™) OLSALAZINE SODIUM SULFASALAZINE SULFASALAZINE CAPSULE CAPDR - ER CAP ER 24H SUPP.RECT TABLET DR *** TABLET DR CAPSULE TABLET TABLET DR

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

† Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List

Effective: January 1, 2018

System	Class	Preferred	
Gastrointestinal	Laxatives, Chronic Constipation	BISACODYL	TABLET
		BISACODYL	TABLET DR
		CALCIUM POLYCARBOPHIL	TABLET
		CELLULOSE	POWDER
		DOCUSATE CALCIUM	CAPSULE
		DOCUSATE SODIUM	CAPSULE
		DOCUSATE SODIUM	LIQUID
		DOCUSATE SODIUM	SYRUP
		DOCUSATE SODIUM	TABLET
		FRUCTOOLIGOSACCH/MALTODEXTRIN	LIQUID
		FRUCTOOLIGOSACCHARIDES/POLYDEX	LIQUID
		FRUCTOOLIGOSACCHARIDES/POLYDEX	LIQUID PKT
		GLYCERIN/MALTODEXTRIN	LIQUID
		GUAR GUM	PACKET
		GUAR GUM	POWDER
		INULIN	TAB CHEW
		ISOMALTOOLIGOSACCHARIDES	POWDER
		LACTULOSE	SOLUTION
		MAGNESIUM CITRATE	SOLUTION
		MAGNESIUM HYDROXIDE	ORAL SUSP
		MAGNESIUM HYDROXIDE	TAB CHEW
		METHYLCELLULOSE	TABLET
		METHYLCELLULOSE (WITH SUGAR)	POWDER ***
		POLYETHYLENE GLYCOL 3350	POWDER
		PSYLLIUM HUSK	CAPSULE ***
		PSYLLIUM HUSK	POWDER
		PSYLLIUM HUSK (WITH DEXTROSE)	POWDER
		PSYLLIUM HUSK (WITH SUGAR)	POWDER
		PSYLLIUM HUSK/ASPARTAME	POWD PACK
		PSYLLIUM HUSK/ASPARTAME	POWDER
		PSYLLIUM HUSK/CALCIUM CARB	CAPSULE
		PSYLLIUM SEED	POWDER
		PSYLLIUM SEED (WITH DEXTROSE)	PACKET
		PSYLLIUM SEED (WITH DEXTROSE)	POWDER
		PSYLLIUM SEED (WITH SUGAR)	POWDER
		PSYLLIUM SEED/ASPARTAME	POWDER
		PSYLLIUM SEED/SOD BICARB	PACKET
		SENNA LEAF	TEA (GRAM)
		SENNA LEAF EXTRACT	SYRUP
		SENNOSIDES	SYRUP
SENNOSIDES	TAB CHEW		
SENNOSIDES	TABLET		
SENNOSIDES/DOCUSATE SODIUM	TABLET		
SENNOSIDES/PSYLLIUM HUSK	CAPSULE		
SOLUBLE CORN FIBER	POWDER		
WHEAT DEXTRIN	POWD PACK ***		
WHEAT DEXTRIN	POWDER		
Gastrointestinal	Pancreatic Enzymes	LIPASE/PROTEASE/AMYLASE (CREON™)	CAPSULE DR

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

**Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List**  
**Effective: January 1, 2018**

<b>System</b>	<b>Class</b>	<b>Preferred</b>
Genito-Urinary	Benign Prostate Hypertrophy Drugs	DOXAZOSIN MESYLATE TABLET FINASTERIDE TABLET TAMSULOSIN HCL CAP ER 24H TERAZOSIN HCL CAPSULE
Genito-Urinary	Overactive Bladder Drugs	FESOTERODINE FUMARATE TAB ER 24H HYOSCYAMINE SULFATE ELIXIR HYOSCYAMINE SULFATE TAB RAPDIS OXYBUTYNIN PATCH TDSW OXYBUTYNIN CHLORIDE GEL MD PMP OXYBUTYNIN CHLORIDE SYRUP OXYBUTYNIN CHLORIDE TAB ER 24 OXYBUTYNIN CHLORIDE TABLET
Hematology-Oncology	Colony Stimulating Factors	FILGRASTIM (NEUPOGEN™) SYRINGE FILGRASTIM (NEUPOGEN™) VIAL FILGRASTIM-SNDZ SYRINGE PEGFILGRASTIM SYR W/ INJ PEGFILGRASTIM SYRINGE SARGRAMOSTIM VIAL TBO-FILGRASTIM (GRANIX™) SYRINGE
Hematology-Oncology	Erythropoietic Stimulating Agents	DARBEPOETIN ALFA IN POLYSORBAT (ARANESP™) * SYRINGE DARBEPOETIN ALFA IN POLYSORBAT (ARANESP™) * VIAL PROCRIT™ - BRAND ONLY * VIAL
Hematology-Oncology	Iron Chelators	DEFEROXAMINE MESYLATE VIAL
Immunological	Biologics for Autoimmune Conditions	ADALIMUMAB (HUMIRA™) * SYRINGEKIT ADALIMUMAB (HUMIRA PEDIATRIC CROHN'S™) * SYRINGEKIT ADALIMUMAB (HUMIRA PEN™) * PEN IJ KIT ADALIMUMAB (HUMIRA PEN CROHN-UC-HS STARTER™) * PEN IJ KIT ADALIMUMAB (HUMIRA PEN PSORIASIS-UVEITIS™) * PEN IJ KIT ETANERCEPT (ENBREL™) * PEN INJCTR ETANERCEPT (ENBREL™) * SYRINGE ETANERCEPT (ENBREL™) * VIAL
Immunological	Immunoglobulins	GAMUNEX-C™ - BRAND ONLY VIAL ***

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred	
Immunological	Immunosuppressants	AZATHIOPRINE	TABLET
		CYCLOSPORINE	CAPSULE
		CYCLOSPORINE	SOLUTION
		CYCLOSPORINE, MODIFIED	CAPSULE
		CYCLOSPORINE, MODIFIED	SOLUTION
		EVEROLIMUS	TABLET
		MYCOPHENOLATE MOFETIL	CAPSULE
		MYCOPHENOLATE MOFETIL	SUSP RECON
		MYCOPHENOLATE MOFETIL	TABLET
		MYCOPHENOLATE SODIUM	TABLET DR
		SIROLIMUS	SOLUTION
		SIROLIMUS	TABLET
		TACROLIMUS	CAPSULE
Neurology	Alzheimer's Disease Drugs	DONEPEZIL HCL	TABLET ***
		GALANTAMINE HBR	CAP24H PEL
		GALANTAMINE HBR	TABLET
		MEMANTINE HCL	SOLUTION
		MEMANTINE HCL	TAB DS PK
		MEMANTINE HCL	TABLET
		RIVASTIGMINE	PATCH TD24
Neurology	Antiepileptics (oral & rectal)	CARBAMAZEPINE	ORAL SUSP
		CARBAMAZEPINE	TAB CHEW
		CARBAMAZEPINE	TAB ER 12H
		CARBAMAZEPINE	TABLET
		DIASTAT <sup>™</sup> - BRAND ONLY	KIT
		DIASTAT ACUDIAL <sup>™</sup> - BRAND ONLY	KIT
		ETHOSUXIMIDE	CAPSULE
		ETHOSUXIMIDE	SOLUTION
		ETHOTOIN	TABLET
		GABAPENTIN	CAPSULE
		GABAPENTIN	TABLET
		LACOSAMIDE (VIMPAT <sup>™</sup> )	TABLET
		LEVETIRACETAM	SOLUTION
		LEVETIRACETAM	TABLET
		METHSUXIMIDE	CAPSULE
		OXCARBAZEPINE	ORAL SUSP
		OXCARBAZEPINE	TABLET
		PHENOBARBITAL	ELIXIR
		PHENOBARBITAL	TABLET
		PHENYTOIN	ORAL SUSP
		PHENYTOIN	TAB CHEW
		PHENYTOIN SODIUM EXTENDED	CAPSULE
		PRIMIDONE	TABLET
		RUFINAMIDE	TABLET
TIAGABINE HCL	TABLET		
TOPIRAMATE	TABLET		
ZONISAMIDE	CAPSULE		

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List

Effective: January 1, 2018

System	Class	Preferred
Neurology	Multiple Sclerosis	COPAXONE™ - BRAND ONLY SYRINGE *** INTERFERON BETA-1A PEN IJ KIT INTERFERON BETA-1A SYRINGEKIT INTERFERON BETA-1A/ALBUMIN KIT INTERFERON BETA-1A/ALBUMIN PEN INJCTR INTERFERON BETA-1A/ALBUMIN SYRINGE INTERFERON BETA-1B KIT
Neurology	Parkinson's Disease Drugs, Oral & Topical	BENZTROPINE MESYLATE TABLET CARBIDOPA/LEVODOPA TABLET CARBIDOPA/LEVODOPA TABLET ER CARBIDOPA/LEVODOPA/ENTACAPONE TABLET ENTACAPONE TABLET PRAMIPEXOLE DI-HCL TABLET SELEGILINE HCL CAPSULE TRIHEXYPHENIDYL HCL ELIXIR TRIHEXYPHENIDYL HCL TABLET
Nutritional	B-vitamins, Oral	CYANOCOBALAMIN (VITAMIN B-12) DROPS CYANOCOBALAMIN (VITAMIN B-12) LOZENGE CYANOCOBALAMIN (VITAMIN B-12) TAB IR ER CYANOCOBALAMIN (VITAMIN B-12) TAB RAPDIS *** CYANOCOBALAMIN (VITAMIN B-12) TAB SUBL *** CYANOCOBALAMIN (VITAMIN B-12) TABLET *** PYRIDOXINE HCL (VITAMIN B6) TABLET THIAMINE HCL TABLET *** THIAMINE MONONITRATE (VIT B1) TABLET
Nutritional	Calcium/Vit D Replacement, Oral	CALCIUM CARBONATE CAPSULE CALCIUM CARBONATE ORAL SUSP CALCIUM CARBONATE TAB CHEW CALCIUM CARBONATE TABLET CALCIUM CARBONATE/VITAMIN D3 CAPSULE *** CALCIUM CARBONATE/VITAMIN D3 LIQUID CALCIUM CARBONATE/VITAMIN D3 TAB CHEW CALCIUM CARBONATE/VITAMIN D3 TABLET *** CALCIUM CITRATE TABLET *** CHOLECALCIFEROL (VITAMIN D3) CAPSULE *** CHOLECALCIFEROL (VITAMIN D3) SPRAY SUSP CHOLECALCIFEROL (VITAMIN D3) TABLET *** ERGOCALCIFEROL (VITAMIN D2) CAPSULE ERGOCALCIFEROL (VITAMIN D2) TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List

Effective: January 1, 2018

System	Class	Preferred
Nutritional	Iron Replacement, Oral	FERROUS GLUCONATE TABLET *** FERROUS SULFATE ELIXIR *** FERROUS SULFATE LIQUID FERROUS SULFATE TABLET FERROUS SULFATE TABLET DR FERROUS SULFATE TABLET ER *** IRON FUM, PS/FA/VIT C/L. CASEI POWD PACK
Nutritional	Magnesium Replacement, Oral	MAGNESIUM TABLET MAGNESIUM AMINO ACID CHELATE TABLET MAGNESIUM CARBONATE LIQUID MAGNESIUM CITRATE TABLET MAGNESIUM GLUCONATE TABLET MAGNESIUM OXIDE CAPSULE MAGNESIUM OXIDE/MAGNESIUM TABLET MAGNESIUM OXIDE/VIT B6 TABLET
Nutritional	Multivitamins, Oral	BETA-CAROTENE(A)-VITS C,E/MINS * TABLET FOLIC ACID/VIT B COMPLEX AND C * TABLET MULTIVIT WITH MINERALS/LUTEIN * TABLET MULTIVIT, TX WITH IRON, MINERALS * TABLET MULTIVITAMIN * TABLET MULTIVITAMIN NO.58/VIT D3/K * CAPSULE MULTIVITAMIN, THERAPEUTIC * TABLET MULTIVITAMIN/IRON/FOLIC ACID * TABLET MULTIVIT-MIN/FA/LYCOPEN/LUTEIN * TABLET MV-MIN 51/FOLIC ACID/VIT K/UBI * TAB CHEW VITAMIN B COMPLEX * CAPSULE
Nutritional	Potassium and K-Phos, Oral	POT CHLORIDE/CAL PHOS/MAG TABLET POTASSIUM TABLET POTASSIUM BICARBONATE/CIT AC TABLET EFF *** POTASSIUM CHLORIDE TAB ER PRT POTASSIUM CHLORIDE TABLET ER POTASSIUM PHOSPHATE, MONOBASIC TABLET SOL SOD PHOS DI, MONO/K PHOS MONO TABLET SOD PHOS, M-B/K PHOS, MONOB TABLET SODIUM, POTASSIUM PHOSPHATES POWD PACK

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

† Age restrictions apply



Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List

Effective: January 1, 2018

System	Class	Preferred	
Nutritional	Prenatal Vitamins	PNV 11/IRON FUM/FOLIC ACID/OM3	CAPSULE
		PNV 15/IRON FUM,PS/FOLIC ACID	CAPSULE
		PNV 16/IRON FUM,PS/FOLIC/OM-3	CAPSULE
		PNV 19/IRON PS,HEME/FOLIC/DHA	CAPSULE
		PNV 21/IRON PS,HEME PPEP/FOLIC	TABLET
		PNV 22/IRON,GLUC/FOLIC/DSS/DHA	COMBO. PKG
		PNV 30/IRON CARB,AG/FOLIC/OM3	CAPSULE
		PNV 39/IRON/FOLIC/DOCUSATE/DHA	CAPSULE
		PNV 66/IRON/FOLIC/DOCUSATE/DHA	CAPSULE
		PNV 67/IRON PS/FOLATE NO.1/DHA	CAPSULE
		PNV 69/IRON/FOLIC/DOCUSATE/DHA	CAPSULE
		PNV 76/IRON,GLUC/FOLIC/DSS/DHA	COMBO. PKG
		PNV 80/IRON FUM/FOLIC/DSS/DHA	CAPSULE
		PNV 85/IRON/FOLIC/DHA/FISH OIL	CAPSULE
		PNV NO.118/IRON FUMARATE/FA	TAB CHEW
		PNV,CALCIUM 72/IRON/FOLIC ACID	TABLET
		PNV,CALCIUM37/IRON/FOLIC/OMEG3	CAPSULE
		PNV/FOLIC AC/B6/CALCIUM/GINGER	TABLET
		PNV19/IRON BG,S.P/FOLIC AC/OM3	CMBPKGDRCP
		PNV20/IRON/FOLIC/DOCUSATE/OM3S	CAPSULE
		PNV53/IRON FUM/FA/DOCUSATE/DHA	CAPSULE
		PNV59/IRON,CARB,FUM/FA/DSS/DHA	CAPSULE
		PNV72/IRON,GLUC/FOLIC/DSS/DHA	COMBO. PKG
		PNV73/IRON,GLUC/FOLIC/DSS/DHA	COMBO. PKG
		PNV81/IRON EDTA,PS/FOLIC/OMEG3	CMBPKGDRCP
		PNV83/IRON,CARB,ASP/FOLIC ACID	TABLET
		PRENAT 115/IRON FUM/FOLIC/DSS	TABLET
		PRENAT90/IRON FUM,PS/FOLIC/DHA	CAPSULE
		PRENATAL 114/IRON A-G/FOLATE 1	TABLET
		PRENATAL 118/IRON/FOLATE 6/DHA	CAPSULE
		PRENATAL 123/IRON/FOLIC/OMEG3S	CAPSULE
		PRENATAL 2/IRON/FOLIC ACID/OM3	COMBO. PKG
		PRENATAL 26/IRON PS/FOLIC/DHA	CAPSULE
		PRENATAL 34/IRON/FOLIC/DSS/DHA	CAPSULE
		PRENATAL 47/IRON/FOLATE 1/DHA	CAPSULE
		PRENATAL 53/IRON/FOLIC AC/OMG3	COMBO. PKG
		PRENATAL 57/IRON/FOLIC/DSS/DHA	CAPSULE
		PRENATAL 68/IRON/FOLIC NO1/DHA	CAPSULE
		PRENATAL 78/IRON/FOLATE 1/DHA	CAPSULE
		PRENATAL 86/IRON/FOLIC/DHA/EPA	COMBO. PKG
		PRENATAL 87/IRON BIS/FOLIC/DHA	COMBO. PKG
		PRENATAL NO.123/IRON/FOLIC AC	TABLET
		PRENATAL NO.52/IRON/FA/DHA	CAPSULE
		PRENATAL NO.75/IRON/FOLATE NO1	TABLET
		PRENATAL NO.77/IRON ASP GLY/FA	TABLET
		PRENATAL NO13/IRON PS/FOLATE 1	TAB CHEW
		PRENATAL NO4/IRON FUM,PS/FOLIC	CAPSULE
		PRENATAL VIT 10/IRON FUM/FOLIC	TABLET
		PRENATAL VIT 10/IRON/FOLIC/DHA	COMBO. PKG
		PRENATAL VIT 113/IRON/LMFOLATE	TAB CHEW

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred			
Nutritional	Prenatal Vitamins	PRENATAL VIT 14/IRON FUM/FOLIC	TAB CHEW		
		PRENATAL VIT 33/IRON/FOLIC/DHA	COMBO. PKG		
		PRENATAL VIT 55/IRON/FOLIC/OM3	CMBPKGDRCP		
		PRENATAL VIT 65/IRON FUM,PS/FA	CAPSULE		
		PRENATAL VIT 84/IRON/FA 1/DHA	CAPSULE		
		PRENATAL VIT 85/IRON/FA 1/DHA	CAPSULE		
		PRENATAL VIT 87/IRON/FOLIC/DHA	CAPSULE		
		PRENATAL VIT NO.112/FOLATE NO6	TAB CHEW		
		PRENATAL VIT NO.127/IRON/FOLIC	TABLET		
		PRENATAL VIT,CAL 73/IRON/FOLIC	TABLET		
		PRENATAL VIT,CAL 74/IRON/FOLIC	TABLET		
		PRENATAL VIT,CALC76/IRON/FOLIC	TABLET		
		PRENATAL VIT103/IRON FUM/FOLIC	TABLET		
		PRENATAL VIT114/FOLATE6/GINGER	TABLET		
		PRENATAL VIT27,CALCIUM/IRON/FA	TABLET		
		PRENATAL VIT37/IRON/FOLIC ACID	TAB CHEW		
		PRENATAL VIT68/IRON/FA NO6/DHA	CAPSULE		
		PRENATAL VIT69/IRON/FOLATE6/DH	CAPSULE		
		PRENATAL VIT86/IRON/FOLIC ACID	TABLET		
		PRENATAL VITS 4/IRON FUM/FOLIC	CAPSULE		
		PRENATAL VITS/IRON/FOLIC ACID	TAB CHEW		
		PRENATAL VITS15/IRON/FOLIC/DSS	TABLET		
		PRENATAL VITS16/IRON/FOLIC/DSS	TABLET		
		PRENATAL,CALC.40/IRON/FOLATE 1	TABLET		
		PRENATAL56/IRON/FOLIC ACID/DHA	CAPSULE		
		PRENATAL81/IRON/FOLIC/DOCUSATE	TABLET		
		Ophthalmics	Antibiotics, Ophthalmic	BACITRACIN/POLYMYXIN B SULFATE	OINT. (G)
				CIPROFLOXACIN HCL	DROPS
CIPROFLOXACIN HCL	OINT. (G)				
ERYTHROMYCIN BASE	OINT. (G)				
GENTAMICIN SULFATE	DROPS				
GENTAMICIN SULFATE	OINT. (G)				
MOXIFLOXACIN HCL	DROPS				
NATAMYCIN	DROPS SUSP				
NEOMYCIN/POLYMYXN B/GRAMICIDIN	DROPS				
OFLOXACIN	DROPS				
POLYMYXIN B SULF/TRIMETHOPRIM	DROPS				
SULFACETAMIDE SODIUM	DROPS				
TOBRAMYCIN	DROPS				
TOBRAMYCIN	OINT. (G)				

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred
Ophthalmics	Antibiotic-Steroids, Ophthalmic	GENTAMICIN SULF/PREDNISOLONE DROPS SUSP GENTAMICIN SULF/PREDNISOLONE OINT. (G) NEOMYCIN/POLYMYXIN B/DEXAMETHA DROPS SUSP NEOMYCIN/POLYMYXIN B/DEXAMETHA OINT. (G) SULFACETAMIDE/PREDNISOLONE DROPS SUSP SULFACETAMIDE/PREDNISOLONE OINT. (G) TOBRAMYCIN/DEXAMETHASONE DROPS SUSP TOBRAMYCIN/DEXAMETHASONE OINT. (G)
Ophthalmics	Anti-Inflammatory Drugs, Ophthalmic	DEXAMETHASONE DROPS SUSP DEXAMETHASONE SOD PHOSPHATE DROPS DICLOFENAC SODIUM DROPS *** FLUOROMETHOLONE DROPS SUSP FLUOROMETHOLONE OINT. (G) FLURBIPROFEN SODIUM DROPS KETOROLAC TROMETHAMINE DROPS LOTEPREDNOL ETABONATE DROPS SUSP PREDNISOLONE ACETATE DROPS SUSP
Ophthalmics	Glaucoma Drugs	BETAXOLOL HCL DROPS BRIMONIDINE TARTRATE DROPS *** BRINZOLAMIDE DROPS SUSP CARTEOLOL HCL DROPS DORZOLAMIDE HCL/TIMOLOL MALEAT DROPS DORZOLAMIDE/TIMOLOL/PF DROPERETTE LATANOPROST DROPS PILOCARPINE HCL DROPS TIMOLOL MALEATE DROPS TRAVOPROST DROPS
Ophthalmics	Vascular Endothelial Growth Factors	BEVACIZUMAB VIAL
Otics	Otic Antibiotics	NEOMYC/COLIST/HYDROCORT/THONZN DROPS SUSP NEOMYCIN/POLYMYXIN B/HYDROCORT DROPS SUSP *** OFLOXACIN DROPS
Psychiatric	ADHD Drugs	DEXMETHYLPHENIDATE HCL CPBP 50-50 DEXMETHYLPHENIDATE HCL TABLET DEXMETHYLPHENIDATE HCL (FOCALIN XR ™) CPBP 50-50 DEXTROAMPHETAMINE/AMPHETAMINE CAP ER 24H DEXTROAMPHETAMINE/AMPHETAMINE TABLET LISDEXAMFETAMINE DIMESYLATE (VYVANSE ™) CAPSULE METHYLPHENIDATE PATCH TD24 METHYLPHENIDATE HCL CPBP 30-70 METHYLPHENIDATE HCL TABLET
Psychiatric	Benzodiazepines	CLONAZEPAM ** TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective: January 1, 2018

System	Class	Preferred
Psychiatric	Opioid Reversal Agents	NALOXONE HCL NALOXONE HCL NALOXONE HCL SPRAY SYRINGE VIAL
Psychiatric	Sedatives	ZOLPIDEM TARTRATE * TABLET
Psychiatric	Substance Use Disorders, Opioid & Alcohol	ACAMPROSATE CALCIUM BUPRENORPHINE HCL/NALOXONE HCL (SUBOXONE™) ** BUPRENORPHINE HCL/NALOXONE HCL (ZUBSOLV™) ** BUPRENORPHINE HCL/NALOXONE HCL ** NALTREXONE HCL NALTREXONE MICROSPHERES (VIVITROL™) TABLET DR FILM TAB SUBL TAB SUBL TABLET SUS ER REC
Psychiatric	Tobacco Smoking Cessation	BUPROPION HCL NICOTINE ** NICOTINE ** NICOTINE POLACRILEX ** NICOTINE POLACRILEX ** NICOTINE POLACRILEX ** VARENICLINE TARTRATE (CHANTIX™) ** VARENICLINE TARTRATE (CHANTIX™) ** TAB ER 12H PATCH DYSQ PATCH TD24 GUM LOZENGE LOZNG MINI TAB DS PK TABLET
Pulmonary	Anticholinergics, Inhaled	IPRATROPIUM BROMIDE IPRATROPIUM BROMIDE IPRATROPIUM/ALBUTEROL SULFATE TIOTROPIUM BROMIDE HFA AER AD SOLUTION AMPUL-NEB CAP W/DEV
Pulmonary	Beta-Agonists, Inhaled Long Acting	SALMETEROL XINAFOATE BLST W/DEV
Pulmonary	Beta-Agonists, Inhaled Short- Acting	ALBUTEROL SULFATE ALBUTEROL SULFATE ALBUTEROL SULFATE HFA AER AD SOLUTION VIAL-NEB
Pulmonary	Corticosteroids, Inhaled	BECLOMETHASONE DIPROPIONATE BUDESONIDE FLUTICASONE PROPIONATE FLUTICASONE PROPIONATE AER W/ADAP AER POW BA AER W/ADAP BLST W/DEV
Pulmonary	Corticosteroids/LABA Combination, Inhaled	BUDESONIDE/FORMOTEROL FUMARATE FLUTICASONE/SALMETEROL FLUTICASONE/SALMETEROL HFA AER AD BLST W/DEV HFA AER AD
Pulmonary	Cystic Fibrosis	DORNASE ALFA SODIUM CHLORIDE FOR INHALATION TOBRAMYCIN/NEBULIZER TOBRAMYCIN/NEBULIZER (KITABIS PAK™) SOLUTION VIAL-NEB AMPUL-NEB AMPUL-NEB
Pulmonary	Miscellaneous Pulmonary Agents	MONTELUKAST SODIUM MONTELUKAST SODIUM TAB CHEW TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
 Effective: January 1, 2018

System	Class	Preferred
Pulmonary	Pulmonary Arterial Hypertension Oral and Inhaled Drugs	BOSENTAN SILDENAFIL CITRATE TABLET TABLET
Pulmonary	Pulmonary Arterial Hypertension Parenteral Drugs	EPOPROSTENOL SODIUM (GLYCINE) VIAL
Renal	Phosphate Binders	CALCIUM ACETATE CALCIUM ACETATE SEVELAMER HCL * CAPSULE TABLET *** TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

† Age restrictions apply

**Table 121-0030-1 Oregon Fee-for-Service Voluntary Mental Health Preferred Drug List**

Effective: January 1, 2018

System	Class	Preferred	
Neurology	Antiepileptics (oral & rectal)	DIVALPROEX SODIUM	CAP DR SPR
		DIVALPROEX SODIUM	TAB ER 24H
		DIVALPROEX SODIUM	TABLET DR
		LAMOTRIGINE	TABLET
		VALPROIC ACID	CAPSULE
		VALPROIC ACID (AS SODIUM SALT)	SOLUTION
Psychiatric	ADHD Drugs	ATOMOXETINE HCL	CAPSULE
Psychiatric	Antidepressants	AMITRIPTYLINE HCL	TABLET
		ANAFRANIL™ - BRAND ONLY	CAPSULE
		BUPROPION HCL	TAB ER 12H
		BUPROPION HCL	TABLET
		CITALOPRAM HYDROBROMIDE	SOLUTION
		CITALOPRAM HYDROBROMIDE	TABLET
		DESIPRAMINE HCL	TABLET
		DOXEPIN HCL	CAPSULE
		DOXEPIN HCL	ORAL CONC
		ESCITALOPRAM OXALATE	TABLET
		FLUOXETINE HCL	CAPSULE
		FLUOXETINE HCL	SOLUTION
		FLUOXETINE HCL	TABLET
		FLUVOXAMINE MALEATE	TABLET
		IMIPRAMINE HCL	TABLET
		MAPROTILINE HCL	TABLET
		MIRTAZAPINE	TAB RAPDIS
		MIRTAZAPINE	TABLET
		NORTRIPTYLINE HCL	CAPSULE
		NORTRIPTYLINE HCL	SOLUTION
		PAROXETINE HCL	TABLET
		PROTRIPTYLINE HCL	TABLET
SERTRALINE HCL	ORAL CONC		
SERTRALINE HCL	TABLET		
TRIMIPRAMINE MALEATE	CAPSULE		
VENLAFAXINE HCL	CAP ER 24H		
VENLAFAXINE HCL	TABLET		
Psychiatric	Antipsychotics, 1st Gen	FLUPHENAZINE HCL	ELIXIR
		FLUPHENAZINE HCL	ORAL CONC
		FLUPHENAZINE HCL	TABLET
		HALOPERIDOL	TABLET
		HALOPERIDOL LACTATE	ORAL CONC
		LOXAPINE SUCCINATE	CAPSULE
		PERPHENAZINE	TABLET
		THIORIDAZINE HCL	TABLET
		THIOTHIXENE	CAPSULE
		TRIFLUOPERAZINE HCL	TABLET

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

‡ Age restrictions apply

**Table 121-0030-1 Oregon Fee-for-Service Voluntary Mental Health Preferred Drug List**

Effective: January 1, 2018

System	Class	Preferred	
Psychiatric	Antipsychotics, 2nd Gen	ASENAPINE MALEATE (SAPHRIS™)	TAB SUBL
		CLOZAPINE	TABLET
		LURASIDONE HCL (LATUDA™)	TABLET
		OLANZAPINE	TABLET
		QUETIAPINE FUMARATE **	TABLET
		RISPERIDONE	SOLUTION
		RISPERIDONE	TABLET
Psychiatric	Antipsychotics, Parenteral	ARIPIPRAZOLE (ABILIFY MAINTENA™)	SUSER SYR
		ARIPIPRAZOLE (ABILIFY MAINTENA™)	SUSER VIAL
		ARIPIPRAZOLE LAUROXIL (ARISTADA™)	SUSER SYR
		CHLORPROMAZINE HCL	AMPUL
		FLUPHENAZINE DECANOATE	VIAL
		FLUPHENAZINE HCL	VIAL
		HALOPERIDOL DECANOATE	AMPUL
		HALOPERIDOL DECANOATE	VIAL
		HALOPERIDOL LACTATE	AMPUL
		HALOPERIDOL LACTATE	VIAL
		RISPERIDONE MICROSPHERES **	SYRINGE

\* Drug coverage subject to meeting clinical prior authorization criteria

\*\* Drug coverage subject to quantity limits

\*\*\* Certain strengths may require Prior Authorization

† Age restrictions apply