Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Allergy/Cold	Anaphylaxis Rescue	epinephrine	AUTO INJCT
		epinephrine (AUVI-Q ™)	AUTO INJCT
Allergy/Cold	Antihistamines, First Generation	chlorpheniramine maleate	TABLET
		cyproheptadine HCl	SYRUP
		cyproheptadine HCl	TABLET
		diphenhydramine HCl	CAPSULE
		diphenhydramine HCl	LIQUID
		diphenhydramine HCl	TABLET
		hydroxyzine HCl	TABLET
		hydroxyzine pamoate	CAPSULE
Allergy/Cold	Antihistamines, Second Generation	cetirizine HCl	SOLUTION
		cetirizine HCl	TABLET
		desloratadine	TABLET
		fexofenadine HCl	TABLET
		levocetirizine dihydrochloride	TABLET
		loratadine	SOLUTION
		loratadine	TAB RAPDIS ***
		loratadine	TABLET
Allergy/Cold	Cough and Cold	codeine phosphate/guaifenesin *	LIQUID
		codeine phosphate/guaifenesin *	SYRUP
		codeine phosphate/guaifenesin *	TABLET
		guaifenesin ‡	LIQUID
		guaifenesin ‡	SYRUP
		guaifenesin ‡	TAB ER 12H
		guaifenesin ‡	TABLET
		guaifenesin ‡	TABLET ER
		guaifenesin/dextromethorphan ‡	CAPSULE
		guaifenesin/dextromethorphan ‡	DROPS
		guaifenesin/dextromethorphan ‡	ELIXIR
		guaifenesin/dextromethorphan ‡	GRAN PACK
		guaifenesin/dextromethorphan ‡	LIQUID
		guaifenesin/dextromethorphan ‡	LIQUID PKT
		guaifenesin/dextromethorphan ‡	SYRUP
		guaifenesin/dextromethorphan ‡	TAB ER 12H
		guaifenesin/dextromethorphan ‡	TABLET
		pseudoephedrine HCl ‡	CAPSULE
		pseudoephedrine HCl ‡	TABLET
Allergy/Cold	Hereditary Angioedema	C1 esterase inhibitor *	KIT
		C1 esterase inhibitor *	VIAL
		icatibant acetate *	SYRINGE

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Updated: September 28, 2026

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Allergy/Cold	Nasal Allergy Inhalers	azelastine HCl	SPRAY/PUMP
		budesonide	SPRAY/PUMP
		fluticasone propionate	SPRAY SUSP
		ipratropium bromide	SPRAY
		triamcinolone acetonide	SPRAY
Allergy/Cold	Ophthalmic Medications for Allergies	azelastine HCl	DROPS
		cromolyn sodium	DROPS
		ketotifen fumarate	DROPS
		olopatadine HCl	DROPS ***
Analgesics	CGRP Inhibitors	erenumab-aooe *	AUTO INJCT
		fremanezumab-vfrm (AJOVY AUTOINJECTOR ™) *	AUTO INJCT
		fremanezumab-vfrm (AJOVY AUTOINJECTOR (3 PACK) ™) *	AUTO INJCT
		fremanezumab-vfrm (AJOVY SYRINGE ™) *	SYRINGE
		ubrogepant (UBRELVY ™) *	TABLET
Analgesics	Gout	allopurinol	TABLET ***
		colchicine **	TABLET
		probenecid/colchicine	TABLET
Analgesics	Muscle Relaxants, Oral	baclofen	TABLET ***
		cyclobenzaprine HCl	TABLET ***
		methocarbamol	TABLET ***
		tizanidine HCl	CAPSULE ***
		tizanidine HCl	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

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

Effective: October 1, 2026

System	Class	Preferred	
Analgesics	Non-Steroidal Anti-Inflammatory Drugs	celecoxib	CAPSULE
		diclofenac potassium	TABLET ***
		diclofenac sodium	TAB ER 24H
		diclofenac sodium	TABLET DR
		etodolac	TABLET
		ibuprofen	CAPSULE
		ibuprofen	DROPS SUSP
		ibuprofen	ORAL SUSP
		ibuprofen	TAB CHEW
		ibuprofen	TABLET ***
		indomethacin	CAPSULE
		indomethacin	CAPSULE ER
		ketoprofen	CAPSULE
		ketorolac tromethamine **	TABLET
		meloxicam	TABLET
		nabumetone	TABLET
		naproxen	TABLET
		naproxen	TABLET DR
		naproxen sodium	CAPSULE
		naproxen sodium	TABLET
		oxaprozin	TABLET
		piroxicam	CAPSULE
		salsalate	TABLET
		sulindac	TABLET
Analgesics	Opioids, Long-Acting	fentanyl *	PATCH TD72
		morphine sulfate *	TABLET ER
		tramadol HCl *	TAB ER 24H
Analgesics	Opioids, Short-Acting	acetaminophen with codeine *	ELIXIR
		acetaminophen with codeine *	SOLUTION
		acetaminophen with codeine *	TABLET
		hydrocodone/acetaminophen **	TABLET
		hydromorphone HCl **	TABLET
		morphine sulfate **	SUPP.RECT
		morphine sulfate **	TABLET
		oxycodone HCl **	SOLUTION
		oxycodone HCl **	TABLET
		oxycodone HCl/acetaminophen **	CAPSULE
		oxycodone HCl/acetaminophen **	TABLET
		tramadol HCl **	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Analgesics	Oral Analgesics, Other	acetaminophen	CAPSULE
		acetaminophen	DROPS
		acetaminophen	ELIXIR
		acetaminophen	LIQUID
		acetaminophen	ORAL SUSP ***
		acetaminophen	TAB CHEW
		acetaminophen	TAB RAPDIS
		acetaminophen	TABLET
		acetaminophen	TABLET ER
		acetaminophen/caffeine	TABLET
		aspirin/acetaminophen/caffeine	TABLET
		aspirin/caffeine	TABLET
Analgesics	Pain Medications, Topical	capsaicin	CREAM (G) ***
		capsaicin	LOTION
		diclofenac sodium	GEL (GRAM) ***
		lidocaine	OINT. (G)
		lidocaine HCl	CREAM (G) ***
		lidocaine HCl	JEL/PF APP
		lidocaine HCl	SOLUTION ***
		lidocaine/prilocaine	CREAM (G)
Analgesics	Serotonin Agonists, Nasal	sumatriptan **	SPRAY
		zolmitriptan **	SPRAY
Analgesics	Serotonin Agonists, Oral	eletriptan hydrobromide **	TABLET
		naratriptan HCl **	TABLET
		rizatriptan benzoate **	TAB RAPDIS
		rizatriptan benzoate **	TABLET
		sumatriptan succinate **	TABLET
		zolmitriptan **	TAB RAPDIS
		zolmitriptan **	TABLET
Analgesics	Serotonin Agonists, Subcutaneous	sumatriptan succinate **	CARTRIDGE
		sumatriptan succinate **	PEN INJCTR
		sumatriptan succinate **	VIAL
Antibiotics	Amoxicillin and Clavulanate, Oral	amoxicillin/potassium clav	SUSP RECON
		amoxicillin/potassium clav	TAB CHEW
		amoxicillin/potassium clav	TABLET
Antibiotics	Antibiotics, Vaginal	clindamycin phosphate	CREAM/APPL
		clindamycin phosphate	SUPP.VAG
		metronidazole	GEL W/APPL ***
Antibiotics	Cephalosporins (1st Gen), Oral	cefadroxil	CAPSULE
		cephalexin	CAPSULE ***
		cephalexin	SUSP RECON

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Antibiotics	Cephalosporins (2nd Gen), Oral	cefaclor	CAPSULE
		cefprozil	SUSP RECON
		cefprozil	TABLET
		cefuroxime axetil	TABLET
Antibiotics	Cephalosporins (3rd Gen), Oral	cefdinir	CAPSULE
		cefdinir	SUSP RECON
		cefpodoxime proxetil	TABLET
Antibiotics	Clostridioides difficile Drugs	metronidazole	TABLET ***
		vancomycin HCl	CAPSULE
		vancomycin HCl	VIAL ***
Antibiotics	Fluoroquinolones, Oral	ciprofloxacin	SUS MC REC
		ciprofloxacin HCl	TABLET
		levofloxacin	SOLUTION
		levofloxacin	TABLET
		moxifloxacin HCl	TABLET
Antibiotics	Macrolides, Oral	azithromycin	SUSP RECON
		azithromycin	TABLET
		clarithromycin	TABLET
Antibiotics	Oxazolidinones, Oral	linezolid	SUSP RECON
		linezolid	TABLET
Antibiotics	Tetracyclines, Oral	doxycycline hyclate **	CAPSULE
		doxycycline hyclate **	TABLET
		doxycycline monohydrate **	CAPSULE
		doxycycline monohydrate **	SUSP RECON
		tetracycline HCl **	CAPSULE
Antifungal	Antifungals, Oral	clotrimazole	TROCHE
		fluconazole	SUSP RECON
		fluconazole	TABLET
		itraconazole	CAPSULE
		ketoconazole	TABLET
		nystatin	ORAL SUSP
		nystatin	TABLET
		terbinafine HCl	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Antifungal	Antifungals, Vaginal	clotrimazole	CREAM/APPL
		clotrimazole	TABLET
		miconazole nitrate	CMB PF CRM
		miconazole nitrate	CREAM/APPL
		miconazole nitrate	CRM/PF APP
		miconazole nitrate	KIT
		miconazole nitrate	SUPP.VAG
		terconazole	CREAM/APPL
		tioconazole	OIN/PF APP
Antivirals	Coronavirus Antivirals	nirmatrelvir/ritonavir	TAB DS PK
		nirmatrelvir/ritonavir (PAXLOVID ™)	TAB DS PK
		remdesivir	VIAL
Antivirals	Hepatitis B	entecavir	TABLET
		tenofovir disoproxil fumarate	TABLET
Antivirals	Hepatitis C, Direct-Acting Antivirals	glecaprevir/pibrentasvir (MAVYRET ™) **	TABLET
		sofosbuvir/velpatasvir (SOFOSBUVIR-VELPATASVIR ™) **	TABLET
Antivirals	Hepatitis C, Other Agents	peginterferon alfa-2a	SYRINGE
		peginterferon alfa-2a	VIAL
		ribavirin	CAPSULE
		ribavirin	TABLET
Antivirals	Herpes Simplex	acyclovir	CAPSULE
		acyclovir	ORAL SUSP
		acyclovir	TABLET
		famciclovir	TABLET
		valacyclovir HCl	TABLET

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Antivirals	HIV	abacavir sulfate	SOLUTION
		abacavir sulfate	TABLET
		abacavir sulfate/lamivudine	TABLET
		abacavir/dolutegravir/lamivudi	TAB SUSP
		abacavir/dolutegravir/lamivudi (TRIUMEQ ™)	TABLET
		atazanavir sulfate	CAPSULE
		atazanavir sulfate	POWD PACK
		atazanavir sulfate/cobicistat (EVOTAZ ™)	TABLET
		bictegrav/emtricit/tenofov ala	TABLET
		cabotegravir	SUSER VIAL
		cabotegravir (APRETUDE ™)	SUSER VIAL
		cabotegravir sodium	TABLET
		cabotegravir/rilpivirine (CABENUVA ™)	SUSER VIAL
		cobicistat	TABLET
		darunavir	ORAL SUSP
		darunavir	TABLET
		darunavir/cob/emtri/tenof alaf (SYMTUZA ™)	TABLET
		darunavir/cobicistat (PREZCOBIX ™)	TABLET
		dolutegravir sodium	TAB SUSP
		dolutegravir sodium	TABLET
		dolutegravir sodium/lamivudine (DOVATO ™)	TABLET
		dolutegravir/rilpivirine (JULUCA ™)	TABLET
		doravirine (PIFELTRO ™)	TABLET
		doravirine/islatravir	TABLET
		doravirine/lamivu/tenofov diso (DELSTRIGO ™)	TABLET
		efavirenz	CAPSULE
		efavirenz	TABLET
		efavirenz/emtricit/tenofovr df	TABLET
		efavirenz/lamivu/tenofov disop	TABLET
		efavirenz/lamivu/tenofov disop (SYMFI ™)	TABLET
		elviteg/cob/emtri/tenof alafen	TABLET
		elviteg/cob/emtri/tenofo disop	TABLET
		emtricita/rilpivirine/tenof DF	TABLET
		emtricitab/rilpiviri/tenof ala	TABLET
		emtricitabine	CAPSULE
		emtricitabine	SOLUTION
		emtricitabine/tenofov alafenam	TABLET
		emtricitabine/tenofovir (TDF)	TABLET
		enfuvirtide	VIAL
		etravirine	TABLET
		fosamprenavir calcium	TABLET
		fostemsavir tromethamine	TAB ER 12H
		ibalizumab-uiyk	VIAL
		lamivudine	SOLUTION
		lamivudine	TABLET
		lamivudine/tenofovir disop fum (CIMDUO ™)	TABLET
		lamivudine/zidovudine	TABLET
		lenacapavir sodium	TABLET
		lenacapavir sodium	VIAL
		lopinavir/ritonavir	SOLUTION

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Antivirals	HIV	lopinavir/ritonavir	TABLET
		maraviroc	SOLUTION
		maraviroc	TABLET
		nevirapine	ORAL SUSP
		nevirapine	TAB ER 24H
		nevirapine	TABLET
		raltegravir potassium	POWD PACK
		raltegravir potassium	TAB CHEW
		raltegravir potassium	TABLET
		rilpivirine	SUSER VIAL
		rilpivirine HCl	TAB SUSP
		rilpivirine HCl	TABLET
		ritonavir	TABLET
		ritonavir (NORVIR ™)	POWD PACK
		ritonavir (NORVIR ™)	TABLET
		tipranavir	CAPSULE
		zidovudine	CAPSULE
		zidovudine	SYRUP
		zidovudine	TABLET
		zidovudine	VIAL
Antivirals	Influenza	oseltamivir phosphate **	CAPSULE
		oseltamivir phosphate **	SUSP RECON
Cardiovascular	Antianginals	isosorbide dinitrate	TAB SUBL
		isosorbide dinitrate	TABLET
		isosorbide mononitrate	TAB ER 24H
		nitroglycerin	PATCH TD24
		nitroglycerin	TAB SUBL
		ranolazine	TAB ER 12H
Cardiovascular	Anticoagulants, Oral and SQ	apixaban (ELIQUIS ™)	TAB DS PK
		apixaban (ELIQUIS ™)	TABLET
		dabigatran etexilate mesylate	CAPSULE
		edoxaban tosylate	TABLET
		enoxaparin sodium	SYRINGE
		enoxaparin sodium	VIAL
		rivaroxaban	TAB DS PK
		rivaroxaban	TABLET
		warfarin sodium	TABLET

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

Effective: October 1, 2026

System	Class	Preferred	
Cardiovascular	Beta-Blockers, Oral	acebutolol HCl	CAPSULE
		atenolol	TABLET
		bisoprolol fumarate	TABLET
		carvedilol	TABLET
		labetalol HCl	TABLET ***
		metoprolol succinate	TAB ER 24H
		metoprolol tartrate	TABLET ***
		nadolol	TABLET
		nebivolol HCl	TABLET
		propranolol HCl	CAP SA 24H
		propranolol HCl	SOLUTION
		propranolol HCl	TABLET
		sotalol HCl	TABLET
Cardiovascular	Calcium Channel Blockers - Dihydropyridine, Oral	amlodipine besylate	TABLET
		felodipine	TAB ER 24H
		nicardipine HCl	CAPSULE
		nifedipine	CAPSULE
		nifedipine	TAB ER 24
		nifedipine	TABLET ER
		nimodipine	CAPSULE
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	TAB ER 24H
		diltiazem HCl	TABLET
		verapamil HCl	CAP24H PEL
		verapamil HCl	TABLET
		verapamil HCl	TABLET ER
Cardiovascular	Combination Antihypertensives	amlodipine bes/olmesartan med	TABLET
		amlodipine besylate/benazepril	CAPSULE
		amlodipine besylate/valsartan	TABLET
		atenolol/chlorthalidone	TABLET
		benazepril/hydrochlorothiazide	TABLET
		bisoprolol/hydrochlorothiazide	TABLET
		candesartan/hydrochlorothiazid	TABLET
		enalapril/hydrochlorothiazide	TABLET
		irbesartan/hydrochlorothiazide	TABLET
		lisinopril/hydrochlorothiazide	TABLET
		losartan/hydrochlorothiazide	TABLET
		olmesartan/amlodipin/hcthiazid	TABLET
		olmesartan/hydrochlorothiazide	TABLET
		telmisartan/hydrochlorothiazid	TABLET
		valsartan/hydrochlorothiazide	TABLET

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Cardiovascular	Diuretics, Outpatient	amiloride HCl	TABLET
		amiloride/hydrochlorothiazide	TABLET
		bumetanide	TABLET
		chlorthalidone	TABLET
		eplerenone	TABLET
		furosemide	SOLUTION ***
		furosemide	TABLET
		hydrochlorothiazide	CAPSULE
		hydrochlorothiazide	TABLET
		indapamide	TABLET
		metolazone	TABLET
		spironolact/hydrochlorothiazid	TABLET
		spironolactone	TABLET
		torsemide	TABLET
		triamterene	CAPSULE
		triamterene/hydrochlorothiazid	CAPSULE
		triamterene/hydrochlorothiazid	TABLET
Cardiovascular	Inhibitors of the Renin-Angiotensin-Aldosterone System (RAAS)	benazepril HCl	TABLET
		candesartan cilexetil	TABLET
		captopril	TABLET
		enalapril maleate	TABLET
		fosinopril sodium	TABLET
		irbesartan	TABLET
		lisinopril	TABLET
		losartan potassium	TABLET
		olmesartan medoxomil	TABLET
		perindopril erbumine	TABLET
		quinapril HCl	TABLET
		ramipril	CAPSULE
		sacubitril/valsartan	TABLET
		telmisartan	TABLET
		valsartan	TABLET
Cardiovascular	Other Dyslipidemia Drugs	cholestyramine	POWD PACK
		cholestyramine	POWDER
		cholestyramine (with sugar)	POWD PACK
		cholestyramine (with sugar)	POWDER
		evolocumab (REPATHA SURECLICK ™) *	PEN INJCTR
		evolocumab (REPATHA SYRINGE ™) *	SYRINGE
		evolocumab *	WEAR INJCT
		ezetimibe	TABLET
		fenofibrate	TABLET ***
		fenofibrate nanocrystallized	TABLET
		fenofibrate,micronized	CAPSULE
		fenofibric acid (choline)	CAPSULE DR
		omega-3 acid ethyl esters *	CAPSULE

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Cardiovascular	Platelet Inhibitors	aspirin	TAB CHEW
		aspirin	TABLET
		aspirin	TABLET DR
		aspirin/dipyridamole	CPMP 12HR
		cilostazol	TABLET
		clopidogrel bisulfate	TABLET
		dipyridamole	TABLET
		prasugrel HCl	TABLET
		ticagrelor	TABLET
Cardiovascular	Statins & Combos	atorvastatin calcium	TABLET
		lovastatin	TABLET
		pravastatin sodium	TABLET
		rosuvastatin calcium	TABLET
		simvastatin	TABLET
Dermatologicals	Acne and Rosacea	adapalene	GEL (GRAM)
		adapalene	GEL W/PUMP
		adapalene	LOTION
		adapalene/benzoyl peroxide	GEL W/PUMP ***
		azelaic acid	GEL (GRAM)
		benzoyl peroxide	CLEANSER ***
		benzoyl peroxide	FOAM
		benzoyl peroxide	GEL (GRAM)
		benzoyl peroxide	LOTION
		clindamycin phos/benzoyl perox	GEL (GRAM)
		clindamycin phos/benzoyl perox	GEL W/PUMP ***
		clindamycin phosphate	GEL (GRAM)
		clindamycin phosphate	LOTION
		clindamycin phosphate	MED. SWAB
		clindamycin phosphate	SOLUTION
		clindamycin/tretinoin	GEL (GRAM)
		dapsone	GEL (GRAM) ***
		erythromycin base in ethanol	GEL (GRAM)
		erythromycin base in ethanol	MED. SWAB
		erythromycin base in ethanol	SOLUTION
		erythromycin/benzoyl peroxide	GEL (GRAM)
		isotretinoin	CAPSULE ***
		metronidazole	CREAM (G)
		metronidazole	GEL (GRAM)
		sulfacetamide sodium	SUSPENSION
		tretinoin	CREAM (G)
		tretinoin	GEL (GRAM)
Dermatologicals	Actinic Keratosis	fluorouracil	CREAM (G) ***
		imiquimod	CREAM PACK ***

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Dermatologicals	Antibiotics, Topical	bacitracin	OINT. (G) ***
		bacitracin zinc	OINT. (G)
		bacitracin zinc/polymyxin B	OINT. (G)
		bacitracin/polymyxin B sulfate	OINT. (G)
		gentamicin sulfate	CREAM (G)
		mupirocin	OINT. (G)
		neomycin/bacitracin/polymyxinB	OINT. (G)
Dermatologicals	Antifungals, Topical	butenafine HCl	CREAM (G)
		ciclopirox	GEL (GRAM)
		ciclopirox	SHAMPOO
		ciclopirox	SOLUTION
		ciclopirox olamine	CREAM (G)
		clotrimazole	CREAM (G)
		clotrimazole	SOLUTION
		clotrimazole/betamethasone dip	CREAM (G)
		econazole nitrate	CREAM (G)
		ketoconazole	CREAM (G)
		ketoconazole	SHAMPOO
		miconazole nitrate	CREAM (G)
		miconazole nitrate	POWDER
		miconazole nitrate	SOL W/APPL
		nystatin	CREAM (G)
		nystatin	OINT. (G)
		nystatin	POWDER ***
		nystatin/triamcinolone acet	CREAM (G)
		nystatin/triamcinolone acet	OINT. (G)
		terbinafine HCl	CREAM (G)
		tolnaftate	CREAM (G)
		tolnaftate	POWDER
Dermatologicals	Antiparasitics, Topical	permethrin	COMBO. PKG
		permethrin	CREAM (G)
		permethrin	LIQUID
		piperonyl but/pyrethins/permet	KIT
		piperonyl butoxide/pyrethrins	GEL (GRAM)
		piperonyl butoxide/pyrethrins	KIT
		piperonyl butoxide/pyrethrins	LIQUID
		piperonyl butoxide/pyrethrins	SHAMPOO

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Dermatologicals	Moisturizers, Topical	ammonium lactate	CREAM (G)
		ammonium lactate	LOTION
		calamine/phenol liquid	LOTION
		calamine/zinc oxide	CREAM (G)
		calamine/zinc oxide	LOTION
		ceramides 1,3,6-II	LOTION
		cetyl alc/stearyl alc/pg/sls	CREAM (G)
		colloidal oatmeal	CREAM (G)
		colloidal oatmeal	CREAM(ML)
		colloidal oatmeal	LOTION
		dimethic/zinc ox/vits A,D/aloe	CREAM (G)
		dimethicone	CREAM (G)
		dimethicone/colloidal oatmeal	LOTION
		dimethicone/zinc oxide	CREAM (G)
		emollient combination no.116	LOTION
		emollient combination no.40	LOTION
		gly/benzyl alc/petrolat,wht	LOTION
		gly/dimeth/petrolat,wht/water	CREAM (G)
		glycerin/dimeth/surfactants	LOTION
		lactic acid/urea	LOTION
		lanolin	CREAM (G)
		lanolin	OINT. (G)
		lanolin/mineral oil	LOTION
		lecithin/glycerin/dimethicone	LOTION
		menthol/zinc oxide	OINT. (G)
		menthol/zinc/aloe/chamomil oil	OINT. (G)
		min oil/petrolatum/castor oil	LOTION
		mineral oil/i-prop myr/water	LOTION
		mineral oil/petrolatum,white	CREAM (G)
		petrolatum,white	CREAM (G)
		petrolatum,white	OINT. (G)
		petrolatum/vits A,C,E/aloe xt	OINT.(ML)
		vit A/vitamin D3/E/aloe v/zinc	OINT. (G)
		vit E acet/gly/dimeth/water	LOTION
		vitamin E	CREAM (G)
		vitamin E/vitamins A and D	CREAM (G)
		vitamins A and D	CREAM (G)
		vits A and D/white pet/lanolin	OINT. (G)
		zinc oxide	CREAM (G)
		zinc oxide	OINT. (G)
		zinc oxide/cod liver oil	OINT. (G)
		zinc oxide/menthol/calamine	OINT. (G)
		zinc oxide/panthenol/vitamin E	CREAM (G)

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

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	FOAM
		betamethasone valerate	LOTION
		betamethasone valerate	OINT. (G)
		betamethasone/propylene glyc	CREAM (G)
		betamethasone/propylene glyc	OINT. (G)
		clobetasol propionate	CREAM (G) ***
		clobetasol propionate	FOAM
		clobetasol propionate	GEL (GRAM)
		clobetasol propionate	OINT. (G)
		clobetasol propionate	SHAMPOO
		clobetasol propionate	SOLUTION
		clobetasol propionate/emoll	CREAM (G)
		desonide	CREAM (G)
		desonide	LOTION
		desonide	OINT. (G)
		desoximetasone	CREAM (G)
		fluocinolone acetonide	CREAM (G)
		fluocinolone acetonide	OIL
		fluocinolone acetonide	OINT. (G)
		fluocinolone acetonide	SHAMPOO
		fluocinolone acetonide	SOLUTION
		fluocinolone/shower cap	OIL
		fluocinonide	CREAM (G)
		fluocinonide	GEL (GRAM)
		fluocinonide	OINT. (G)
		fluocinonide	SOLUTION
		fluocinonide/emollient base	CREAM (G)
		fluticasone propionate	CREAM (G)
		fluticasone propionate	OINT. (G)
		halobetasol propionate	CREAM (G)
		halobetasol propionate	OINT. (G)
		hydrocortisone	CREAM (G)
		hydrocortisone	CRM/PE APP
		hydrocortisone	LOTION ***
		hydrocortisone	OINT. (G)
		hydrocortisone acet/aloe vera	CREAM (G)
		hydrocortisone acetate	CREAM (G)
		hydrocortisone butyrate	SOLUTION
		hydrocortisone/aloe vera	CREAM (G)
		mometasone furoate	CREAM (G)
		mometasone furoate	OINT. (G)
		mometasone furoate	SOLUTION
		triamcinolone acetonide	CREAM (G)
		triamcinolone acetonide	LOTION

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Dermatologicals	Steroids, Topical	triamcinolone acetonide	OINT. (G)
Dermatologicals	Topical Products for Inflammatory Skin Diseases	calcipotriene ‡	CREAM (G)
		calcipotriene/betamethasone ‡	OINT. (G)
		pimecrolimus ‡	CREAM (G)
		tacrolimus ‡	OINT. (G)
		tazarotene ‡	CREAM (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	alogliptin benz/metformin HCl *	TABLET
		alogliptin benzoate *	TABLET
		linagliptin/metformin HCl *	TABLET
		saxagliptin HCl *	TABLET
		sitagliptin phos/metformin HCl *	TABLET
		sitagliptin phosphate *	TABLET
Endocrine	Diabetes, GLP-1 Receptor Agonists and GIP Therapies	dulaglutide (TRULICITY ™) *	PEN INJCTR
		exenatide *	PEN INJCTR
		liraglutide *	PEN INJCTR
Endocrine	Diabetes, Glucagon	glucagon	VIAL
		glucagon (BAQSIMI ™)	SPRAY
Endocrine	Diabetes, Insulins	HUMALOG ™ - BRAND ONLY	CARTRIDGE
		HUMALOG ™ - BRAND ONLY	VIAL
		HUMALOG KWIKPEN U-100 ™ - BRAND ONLY	INSULN PEN
		insulin lispro	INS PEN HF
		insulin lispro	INSULN PEN
		INSULIN LISPRO - GENERIC ONLY	VIAL
		insulin lispro protamin/lispro	INSULN PEN
		insulin lispro protamin/lispro	VIAL
		insulin NPH hum/reg insulin hm *	INSULN PEN
		insulin NPH hum/reg insulin hm *	VIAL
		insulin NPH human isophane	VIAL
		insulin regular, human	INSULN PEN
		insulin regular, human	VIAL
		insulin zinc human recombinant	VIAL
		LANTUS ™ - BRAND ONLY	VIAL
		LANTUS SOLOSTAR ™ - BRAND ONLY	INSULN PEN

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Endocrine	Diabetes, Miscellaneous Antidiabetic Agents	acarbose	TABLET
		glipizide/metformin HCl	TABLET
		glyburide/metformin HCl	TABLET
		metformin HCl	TAB ER 24
		metformin HCl	TAB ER 24H
		metformin HCl	TABERGR24H
		metformin HCl	TABLET ***
		nateglinide	TABLET
		repaglinide	TABLET
Endocrine	Diabetes, SGLT-2 Inhibitors	dapagliflozin	TABLET
		empagliflozin (JARDIANCE ™)	TABLET
Endocrine	Diabetes, Sulfonylureas	chlorpropamide	TABLET
		glimepiride	TABLET ***
		glipizide	TAB ER 24
		glipizide	TABLET
		glyburide	TABLET
		glyburide,micronized	TABLET
Endocrine	Diabetes, Thiazolidinediones	pioglitazone HCl	TABLET
Endocrine	Estrogen Replacement, Oral	drospirenone/estradiol	TABLET
		estradiol	TABLET
		estrogen,con/m-progest acet	TABLET
		estrogens, conjugated	TABLET
		estrogens,conj.,synthetic A	TABLET
		estropipate	TABLET
Endocrine	Estrogen Replacement, Topical	estradiol	GEL MD PMP
		estradiol	PATCH TDSW
		estradiol	PATCH TDWK
Endocrine	Estrogen Replacement, Vaginal	estradiol	CREAM/APPL
		estradiol	TABLET
		estradiol	VAG RING
		estradiol acetate	VAG RING
		estrogens, conjugated	CREAM/APPL

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Endocrine	Glucocorticoids, Oral	cortisone acetate	TABLET
		dexamethasone	DROPS
		dexamethasone	ELIXIR
		dexamethasone	SOLUTION
		dexamethasone	TAB DS PK
		dexamethasone	TABLET
		hydrocortisone	TABLET
		methylprednisolone	TAB DS PK
		methylprednisolone	TABLET
		prednisolone	SOLUTION
		prednisone	ORAL CONC
		prednisone	SOLUTION
		prednisone	TAB DS PK
		prednisone	TABLET
		prednisone	TABLET DR
Endocrine	GnRH Agonists	leuprolide acetate *	KIT
Endocrine	Growth Hormones	somatropin (GENOTROPIN ™) *	CARTRIDGE
		somatropin (GENOTROPIN ™) *	SYRINGE
		somatropin (NORDITROPIN FLEXPRO ™) *	PEN INJCTR
Endocrine	Progestational Agents	medroxyprogesterone acetate	TABLET
		norethindrone acetate	TABLET
		progesterone, micronized	CAPSULE
Endocrine	Thyroid Hormone, Oral	levothyroxine sodium	TABLET
Endocrine	Vitamin D Analogs	calcitriol	CAPSULE
		calcitriol	SOLUTION
Endocrine	Weight Management Drugs	tirzepatide (ZEPBOUND ™) *	PEN INJCTR
		tirzepatide (ZEPBOUND KWIKPEN ™) *	PEN INJCTR
Gastrointestinal	Antacid, H. pylori	bismuth/metronid/tetracycline	CAPSULE
		lansoprazole/amoxiciln/clarith	COMBO. PKG
		omeprazole/amoxicill/rifabutin	CAP IR DR
Gastrointestinal	Antacid, H2 Antagonists	famotidine	TABLET
		famotidine/Ca carb/mag hydrox	TAB CHEW
		ranitidine HCl	SYRUP
		ranitidine HCl	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Gastrointestinal	Antacid, Proton Pump Inhibitors	esomeprazole magnesium **	CAPSULE DR
		esomeprazole magnesium **	TABLET DR
		lansoprazole **	CAPSULE DR
		omeprazole **	CAPSULE DR
		omeprazole **	TAB RAP DR
		omeprazole **	TABLET DR
		omeprazole magnesium **	CAPSULE DR
		omeprazole magnesium **	TABLET DR
		omeprazole/sodium bicarbonate **	CAPSULE
		pantoprazole sodium **	TABLET DR
		rabeprazole sodium **	TABLET DR
Gastrointestinal	Antidiarrheals	bismuth subsalicylate	ORAL SUSP
		bismuth subsalicylate	TAB CHEW
		bismuth subsalicylate	TABLET
		diphenoxylate HCl/atropine	TABLET
		loperamide HCl **	CAPSULE
		loperamide HCl **	LIQUID
		loperamide HCl **	TABLET
Gastrointestinal	Antiemetics, Conventional	metoclopramide HCl	ORAL CONC
		metoclopramide HCl	SOLUTION
		metoclopramide HCl	TABLET
		phosphorated carbo(dext-fruct)	SOLUTION
		prochlorperazine	SUPP.RECT
		prochlorperazine edisylate	SYRUP
		prochlorperazine maleate	TABLET
		promethazine HCl	SUPP.RECT
		promethazine HCl	SYRUP
		promethazine HCl	TABLET
Gastrointestinal	Antiemetics, Newer	ondansetron	TAB RAPDIS ***
		ondansetron HCl	SOLUTION
		ondansetron HCl	TABLET
Gastrointestinal	Bile Therapy	ursodiol	CAPSULE ***
		ursodiol	TABLET
Gastrointestinal	Bowel Preparation Agents	peg3350/sod sulf,bicarb,Cl/KCl	SOLN RECON
		sodium chloride/NaHCO3/KCl/peg	SOLN RECON
		sodium phosphate,mono-dibasic	LIQUID
		sodium phosphate,mono-dibasic	SOLUTION
		sodium, potassium,mag sulfates	SOLN RECON
Gastrointestinal	Hyoscyamine	hyoscyamine sulfate	ELIXIR
		hyoscyamine sulfate	TAB RAPDIS

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Gastrointestinal	Inflammatory Bowel Disease	balsalazide disodium	CAPSULE
		budesonide	CAPDR - ER
		mesalamine	CAP ER 24H
		mesalamine	SUPP.RECT
		mesalamine	TABLET DR
		olsalazine sodium	CAPSULE
		sulfasalazine	TABLET
		sulfasalazine	TABLET DR

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

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
		fructooligosaccharides/polydex	LIQUID
		guar gum	PACKET
		guar gum	POWDER
		inulin	TAB CHEW
		lactulose	SOLUTION
		lubiprostone	CAPSULE
		magnesium citrate	SOLUTION
		magnesium hydroxide	ORAL SUSP
		magnesium hydroxide	TAB CHEW ***
		magnesium sulfate	GRANULES
		methylcellulose	TABLET
		methylcellulose (with sugar)	POWDER
		polyethylene glycol 3350	POWD PACK ***
		polyethylene glycol 3350	POWDER
		prucalopride succinate	TABLET
		psyllium husk	CAPSULE ***
		psyllium husk	POWD PACK
		psyllium husk	POWDER
		psyllium husk (with sugar)	POWDER
		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
		psyllium/sucr/sacchar/dextrose	POWD PACK
		senna leaf extract	SYRUP
		senna leaf extract	TAB CHEW
		senna/psyllium seed	GRANULES
		sennosides	CAPSULE
		sennosides	SYRUP
		sennosides	TAB CHEW
		sennosides	TABLET
		sennosides/docusate sodium	TABLET
		soluble corn fiber	POWDER
Gastrointestinal	Pancreatic Enzymes	lipase/protease/amylase (pork)	CAPSULE DR
		lipase/protease/amylase (pork) (ZENPEP ™)	CAPSULE DR

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Genito-Urinary	Benign Prostate Hypertrophy Drugs	doxazosin mesylate	TABLET
		finasteride	TABLET
		tamsulosin HCl	CAPSULE
		terazosin HCl	CAPSULE
Genito-Urinary	Overactive Bladder Drugs	fesoterodine fumarate	TAB ER 24H
		oxybutynin	PATCH TDSW
		oxybutynin chloride	SYRUP
		oxybutynin chloride	TAB ER 24
		oxybutynin chloride	TABLET ***
		solifenacin succinate	TABLET
Hematology-Oncology	Colony Stimulating Factors	filgrastim (NEUPOGEN ™)	SYRINGE
		filgrastim (NEUPOGEN ™)	VIAL
		sargramostim	VIAL
Hematology-Oncology	Erythropoiesis Stimulating Agents	darbepoetin alfa in polysorbat (ARANESP ™)	SYRINGE
		darbepoetin alfa in polysorbat (ARANESP ™)	VIAL
Hematology-Oncology	Iron Chelators	deferoxamine mesylate	VIAL
Hematology-Oncology	Sickle Cell Disease	hydroxyurea	CAPSULE
Hematology-Oncology	Sickle Cell Gene Therapy	exagamglogene autotemcel (CASGEVY ™) *	VIAL
		lovotibeglogene autotemcel (LYFGENIA ™) *	PLAST. BAG
Hematology-Oncology	Thrombocytopenia Drugs	eltrombopag olamine	POWD PACK
		eltrombopag olamine	TABLET
		romiplostim	VIAL
Immunological	Immunoglobulins	immun glob G(IgG)/gly/IgA ov50	VIAL
		immun glob G(IgG)/pro/IgA 0-50	SYRINGE
		immun glob G(IgG)/pro/IgA 0-50	VIAL
Immunological	Immunosuppressants	azathioprine	TABLET
		cyclosporine	CAPSULE
		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	CAP ER 24H
		tacrolimus	CAPSULE
		tacrolimus	GRAN PACK
		tacrolimus	TAB ER 24H

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Immunological	Targeted Immune Modulators	adalimumab (HUMIRA ™) *	SYRINGEKIT
		adalimumab (HUMIRA PEN ™) *	PEN IJ KIT
		adalimumab (HUMIRA(CF) ™) *	SYRINGEKIT
		adalimumab (HUMIRA(CF) PEN ™) *	PEN IJ KIT
		adalimumab (HUMIRA(CF) PEN CROHN'S-UC-HS ™) *	PEN IJ KIT
		adalimumab (HUMIRA(CF) PEN PSOR-UV-ADOL HS ™) *	PEN IJ KIT
		adalimumab-atto (AMJEVITA(CF) ™)	SYRINGE ***
		adalimumab-atto (AMJEVITA(CF) AUTOINJECTOR ™)	AUTO INJCT ***
		adalimumab-fkjp (ADALIMUMAB-FKJP(CF) ™) *	SYRINGEKIT
		adalimumab-fkjp (ADALIMUMAB-FKJP(CF) PEN ™) *	PEN IJ KIT
		adalimumab-fkjp *	PEN INJCTR
		adalimumab-fkjp *	SYRINGE
		adalimumab-ryvk (SIMLANDI(CF) ™) *	SYRINGEKIT
		adalimumab-ryvk (SIMLANDI(CF) AUTOINJECTOR ™) *	AUTOINJKIT
		apremilast *	TAB DS PK
		apremilast *	TABLET
		etanercept (ENBREL ™) *	SYRINGE
		etanercept (ENBREL ™) *	VIAL
		etanercept (ENBREL MINI ™) *	CARTRIDGE
		etanercept (ENBREL SURECLICK ™) *	PEN INJCTR
		guselkumab (TREMFYA ™) *	SYRINGE
		guselkumab (TREMFYA ONE-PRESS ™) *	AUTO INJCT
		guselkumab (TREMFYA PEN ™) *	PEN INJCTR
		guselkumab (TREMFYA PEN INDUCTION (2 PEN) ™) *	PEN INJCTR
		guselkumab *	VIAL
		infliximab *	VIAL
		infliximab-axxq *	VIAL
		ixekizumab (TALTZ AUTOINJECTOR ™) *	AUTO INJCT
		ixekizumab (TALTZ AUTOINJECTOR (2 PACK) ™) *	AUTO INJCT
		ixekizumab (TALTZ AUTOINJECTOR (3 PACK) ™) *	AUTO INJCT
		ixekizumab (TALTZ SYRINGE ™) *	SYRINGE
		PYZCHIVA ™ - BRAND ONLY *	SYRINGE
		PYZCHIVA ™ - BRAND ONLY *	VIAL
		tofacitinib citrate *	SOLUTION
		tofacitinib citrate *	TAB ER 24H
		tofacitinib citrate *	TABLET
Metabolic Disorders	Lysosomal Storage Disorders	taliglucerase alfa *	VIAL
		ZAVESCA ™ - BRAND ONLY *	CAPSULE
Metabolic Disorders	Urea Cycle Disorders	sodium phenylbutyrate	GRANULES
		sodium phenylbutyrate	POWDER
		sodium phenylbutyrate	TABLET
Miscellaneous	Ammonia Inhibitors, Other	CARBAGLU ™ - BRAND ONLY *	TAB DISPER

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Neurology	Alzheimer's Disease, Non-injectable Drugs	donepezil HCl	TAB RAPDIS
		donepezil HCl	TABLET
		galantamine HBr	CAP24H PEL
		galantamine HBr	TABLET
		memantine HCl	CAP SPR 24
		memantine HCl	SOLUTION
		memantine HCl	TAB DS PK
		memantine HCl	TABLET
		memantine HCl/donepezil HCl	CAP SPR 24
		rivastigmine	PATCH TD24
		rivastigmine tartrate	CAPSULE
Neurology	Amyotrophic Lateral Sclerosis	riluzole	TABLET
Neurology	Antiepileptics, Outpatient	carbamazepine	TAB CHEW ***
		carbamazepine	TAB ER 12H
		carbamazepine	TABLET
		clobazam	ORAL SUSP
		clobazam	TABLET
		diazepam	KIT
		diazepam (VALTOCO ™)	SPRAY
		ethosuximide	CAPSULE
		ethosuximide	SOLUTION
		gabapentin	CAPSULE ***
		gabapentin	TABLET
		lacosamide	TABLET
		levetiracetam	SOLUTION
		levetiracetam	TAB ER 24H
		levetiracetam	TABLET
		methsuximide	CAPSULE
		midazolam (NAYZILAM ™)	SPRAY
		oxcarbazepine	ORAL SUSP
		oxcarbazepine	TABLET
		phenobarbital	ELIXIR ***
		phenobarbital	TABLET
		phenytoin	ORAL SUSP
		phenytoin	TAB CHEW
		phenytoin sodium extended	CAPSULE
		pregabalin *	CAPSULE
		primidone	TABLET ***
		rufinamide	TABLET
		tiagabine HCl	TABLET
		topiramate	TABLET
		zonisamide	CAPSULE
Neurology	Duchenne Muscular Dystrophy	deflazacort (EMFLAZA ™) *	TABLET
		deflazacort *	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Neurology	Multiple Sclerosis	COPAXONE ™ - BRAND ONLY *	SYRINGE
		interferon beta-1a	PEN IJ KIT
		interferon beta-1a	SYRINGE
		interferon beta-1a	SYRINGEKIT
		interferon beta-1a/albumin	PEN INJCTR
		interferon beta-1a/albumin	SYRINGE
		interferon beta-1b (BETASERON ™)	KIT
		peginterferon beta-1a (PLEGRIDY ™)	SYRINGE
		peginterferon beta-1a (PLEGRIDY PEN ™)	PEN INJCTR
Neurology	Parkinson's Disease Drugs, Oral & Topical	amantadine HCl	CAPSULE
		amantadine HCl	TABLET
		benztropine mesylate	TABLET
		carbidopa/levodopa	TABLET
		carbidopa/levodopa	TABLET ER
		carbidopa/levodopa/entacapone	TABLET
		entacapone	TABLET
		pramipexole di-HCl	TABLET
		ropinirole HCl	TABLET
		selegiline HCl	CAPSULE
		trihexyphenidyl HCl	SOLUTION
		trihexyphenidyl HCl	TABLET
Nutritional	B-vitamins, Oral	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	ORAL SUSP
		calcium carbonate	TABLET
		calcium carbonate/vitamin D3	TAB CHEW
		calcium carbonate/vitamin D3	TABLET ***
		cholecalciferol (vitamin D3)	CAPSULE ***
		cholecalciferol (vitamin D3)	DROPS ***
		cholecalciferol (vitamin D3)	TABLET ***
		ergocalciferol (vitamin D2)	CAPSULE ***

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Nutritional	Iron Replacement, Oral	ferrous fumarate	TAB CHEW
		ferrous fumarate	TABLET
		ferrous gluconate	TABLET
		ferrous sulfate	DROPS
		ferrous sulfate	ELIXIR
		ferrous sulfate	LIQUID
		ferrous sulfate	SOLUTION
		ferrous sulfate	TABLET
		ferrous sulfate	TABLET DR
		ferrous sulfate	TABLET ER
		ferrous sulfate, dried	TABLET ER
		iron polysaccharide complex	CAPSULE
		iron polysaccharide complex	LIQUID
		iron polysaccharide complex	TABLET
Nutritional	Magnesium Replacement, Oral	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 38/folate no.6/ginger *	TABLET
		multivit 47/iron/folate 1/dha *	CAPSULE
		multivit no.40/iron/folat1/dha *	CAPSULE
		multivit no.42/iron/folate/dha *	CAPSULE
		multivit with minerals/lutein *	TABLET
		multivit37/iron/Lmfolate/algal *	CAPSULE
		multivit41/iron/folate8/ps-dha *	CAP IR DR
		multivitamin *	TABLET
		multivitamin no.36/folate no.6 *	TAB CHEW
		multivitamin,therapeutic *	TABLET
		multivitamin/iron/folic acid *	TABLET
		multivit-min/FA/lycopen/lutein *	TABLET
		multivit-min69/iron/folic acid *	TABLET
		mv-mins 71/iron/folic no.1/dha *	CAPSULE
		mvn-min 74/iron fum/iron/FA *	CAPSULE
		mvn-min75/iron/iron ps/om3/dha *	CAPSULE
		vitamin B complex *	CAPSULE
Nutritional	Potassium and K-Phos, Oral	potassium	TABLET
		potassium bicarbonate/cit ac	TABLET EFF
		potassium chloride	CAPSULE ER
		potassium chloride	LIQUID
		potassium chloride	PACKET ***
		potassium chloride	TAB ER PRT
		potassium chloride	TABLET ER
		potassium gluconate	ELIXIR
		potassium phosphate,monobasic	TABLET SOL
		sod phos di, mono/K phos mono	TABLET
		sod phos,m-b/K phos,monob	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Nutritional	Prenatal Vitamins	PNV 11/iron fum/folic acid/om3	CAPSULE
		PNV 30/iron carb,ag/folic/om3	CAPSULE
		PNV 66/iron/folic/docusate/dha	CAPSULE
		PNV 67/iron ps/folate no.1/dha	CAPSULE
		PNV 85/iron/folic/dha/fish oil	CAPSULE
		PNV no.164/iron/folate no.6	TABLET
		PNV no.207/iron glu/folic acid	TABLET
		PNV no.52/iron/FA/omega-3/dha	COMBO. PKG
		PNV w-CA8/iron/FA/lmefolate Ca	TABLET
		PNV,Ca42/iron/FA/lmefolate/dha	CAPSULE
		PNV,calcium 72/iron/folic acid	TABLET
		PNV/iron b-g,fum/folic acid	TABLET
		PNV/iron ps cplx/folic acid	TABLET
		PNV72/iron,gluc/folic/dss/dha	COMBO. PKG
		PNV73/iron,gluc/folic/dss/dha	COMBO. PKG
		PNV83/iron,carb,asp/folic acid	TABLET
		prenatal 114/iron a-g/folate 1	TABLET
		prenatal 136/iron/folic acid	TABLET
		prenatal 147/iron/folic acid	TABLET
		prenatal 199/iron/folate no.10	TABLET
		prenatal 25/iron/folate 6/dha	CAPSULE
		prenatal 26/iron ps/folic/dha	CAPSULE
		prenatal 56/iron/folic ac/dha	CAPSULE
		prenatal 69/iron/folate 6/dha	CAPSULE
		prenatal 71/iron/folic ac/dha	CAP IR DR
		prenatal 78/iron/folate 1/dha	CAPSULE
		prenatal 87/iron bis/folic/dha	COMBO. PKG
		prenatal no.103/iron fum/folic	TABLET
		prenatal no.68/iron/FA no6/dha	CAPSULE
		prenatal no.77/iron asp gly/FA	TABLET
		prenatal vit 10/iron fum/folic	TABLET
		prenatal vit 10/iron/folic/dha	COMBO. PKG
		prenatal vit 128/iron/folic ac	TAB CHEW
		prenatal vit 14/iron fum/folic	TAB CHEW
		prenatal vit 27,calc/iron/FA	TABLET
		prenatal vit 33/iron/folic/dha	COMBO. PKG
		prenatal vit 65/iron fum,ps/FA	CAPSULE
		prenatal vit 87/iron/folic/dha	CAPSULE
		prenatal vit no.204/iron/folic	TABLET
		prenatal vit,cal 76/iron/folic	TABLET
		prenatal vit/iron carb,sulf/FA	TABLET
		prenatal vit/iron fum/folic ac	TABLET
		prenatal vits 85/iron/FA 1/dha	CAPSULE
		prenatal vits 86/iron/folic ac	TABLET
		prenatal,calc 40/iron/folate 1	TABLET
		Pv w-o Vit A/iron/docus/FA/Zn	CAP SEQ

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Ophthalmics	Antibiotics, Ophthalmic	bacitracin/polymyxin B sulfate	OINT. (G)
		ciprofloxacin HCl	DROPS
		ciprofloxacin HCl	OINT. (G)
		erythromycin base	OINT. (G)
		gentamicin sulfate	DROPS
		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)
Ophthalmics	Antibiotic-Steroids, Ophthalmic	neomycin/polymyxin B/dexametha	DROPS SUSP
		neomycin/polymyxin B/dexametha	OINT. (G)
		tobramycin/dexamethasone	DROPS SUSP
		tobramycin/dexamethasone	OINT. (G)
Ophthalmics	Anti-Inflammatory Drugs, Ophthalmic	dexamethasone	DROPS SUSP
		dexamethasone sodium phosphate	DROPS
		diclofenac sodium	DROPS ***
		difluprednate	DROPS
		fluorometholone	DROPS SUSP
		flurbiprofen sodium	DROPS
		ketorolac tromethamine	DROPS
		loteprednol etabonate	DROPS SUSP ***
		prednisolone acetate	DROPS SUSP
		prednisolone sodium phosphate	DROPS
Ophthalmics	Glaucoma Drugs	betaxolol HCl	DROPS
		brimonidine tartrate	DROPS ***
		brinzolamide	DROPS SUSP
		carteolol HCl	DROPS
		dorzolamide HCl	DROPS
		dorzolamide HCl/timolol maleat	DROPS
		dorzolamide/timolol/PF	DROPERETTE
		latanoprost	DROPS
		levobunolol HCl	DROPS
		pilocarpine HCl	DROPS
		timolol maleate	DROPS
		timolol maleate/PF	DROPERETTE
		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

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Psychiatric	ADHD Drugs	amphetamine sulfate ** ‡	TABLET
		dexmethylphenidate HCl ** ‡	CPBP 50-50
		dexmethylphenidate HCl ** ‡	TABLET
		dextroamphetamine sulfate ** ‡	CAPSULE ER
		dextroamphetamine/amphetamine ** ‡	CAP ER 24H
		dextroamphetamine/amphetamine ** ‡	TABLET
		lisdexamfetamine dimesylate (VYVANSE ™) ** ‡	CAPSULE
		lisdexamfetamine dimesylate (VYVANSE ™) ** ‡	TAB CHEW
		lisdexamfetamine dimesylate ** ‡	CAPSULE
		lisdexamfetamine dimesylate ** ‡	TAB CHEW
		methylphenidate ** ‡	PATCH TD24
		methylphenidate HCl ** ‡	CPBP 30-70
		methylphenidate HCl ** ‡	TAB ER 24
		methylphenidate HCl ** ‡	TABLET
		methylphenidate HCl ** ‡	TABLET ER
Psychiatric	Benzodiazepines	chlordiazepoxide/clidinium Br **	CAPSULE
		clonazepam **	TAB RAPDIS
		clonazepam **	TABLET
Psychiatric	Opioid Reversal Agents	nalmefene HCl (OPVEE ™)	SPRAY
		naloxone HCl	AMPUL
		naloxone HCl	CARTRIDGE
		naloxone HCl	SPRAY
		naloxone HCl	SYRINGE
		naloxone HCl	VIAL
		naloxone HCl (KLOXXADO ™)	SPRAY
Psychiatric	Sedatives	melatonin *	TABLET
		ramelteon *	TABLET
		suvorexant *	TABLET
		zolpidem tartrate *	TABLET
Psychiatric	Substance Use Disorders, Opioid & Alcohol	acamprosate calcium	TABLET DR
		buprenorphine (BRIXADI ™)	SOLER SYR
		buprenorphine (SUBLOCADE ™)	SOLER SYR
		buprenorphine HCl/naloxone HCl (SUBOXONE ™) **	FILM
		buprenorphine HCl/naloxone HCl (ZUBSOLV ™) **	TAB SUBL
		buprenorphine HCl/naloxone HCl **	FILM
		buprenorphine HCl/naloxone HCl **	TAB SUBL
		naltrexone HCl	TABLET
		naltrexone microspheres (VIVITROL ™)	SUS ER REC

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Psychiatric	Tobacco Smoking Cessation	bupropion HCl	TAB ER 12H
		nicotine	PATCH DYSQ
		nicotine	PATCH TD24
		nicotine polacrilex	GUM
		nicotine polacrilex	LOZENGE
		nicotine polacrilex	LOZNG MINI
		varenicline tartrate ‡	TAB DS PK
		varenicline tartrate ‡	TABLET
Pulmonary	Beta-Agonists, Inhaled Long Acting	arformoterol tartrate	VIAL-NEB
		olodaterol HCl	MIST INHAL
Pulmonary	Beta-Agonists, Inhaled Short-Acting	albuterol sulfate	HFA AER AD
		albuterol sulfate	VIAL-NEB
		levalbuterol HCl	VIAL-NEB
		levalbuterol tartrate	HFA AER AD
Pulmonary	Corticosteroids, Inhaled	beclomethasone dipropionate	HFA AEROBA
		budesonide	AER POW BA
		budesonide	AMPUL-NEB
		fluticasone propionate	AER W/ADAP
		fluticasone propionate	BLST W/DEV
		mometasone furoate	AER POW BA
		mometasone furoate	HFA AER AD
Pulmonary	Corticosteroids/Beta-Agonist Combination, Inhaled	fluticasone propion/salmeterol	AER POW BA ***
		fluticasone propion/salmeterol	BLST W/DEV
		fluticasone propion/salmeterol	HFA AER AD
		mometasone/formoterol	HFA AER AD
		SYMBICORT ™ - BRAND ONLY	HFA AER AD
Pulmonary	Cystic Fibrosis	dornase alfa	SOLUTION
		sodium chloride for inhalation	VIAL-NEB
		tobramycin in 0.225% sod chlor	AMPUL-NEB
Pulmonary	LAMA/LABA Combination, Inhalers	glycopyrrolate/formoterol fum	HFA AER AD
		tiotropium Br/olodaterol HCl (STIOLTO RESPIMAT ™)	MIST INHAL
		umeclidinium brm/vilanterol tr	BLST W/DEV
Pulmonary	Miscellaneous Pulmonary Agents	montelukast sodium	TAB CHEW
		montelukast sodium	TABLET
Pulmonary	Muscarinic Antagonists, Inhaled	ipratropium bromide	HFA AER AD
		ipratropium bromide	SOLUTION
		ipratropium/albuterol sulfate	AMPUL-NEB
		ipratropium/albuterol sulfate (COMBIVENT RESPIMAT ™)	MIST INHAL
		tiotropium bromide (SPIRIVA RESPIMAT ™)	MIST INHAL
		umeclidinium bromide	BLST W/DEV

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective: October 1, 2026

System	Class	Preferred	
Pulmonary	Pulmonary Arterial Hypertension Oral and Inhaled Drugs	bosentan	TABLET
		sildenafil citrate *	TABLET
		tadalafil *	TABLET
Renal	Phosphate Binders & Absorption Inhibitors	calcium acetate	CAPSULE
		calcium acetate	TABLET ***
		sevelamer carbonate	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria
** Drug coverage subject to quantity limits
*** Certain strengths are non-preferred and may require prior authorization
‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

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

Effective: October 1, 2026

System	Class	Preferred	
Neurology	Agents for Hypersomnolence	armodafinil *	TABLET
		modafinil *	TABLET
Neurology	Antiepileptics, Outpatient	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
		clonidine HCl	TAB ER 12H
		guanfacine HCl	TAB ER 24H
		viloxazine HCl (QELBREE ™) ** ‡	CAP ER 24H
Psychiatric	Antidepressants	amitriptyline HCl ‡	TABLET
		bupropion HCl	TAB ER 24H
		bupropion HCl	TAB SR 12H
		bupropion HCl	TABLET
		buspirone HCl	TABLET
		citalopram hydrobromide	SOLUTION
		citalopram hydrobromide	TABLET
		desipramine HCl ‡	TABLET
		desvenlafaxine succinate	TAB ER 24H
		doxepin HCl ‡	CAPSULE
		doxepin HCl ‡	ORAL CONC
		duloxetine HCl	CAPSULE DR
		escitalopram oxalate	TABLET
		fluoxetine HCl	CAPSULE
		fluoxetine HCl	SOLUTION
		fluoxetine HCl	TABLET
		fluvoxamine maleate	TABLET
		imipramine HCl ‡	TABLET
		lithium carbonate	CAPSULE
		lithium carbonate	TABLET
		lithium carbonate	TABLET ER
		mirtazapine	TAB RAPDIS
		mirtazapine	TABLET
		nefazodone HCl	TABLET
		nortriptyline HCl ‡	CAPSULE
		nortriptyline HCl ‡	SOLUTION
		paroxetine HCl	TABLET
		sertraline HCl	ORAL CONC
		sertraline HCl	TABLET
		venlafaxine HCl	CAP ER 24H
		venlafaxine HCl	TAB ER 24
		venlafaxine HCl	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

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

Effective: October 1, 2026

System	Class	Preferred	
Psychiatric	Antipsychotics, 1st Gen	chlorpromazine HCl ‡	ORAL CONC
		fluphenazine HCl ‡	ELIXIR
		fluphenazine HCl ‡	ORAL CONC
		fluphenazine HCl ‡	TABLET
		haloperidol ‡	TABLET
		haloperidol lactate ‡	ORAL CONC
		loxapine succinate ‡	CAPSULE
		perphenazine ‡	TABLET
		thioridazine HCl ‡	ORAL CONC
		thioridazine HCl ‡	TABLET
		thiothixene ‡	CAPSULE
		thiothixene HCl ‡	ORAL CONC
		trifluoperazine HCl ‡	TABLET
Psychiatric	Antipsychotics, 2nd Gen	aripiprazole ‡	TABLET
		asenapine maleate ‡	TAB SUBL
		cariprazine HCl (VRAYLAR ™) ‡	CAPSULE
		clozapine ‡	TABLET
		lurasidone HCl ‡	TABLET
		olanzapine ‡	TABLET
		quetiapine fumarate ** ‡	TAB ER 24H
		quetiapine fumarate ** ‡	TAB24HDSPK
		quetiapine fumarate ** ‡	TABLET
		risperidone ‡	SOLUTION
		risperidone ‡	TABLET
		ziprasidone HCl ‡	CAPSULE
Psychiatric	Antipsychotics, Parenteral	aripiprazole (ABILIFY ASIMTUFII ™)	SUSER SYR
		aripiprazole (ABILIFY MAINTENA ™)	SUSER SYR
		aripiprazole (ABILIFY MAINTENA ™)	SUSER VIAL
		aripiprazole lauroxil (ARISTADA ™)	SUSER SYR
		aripiprazole lauroxil,submicr. (ARISTADA INITIO ™)	SUSER SYR
		chlorpromazine HCl	AMPUL
		chlorpromazine HCl	VIAL
		fluphenazine decanoate	VIAL
		fluphenazine HCl	VIAL
		haloperidol decanoate	AMPUL
		haloperidol decanoate	VIAL
		haloperidol lactate	VIAL
		paliperidone palmitate (ERZOFRI ™)	SYRINGE
		paliperidone palmitate (INVEGA HAFYERA ™)	SYRINGE
		paliperidone palmitate (INVEGA SUSTENNA ™)	SYRINGE
		paliperidone palmitate (INVEGA TRINZA ™)	SYRINGE
		RISPERDAL CONSTA ™ - BRAND ONLY **	VIAL
		risperidone (PERSERIS ™)	SUSER SYR
		risperidone (UZEDY ™)	SUSER SYR
		RYKINDO ™ - BRAND ONLY **	VIAL

* Drug coverage subject to meeting clinical prior authorization criteria

** Drug coverage subject to quantity limits

*** Certain strengths are non-preferred and may require prior authorization

‡ Age restrictions apply

Note: New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T (see OAR 410-121-0030).

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

Effective: October 1, 2026

System	Class	Preferred	
Psychiatric	Benzodiazepines	alprazolam **	TAB ER 24H
		alprazolam **	TABLET
		amitriptyline/chlordiazepoxide **	TABLET
		chlordiazepoxide HCl **	CAPSULE
		clorazepate dipotassium **	TABLET
		diazepam **	ORAL CONC
		diazepam **	SOLUTION
		diazepam **	TABLET
		lorazepam **	ORAL CONC
		lorazepam **	TABLET
		oxazepam **	CAPSULE