Alberta Health and Wellness Drug Benefit List

Effective April 1, 2010

Government of Alberta

Health and Wellness

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Website: http://www.health.alberta.ca/AHCIP/drug-benefit-list.html

Administered by Alberta Blue Cross
on behalf of Alberta Health and Wellness.

The Drug Benefit List (DBL) is a list of drugs for which coverage may be provided to program participants. The DBL is not intended to be, and must not be used as a diagnostic or prescribing tool. Inclusion of a drug on the DBL does not mean or imply that the drug is fit or effective for any specific purpose. Prescribing professionals must always use their professional judgment and should refer to product monographs and any applicable practice guidelines when prescribing drugs. The product monograph contains information that may be required for the safe and effective use of the product.

Copies of the *Alberta Health and Wellness Drug Benefit List* Publication CD are available from Pharmacy Services, Alberta Blue Cross at the address shown above.

Binder and contents: **$42.00** ($40.00 + $2.00 G.S.T.)
Contents only: **$36.75** ($35.00 + $1.75 G.S.T.)

A cheque or money order must accompany the request for copies.

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The DBL is not a prescribing or a diagnostic tool. Prescribers should refer to drug monographs and utilize professional judgment.

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PART 1

SECTION 1

Policies and Guidelines

INTRODUCTION

Acknowledgments

Alberta Health and Wellness acknowledges the important role Alberta Blue Cross continues to play in the production of the List and in the development of an overall strategy and initiatives to better manage Alberta Health and Wellness sponsored drug programs.

Eligibility

The *Alberta Health and Wellness Drug Benefit List* defines the drugs and drug products that are covered by Alberta government-sponsored drug programs. These programs are for Albertans and their dependents who are covered by:

1. the Alberta Blue Cross *Non-Group Coverage (Group 1)* offered by the Alberta Health Care Insurance Plan,
2. the Alberta Blue Cross *Coverage for Seniors (Group 66)* provided to all Alberta senior citizens and those on the Alberta Widows' Pension Plan *(Group 66A)*, or
3. the drug coverage provided to individuals approved by Alberta Health and Wellness for *Palliative Care Drug Coverage.* (For these individuals the *Palliative Care Drug Benefit Supplement* must also be considered), or
4. the drug coverage provided to Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients. (For these clients the *Alberta Employment and Immigration Drug Benefit Supplement* must also be considered.)

Additional Notes Regarding Application of the List

1. The List is not intended to be used as a scientific reference or prescribing guide.
2. Formularies used by hospitals and continuing care facilities are developed independently of the *List.*
3. Drugs are classified according to the Pharmacologic–Therapeutic classifications (PTC) developed by the American Society of Health-System Pharmacists for the purpose of the American Hospital Formulary Service.

   Permission to use this system has been granted by the American Society of Health-System Pharmacists. The Society is not responsible for the accuracy of transpositions or excerpts from the original content.

   Where necessary, additional PTCs may have been assigned by Alberta Health and Wellness to facilitate product location in the *List*.
4. Where appropriate, the *Compendium of Pharmaceuticals and Specialties*, published by the Canadian Pharmacist's Association, was used as a reference source for the trade name, generic name, manufacturer, strength and dosage form.

   The Canadian Pharmacist's Association is not responsible for the accuracy of transpositions or excerpts from the original content.
5. Other reference sources used for the trade name, generic name, manufacturer, strength and dosage form are:
   - completed Drug Identification Number (DIN) notification form
   - Notice of Compliance (NOC)
   - Product Monograph
6. DINs listed reflect current manufacturer information available as of March 31, 2010.

7. Alberta Health and Wellness reserves the right to make changes, without notice, to the *List* through the on-line interactive *List*, and any such changes to the on-line interactive *List* are effective the date of the change (unless otherwise stated) and regardless of the date of publication in the paper/CD Rom version or updates.

Legend

1. Pharmacologic–Therapeutic classification.
2. Pharmacologic–Therapeutic sub-classification.
3. Nonproprietary or generic ingredient name of the drug.
4. Drug strength and dosage form.
5. The Drug Identification Number (DIN), assigned by the Therapeutic Products Directorate (TPD), Health Protection Branch, Health Canada.
6. A box containing an X ☒ to the left of the DIN indicates that the product is not interchangeable with other products or interchangeability has not been assessed within the category.
7. All active ingredients of combination products are listed.
8. Strengths of active ingredients are listed in the same order as the ingredients. This example indicates that the topical cream contains 1% hydrocortisone acetate and 10% urea.
9. Brand name of the drug.
10. Three letter identification code assigned to each manufacturer. The codes are listed in Appendix 2 at the end of the List.
11. For products which are marked as non-interchangeable, the price is indicated in regular type (not bold type). These prices are supplied by the manufacturer and are expressed in decimal dollars.
12. For those products which are single source, the price is indicated in regular type (not bold type). These prices are supplied by the manufacturer and are expressed in decimal dollars.
13. Interchangeable grouping where the Least Cost Alternative (LCA) Price Policy has not been applied. This example indicates these two products are deemed interchangeable. These prices are supplied by the manufacturer and are expressed in decimal dollars.
14. The LCA Price for the selected interchangeable category appears in bold type. The LCA price is the maximum price which will be paid. The prices listed are expressed as decimal dollars. An authorized health care provider may request special authorization if a particular brand is essential in the care of a patient where the LCA Price would otherwise apply. For further information refer to the Special Authorization Guidelines section of the AHWDBL or List.
15. Products or devices designated as restricted benefits and limited restricted benefits are identified by a comment after the generic name. The comment indicates “RESTRICTED BENEFIT” or “LIMITED RESTRICTED BENEFIT” along with an explanation of the limits and/or restrictions. In this example, coverage of Accolate is restricted to the treatment of asthma in patients 12 to 18 years of age inclusive. For more information about products or devices designated as restricted benefits, refer to the restricted benefits section of the List.

Example of Drug Product Listings

08:00 ANTI-INFECTIVE AGENTS

08:30.92 ANTIPROTOZOALS

(MISCELLANEOUS ANTIPROTOZOALS)

METRONIDAZOLE

250 MG ORAL TABLET

00000545066	APO-METRONIDAZOLE	(10)	APX	$	0.0595 (12)

5 MG / ML INJECTION

00000870420	**FLAGYL**	(10)	**BAX**	$	**0.0240** (14)
00000649074	METRONIDAZOLE		HSP	$	0.1563

(1) **28:00 CENTRAL NERVOUS SYSTEM AGENTS**

(2) 28:08.04.92 ANALGESICS AND ANTIPYRETICS

NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

(3) **NAPROXEN**

(4) **250 MG ORAL ENTERIC-COATED TABLET**

00002246699	APO-NAPROXEN EC	APX	***$ 0.1068***	$	0.2835
(5) 00002243312	NOVO-NAPROX EC	NOP	***$ 0.1068***	$	0.2835
00002162792	NAPROSYN E	HLR	***$ 0.1068***	$	0.4405

MAC pricing has been applied based on the LCA price for 1 x 250 mg oral tablet.

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.04 ESTROGENS AND ANTIESTROGENS

(ESTROGENS)

CONJUGATED ESTROGENS

0.3 MG ORAL TABLET

00002043394	PREMARIN	WAY	$	1.0535

0.625 MG ORAL TABLET

00000265470	C.E.S. (13)	VCL	$	0.1045
00002043408	PREMARIN (13)	WAY	$	1.0535

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

(7) **HYDROCORTISONE ACETATE/ UREA**

(8) **1 % * 10 % TOPICAL CREAM**

00000503134	UREMOL-HC (9)	TCD	$	0.1834

1 % * 10 % TOPICAL LOTION

00000560022	UREMOL-HC	TCD	$	0.1019

1 % TOPICAL LOTION

☒ 00000578541	SARNA HC	STI	$	0.0985
(6) ☒ 00000192600	EMO-CORT	TCD	$	0.1666 (11)

48:00 RESPIRATORY TRACT AGENTS

48:10.24 ANTI-INFLAMMATORY AGENTS

(LEUKOTRIENE MODIFIERS)

ZAFIRLUKAST

(15) RESTRICTED BENEFIT - This product is a benefit for patients 12 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to the Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients).

20 MG ORAL TABLET

00002236606	ACCOLATE	AZC	$	0.7749

The DBL is not a prescribing or a diagnostic tool. Prescribers should refer to drug monographs and utilize professional judgment.

DRUG REVIEWS

The Minister of Health and Wellness makes the final decisions on changes to the *Alberta Health and Wellness Drug Benefit List (List)* after considering the recommendations of the Expert Committee on Drug Evaluation and Therapeutics (Expert Committee), and/or the Canadian Expert Drug Advisory Committee (CEDAC), and/or Alberta Health and Wellness.

Drug manufacturers wishing to have their drug product(s) listed on the *List* are required to make submissions in accordance with the procedures and criteria published in the *List*.

Common Drug Review

Alberta is a participant in the national Common Drug Review procedure (CDR Procedure*) and considers recommendations from CEDAC. Submissions relating to the New Chemical Entities and New Combination Products that have received a Health Canada Notice of Compliance (NOC) should be directed to the CDR Directorate for consideration, and must comply with the CDR Procedure requirements.

- **New Chemical Entity** is an active moiety that has not been previously approved for sale in Canada by Health Canada and marketed in Canada.
- **New Combination Product** consists of two or more active moieties that have not previously been approved for sale in Canada and marketed in Canada in that combination. It may consist of either two or more new active moieties or two or more old active moieties or a combination of new and old active moieties.

Expert Committee on Drug Evaluation and Therapeutics Drug Reviews

The Minister of Health and Wellness has established an Expert Committee on Drug Evaluation and Therapeutics to refine and maintain the *List* on an ongoing basis. All drug products not eligible for review under the CDR Procedure or the Interchangeable Expedited Review procedure must be reviewed by the Expert Committee prior to their determination as benefits on the *List*.

The Expert Committee considers the scientific, therapeutic, clinical and socio-economic merits of drug products. The Committee receives advice and assistance from external consultants and agencies when needed. The Expert Committee makes recommendations on the *List* to Alberta Health and Wellness through the Executive Director, Pharmaceutical Funding and Guidance, Health Policy and Service Standards Division.

Interchangeable Reviews

Drug products may be considered for listing as interchangeable through Expedited Review or Full Review. Expedited Review drug products are not required to undergo a full review by the Expert Committee. Interchangeable drug product submissions will be screened by Alberta Blue Cross to determine eligibility for an Expedited Review and the results provided to Alberta Health and Wellness. Interchangeable drug submissions requiring Full Review will be reviewed by the Expert Committee under its usual drug review procedure.

Referrals

Alberta Health and Wellness at all times and in all circumstances reserves the right to refer any submission to the CDR Procedure and/or the Expert Committee for further advice or for a full review.

Deferrals

The Expert Committee and/or Alberta Health and Wellness reserve the right to defer any submission it deems appropriate in order to ensure that it may complete a review in a manner that protects patient safety and maintains the integrity of the AHWDBL and the government-sponsored drug programs. Examples of reasons for deferrals include, but are not limited to:

1. To request additional information in order to conduct a review and prepare recommendations;
2. Where additional time, research and/or consultation is required before a review can be completed or a recommendation can be made;
3. Where new or novel issues are raised;
4. Where issues, questions or concerns relating to any of the listing criteria or factors arise, including but not limited to:
    (a) interchangeable safety issues,
    (b) whether the criteria requires expansion or clarification,
    (c) the drug product,
    (d) the listing,
    (e) the price,
    (f) any other relevant criteria or factor.

*Information regarding the CDR Procedure may be obtained through the Canadian Agency for Drugs and Technologies in Health.

Alberta Health and Wellness
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SUBMISSIONS for DRUG REVIEWS

1) Only submissions satisfying all of the submission requirements of the applicable category of drug product that are deemed complete by the applicable submission deadline date will be put forward for review.
2) In addition to the submission requirements, the Expert Committee and/or Alberta Health and Wellness, at their sole discretion, reserve the right to request the drug product file from Health Canada's Therapeutic Products Directorate (TPD), or any additional information from the manufacturer, CEDAC, or any other entity that the Expert Committee and/or Alberta Health and Wellness consider necessary, which may result in a delay in the listing recommendation for the drug product.
3) There is no obligation or guarantee that every completed submission will be reviewed, and/or a recommendation made, by a specific date or at the next scheduled meeting of the Expert Committee.
4) Pre-NOC submissions may be made; however, the submission will only be reviewed once it is complete.
5) Any request by a manufacturer to hold a submission will result in a submission being deemed incomplete as of the date of the request. A submission on hold will only be considered complete once correspondence is received from a manufacturer to proceed with the submission.
6) Only one (1) copy of a submission for a drug product is required. A determination by Alberta Blue Cross that a submission is complete is preliminary and made only for the purposes of forwarding the submission for review.
7) Drug manufacturers are permitted to provide other information they feel may be important to the review of a submission e.g. selected references or additional studies completed after a drug product had been submitted to the Therapeutic Products Directorate, Health Canada. Comparative studies with other listed drug products are most relevant.
8) Information on submission deadlines are posted on the *Alberta Health and Wellness Drug Benefit List* website which can be accessed at http://www.ab.bluecross.ca/dbl/manufacturers.html.

Notice of Significant Changes - By making a submission, and if a drug product is listed on the *List*, manufacturers acknowledge and agree that they are required to notify the Senior Manager, Scientific and Research Services of any significant change to listed drug products. Significant changes are considered to be changes in NOC, DIN, product name, manufacturer or distributor, indication, product monograph, packaging, formulation, manufacturing specifications or any change that could potentially affect the bioavailability or bioequivalence of a drug product.

All submissions should be sent to the attention of:

Senior Manager
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

All inquiries should be directed to:

Coordinator
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5
Phone: (780) 498-8098

Fax: (780) 498-3534

Interpretation Notices

From time to time, or as circumstances warrant, certain practices or procedures may be adopted by the Committee pertaining to the interpretation of the procedures and criteria published in the *AHWDBL Policies and Guidelines*. In order to assist manufacturers in preparing and submitting effective drug review submissions, the Expert Committee has determined that, where it deems appropriate, notice of these practices will be provided to manufacturers through "Interpretation Notices".

The Notices are intended to be a guide to assist manufacturers, but in situations where the Notices lead to inconsistencies or conflicts, the criteria in the Drug Review Procedure and Submission Requirements and Criteria, will apply.

Notices will be published electronically and it continues to be the responsibility of manufacturers to monitor amendments to the *AHWDBL*. For convenience only, hard copies of Notices may be provided with the *AHWDBL Quarterly Updates* where deemed appropriate by Alberta Blue Cross.

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST

INTERPRETATION NOTICE #1

INTERCHANGEABILITY and NON-CANADIAN REFERENCE PRODUCTS

The *Submission Requirements and Criteria* of the AHWDBL require manufacturers to provide the *Expert Committee on Drug Evaluation and Therapeutics* ("Expert Committee") with data comparing the submitted drug product to the reference drug product. Under the *Interchangeable Drug Products Criteria*, manufacturers are also required to demonstrate bioequivalence with the reference drug product in accordance with the Criteria.

At various times, some manufacturers have submitted interchangeability submissions using a Non-Canadian Reference Product (NCRP). After reviewing several submissions, the Expert Committee has adopted the practice of permitting manufacturers to demonstrate bioequivalency by providing data comparing the submitted drug product to a NCRP that meets the *Criteria for use of a Non-Canadian Reference Product* as set out in Health Canada's *Drugs Directorate Policy regarding the use of a Non-Canadian Reference Product under the provisions of Section C.08.002.1(c) of the* Food and Drug Regulations (the "NCRP Criteria").

Important Note: Health Canada does not determine interchangeability and therefore, a determination by Health Canada that a product meets the NCRP Criteria *is not sufficient proof* for the Expert Committee's purposes. The Expert Committee will continue to consider and assess all of the submission materials, and make its own determination whether the NCRP Criteria, the Submission Requirements and the Criteria are met, and whether the product may be designated as interchangeable.

The practice in these situations is that, after receipt of the submission, Alberta Blue Cross makes a request to Health Canada for a copy of the Therapeutic Products Directorate's review (TPD File) for the submitted product(s). Manufacturers are advised that, in order to avoid a possible deferral, they may include a full copy of the TPD File in their submission. If necessary, submissions may be deferred until the TPD File is received. Product submissions may, at the discretion of Alberta Blue Cross, be scheduled for review if the TPD File is received 7 days prior to the meeting date.

As with all submissions, the Expert Committee retains the right to request additional materials from the manufacturer, Health Canada or any other entity it determines appropriate in order to conduct its review.

Issue Date: November 9, 2006

SUBMISSION REQUIREMENTS

The following Submission Requirements pertain to submissions not eligible for review under the CDR Procedure.

A) New Chemical Entities/Single Source Drug Products

The following submission requirements pertain to New Chemical Entities, New Combination Products where one or more of the active moieties have never been listed on the *List*, and other single source drug products that have never been listed on the *List*; and are not eligible for review under the CDR Procedure. Submissions for drug products in this category should first be directed to the CDR Directorate.

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Health Services and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. A hard copy and electronic (CD) copy of the following from the Common Technical Document:
   a. Clinical Overview (Module 2.5), and
   b. Clinical Summary (modules 2.7.1, 2.7.3, 2.7.4 and 2.7.6).

   Note: If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu.
4. Copy of completed Drug Identification Number (DIN) notification form
5. Copy of Notice of Compliance (NOC)
6. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
7. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
8. Product Monograph
   - in addition to a hard copy, an electronic (CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word is required
9. Economic Information
   - a comprehensive pharmacoeconomic analysis in accordance with: the "*Guidelines for the economic evaluation of health technologies: Canada* [3rd Edition]". Ottawa: Canadian Agency for Drugs and Technologies in Health; 2006.; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful
   - a completed *Budget Impact Assessment for the Alberta Health and Wellness Drug Benefit List* form. Note: copies of the most recent version of this form can be obtained by accessing the *Alberta Health and Wellness Drug Benefit List* website at

www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-3534.

10. If requested, the manufacturer must provide written confirmation from the CDR Directorate that the drug product is not eligible for review under the CDR Procedure.

B) Changes to Special Authorization or Restricted Benefit Status of Listed Single Source Drug Products Due to a New Indication

The following submission requirements pertain to single source drug products currently listed via special authorization or as restricted benefits that have received a new indication from Health Canada, where the manufacturer wishes to request expansion of the coverage criteria or change in benefit status due to the new indication and where the drug products are not eligible for review under the CDR Procedure. Submissions for drug products in this category that have been previously reviewed under the CDR Procedure should first be directed to the CDR Directorate.

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Health Services and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Justification for the Expanded Coverage Criteria or Change in Benefit Status
   - a separate document indicating the reason for and evidence to justify the need for the expanded coverage criteria or change in benefit status due to the new indication
4. A hard copy and electronic (CD) copy of the following from the Common Technical Document:
   - Clinical Overview (Module 2.5), and
   - Clinical Summary (modules 2.7.1, 2.7.3, 2.7.4 and 2.7.6)
5. Note: If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu. Copy of Notice of Compliance (NOC) for the new indication.
6. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
7. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
8. Product Monograph (revised to include the new indication)
   - in addition to a hard copy, an electronic (CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word is required
9. Economic Information
   - a comprehensive pharmacoeconomic analysis **prepared with respect to the new indication only** in accordance with: the "*Guidelines for the economic evaluation of health technologies: Canada* [3rd Edition]". Ottawa: Canadian Agency for Drugs and Technologies in Health; 2006.; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful
   - a completed Budget Impact Assessment for the *Alberta Health and Wellness Drug Benefit List* form **prepared with respect to the new indication only**. Note: copies of the most recent version of this form can be obtained by accessing the *Alberta Health and Wellness Drug Benefit List* website at www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-3534.

10. If requested, the manufacturer must provide written confirmation from the CDR Directorate that the drug product is not eligible for review under the CDR Procedure.

C) Line Extension Drug Products

The following submission requirements pertain to new strengths and formulations or reformulations of drug products that are currently listed or are under consideration for listing on the *List* and where products are not eligible for review under the CDR Procedure. Submissions for drug products in this category that have previously been reviewed under the CDR Procedure should first be directed to the CDR Directorate.

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Health Services and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Justification for the Line Extension
   - a separate document indicating the reason for and evidence to justify the need for the new strength, formulation or reformulation of the drug product
4. A hard copy and electronic (CD) copy of the following from the Common Technical Document:
   - Clinical Overview (Module 2.5), and
   - Clinical Summary (modules 2.7.1, 2.7.3, 2.7.4 and 2.7.6).

   Note: If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu.
   In the event a Comprehensive Summary was not prepared for Health Canada (i.e. clinical studies have not been conducted on the new strength, formulation or reformulation) then the manufacturer must provide evidence establishing a clear linkage between the submitted product(s) and a currently listed product(s). This can be in the form of:
      i. bioequivalence data; or
      ii. evidence of formulation proportionality (i.e. a comparison of master formulae for all submitted strengths) and evidence of a similar dissolution profile.
5. Copy of completed Drug Identification Number (DIN) notification form
6. Copy of Notice of Compliance (NOC)
7. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
8. Copy of completed and approved Certified Product Information Document (CPID)
   - in lieu of the CPID, a Master Formula and Final Product Specifications must be provided
9. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
10. Product Monograph (revised to include the line extension)
    - in addition to a hard copy, an electronic (CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word
11. Economic Information
    - a completed *Budget Impact Assessment for the Alberta Health and Wellness Drug Benefit List* form. Note: copies of this form can be obtained by accessing the *Alberta Health and Wellness*

Drug Benefit List website at www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-3534.

12. If requested, the manufacturer must provide written confirmation from the CDR Directorate that the drug product is not eligible for review under the CDR Procedure.

D) Interchangeable Drug Products

The following submission requirements pertain to multisource drug products submitted for listing in an interchangeable grouping in the *Alberta Health and Wellness Drug Benefit List*.

For Expedited and Full Reviews:

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Health Services and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Copy of completed Drug Identification Number (DIN) notification form
4. Copy of Notice of Compliance (NOC)
   - Note: For Old Drug Products (a drug product where the active ingredient is designated as an "old drug" by Health Canada and the drug product was approved on the basis of a DIN application), a Notice of Compliance is not required.
5. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
6. *For Pseudo-Generic Drug Products:* Letters from both the manufacturer of the submission drug product and the manufacturer of the innovator brand or a currently listed drug product within the submission product's interchangeable grouping, stating that the submission drug product is manufactured under the identical master formula and manufacturing and quality control specifications, as the innovator brand or the currently listed drug product.
7. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
8. Copy of completed and approved Certified Product Information Document (CPID)
   Note: In lieu of the CPID, a Master Formula and Final Product Specifications must be provided
9. Product Monograph
   - in addition to a hard copy, an electronic (CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word is required

   Note: For Old Drug Products, the Prescribing Information may be provided in lieu of the Product Monograph.

For FULL REVIEWS ONLY, the following ADDITIONAL information must be provided:

10. Evidence that the listing criteria for interchangeable drug products has been met. See *Criteria for Listing Drug Products* **and** *Interchangeable Drug Products* sections for specific applicable criteria.

E) Resubmissions

The following resubmission requirements apply to those drug products that have been reviewed by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics and a decision has been made by the Minister of Health and Wellness to:

- not add the drug product to the *Alberta Health and Wellness Drug Benefit List*
- add the drug product to the *Alberta Health and Wellness Drug Benefit List* as a special authorization or restricted benefit, or
- maintain the criteria for coverage of a special authorization or restricted benefit drug product despite the manufacturer's request for a change

NOTE: Only 1 resubmission per product will be accepted per calendar year.

1. Resubmission Form
   - if a manufacturer wishes to request reconsideration of a previously submitted drug product, the manufacturer must complete and submit the *Resubmission for the Alberta Health and Wellness Drug Benefit List* form. This form can be obtained by accessing the *Alberta Health and Wellness Drug Benefit List* website which can be accessed at www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-3534.
2. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Health Services and the government of any province or territory in Canada.
3. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
4. Economic Information
   - If new economic information is provided in support of the resubmission for a new chemical or line extension, a revised BIA form must be completed that incorporates the new economic information.

Criteria for Listing Drug Products

- **The *Criteria for Listing Drug Products* apply to all drug product submissions.**
- **If more than one criterion apply, at the sole discretion of the Expert Committee on Drug Evaluation and Therapeutics (Expert Committee), Alberta Health and Wellness or the Minister, the most stringent and/or appropriate combination of criteria will apply.**
- **For multisource drug products seeking a designation of interchangeability, the drug product must also meet the additional criteria outlined under "*Interchangeable Drug Products*".**

1. Clinical studies must have demonstrated the safety and efficacy of the product in appropriate populations.

2. The product must:
   a. possess therapeutic advantage over other presently accepted therapies or treatments of the disease entity for which the product is indicated, or
   b. be more cost-effective than presently accepted therapy.

3. Assessment of therapeutic advantage may include consideration of:
   i. clinical efficacy;
   ii. risk/benefit ratio;
   iii. toxicity;
   iv. compliance;
   v. clinical outcomes;
   vi. Health Canada warnings and advisories;
   vii. population health issues; or
   viii. any other factor which affects the therapeutic value of the product.

4. The Expert Committee, Alberta Health and Wellness and/or the Minister may, in addition to all of the factors listed above, also consider any factors that they consider appropriate, including but not limited to any or all of the following:

   i. the recommendations from the CDR review,
   ii. failure by a manufacturer to supply a sufficient quantity of drug product to meet the demand in Alberta (as determined by Alberta Health and Wellness at its sole discretion, and based on any information it deems appropriate),
   iii. failure by a manufacturer to provide
      (A) a Price Confirmation, or
      (B) a Price Confirmation or Confirmed Price in accordance with the Price Policy and/or the Alberta Price Confirmation (APC) Terms and Conditions;
   iv. failure by a manufacturer to comply with any APC Terms and Conditions;
   v. type of drug, drug product, class or category and indications for use,
   vi. other available alternative products, treatments or therapies,
   vii. whether the product is interchangeable,

viii. cost of the product and/or potential cost savings or impact on drug expenditures under the List,
ix. volume of use and amounts paid out for similar products, classes or categories,
x. utilization patterns
xi. expenditure management and resources,
xii. patent issues,
xiii. coverage provided by other programs,
xiv. for interchangeable products, concerns that are related to or affect the interchangeability of the drug product,
xv. issues, concerns, objectives, goals and/or mandates related to any government policies, plans or programs, and
xvi. patient care concerns related to factors external to the drug product.

5. New Chemical Entities, New Combination Products and other single source products not eligible for review under the CDR Procedure may, at the sole discretion of Alberta Health and Wellness and/or the Minister, be considered for priority review and possible addition to the *List* if the product submission is otherwise complete, and the product has been granted "Priority Review" status by the Therapeutic Products Directorate, Health Canada. A copy of documentation from the Therapeutic Products Directorate granting 'Priority Review' status is required.

6. The onus is on the manufacturer to formally request, in writing, consideration on a priority review basis if, in the opinion of the manufacturer, the product meets any of the above priority review criteria. Request for priority review does not automatically mean that the submission will be considered on that basis. The decision whether to conduct a priority review will be made by Alberta Health and Wellness and/or the Minister at their sole option and discretion.

Interchangeable Drug Products - Additional Criteria

Principle:

Decisions respecting interchangeability and drug lists remain in the domain of the institution responsible for the costs of the product which includes hospitals, provincial governments and other third party payers (*6/9/95 Canada Gazette Part ll, Vol. 129, No. 18)*

Preface:

The *Alberta Health and Wellness Drug Benefit List (AHWDBL*) contains designations of interchangeability for approved multisource drug products. The Expert Committee on Drug Evaluation and Therapeutics makes recommendations on interchangeability to Alberta Health and Wellness through the Executive Director, Pharmaceutical Funding and Guidance Branch, Health Policy and Service Standards Division. The Minister of Health and Wellness makes the final decisions on interchangeability after reviewing the recommendations of the Expert Committee and/or Alberta Health and Wellness.

Definitions:

(Note: additional definitions in the applicable Appendices may apply)

Interchangeable Drug Product: An interchangeable drug product is a drug product that has been designated as interchangeable by the Minister of Health and Wellness after reviewing the recommendations of the Expert Committee or Alberta Health and Wellness. Recommendations regarding interchangeability are made taking into consideration the scientific, therapeutic, clinical and socio-economic merits of drug products in accordance with the published criteria. Drug products designated as interchangeable are expected to be safe when interchanged with other drug products in the interchangeable grouping, and to have the same therapeutic effectiveness when administered to patients under the conditions specified in the labeling. The designation of interchangeability is made only for the purpose of funding of drug benefits covered under the Alberta government-sponsored drug benefit programs and is not to be used as a scientific reference or prescribing guide.

Multisource Drug Product: Drug products are considered to be multisource drug products when they are manufactured and/or distributed by more than one manufacturer.

Pharmaceutical Alternative: Drug products may be considered to be pharmaceutical alternatives if they use the same route of administration and contain the same active therapeutic ingredient(s) but are different salts, esters or complexes of that moiety, or are different dosage forms or strengths.

Pharmaceutical Equivalent: Drug products are considered to be pharmaceutical equivalents if they contain the same active therapeutic ingredient(s), are of comparable dosage form(s), route of administration and are identical in strength or concentration.

Pseudo-Generic Drug Product: A pseudo-generic drug product is a drug product that is manufactured under the identical master formulae and manufacturing and quality control specifications as a) the innovator brand of the drug; or b) any drug product that is currently listed on the *AHWDBL* within the submission product's interchangeable grouping.

TPD Reports - refers collectively to the following Health Canada Therapeutic Products Directorate (TPD) guidance publications as of December 31, 2009:

- *Conduct and Analysis of Bioavailability and Bioequivalence Studies - Part A: Oral Dosage Formulations Used for Systemic Effects, and Part B: Oral Modified Release Formulations*; (which may be referred to in the *List* as "**TPD Part A**", and "**TPD Part B**"); and
- *Report C: Report on Bioavailability of Oral Dosage Formations, Not in Modified Release Form, of Drugs used for System Effects, Having Complicated or Variable Pharmacokinetics (*which may be referred to in the List as "**TPD Report C**"); and
- *Bioequivalence Requirements: Comparative Bioavailability Studies Conducted in the Fed State*.

Interchangeable Reviews:

A. The Expert Committee and/or Alberta Health and Wellness and/or the Minister may, in addition to considering the *Interchangeable Drug Products* criteria, also consider any other criteria in the AHWDBL, including but not limited to the *Criteria for Listing Drug Products*.

B. Recommendations regarding interchangeability are made taking into consideration the scientific, therapeutic, clinical and socio-economic merits of drug products in accordance with the published criteria. Drug products designated as interchangeable are expected to be safe when interchanged with other drug products in the interchangeable grouping, and to have the same therapeutic effect when administered to patients under the conditions specified in the labeling.

C. Issuance of a Notice of Compliance by the TPD which includes a Declaration of Equivalence does <u>not</u> mean the drug product will automatically be designated as interchangeable.

<u>Expedited Reviews</u>

1. Multisource drug products seeking a listing designation as interchangeable may be eligible for an expedited review if:

a. The drug product submission complies with the submission requirements.

b. The drug product does **NOT** fall into any of the categories of drug products that require a Full Review (below), unless the drug product is a Pseudo-Generic Drug Product.

c. The drug product is not a subsequent entry biologic (subsequent entry biologics are not eligible for review as interchangeable products).

d. The drug product has been granted a Notice of Compliance by Health Canada that includes a declaration of bioequivalence with a <u>Canadian brand/innovator reference product that is listed (or at the sole discretion of Alberta Health and Wellness and/or the Minister, has been previously listed)</u> on the *Alberta Health and Wellness Drug Benefit List*.

e. The drug product must be a pharmaceutical equivalent to the Canadian innovator reference product.

f. The proposed price in Alberta provided in the manufacturer's submission complies with the Price Policy.

g. Even if the drug submission review is expedited, Alberta Health and Wellness and/or the Minister may refuse to list a drug product, or the listing of the drug product may be delayed, if the manufacturer has failed
   (A) to provide a Price Confirmation,
   (B) to provide a Price Confirmation or Confirmed Price in accordance with the Price Policy and/or the applicable APC Terms and Conditions; or
   (C) to comply with the terms and conditions of an applicable APC.

Full Reviews

Multisource drug products seeking a listing designation as interchangeable that fall within the categories listed below are required to undergo a Full Review by the Expert Committee. The following additional interchangeability criteria will apply to Full Reviews:

1. The drug product must be a
   a. pharmaceutical equivalent; or
   b. pharmaceutical alternative,
   as determined at the sole discretion of the Expert Committee.

2. The drug product is not a subsequent entry biologic (subsequent entry biologics are not eligible for review as interchangeable products).

3. The proposed price in Alberta contained in the manufacturer's submission complies with the Price Policy.

4. The drug product has been demonstrated to be bioequivalent, or has provided evidence of comparative therapeutic efficacy, with the reference drug product as outlined below;

   a. For drug products in the following categories, for which bioequivalence studies CAN be conducted:

      i. For Critical Dose Drug Products, the drug product must meet the criteria in the *Critical Dose Drug Product Appendix*.

      ii. For Non-Linear Drug Products, the drug product must meet the criteria in the *Non-Linear Drug Product Appendix*.

      iii. For Rapid Onset Drug Products, the drug product must meet the criteria in the *Rapid Onset Drug Product Appendix*.

      iv. For Drug Products for which Bioequivalence is Supported by Metabolite Data, the drug product must meet the criteria in the *Drug Products with Metabolite Data Appendix*.

      v. For Drug Products for which Bioequivalence is Supported by Measurement of the Drug in a Matrix other than Plasma or Serum (e.g., Whole Blood, Urine, Tissue), the drug product must meet the criteria in the *Drug Product with Alternate Matrix Measurement Appendix*.

      vi. For Old Drug Products, the product must meet the criteria in the *Old Drug Product Appendix*.

vii. For Drug products which possess complex delivery systems, the product must meet the criteria in the *Complex Delivery System Drug Product Appendix*.

b. For drug products in the above categories for which bioequivalence studies CANNOT be conducted:

i) Evidence of comparative therapeutic efficacy of the submitted product with the reference product via:

(A) a therapeutic equivalence study; or

(B) Studies that meet the requirements and standards for pharmacodynamic studies outlined in TPD Report C;

and

ii) Sufficient rationale for why a bioequivalence study cannot be conducted.

c. For drug product submissions using a Non-Canadian Reference Product (NCRP):

i) An NCRP may only be used when it meets the *Criteria for use of a Non-Canadian Reference Product* as set out in Health Canada's *Drugs Directorate Policy regarding the use of a Non- Canadian Reference Product under the provisions of Section C.08.002.1(c) of the* Food and Drug Regulations (the "NCRP Criteria"). See also *Interpretation Notice #1*.

ii) If the NCRP Criteria is met, the drug product must demonstrate bioequivalence to the NCRP through studies that meet the requirements and standards of the applicable TPD Reports.

5. The drug product must meet all other criteria outlined in the applicable Appendix.

6. In addition, the Expert Committee may also consider any other factor that may affect the interchangeability of a drug product, including but not limited to:

- characteristics of the drug product (e.g. shape, scoring, configuration, packaging, labelling);
- excipients and non-medicinal ingredient(s) (e.g. sugar, sodium);
- expiration times;
- storage conditions.

Interchangeable Drug Products - Additional Criteria APPENDICES

Critical Dose Drug Product Appendix

Critical Dose Drug: Is a drug where comparatively small differences in dose or concentration lead to dose- and concentration-dependent, serious therapeutic failures and/or serious adverse drug reactions which may be persistent, irreversible, slowly reversible or life threatening, which could result in inpatient hospitalization or prolongation of existing hospitalization, persistent disability or incapacity, or death.

Critical dose drugs include:

a) Any drug listed in *Appendix I - List of Critical Dose Drugs* of Health Canada's Guidance for Industry entitled *Bioequivalence Requirements: Critical Dose Drugs*; and
b) Any other drug that the Expert Committee determines meets the above definition, which determination may include consideration of any other matter that may affect the interchangeability of a product containing a critical dose drug.

Criteria: Bioequivalence studies must meet the requirements and standards in the TPD Reports, with the exception that the following standards will be used:

1. The 90% confidence interval of the relative mean AUC of the test to reference formulation should be within 90.0 to 112.0%; the relevant AUC or AUCs as described in TPD Reports A and B are to be determined.
2. The 90% confidence interval of the relative mean measured Cmax of the test to reference formulation should be between 80.0 and 125.0%.
3. These requirements are to be met in both the fasted and fed states.
4. These standards should be met on log transformed parameters calculated from the measured data and from data corrected for measured drug content (percent potency of label claim).
5. If a steady-state study is required, the 90% confidence interval of the relative mean measured Cmin of the test to reference formulation should also be between 80.0 and 125.0%.

Non-Linear Drug Product Appendix

Non-Linear Drug: A drug is considered to be a Non-Linear Drug if the Health Canada approved product monograph for the Canadian innovator drug product states that it is a non-linear drug.

Criteria:

1. Bioequivalence studies must meet the requirements and standards in the TPD *Reports*, and these requirements and standards should be met in single dose studies in both the fasted and fed states, with the following exceptions:

a) if non-linearity occurs after the drug enters the systemic circulation, a fed study may be waived unless there is sufficient evidence, at the Expert Committee's sole discretion, that a product exhibits a food effect; or

b) if a condition (fasted or fed) for product ingestion is contraindicated, that condition may be waived in a bioequivalence trial. For bioequivalence testing the fasting and fed doses should be the same.

2. At the sole discretion of the Expert Committee, it may be acceptable to conduct bioequivalence studies at either the highest or lowest strength of a range of proportionally formulated strengths as outlined below:

a) For drugs with non-linear pharmacokinetics in the single unit dose range of approved strengths resulting in **greater than proportional increases in AUC** with increasing dose, the bioequivalence studies should be conducted on at least the **highest** strength. That is, where non-linearity arises from capacity-limited clearance, the highest strength for the proposed indications should be tested. For drugs where the non-linear concentration range is reached only after multiple doses within the approved dosing regimen, studies utilizing multiple units of the highest formulation strength or steady-state studies in the non-linear range may be required. Where steady-state studies are conducted, single dose studies will not be required. In all situations, safety in dosing should be considered.

b) For drugs with non-linear pharmacokinetics in the single unit dose range of approved strengths resulting in **less than proportional increases in AUC** with increasing dose, the bioequivalence studies should be conducted on at least the **lowest** strength (single dose unit). That is, where non-linearity arises from capacity-limited absorption, the test dose should be a single unit of the lowest strength.

Rapid Onset Drug Product Appendix

Rapid Onset Drugs: Are as defined in TPD Report C.

Criteria: Bioequivalence studies must meet the requirements and standards in the TPD *Reports*, except that the relative mean $AUC_{Reftmax}$ of the test to reference formulation should be within 80 to 125%, where $AUC_{Reftmax}$ for a test product is defined as the area under the curve to the time of the maximum concentration of the reference product, calculated for each study subject.

Drug Product with Metabolite Data Appendix

For drug product submissions for which evidence of bioequivalence is supported by metabolite, rather than the parent drug, data.

Criteria:

1. Bioequivalence studies must meet the requirements and standards in the TPD Reports.
2. If the parent drug is not detectable due to rapid biotransformation or limitations in available assay methodology, the use of metabolite data may be acceptable.
3. The measured metabolite must be a primary (first step) measureable by a validated assay, and there must be sufficient scientific justification for a waiver of the measurement of the parent drug and the use of metabolite data.
4. The choice of using the metabolite instead of the parent drug is to be clearly stated, *a priori*, in the objective of the study in the study protocol.
5. The use of metabolite concentrations in urine is not acceptable.

Drug Product with Alternate Matrix Measurement Appendix

For drug product submissions for which bioequivalence data is supported by measurement of the drug in a matrix other than plasma or serum (e.g., whole blood, urine, extravascular tissue).

Criteria:

- Bioequivalence studies must meet the requirements and standards in the TPD *Reports.*
- The assay used for measurement of the drug (or metabolite) must be validated for the alternate matrix of measurement.
- Sufficient rationale for why the use of an alternate matrix measurement study is appropriate.

Old Drug Product Appendix

Old Drugs: Are drug products where the active therapeutic ingredient(s) is designated as an "old drug" by Health Canada and the drug product is approved on the basis of a DIN application (i.e. an NOC is not issued by Health Canada).

Criteria:

1. Bioequivalence studies must meet the requirements and standards in the TPD *Reports.*
2. For old drug products for which bioequivalence studies CANNOT be conducted, the submission must include:

    i) Evidence of comparative therapeutic efficacy of the submitted product with the reference product via:

        (A) a therapeutic equivalence study; or

        (B) studies that meet the requirements and standards for pharmacodynamic studies outlined in TPD Report C; or

        (C) surrogate comparisons using *in vivo* or *in vitro* test methods.

    and

    ii) Sufficient rationale for why a bioequivalence study cannot be conducted**.**

Complex Delivery System Drug Product Appendix

Complex Delivery System Drugs: Are drug products that possess complex drug release characteristics in the pharmaceutical dosage form that are intended to:

(1) deliver the drug at a rate that is independent of time and the concentration of the drug (i.e. zero order process), or

(2) deliver the drug to a specific physiological site (i.e. site-specific release).

Criteria:

1. Bioequivalence studies must meet the requirements and standards in the TPD Reports.

2. A detailed description of the pharmaceutical dosage forms and specific drug release characteristics of the submitted drug product and reference drug product must be provided to permit evaluation of the similarity of drug release of the respective formulations.

Review of Benefit Status (ROBS) Criteria

The Expert Committee and/or Alberta Health and Wellness may at any time review the benefit status of a drug product, a group of drug products, a class or classes of drug products, or a category or categories of drug products listed or being considered for listing on the *AHWDBL* (collectively "Products"). The Expert Committee and/or Alberta Health and Wellness may, at their sole option and discretion, recommend altering or discontinuing the benefit status for Products if one or more of the following criteria are met. These are general criteria only, which are intended to be applied flexibly, having regard to each individual case. The criteria may be modified or adapted as the situation may require, and not all criteria will apply to each case:

1. There has been a significant change to the Product(s). Significant changes may include changes in NOC, DIN, product name, manufacturer or distributor, indication, product monograph, packaging, formulation, or any change that could potentially affect the bioavailability or bioequivalence of a product.
2. The Product(s), no longer possesses demonstrated therapeutic advantage compared to other presently accepted therapies or treatments of the disease entity for which the Product(s) is/are indicated. Assessment of therapeutic advantage may include consideration of clinical efficacy, risk/benefit ratio, toxicity, compliance, clinical outcomes, Health Canada advisories, population health issues, and any factor which affects the therapeutic value of the product, class or category.
3. The Product(s) is/are no longer cost-effective compared to other presently accepted therapies or treatments of the disease entity for which the Product(s) is/are indicated.
4. To enable broader coverage of higher priority Product(s).
5. When a product has been discontinued by the manufacturer.
6. When Product(s) is/are changed from prescription to non-prescription status, the Expert Committee may recommend continuing, altering or discontinuing benefit status of the Product(s) based upon scientific, therapeutic, clinical and socio-economic merits of the Product(s).
7. For all ROBS reviews, the Expert Committee, Alberta Health and Wellness and/or the Minister may, in addition to all of the factors listed above, also consider any factors that they consider appropriate, including but not limited to any of the criteria for listing drug products and interchangeable drug products.

Unsolicited information from manufacturers relating to ROBS Reviews will not be put before the Expert Committee. However, if the Expert Committee determines that a change in benefit status may be warranted, manufacturers of the affected Product(s) will be notified and provided with an opportunity to make submissions to the Expert Committee prior to the final recommendation being made. Notification will include advice regarding the form of submission that will be accepted, the deadline for filing the submission and any other relevant advice. Any submissions that do not comply with the notification advice will not be put before the Expert Committee.

Supply Shortages

Where a manufacturer has not supplied, or is not supplying, a sufficient quantity of drug product to meet the demand in Alberta (as determined by Alberta Health and Wellness at its sole option and discretion, and based on any information it deems appropriate):

1. If the unavailable product is a single-source product on the *List*, products not otherwise allowed as benefits may be added temporarily or temporarily reimbursed for the Alberta government-sponsored drug programs.

3. Products added or reimbursed under this policy may remain as temporary benefits until the supply shortage is rectified.

4. In order to remain as benefits after the shortage is rectified, manufacturers of these products must follow the usual submission and review process for listing.

5. Alberta Health and Wellness may recover any cost difference from the manufacturer unable to supply a drug product.

6. Alberta Health and Wellness may at its sole discretion, take any other steps or require any information from a manufacturer or other person, that is reasonably required to manage a supply shortage.

7. Alberta Health and Wellness may:

    - refuse to list any product of the manufacturer,
    - refuse to consider any product submission of the manufacturer for expedited or priority review; or
    - cancel or modify the listing of the product that is not meeting the supply demand.

Units of Issue for Pricing

These units of issue are used for presenting prices in the *List*.

Dosage Form	Unit of Issue Priced in *AHWDBL*
Ampoules	Millilitre
Bladder Irrigation Solutions	Millilitre
Dental Pastes	Gram
Devices	Device
Inhalation Capsules	Capsule
Inhalation Cartridges	Cartridge
Inhalation Disks	Disk
Inhalation Solutions or Suspensions	Millilitre – all preparations including nebules
Inhalation Unit Dose Solution	Millilitre
Injections	Vial – where reconstitution is required (or Millilitre or Unit where indicated)
Injections	Millilitre – where no reconstitution is required (or Vial where indicated)
Injections – Cartridges	Millilitre
Injections – Emulsion	Millilitre
Injections – Syringes	Syringe (or Millilitre where indicated)
Injection – Implant	System
Injection Syringe/Oral Capsule	Kit
Injection Vial/Oral Capsule	Kit
Injection Vial/Oral Tablet	Kit
Injection Syringe/Oral Tablet	Kit
Intrauterine Insert	System
Irrigating Solutions	Millilitre
Lock Flush	Millilitre
Metered Dose Aerosols	Dose
Metered Inhalation Powder	Dose
Nasal Metered Dose Aerosols	Dose
Nasal Metered or Unit Dose Sprays	Dose
Nasal Solutions	Millilitre
Nasal Sprays	Millilitre
Ophthalmic Solutions or Suspensions or Drops	Millilitre
Ophthalmic Gels or Ointment	Gram
Ophthalmic Long Acting Gellan Solutions	Millilitre
Oral Caplets	Caplet
Oral Capsules – all formulations	Capsule
Oral Drops	Millilitre
Oral Granules	Bulk size – Gram Individual Packet – Packet
Oral Liquids – all formulations	Millilitre
Oral Powders	Gram (or Dose where indicated)
Oral Powder Packets	Individual Packet

Units of Issue for Pricing, continued

Dosage Form	Unit of Issue Priced in AHWDBL
Oral Rinses	Millilitre
Oral Tablets – all formulations	Tablet
Oral Tablets – oral contraceptives	Tablet
Oral Tablet/Capsule	Kit
Oral Wafer	Wafer
Otic Ointments or Gels	Gram
Otic Solutions or Suspensions or Drops	Millilitre (or Vial where indicated)
Rectal Enemas	Enema
Rectal Foams	Gram
Rectal Ointments	Gram
Rectal Retention Enemas	Enema
Rectal Suppositories - all formulations	Suppository
Scalp Lotions	Millilitre
Scalp Solutions	Millilitre
Sublingual Metered Dose Spray	Dose
Sublingual Tablet	Tablet
Topical Bars	Gram
Topical Cleansers	Millilitre
Topical Creams/Ointments - all formulations	Gram
Topical Gauzes	Dressing
Topical Gels - all formulations	Gram
Topical Jellies	Millilitre
Topical Lotions	Millilitre or Gram
Topical Powders	Gram
Topical Solutions	Millilitre
Topical Washes	Millilitre or Gram
Transdermal Gel	Gram
Transdermal Patches	Patch
Vaginal Capsules or Ovules or Tablets	Capsule or Ovule or Tablet
Vaginal Creams or Ointments or Gels	Gram
Vaginal Douches	Millilitre
Vaginal Ovule/Topical Cream	Kit
Vaginal Slow Release Rings	Ring
Vaginal Suppositories	Suppository

Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics: Policy for Administering Interchangeability Challenges

Note: This Policy is not applicable for drug products that are eligible for, and are reviewed under, the Expedited Review Process for interchangeable drug products.

From time-to-time, the Expert Committee on Drug Evaluation and Therapeutics receives unsolicited information ("Challenge Information") from a manufacturer (the "Challenger") suggesting that additional information should be taken into account when a submission for interchangeability for a multisource product is being considered by the Expert Committee. Alberta Health and Wellness is not prepared to have any Challenge Information considered by the Expert Committee unless the manufacturer whose product is being challenged (the "Applicant") is provided with a full copy of the Challenge Information and is given an opportunity to respond to it.

As a result, Alberta Health & Wellness has developed and approved the following process for the handling of Challenge Information.

1. Challenge Information must comply with the following conditions.
2. Challenge information must be received by Alberta Blue Cross:
   - For first-entry interchangeable product submissions – Within 15 days of the date of issuance of the NOC for the Applicant's product.
   - For all other submissions, by the submission deadline date.
3. All Challenge Information must include an unconditional Written Consent, signed by the Challenger, authorizing Alberta Health and Wellness and its agent/designate to (a) disclose to the Applicant all Challenge Information; and (b) to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services and the government of any province or territory in Canada, all submission information and Challenge Information and any information in the possession of Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), the Patented Medicine Price Review Board (PMPRB), Alberta Health Services and the government of any province or territory in Canada.
4. If the above unconditional Written Consent is not submitted as required, the Challenge Information will not be considered by the Expert Committee.
5. If Written Consent is submitted as required, the Challenge Information will be duplicated in its entirety and forwarded by Alberta Blue Cross to the Applicant, inviting a response ("Applicant Response"). The Applicant Response must be received by Alberta Blue Cross no later than 15 days after the date of the letter from Alberta Blue Cross.
6. If an Applicant Response is not received by Alberta Blue Cross within the time provided, only the Challenge Information will be provided to the Expert Committee for consideration. If an Applicant Response is received within the time provided, both the Applicant Response and the Challenge Information will be provided to the Expert Committee for consideration.
7. No further information may be submitted to the Expert Committee for consideration.
8. The Applicant Response should only address information contained in the Challenge Information. Anything in the Applicant Response that does not relate to information contained in the Challenge Information may, at the sole discretion of the Expert Committee, be disregarded.

9. It is a condition of each and every Submission and Challenge that the terms, conditions, criteria and time limitations contained in this policy will apply and that:
    a) Applicants, by filing a Submission and Applicant Response; and,
    b) Challengers, by submitting Challenge Information agree to and are bound by this policy.
10. In the event the anticipated Applicant submission is not received, Challenge Information will be destroyed 6 months after receipt.

Inquiries may be made to:

Senior Manager
Scientific and Research Services
Alberta Blue Cross
10009 - 108 Street NW
Edmonton AB T5J 3C5
Phone: (780) 498-5978
Fax: (780) 498-3534

Your Comments are Important to Us

To improve the high standards established for this publication, the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics would like to offer you an opportunity for input. Should you have any concerns and/or suggestions concerning product listings or criteria for coverage of products available via special authorization, etc. please let us know. If you are writing in support of a product listing change or a revision to the special authorization criteria for coverage, you must provide evidence in support of your comments from the peer-reviewed scientific literature. In order to meet the expectations of stakeholders relative to objectivity and transparency, all individuals providing comments are required to advise the Expert Committee of any potential conflicts of interest below (please check appropriate box):

Please note: this is not a mechanism for an appeal for a specific patient.

Conflict of Interest: ☐ **Yes** ☐ **No**

If Yes, please indicate the nature of the potential conflict of interest below:

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Please provide your comments in the space provided below:

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Contact Information:

Name and Address: _____

Phone/Fax: _____

Please print form and mail/fax to:

Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics
c/o Senior Manager
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5
FAX to: (780) 498-3534

The DBL is not a prescribing or a diagnostic tool. Prescribers should refer to drug monographs and utilize professional judgment.

PRICE POLICY

Definitions

In this Price Policy,

Alberta Health and Wellness Drug Benefit List **or AHWDBL** means the most recent *Alberta Health and Wellness Drug Benefit List* published by the Minister on or before March 31, 2011,

Alberta Price Confirmation or APC means an Alberta Price Confirmation that may be issued by the Minister from time to time,

APC Terms and Conditions means the terms and conditions outlined in an APC,

Base Cost means, for Drug Products subject to the Non-Fixed Pricing Rules, the base cost quoted by the Manufacturer for the Drug Product in the last applicable Request for Quotation for the Drug Product (prior to the issuance of this APC),

Brand Drug means an originator/brand Drug Product listed in the AHWDBL or List,

Brand Price means the price of the originator/brand Drug Product published in the AHWDBL in an Established IC Grouping on October 1, 2009 or if there is more than one originator/brand product in the Established IC Grouping, the Brand Price is the lowest published price of an originator/brand Drug Product in the Established IC Grouping,

Confirmed Price means a Confirmed Price as set out in clause 3,

Distribution Allowance means the amount that may be included in a Price Confirmation where permitted by this Price Policy,

Device means a product approved by Health Canada as a device and listed on the AHWDBL or List,

Drug Product means anything that is listed or under consideration for listing by the Minister on the AHWDBL or the List,

Drug Program Act or **DPA** means the *Drug Program Act* of Alberta,

Effective Brand Price means the price of the originator/brand Drug Product published in the AHWDBL or List in the New IC Grouping effective the date Alberta Blue Cross received the Drug Product submission or if there is more than one originator/brand product, the Effective Brand Price is the published price of the lowest originator/brand Drug Product in the New IC Grouping,

Effective Period means the Effective Period stated in an APC,

Entry IC Drug means a Drug Product that is listed or under consideration for listing, in a New IC Grouping.

Established IC Grouping means a grouping of IC Drugs that was established on or before October 1, 2009,

Fixed Price means the applicable Fixed Price as set out in the Fixed Pricing Rules,

IC Drug means a Drug Product that is listed, or is under consideration for listing, as interchangeable with other Drug Products,

Interim APC means an APC issued by the Minister for one or more Drug Products, or one or more groupings of Drug Products during an Effective Period,

Least Cost Alternative Price or LCA Price means the maximum amount established by the Minister which will be paid by the Government of Alberta for a Drug Product in an Established or New IC Grouping for members of a Plan,

List means the drug benefit list to be established by the Minister of Health and Wellness effective April 1, 2010, and any updates, additions and amendments made to the list from time to time,

MAC Grouping means a grouping of Drug Products that have been listed in the AHWDBL or the List as being subject to a MAC Price; a MAC Grouping may include a grouping of IC Drugs, in which case the grouping shall be treated as an Established IC Grouping,

Maximum Allowable Price or MAC Price means the maximum amount established by the Minister which will be paid by the Government of Alberta for a Drug Product in a MAC Grouping for members of a Plan,

Manufacturer means an entity who manufacturers, sells or distributes Drug Products,

Minister means Her Majesty the Queen in Right of Alberta, as represented by the Minister of Health and Wellness,

New IC Grouping means a grouping of IC Drugs that was established after October 1, 2009,

Other Drug means Devices (whether they are listed as interchangeable or not) and any other Drug Product that is not an IC Drug, Entry IC Drug or a Brand Drug listed on the AHWDBL or the List,

Plan means a plan or program, for which the Government of Alberta provides benefits in respect of Drug Products listed on the AHWDBL or List,

Price Confirmation means the package of documents identified in an APC, which must be completed and submitted in accordance with this Price Policy and the APC Terms and Conditions.

Alberta Price Confirmation (APC)

1. The Minister may from time to time issue an Alberta Price Confirmation (APC), where a Manufacturer will be invited to submit a Price Confirmation in accordance with the APC Terms and Conditions.

2. The Manufacturer must ensure that a Price Confirmation and a Confirmed Price submitted by a Manufacturer comply with this Price Policy and the APC Terms and Conditions.

3. For purposes of an APC and submitting a Price Confirmation, and subject to exceptions permitted by and approved under the Price Policy, the Confirmed Price for a Drug Product is:

    a. **For a Drug Product subject to the Fixed Pricing Rules**, the Base Cost which must not exceed the Fixed Price (per Unit of Issue) as defined in the Price Policy. A Distribution Allowance is not permitted.

    b. **For a Drug Product subject to the Non-Fixed Pricing Rules**:

        i. either

        (a) the **Base Cost** (which is the base cost submitted by the Manufacturer in the last Quotation for the Drug Product prior to the issuance of this APC), or

        (b) the **Revised Base Cost**, which must not exceed the highest price permitted in the Non-Fixed Pricing Rules;

        and

        ii. where permitted, a **Distribution Allowance** which must not exceed the amount permitted by the Price Policy.

4. In addition, **a Confirmed Price**:

    a. must comply with the APC Terms and Conditions;
    b. is applicable to a Drug Product regardless of the package size for each Drug Product; and
    c. must not include the Goods and Services Tax (GST) or any other tax.

5. Exceptions to the Fixed Pricing and Non-Fixed Pricing Rules may be requested.

6. If an exception is requested in a Price Confirmation, but is not approved by the Minister, the Manufacturer will not be given another opportunity to provide a new Price Confirmation, unless the Minister, at the Minister's sole discretion, determines it is advisable to do so.

7. The Manufacturer is responsible for ensuring that sufficient supply of a Drug Product for which a Confirmed Price has been submitted is available for the Alberta market for the Effective Period. If there are circumstances beyond the Manufacturer's control that will cause a Drug Product shortage, the Manufacturer must advise Alberta Blue Cross immediately in writing at the address indicated in the AHWDBL or List.

8. The Manufacturer agrees that the Confirmed Price is the price at which the Manufacturer will make the Drug Product(s) available for sale to the public in Alberta for the duration of the Effective Period.

9. The Minister may consider a Price Confirmation or Confirmed Price and may, at the Minister's sole discretion:

    a. accept none, one or more Price Confirmations;
    b. accept none, one or more Confirmed Prices submitted in one or more Price Confirmations; and
    c. establish special pricing rules regarding Confirmed Prices, including but not limited to establishing an LCA Price or MAC Price.

10. Notwithstanding the acceptance of a Confirmed Price, the Minister is not obligated to pay that price for members of the Plan, but may establish special or exceptional prices, including but not limited to establishing:

    a. an LCA Price,
    b. a MAC Price, or
    c. an exceptional price.

11. When considering a Price Confirmation or Confirmed Price for acceptance, and in determining whether to establish a special price, the Minister may consider any factor or criteria outlined in the AWHDBL or List, any matter permitted by the *Drug Program Act*, or any matter that the Minister determines is in the public interest.

Interim APC

12. Notwithstanding the acceptance of a Price Confirmation, or all or part of a Price Confirmation, or one or more Confirmed Prices, in the event that, during an Effective Period:

    a. a new Drug Product is being considered for listing in an Established IC Grouping, New IC Grouping or MAC Grouping,

    b. a Manufacturer submits a price reduction in accordance with this Price Policy for a Drug Product listed in an Established IC Grouping, New IC Grouping or MAC Grouping, or

    c. for any reason that the Minister determines that it is advisable to do so,

    the Minister may, at the Minister's sole discretion, issue an Interim APC for one or more Drug Products, or one or more groupings of Drug Products.

13. If a Manufacturer submits a new Drug Product submission for review and listing on the AHWDBL or List, and an Interim APC is issued, the Manufacturer must submit a Confirmed Price that:

    a. is the same as the price as outlined in the Drug Product submission, and
    b. does not exceed the prices permitted under this Price Policy (as applicable),

    or the Drug Product may not be listed or the listing of the Drug Product may be delayed.

14. In the event the Minister issues an Interim APC, and a Price Confirmation, or all or part of a Price Confirmation, or one or more Confirmed Prices are accepted as a result of the Interim APC, the Interim APC Terms and Conditions supercede any previous APC Terms and Conditions for the affected Drug Products for the remainder of the Effective Period.

15. Publication of amended Confirmed Prices is at the discretion of the Minister.

Fixed pricing Rules (For Interchangeable Drugs)

16. Effective April 1, 2010, a Confirmed Price:

    a. must not exceed the Fixed Price as follows:

        i. For an IC Drug in an Established IC Grouping (subject to 16 b.), the Fixed Price will be equal to:
            A. 56% of the Brand Price; or
            B. if there is no Brand Price, 75% of the lowest price published for the IC Grouping on October 1, 2009.

        ii. For an Entry IC Drug, the Fixed Price will be equal to 45% of the Effective Brand Price.

    b. for an IC Drug where the published price on the AHWDBL on October 1, 2009 was equal to or lower than the Fixed Price set out in clause 16.a.i, must not exceed the Drug Product's published price on October 1, 2009, and

    c. for an IC Drug, must not include a Distribution Allowance.

Non-Fixed Pricing Rules (For Brand and Other Drugs)

17. Effective April 1, 2010, the Confirmed Price for a Brand Drug and Other Drug must comply with the following:

    a. The price must not exceed the Base Cost plus a percentage (%) of the Base Cost that is equal to the annual average percentage change from the previous year of the Consumer Price Index for Canada, all-items, not seasonally adjusted published by Statistics Canada.

    b. The price may only increase once per year and must be submitted through the Manufacturer's Price Confirmation for the Effective Period.

    c. A Distribution Allowance is permitted if:
        i. the Manufacturer confirms through the Price Confirmation that it distributes or sells the Drug Product only through a licensed wholesaler; and
        ii. the Distribution Allowance does not exceed 7.5% of the price permitted under clause 17.a.

Exceptions

18. Notwithstanding the Fixed Pricing Rules and the Non-Fixed Pricing Rules, exceptions to the Fixed and Non-Fixed Pricing Rules may be considered at the sole discretion of the Minister.

19. The Minister may, but is not required to, consider exceptions where:

    a. For an IC Drug, the cost differential between the Brand Price and the IC Drug was less than 25% on October 1, 2009;

    b. For an Entry IC Drug, there was a decrease of greater than 20% in the price of the originator/brand-name Drug Product published in the AHWDBL or List within the 12 months preceding the date that the Drug Product submission was received by Alberta Blue Cross;

    c. For an IC Drug, all Drug Products in the Established IC Grouping or New IC Grouping have
       i. less than 250 claims[1]; and
       ii. an annual net cost[2] of less than $50,000;
       for Plans, as calculated by the Minister, for the previous 12 month benefit period;

    d. The Manufacturer provides sufficient information that the cost of manufacturing the Drug Product is too high for the Manufacturer to sell it at the maximum prices permitted by the Fixed and Non-Fixed Pricing Rules;

    e. Where exceptional circumstances exist[3], and the Minister determines that an exception is appropriate.

20. Exceptions will not be considered for an IC Drug if another Manufacturer with a Drug Product in the Established IC Grouping or New IC Grouping provides a Price Confirmation at or below the Fixed Price.

21. Requests for an exception may delay the listing or price publication of the Drug Product.

Price Reductions

22. During an Effective Period, further price reductions for Drug Products listed on the AHWDBL or List will be considered as follows:

    a. For IC Drugs and Drug Products listed in a MAC Grouping if the proposed price is
       i. 5% less than, or

[1] "claims" means the total number of prescriptions submitted for reimbursement to the Plans for all Drug Products in the grouping.

[2] "cost" means the drug material cost for claims

[3] Exceptional circumstances include, but are not limited to, circumstances where, in the opinion of the Minister, significant patient safety or access concerns, or significant increased costs to the Plans could result if the drug were not available on the List.

ii. would represent an annual net cost[4] savings of more than $100,000 for the Plans, as calculated by the Minister, for the previous 12 month benefit period, in comparison to

the LCA Price or MAC Price published at the time Alberta Blue Cross receives the proposed price reduction.

b. For all other Drug Products, by notifying the Minister by sending a written notice to Alberta Blue Cross.

23. Establishment of a new LCA or MAC Price and publication of a reduced price is subject to:

a. the Manufacturer submitting a Price Confirmation for the new price in accordance with the APC Terms and Conditions;
b. acceptance of the new Confirmed Price by the Minister; and
c. the Minister's sole discretion regarding the establishment of a new LCA or MAC Price, and the time, place and method of publication.

Minister's Authority

24. Notwithstanding anything to the contrary, where there is

a. a failure to submit a Price Confirmation or Confirmed Price in accordance with the APC Terms and Conditions,

b. rejection or non-acceptance of a Price Confirmation, or all or part of a Price Confirmation, or one or more Confirmed Prices,

c. failure by the Manufacturer to comply with the APC Terms and Conditions;

the Minister may, at the Minister's sole discretion, do any one or more of the following:

d. cancel the listing of,

e. modify the listing of,

f. refuse to add to the List,

g. refuse to expedite the submission of,

h. cancel or modify the benefit payable for,

i. modify or impose rules, terms, restrictions or conditions relating to,

the Drug Product for any period of time deemed appropriate by the Minister.

25. The Minister reserves the right to pursue any other remedies available to the Minister.

[4] "cost" means the drug material cost for claims

26. Notwithstanding anything to the contrary, and notwithstanding the acceptance of a Price Confirmation, or all or part of a Price Confirmation, or one or more Confirmed Prices, the Minister shall have the unfettered discretion to

    a. make any decisions or take any steps to amend a published price, an LCA Price, a MAC Price, the Price Policy, the AHWDBL or the List or make any other adjustments the Minister considers advisable;

    b. make any decisions, take any actions or steps, or do anything that is authorized by the *Drug Program Act*;

    c. pursue, negotiate and enter into agreements with one or more manufacturers, distributors or vendors,

    d. make arrangements with other persons to provide access to Drug Products for members of the Plans,

    e. make any decisions, or take any actions or steps, or do anything that the Minister considers appropriate, and

    f. terminate an APC, a Price Confirmation, or all or part of a Price Confirmation, or one or more Confirmed Prices upon 10 days written notice to the affected Manufacturer, which notice is deemed to be given by the Minister and received by the Manufacturer upon (a) publication of the written notice on the List website operated by Alberta Blue Cross, or (b) by sending the notice via telefax to the last known telefax number of the Manufacturer, and the method of notice is at the Minister's discretion,

    in order to maintain the integrity of the List, to ensure reasonable access to treatment for members of the Plans, or to serve the public interest.

27.

    a. The Minister and Alberta Blue Cross are not liable for any actions, damages, claims, liabilities, costs, expenses, or losses in any way, including consequential, special, indirect, incidental, punitive or special damages, costs, expenses, or losses (including, without limitation, lost profits and opportunity costs) arising out of or relating to an APC, any Price Confirmation, a Confirmed Price, the AHWDBL or the List, even if the Minister or Alberta Blue Cross have been advised of the possibility of such damages beforehand. The provisions of this clause shall apply regardless of the form of action, damage, claim, liability, cost, expense, or loss, whether in contract, statute, tort (including, without limitation, negligence), or otherwise, and

    b. in no event shall the maximum aggregate liability of the Minister and Alberta Blue Cross for damages related to this APC, a Price Confirmation, a Confirmed Price, the AHWDBL or the List be greater than the Manufacturer's actual costs of preparing and submitting this APC, up to a maximum of $25,000.

Least Cost Alternative (LCA) Price Policy

1. The Least Cost Alternative Price or LCA Price means the maximum amount established by the Minister which will be paid by the Government of Alberta for a Drug Product in an Established or New IC Grouping for members of a Plan.

2. Where the Minister establishes an LCA Price in Established and New IC Groupings the LCA Price:
    a. is the lowest unit cost for a Drug Product in an IC Grouping that was submitted by the Manufacturer and accepted by the Minister in the most recent Alberta Price Confirmation.
    b. appears in **bold** type in the far right column of the AHWDBL.
    c. applies to all Drug Products in the applicable IC Grouping, unless the Minister determines that an exception should be made.

3. Where the Minister establishes an LCA Price in Established and New IC Groupings, the Government of Alberta will pay the Actual Acquisition Cost for the Drug Product to a maximum of the LCA Price.

4. Notwithstanding section 2 above, the LCA Price Policy does not apply to:
    - conjugated estrogens;
    - devices; and
    - injectable Drug Products with different package sizes in an IC Grouping.

5. Subject to a Special Authorization being granted pursuant to section 6, where a physician prescribes or a patient chooses an IC Drug that is priced higher than the LCA Price established by the Minister in the applicable IC Grouping, the patient will be responsible for any additional costs (being the difference in price between the higher-priced IC Drug and the LCA Price).

6. A physician may request Special Authorization if an IC Drug that is priced higher than the applicable LCA Price is essential in the care of a patient. For further information refer to the Special Authorization Guidelines section of the AHWDBL.

Maximum Allowable (MAC) Price Policy

1. The MAC Price means the maximum amount established by the Minister which will be paid by the Government of Alberta for a Drug Product in a MAC Grouping for members of a Plan.

2. A MAC Grouping means a grouping of Drug Products that have been listed in the AHWDBL or the List as being subject to a MAC Price; a MAC Grouping may include a grouping of IC Drugs, in which case the grouping shall be treated as an Established IC Grouping.

3. Where the Minister has established a MAC Price for a MAC Grouping:
   a. The MAC Price appears in ***bold italic*** type and is displayed in the AHWDBL in the second column from the right where two price columns are listed. A comment in ***bold italic*** type appears following a MAC Grouping to explain the basis for establishing the MAC Price.
   b. The Government of Alberta will pay the Actual Acquisition Cost for the Drug Product to a maximum of the MAC Price.

4. The MAC Price Policy applies to the following MAC Groupings:
   - PTC 28:08.04.92
     Selected Oral Modified-Release Dosage Forms of Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)
   - PTC 40:12
     Potassium Chloride (K+) 8 mEq Oral Sustained-Release Tablets

5. Subject to a Special Authorization being granted, where a physician prescribes or a patient chooses a Drug Product in a MAC Grouping that is priced higher- than a MAC Price established by the Minister for the applicable MAC Grouping, the patient will be responsible for any additional costs (being the difference in price between the higher-priced Drug Product and the MAC Price).

6. A physician may request Special Authorization if the Drug Product that is priced higher than the applicable MAC Price is essential in the care of a patient. For further information refer to the Special Authorization Guidelines section of the AHWDBL.

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RESTRICTED BENEFITS

Restricted Benefits

Selected devices or drug products are eligible benefits with restrictions in the *Alberta Health and Wellness Drug Benefit List*. For these products a comment is displayed in the *List* after the ingredient name. The comment initially states "RESTRICTED BENEFIT" and is followed by an explanation of the restriction. For an example, refer to the Legend in the Introduction section of the *List*.

Products Designated as Restricted Benefits

The products listed below are restricted benefits in the *List.*

PTC 08:18.08.20

- **Lamivudine** 100 mg oral tablet
- **Tenofovir Disoproxil Fumarate** 300 mg oral tablet

PTC 08:18.20

- **Peginterferon Alfa-2A** 180 mcg/0.5 ml injection syringe and 180 mg/ml injection

PTC 08:18.32

- **Adefovir Dipivoxil** 10 mg oral tablet
- **Entecavir** 0.5 mg oral tablet

PTC 12:24.04

- **Cyclobenzaprine HCL** 10 mg oral tablet

PTC 20:12.04.92

- **Rivaroxaban** 10 mg oral tablet

PTC 28:16.08.04

- **Risperidone** 1 mg/ml oral solution

PTC 28:32.28

- **Almotriptan Malate** 6.25 mg and 12.5 mg oral tablet
- **Naratriptan HCL** 1 mg and 2.5 mg oral tablet
- **Rizatriptan Benzoate** 5 mg oral tablet, 10 mg oral tablet, 5 mg oral wafer and 10 mg oral wafer
- **Sumatriptan Hemisulfate** 5 mg/dose and 20 mg/dose unit dose nasal spray
- **Sumatriptan Succinate** 50 mg oral tablet, 100 mg oral tablet and 6 mg/syr injection syringe
- **Zolmitriptan** 2.5 mg oral tablet, 2.5 mg oral dispersible tablet and 5 mg/dose unit dose nasal spray

PTC 48:10.24

- **Montelukast Sodium** 4 mg oral chewable tablet, 5 mg oral chewable tablet, 10 mg oral tablet, and 4 mg oral granule
- **Zafirlukast** 20 mg oral tablet

PTC 52:08.08

- **Mometasone Furoate** 50 mcg/dose aqueous nasal spray

PTC 52:92

- **Ranibizumab** 2.3 mg/vial injection

PTC 56:22.92

- **Aprepitant/Aprepitant** 80 mg/125 mg capsule

PTC 92:00

- **Leflunomide** 10 mg oral tablet and 20 mg oral tablet

PTC 94:00

- **Aerosol Holding Chamber**
- **Aerosol Holding Chamber/Mask - Infant**
- **Aerosol Holding Chamber/Mask - Pediatric**
- **Aerosol Holding Chamber Mask - Adult**

Limited Restricted Benefits

Selected drug products are eligible benefits with limits and restrictions in the *Alberta Health and Wellness Drug Benefit List*. For these products a comment is displayed in the *List* after the ingredient name. The comment initially states “LIMITED RESTRICTED BENEFIT” and is followed by an explanation of the limits and restrictions. For an example, refer to the Legend in the Introduction of the *List*.

Product(s) Designated as Limited Restricted Benefits

The product(s) listed below are limited restricted benefits in the *List*.

PTC 20:12.18

- **Clopidogrel Bisulfate (Plavix)** 75 mg oral tablet

SPECIAL AUTHORIZATION GUIDELINES

Special Authorization Policy

Drug Products Eligible for Consideration by Special Authorization

Drug products may be considered for coverage by special authorization under one or more of the following circumstances, unless a specific product falls under the criteria for drug products **not** eligible for consideration by special authorization. Please see the end of this section for information regarding drug products not eligible for consideration by special authorization.

1. The drug is covered by Alberta Health and Wellness under specified criteria (listed in the following sections). Drug Products and indications other than those specified are not eligible for consideration by special authorization.
2. The drug is normally covered by another government program or agency for a specific approved clinical condition, but is needed for the treatment of a clinical condition that is not covered by that government program or agency.
3. The drug is required because other drug products listed in the *Alberta Health and Wellness Drug Benefit List* are contraindicated or inappropriate because of the clinical condition of the patient.
4. The particular brand of drug is considered essential in the care of a patient, where the LCA price policy would otherwise apply. Coverage of a specific brand may be considered where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with alternate brands in an interchangeable grouping. Coverage of a brand name product will not be considered in situations where the interchangeable grouping includes a pseudo-generic to the brand name drug.
5. A particular drug product or dosage form of a drug is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the product level. Coverage may be considered only where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with the drug product which establishes the MAC pricing.

Prior approval must be granted by Alberta Blue Cross to ensure coverage by special authorization. For those special authorization requests that are approved, the effective date for authorization is the beginning of the month in which the physician's request is received by Alberta Blue Cross.

Special authorization is granted for a defined period as indicated in each applicable special authorization drug product criteria (the "Approval Period"). If continued treatment is necessary beyond the Approval Period, it is the responsibility of the patient and physician to **re-apply for coverage prior to the expiration date of the Approved Period, unless the Auto-Renewal Process or Step Therapy Approval Process apply** (see below).

Auto-Renewal Process

Selected drug products are eligible for the following auto-renewal process (for eligibility, see the Special Authorization criteria for each drug product).

1. For initial approval, a special authorization request must be submitted. If approval is granted, it will be effective for the Approval Period outlined in the drug product's Special Authorization criteria.
2. As long as the patient has submitted a claim for the drug product within the preceding Approval Period (example: within the preceding 6 months), approval will be automatically renewed for a further Approval Period (example: a further 6 months). There is no need for the prescriber to submit a new request as the automated real-time claims adjudication system will read the patient's claims history to determine if a claim has been made within the preceding Approval Period.
3. If the patient does not make a claim for the drug product during the Approval Period, the approval will lapse and a new special authorization request must be submitted.

Step Therapy Approval Process

Select drug products are eligible for coverage via the step therapy process, outlined below.

1. If the patient has made a claim for the First-Line* drug product(s) within the preceding 12 months, the claim for the step therapy drug will be approved.

2. The automated real-time claims adjudication system will read the patient's claims history to determine if the required First-Line* drug product(s) have been claimed within the preceding 12 months.

3. Subsequent claims for drug product(s) permitted by step therapy will continue to be approved as long as the drug product has been claimed within the preceding 12 months.

4. The regular special authorization approval process will continue to be available for step therapy approvals for those patients whose First-Line* drug claims cannot be adjudicated through the automated real-time claims adjudication system.

* A First-Line drug product includes any drug(s) or drug product(s) that, under the drug product's Special Authorization criteria, are required to be utilized before reimbursement for the drug product is permitted.

Drug Products *Not Eligible* for Consideration by Special Authorization

The following categories of drug products are **not** eligible for special authorization:

1. Drug products **deleted** from the *List*.
2. Drug products **not yet reviewed** by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics. This applies to:
   - products where a complete submission has been received from the manufacturer and the product is under review,
   - products where an incomplete submission has been received from the manufacturer, and
   - products where the manufacturer has not made a submission for review.

   Drug products not yet reviewed may encompass new pharmaceutical products, new strengths of products already listed, reformulated products and new interchangeable (generic) products.
3. Drug products that have **completed the review** process and are **not included** on the *List.*
4. Most drugs available through Health Canada's Special Access Program.
5. Drug products when prescribed for cosmetic indications.
6. Nonprescription or over-the-counter drug products are generally not eligible.

Special Authorization Procedures

A prescriber's request for special authorization should be directed by mail or FAX to:

Clinical Drug Services and Evaluation
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

FAX: (780) 498-8384 in Edmonton and area
1-877-828-4106 toll-free fax for all other areas

1. For most drug products, written requests from a prescriber may be submitted on the general *Drug Special Authorization Request* (form number ABC 20061).

   Select drug products such as Donepezil/Galantamine/Rivastigmine (form number ABC 30776), Clopidogrel (form number ABC 30786), Darbepoetin/Epoetin (form number ABC 30888), Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis (form number ABC 30902), Ezetimibe (form number ABC 30925), Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin (form number ABC 30932), Peginterferon Alfa-2b for Chronic Hepatitis C (form number ABC 30933), Peginterferon Alfa-2a for Chronic Hepatitis C (form number ABC 30944), Etanercept for Juvenile Rheumatoid Arthritis (form number ABC 30948), Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis (form number ABC 30964), Select Quinolones (form number 30966), Alendronate/Raloxifene/ Risedronate/Synthetic Calcitonin Salmon for Osteoporosis (form number ABC 31086), Celecoxib (form number ABC 31140), Filgrastim/Pegfilgrastim (form number ABC 31150) Fentanyl (form number ABC 31169), Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis *(*Form number ABC 31192), Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis *(*form number ABC 31195), Adalimumab for Crohn's/ Infliximab for Crohn's/Fistulizing Crohn's Disease *(*form number ABC 31200), Abatacept/Rituximab for Rheumatoid Arthritis (form number ABC 31205), Imiquimod (form number ABC 31222), Dutasteride/Finasteride (form number ABC 31257), Risperidone Prolonged Release Injection (form number ABC 31258), Abatacept for Juvenile Idiopathic Arthritis (form number ABC 31291) and Montelukast/Zafirlukast (form number ABC 31313) have a unique special authorization request form. All requests for these drug products must be submitted using the applicable form.

   Special authorization request forms can be found on the following pages.

2. A separate request is required for each patient.

3. For a request for special authorization to be considered, the prescriber (an individual authorized by law to prescribe) must contact Alberta Blue Cross and provide the following information:

   Patient Identification
   - patient's name, address and card holder's name (if different than the patient's),
   - Alberta Blue Cross identification number or coverage number/client number of any other applicable coverage (e.g. Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Services (AISH) or Alberta Personal Health number, and
   - date of birth.

   Prescriber Identification
   - name of prescriber (e.g. physician, dentist, or optometrist),
   - address,
   - telephone number and FAX number (if applicable), and
   - professional association registration number (e.g. College of Physicians and Surgeons, Alberta Dental Association, or Alberta College of Optometrists registration number).

Drug Requested
- name, strength and dosage form,
- dosage schedule, and
- proposed duration of therapy.

Reason for the Request
- diagnosis and/or indication for which the drug is being used,
- information regarding previous medications which have been used and the patient's response to therapy where appropriate,
- proposed results of therapy, and
- any additional information that may assist in making a decision on the request for special authorization.

Special Authorization Forms

Special Authorization forms can be found on the following pages:

- *Drug Special Authorization Request Form* (ABC 20061)
- *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* (ABC 30776) - All requests for donepezil HCl, galantamine hydrobromide or rivastigmine hydrogen tartrate must be submitted using this form only.
- *Clopidogrel Special Authorization Request Form* (ABC 30786) - All requests for clopidogrel bisulfate must be submitted using this form only.
- *Darbepoetin/Epoetin Special Authorization Request Form* (ABC 30888) - All requests for darbepoetin or epoetin alfa must be submitted using this form only.
- *Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form* (ABC 30902) - All requests for adalimumab, anakinra, etanercept or infliximab for Rheumatoid Arthritis must be submitted using this form only.
- *Ezetimibe Special Authorization Request Form* (ABC 30925) - All requests for ezetimibe must be submitted using this form only.
- *Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form* (ABC 30932) - All requests for peginterferon alfa-2a/ribavirin or peginterferon alfa-2b/ribavirin must be submitted using this form only.
- *Peginterferon Alfa-2b for Chronic Hepatitis C Special Authorization Request Form* (ABC 30933) - All requests for peginterferon alfa-2b for Chronic Hepatitis C must be submitted using this form only.
- *Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form* (ABC 30944) - All requests for peginterferon alfa-2a for Chronic Hepatitis C must be submitted using this form only.
- *Etanercept for Juvenile Rheumatoid Arthritis Special Authorization Request Form* (ABC 30948) - All requests for etanercept for Juvenile Rheumatoid Arthritis must be submitted using this form only.
- *Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis Special Authorization Request Form* (ABC 30964) - All requests for adalimumab, etanercept or infliximab for Psoriatic Arthritis must be submitted using this form only.
- *Select Quinolones Special Authorization Request Form* (ABC 30966) - All requests for ciprofloxacin, levofloxacin, moxifloxacin or ofloxacin must be submitted using this form only.
- *Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form* (ABC 31086) - All requests for alendronate, raloxifene, risedronate or synthetic calcitonin salmon for Osteoporosis must be submitted using this form only.
- *Celecoxib Special Authorization Request Form (ABC 31140)* – All requests for celecoxib must be submitted using this form only.

- *Filgrastim/Pegfilgrastim Special Authorization Request Form (form number ABC 31150) – All request for filgrastim or pegfilgrastim must be submitted using this form only.*
- *Fentanyl Special Authorization Request Form (form number ABC 31169) - All requests for fentanyl or fentanyl citrate must be submitted using this form only.*
- *Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 31192) - All requests for adalimumab, etanercept, infliximab or ustekinumab for Plaque Psoriasis must be submitted using this form only.*
- *Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis Special Authorization Request Form (ABC 31195) - All requests for adalimumab, etanercept or infliximab for Ankylosing Spondylitis must be submitted using this form only.*
- *Adalimumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 31200) - All requests for adalimumab for Moderately to Severely Active Crohn's Disease or infliximab for Moderately to Severely Active Crohn's/Fistulizing Crohn's Disease must be submitted using this form only.*
- *Abatacept/Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 31205) - All requests for abatacept or rituximab for Rheumatoid Arthritis must be submitted using this form only.*
- *Imiquimod Special Authorization Request Form (ABC 31222) – All requests for imiquimod must be submitted using this form only.*
- *Dutasteride/Finasteride Special Authorization Request Form (ABC 31257) – All requests for dutasteride or finasteride must be submitted using this form only.*
- *Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 31258) – All requests for risperidone prolonged release injection must be submitted using this form only.*
- *Abatacept for Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 31291) - All requests for abatacept for Juvenile Idiopathic Arthritis must be submitted using this form only.*
- *Montelukast/Zafirlukast Special Authorization Request Form (ABC 31313) – All requests for montelukast or zafirlukast must be submitted using this form only.*

The following official forms are provided for your convenience to photocopy and use as required.

Submit completed forms by FAX to Alberta Blue Cross:

(780) 498-8384 in Edmonton and area

1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please DO NOT mail or re-fax your request

Drug Special Authorization Request Form

On the reverse is the official *Drug Special Authorization Request Form* (ABC 20061).

- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DRUG SPECIAL AUTHORIZATION REQUEST

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
PRESCRIBER SURNAME FIRST NAME INITIAL	PHONE:	FAX:	
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.	Fax number must be provided with each request submitted	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

☐ **NEW** ☐ **RENEWAL DRUG REQUEST** **Note: Request may or may not be approved by Alberta Blue Cross**

Drug(s), Dosage(s) and Duration Requested:

Diagnosis and / or Indication which drug is being used to treat:
(Include applicable information regarding previous medications, patient response to therapy and proposed results of therapy.)

Additional information relating to request:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Donepezil/Galantamine/Rivastigmine Special Authorization Request Form

On the reverse is the official *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* (ABC 30776).

- All requests for donepezil HCl, galantamine hydrobromide or rivastigmine hydrogen tartrate must be submitted using the *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DONEPEZIL/GALANTAMINE/RIVASTIGMINE SPECIAL AUTHORIZATION REQUEST FORM

Please complete ALL sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.		Fax number must be provided with each request submitted	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Criteria for Coverage of DONEPEZIL, GALANTAMINE, RIVASTIGMINE

For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Initial special authorization for new patients may be granted for a maximum of 12 weeks. Continued special authorization coverage may be granted for a maximum of 24 months.

In order to be considered for coverage beyond the initial 12-week authorization, those patients with an MMSE score of 10 or higher may be eligible for continued coverage provided their MMSE score has not dropped by more than 3 points during the 12-week period.

Note:

- new patients (those who have never taken the requested drug before or who have taken the drug for 60 days or less) will be approved for an initial 12 week authorization. Subsequent renewals, and approvals for existing patients (those who have already been on the requested drug for more than 60 days) will be for 24 months.
- an MMSE score below 10 at any time will also result in discontinuation of coverage.

PLEASE COMPLETE ALL SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

Indicate which drug is requested:

- ☐ **Donepezil**
- ☐ **Galantamine**
- ☐ **Rivastigmine**

Please confirm the diagnosis for which this drug is requested:

For the treatment of:

- ☐ Dementia of the Alzheimer's Type
- ☐ other, please specify: _____

Please provide a **recent MMSE score*** and the **date** the exam was administered:

MMSE Score: _____

Date of exam: _____

*a recent MMSE score is that which is within 3 months from the time of this application, or from the date of expiration of the current authorization.

Please confirm request type:

- ☐ request for donepezil, galantamine or rivastigmine for a **new** patient, (i.e. a patient who has either: never taken the requested drug before, or, has taken it for 60 days or less).
- ☐ request for an **existing** donepezil, galantamine or rivastigmine patient (i.e. a patient who has already been on the requested drug for more than 60 days).

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

Clopidogrel Special Authorization Request Form

On the reverse is the official *Clopidogrel Special Authorization Request Form* (ABC 30786).

- All requests for clopidogrel bisulfate must be submitted using the *Clopidogrel Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

CLOPIDOGREL
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
PRESCRIBER SURNAME FIRST NAME INITIAL	PHONE:	FAX:	
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NO.	Fax number must be provided with each request submitted		
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Criteria for Post-Stent Coverage	**Section I (Must complete for requests for post-stent coverage)**
For the prevention of thrombosis, for one month, when prescribed following intravascular bare metal stent placement. Patients who have received one month of coverage via the Limited Restricted Benefit will not be eligible for additional coverage under this criterion. * **For the prevention of thrombosis, for up to 12 months, when prescribed following intravascular drug eluting stent (DES) placement. Patients who have received one month of coverage via the Limited Restricted Benefit may be eligible for an additional 11 months of coverage (i.e., up to 12 months of coverage) following the submission of a special authorization request. *** **** Special Authorization for post-stent coverage is required when the prescriber prescribing the medication is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery; for treatment after repeat stents; or for continued coverage of up to 12 months following intravascular drug eluting stent (DES) placement.***	**Please indicate the type and date of the stent:** Date of stenting procedure: _____ ☐ bare metal stent (1 month of coverage) ☐ drug eluting stent (12 months of coverage) *For additional coverage, please proceed to Section II below*

Other Criteria for Coverage

For the prevention of cerebrovascular (e.g. stroke, TIA) and non-cerebrovascular ischemic events in patients who have a contraindication to ASA. Special Authorization for this criterion may be granted for 24 months.

For use in patients who have experienced a non-cerebrovascular ischemic event while on ASA. Special Authorization for this criterion may be granted for 24 months.

For use in patients who have experienced a cerebrovascular ischemic event (e.g. stroke, TIA) while on dipyridamole/ASA (Aggrenox) or for whom dipyridamole/ASA (Aggrenox) is contraindicated. Special Authorization for this criterion may be granted for 24 months.

Coverage will not be considered when clopidogrel and ASA/dipyridamole are intended for use in combination.

Section II (Complete ALL that apply)

Does this patient have a contraindication/intolerance to ASA? ☐ YES ☐ NO

Please indicate the **cerebrovascular** ischemic event experienced: ☐ stroke ☐ TIA	Please specify the **non-cerebrovascular** ischemic event experienced:
Did the **cerebrovascular** event occur while this patient was on dipyridamole/ASA (Aggrenox)? ☐ YES ☐ NO	Please indicate which anti-platelet therapy this patient was on when the **non-cerebrovascular** event occurred: ☐ ASA ☐ other (specify):_____
If applicable, please indicate which product this patient has a contraindication/intolerance to: ☐ dipyridamole/ASA (Aggrenox) ☐ dipyridamole	☐ Patient was not on anti-platelet therapy

PRESCRIBER 'S SIGNATURE	DATE	Please forward this request to: **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Darbepoetin/Epoetin Special Authorization Request Form

On the reverse is the official *Darbepoetin/Epoetin Special Authorization Request Form* (ABC 30888).

- All requests for darbepoetin or epoetin alfa must be submitted using the *Darbepoetin/Epoetin Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DARBEPOETIN/EPOETIN SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
PRESCRIBER SURNAME / FIRST NAME / INITIAL	PHONE:	FAX:	
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.	Fax number must be provided with each request submitted	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Indicate which drug is requested (check one box): ☐ Darbepoetin ☐ Epoetin

PLEASE COMPLETE ALL APPLICABLE SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

ANEMIA OF CHRONIC RENAL FAILURE (does not apply to epoetin 30,000 or 40,000 IU/mL strengths)

☐ anemia of chronic renal failure
☐ other, please specify:

This section applies only to patients who received a renal transplant:
Please indicate if the renal transplant is failing or has failed:
☐ Yes ☐ No

Hemoglobin level:
For new patients: pre-treatment hemoglobin level (g/L):

For patients with prior special authorization for darbepoetin or epoetin with Alberta Blue Cross: current hemoglobin level (g/L):

Please provide the current iron status:
Serum ferritin is >100 mcg/L: ☐ Yes ☐ No AND Transferrin saturation is >20%: ☐ Yes ☐ No

CHEMOTHERAPY-INDUCED ANEMIA (includes epoetin 30,000 and 40,000 IU/mL strengths)

Please specify the type of cancer:
_____
☐ other, please specify: _____

For the treatment of anemia:
Please indicate if the anemia is chemotherapy-induced:
☐ Yes ☐ No, please specify: _____

Please provide the patient's hemoglobin level (g/L):

Please specify the reason why blood transfusions are not an option:
☐ Transfusion reactions in the past ☐ Difficulty cross-matching the patient
☐ Iron overload ☐ Other, please specify:_____

ANEMIA IN AZT-TREATED/HIV INFECTED PATIENTS (does not apply to darbepoetin nor the epoetin 30,000 or 40,000 IU/mL strength)

☐ anemia in AZT-treated/HIV infected patients
☐ other, please specify: _____

Additional information relating to request:

PRESCRIBER 'S SIGNATURE	DATE	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation 10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

ALBERTA BLUE CROSS®

DARBEPOETIN/EPOETIN SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for Coverage:

DARBEPOETIN

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<100 g/L). Hemoglobin levels should be maintained within 100 – 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin >100 mcg/L and transferrin saturation >20%."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Aranesp should be reduced by about 25%."

In order to comply with the second criterion: if the patient has iron overload the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with results of liver function tests if applicable.

For the first criterion, renewal requests may be considered if the patient's hemoglobin is < 120 g/L while on Aranesp.

For the second criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on Aranesp.

EPOETIN (ALL strengths except 30,000 and 40,000 IU/mL)

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (< 100 g/L). Hemoglobin levels should be maintained within 100 - 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin >100 mcg/L and transferrin saturation >20%."

"For the treatment of anemia in AZT-treated/HIV infected patients."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%."

In order to comply with the third criterion: if the patient has iron overload the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the first criterion, renewal requests may be considered if the patient's hemoglobin is < 120 g/L while on Eprex.

For the third criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on Eprex.

EPOETIN 30,000 and 40,000 IU/mL strengths

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%. Patients may be granted a maximum allowable dose of 40,000 IU per week."

In order to comply with this criterion, if the patient has iron overload the prescriber must state this in the request, or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests, if applicable. Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Eprex.

Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form* (ABC 30902).

- All requests for adalimumab, anakinra, etanercept or infliximab for Rheumatoid Arthritis must be submitted using the *Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

-

ALBERTA BLUE CROSS®

ADALIMUMAB/ANAKINRA/ETANERCEPT/INFLIXIMAB for Rheumatoid Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:	**PATIENT CONSENT:**
You may be eligible to receive Enbrel, Humira, Kineret or Remicade drug benefits. Personal and health information is required in order to determine eligibility and, in the event you are approved to receive drug benefits, to maintain eligibility, process payments and conduct the *Alberta Post-Marketing Study Addressing ENBREL/HUMIRA/KINERET/REMICADE ("Study")*. The *Study* will assist Alberta Health and Wellness to monitor, plan, evaluate and manage the cost-effectiveness of providing Enbrel, Humira, Kineret or Remicade as a benefit under the AHWDBL. Therefore, your consent is required as set out herein. **Important:** In order to be eligible for, and to maintain eligibility for, Enbrel, Humira, Kineret or Remicade drug benefit both you and your physician(s) must agree to and continue to actively and consistently participate in the *Study* as required by Alberta Blue Cross, Alberta Health and Wellness, its affiliates and agents throughout the special authorization period. **Refusal to provide the requested consent will result in benefits being denied, and withdrawal of consent will result in benefits being revoked.**	**I hereby authorize:** (A)The below physician(s) to disclose to Alberta Blue Cross, Alberta Health and Wellness, Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports (the "Designated Recipients") any of my personal or health information contained on this Request Form or requested by the Designated Recipients (collectively "My Information"); and (B) The Designated Recipients to use and collect My Information for the purposes stated on this form; and (C) The Designated Recipients to disclose My Information to any affiliates or agents of the Designated Recipients for the purposes stated on this form. **I acknowledge that:** I have been made aware of the reasons why my health information is needed, and the risks and benefits of consenting or refusing to consent to disclosure of my health information; and (2) I am aware that I may revoke this consent (in writing) at anytime. Signature/Effective Date Patient's Signature

PRESCRIBER INFORMATION			
RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis: ☐ Rheumatoid Arthritis ☐ Other (specify)	Current weight (kg):	Indicate requested drug: ☐ Adalimumab ☐ Anakinra ☐ Etanercept ☐ Infliximab	Dosage: Dosing Frequency:
Scores: * DAS28 Score _____ **OR** ☐ ACR20 (renewals only) Date: _____ **AND** HAQ Score _____ Date: _____ * New requests for patients currently maintained on the requested biologics require pre-treatment scores. Scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places, as indicated above.		Please provide reason if a switch to a different biologic agent is requested: (If switching to anakinra, complete last section)	
Will the patient be maintained on methotrexate in combination with the requested biologic? ☐ YES ☐ NO (If not, please specify reason):		Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.	

Please provide the following information for all NEW requests:

Previous medications utilized: Dose, duration and response is required for ALL FOUR of the following:

☐ Methotrexate PO:

☐ Methotrexate SC or IM:

☐ Methotrexate with another DMARD other than leflunomide (specify agent) :

☐ Leflunomide:

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

Please provide the following information for all NEW anakinra requests:

Previous medications utilized: Indicate the contraindication or adverse effects related to ALL of the following:

☐ Adalimumab:

☐ Etanercept:

☐ Infliximab:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

☐ **I am currently an active participant in the Alberta Post-Marketing Study addressing Enbrel / Humira / Kineret / Remicade**

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Ezetimibe Special Authorization Request Form

On the reverse is the official *Ezetimibe Special Authorization Request Form* (ABC 30925).

- All requests for ezetimibe must be submitted using the *Ezetimibe Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

EZETIMIBE
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT SURNAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Employment and Immigration
- ☐ Alberta Children and Youth Services
- ☐ Alberta Seniors and Community Supports
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION

PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA
- ☐ CARNA
- ☐ ACP
- ☐ ACO
- ☐ ADA+C
- ☐ Other

REGISTRATION NO.

Fax number must be provided with each request submitted

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Criteria for Coverage of EZETIMIBE

For the treatment of hypercholesterolemia in patients who are intolerant to statins or in whom a statin is contraindicated and who are at high cardiovascular risk*, or;

For the treatment of hypercholesterolemia when used in combination with a statin in patients failing to achieve target LDL with a statin at maximum tolerable dose or maximum recommended dose as per respective product monograph and who are at high cardiovascular risk*

Special authorization may be granted for 6 months.
This product is eligible for auto-renewal.

High cardiovascular risk is defined as possessing one of the following:

1) ***pre-existing cardiovascular disease and/or cerebrovascular disease, or***
2) ***diabetes, or***
3) ***familial hypercholesterolemia, or***
4) ***greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool, OR***
5) ***three or more of the following risk factors:***
   - ***family history of premature cardiovascular disease***
   - ***smoking***
   - ***hypertension***
   - ***obesity***
   - ***glucose intolerance***
   - ***renal disease.***

☐ **NEW** **Please provide the following information for all NEW requests:**

A. Diagnosis: ☐ hypercholesterolemia ☐ other, please specify _____

B. Information regarding previous STATIN use:

☐ Statin(s) HAS been utilized. Please specify which statin has been utilized (including dose and duration): _____

Nature of response to STATIN: ☐ Intolerance ☐ Failure to achieve target LDL ☐ Other _____

☐ Statin(s) has NOT been utilized. Contraindication? ☐ Yes ☐ No Please elaborate: _____

C. Presence of CARDIOVASCULAR risk factors (CHECK ALL THAT APPLY):

*In order to comply with the above criteria check **at least three** of the following:*

☐ family history of premature cardiovascular disease ☐ smoking ☐ hypertension ☐ obesity ☐ glucose intolerance ☐ renal disease

AND/OR

*In order to comply with the above criteria check **at least one** of the following:*

☐ pre-existing cardiovascular disease and/or cerebrovascular disease ☐ diabetes ☐ familial hypercholesterolemia

☐ greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool

D. Additional information relating to request:

☐ **RENEWAL**

This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).
Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services & Evaluation 10009-108 Street NW, Edmonton, Alberta T5J 3C5**
		• FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form

On On the reverse is the official *Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form* (ABC 30932).

- All requests for for peginterferon alfa-2a/ribavirin or peginterferon alfa-2b/ribavirin must be submitted using the *Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

PEGINTERFERON ALFA-2A+RIBAVIRIN/PEGINTERFERON ALFA-2B+RIBAVIRIN
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT SURNAME	FIRST NAME	INITIAL
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER	

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Employment and Immigration
- ☐ Alberta Children and Youth Services
- ☐ Alberta Seniors and Community Supports
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Pegetron or Pegasys RBV drug benefits. Information from your prescriber is required to determine eligibility. Your consent is required: (A) for your prescriber to release necessary and relevant information to Alberta Blue Cross, Alberta Health and Wellness and, if requested, to Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health and Wellness.

PATIENT CONSENT:

I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health and Wellness, and (if they request it) to Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and Wellness the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.

Date Patient's Signature

PRESCRIBER INFORMATION

PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA
- ☐ CARNA
- ☐ ACP
- ☐ ACO
- ☐ ADA+C
- ☐ Other

REGISTRATION NO.

Fax number must be provided with each request submitted

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Drug Requested:

- ☐ **Peginterferon Alfa-2a+Ribavirin (E.g. Pegasys RBV)**
- ☐ **Peginterferon Alfa-2b+Ribavirin (E.g. Pegetron)**

Diagnosis of chronic hepatitis C:

Both:

	YES	NO	Not Tested
a) is the patient anti-HCV positive, pre-treatment.....	☐	☐	☐
AND;			
b) is the patient serum HCV RNA positive (by PCR), pre-treatment.....	☐	☐	☐

If the patient is anti-HCV negative but serum HCV RNA positive, please explain:

Evidence of active liver disease:

Either:

	YES	NO	Not Tested
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment ……	☐	☐	☐
OR;			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis)	☐	☐	☐

If patient is currently on Peginterferon Alfa-2a + Ribavirin or Peginterferon Alfa-2b + Ribavirin indicate start date: Year / Month / Day

INITIAL REQUEST:

Initial length of approval:

- ☐ **Advanced fibrosis or cirrhosis** (regardless of genotype)…….. 48 weeks
- ☐ **Genotype 1** …….. 14 weeks
  - Is a baseline serum sample stored for future testing? ☐ YES ☐ NO
- ☐ **Genotype 2 or 3 with HIV co-infection**…… 14 weeks
  - Is a baseline serum sample stored for future testing? ☐ YES ☐ NO
- ☐ **Genotype 1, 2 or 3 post-liver transplant** … 26 weeks

Initial **and maximum** length of approval:

- ☐ **Genotype 2 or 3** (not co-infected with HIV) … 24 weeks
- ☐ **Genotype 4, 5 or 6** …….. 48 weeks

EXTENSION REQUEST:

Request for treatment extension at 14 weeks:

For Genotype 1 (non-liver transplant) patients and Genotype 2 or 3 patients with HIV co-infection:

Is the patient serum HCV RNA negative at 12 weeks?

- ☐ YES — Patient may be eligible for additional 34 weeks of coverage (total 48 wks)
- ☐ NO — Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)?
  - ☐ YES — The patient may be eligible for an additional 14 weeks of therapy to confirm response. Additional serum HCV RNA test results are required at 24 weeks
  - ☐ NO

Request for treatment extension at 26 weeks:

For Genotype 1, 2 or 3 post-liver transplant patients and for patients from the above section that achieved a 2-log drop but were not serum HCV negative at 12 weeks:

Is the patient serum HCV RNA negative at 24 weeks?

☐ YES ☐ NO The patient may be eligible for a total of 48 weeks of therapy.

PREVIOUS THERAPY: Consideration may be given in patients who have previously received therapy who meet at least one of the following criteria:

- ☐ Advanced fibrosis or cirrhosis.
- ☐ Patient relapsed following non-pegylated interferon/ribavirin combination therapy.
- ☐ Patient failed to respond to or relapsed following interferon monotherapy

Additional information relating to request:

PRESCRIBER 'S SIGNATURE	DATE

Please forward this request to:

- **Alberta Blue Cross, Clinical Drug Services & Evaluation**
  10009-108 Street NW, Edmonton, Alberta T5J 3C5
- FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

Peginterferon Alfa-2b for Chronic Hepatitis C Special Authorization Request Form

On the reverse is the official *Peginterferon Alfa-2b for Chronic Hepatitis C Special Authorization Request Form* (ABC 30933).

- On the reverse is the official *Peginterferon Alfa-2b for Chronic Hepatitis C Special Authorization Request Form* (ABC 30933).
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

PEGINTERFERON ALFA-2B for Chronic Hepatitis C
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT SURNAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Employment and Immigration
- ☐ Alberta Children and Youth Services
- ☐ Alberta Seniors and Community Supports
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Unitron-PEG drug benefits. Information from your physician is required to determine eligibility. Your consent is required: (A) for your physician to release necessary and relevant information to Alberta Blue Cross, Alberta Health and Wellness and, if requested, to Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health and Wellness.

PATIENT CONSENT:

I hereby authorize: (A) my physician to release to Alberta Blue Cross, Alberta Health and Wellness, and (if they request it) to Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and Wellness the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.

Date Patient's Signature

PRESCRIBER INFORMATION

PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA
- ☐ CARNA
- ☐ ACP
- ☐ ACO
- ☐ ADA+C
- ☐ Other

REGISTRATION NO.

Fax number must be provided with each request submitted

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

CRITERIA 1

Diagnosis of chronic hepatitis C:

	YES	NO	Not Tested
a) is the patient anti-HCV positive, pre-treatment.....	☐	☐	☐
AND;			
b) is the patient serum HCV RNA positive (by PCR), pre treatment.....	☐	☐	☐

If the patient is anti-HCV negative but serum HCV RNA positive, please explain:

CRITERIA 2

Evidence of active liver disease, either:

	YES	NO	Not Tested
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment	☐	☐	☐
OR;			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis)	☐	☐	☐

If patient is currently receiving peginterferon alfa-2b indicate start date: Year / Month / Day

CRITERIA 3 : Contraindication/ intolerance to ribavirin

Please indicate why peginterferon alfa-2b is requested: ☐ patient has contraindication to use of ribavirin ☐ patient experienced intolerance to ribavirin ☐ other (specify) _____

Additional information relating to request: _____

The personal information collected in this section is for quality monitoring purposes only. It will be used to review the current provision of peginterferon alfa-2b This personal information will not be used to make any program decisions about the patient named above.

Genotype:
- **Type 1** ☐
- **Type 2** ☐
- **Type 3** ☐
- **Other** ☐ _____

Please confirm whether previous therapy has been tried:

- ☐ No previous treatment with interferon alfa monotherapy or ribavirin/interferon alfa (naive patient).
- ☐ Previous treatment with interferon alfa monotherapy and the patient:
  - ☐ has since relapsed ☐ did not respond
- ☐ Previous treatment with ribavirin / interferon alfa combination therapy, and the patient:
  - ☐ has since relapsed ☐ did not respond

PRESCRIBER'S SIGNATURE	DATE

Please forward this request to:

- **Alberta Blue Cross, Clinical Drug Services & Evaluation**
  10009-108 Street NW, Edmonton, Alberta T5J 3C5
- FAX: **780-498 -8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form

On the reverse is the official *Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form* (ABC 30944).

- All requests for peginterferon alfa-2a for Chronic Hepatitis C must be submitted using the *Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

PEGINTERFERON ALFA-2A for Chronic Hepatitis C
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT SURNAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Employment and Immigration
- ☐ Alberta Children and Youth Services
- ☐ Alberta Seniors and Community Supports
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Pegasys drug benefits. Information from your prescriber is required to determine eligibility. Your consent is required: (A) for your prescriber to release necessary and relevant information to Alberta Blue Cross, Alberta Health and Wellness and, if requested, to Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health and Wellness.

PATIENT CONSENT:

I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health and Wellness, and (if they request it) to Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and Wellness the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.

Date   Patient's Signature

PRESCRIBER INFORMATION

PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA
- ☐ CARNA
- ☐ ACP
- ☐ ACO
- ☐ ADA+C
- ☐ Other

REGISTRATION NO.

Fax number must be provided with each request submitted

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

DIAGNOSIS OF CHRONIC HEPATITIS C:

Both:

	YES	NO	Not Tested
a) is the patient anti-HCV positive, pre-treatment……………………………	☐	☐	☐
AND;			
b) is the patient serum HCV RNA positive (by PCR), pre-treatment…………………….	☐	☐	☐

If the patient is anti-HCV negative but serum HCV RNA positive, please explain:

EVIDENCE OF ACTIVE LIVER DISEASE:

Either:

	YES	NO	Not Tested
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment…………………	☐	☐	☐
OR;			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis)..……………………	☐	☐	☐

If patient is currently on peginterferon alfa-2a, indicate start date: Year / Month / Day

INITIAL REQUEST:

Is the patient intolerant to ribavirin? ☐ YES ☐ NO

Is a baseline serum sample stored for future testing? ☐ YES ☐ NO

Initial length of approval:

- ☐ **Advanced fibrosis or cirrhosis** (regardless of genotype)…… 48 weeks
- ☐ **Genotype 1**……………………………………………………… 14 weeks
- ☐ **Genotype 2 or 3** ……………………………………………… 14 weeks
- ☐ **Genotype 4, 5 or 6** ……………………………………………. 14 weeks

EXTENSION REQUEST:

Request for treatment extension at 14 weeks (excluding patients with advanced fibrosis and cirrhosis):

Is the patient serum HCV RNA negative at 12 weeks?

☐ YES → Patient may be eligible for additional 34 weeks of coverage (total 48 wks)

☐ NO → Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)?

  ☐ YES → Patient may be eligible for additional 34 weeks of coverage (total 48 wks)

  ☐ NO

PREVIOUS THERAPY: Consideration may be given to patients who have previously received therapy and who meet at least one of the following:

- ☐ Advanced fibrosis or cirrhosis.
- ☐ Patient relapsed following non-pegylated interferon/ribavirin combination therapy.

Additional information relating to request:

PRESCRIBER'S SIGNATURE	DATE

Please forward this request to:

- **Alberta Blue Cross, Clinical Drug Services & Evaluation 10009-108 Street NW, Edmonton, Alberta T5J 3C5**
- FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Etanercept for Juvenile Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Etanercept for Juvenile Rheumatoid Arthritis Special Authorization Request Form* (ABC 30948).

- All requests for etanercept for Juvenile Rheumatoid Arthritis must be submitted using the *Etanercept for Juvenile Rheumatoid Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ETANERCEPT for Juvenile Rheumatoid Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Enbrel drug benefits. Personal and health information is required in order to determine eligibility and, in the event you are approved to receive drug benefits, to maintain eligibility, process payments and conduct the *Alberta Post-Marketing Study Addressing ENBREL ("Study")*. The *Study* will assist Alberta Health and Wellness to monitor, plan, evaluate and manage the cost-effectiveness of providing Enbrel as a benefit under the AHWDBL.

Therefore, your consent is required as set out herein. **Important:** In order to be eligible for, and to maintain eligibility for Enbrel drug benefit both you and your physician(s) must agree to and continue to actively and consistently participate in the *Study* as required by Alberta Blue Cross, Alberta Health and Wellness, its affiliates and agents throughout the special authorization period. **Refusal to provide the requested consent will result in benefits being denied, and withdrawal of consent will result in benefits being revoked.**

PATIENT CONSENT:

I hereby authorize:
(A)The below physician(s) to disclose to Alberta Blue Cross, Alberta Health and Wellness, Alberta Employment and Immigration, Alberta Children and Youth Services, and Alberta Seniors and Community Supports (the "Designated Recipients") any of my personal or health information contained on this Request Form or requested by the Designated Recipients (collectively "My Information"); and (B) The Designated Recipients to use and collect My Information for the purposes stated on this form; and (C) The Designated Recipients to disclose My Information to any affiliates or agents of the Designated Recipients for the purposes stated on this form.

I acknowledge that:
I have been made aware of the reasons why my health information is needed, and the risks and benefits of consenting or refusing to consent to disclosure of my health information; and (2) I am aware that I may revoke this consent (in writing) at anytime.

_____ _____
Signature Effective Date Patient or Guardian Signature:

_____
Print Name of Guardian

PRESCRIBER INFORMATION

RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL	PHONE: FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:
- ☐ Polyarticular Juvenile Rheumatoid Arthritis
- ☐ Other (specify)

Patient's current weight (kg): _____

Requested dose (mg/kg): _____

JRA30 Date of assessment: _____

1. Rheumatologist global assessment (0-10) _____
2. Patient global assessment (0-10) _____
3. Number of active joints* _____
4. No. of joints with LROM _____
5. CHAQ (0-3) _____
6. ESR (mm/hr) _____ or CRP _____

*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both

Please provide the following information for ALL new requests:

Previous DMARDs utilized (specify agent): Dose, duration and response is required:

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **(780) 498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

☐ **I am currently an active participant in the Alberta Post-Marketing Study addressing Enbrel**

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection of this information, please contact the Co-chairs of the Alberta Blue Cross Privacy Steering Committee at 780-498-8108 or 780-498-8597, 10009 - 108 Street, Edmonton AB, T5J 3C5.

Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis Special Authorization Request Form

On the reverse is the official *Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis Special Authorization Request Form* (ABC 30964).

- All requests for adalimumab, etanercept or infliximab for Psoriatic Arthritis must be submitted using the *Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

  Once your request has successfully transmitted, please do not mail or re-fax your request.

-

ALBERTA BLUE CROSS®

ADALIMUMAB/ETANERCEPT/INFLIXIMAB for Psoriatic Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:	Current weight (kg):	Indicate requested drug:	Dosage:
☐ Polyarticular Psoriatic Arthritis ☐ Pauciarticular Psoriatic Arthritis→Joints affected: ☐ Knee joint(s) ☐ Hip joint(s) ☐ Other (specify): ☐ Other (specify):		☐ Adalimumab ☐ Etanercept ☐ Infliximab	Dosing Frequency:

Scores:* DAS28 Score ___._____ **OR** ☐ ACR20 (renewals only) Date:_____

AND

HAQ Score ___._____ Date: _____

* New requests for patients currently maintained on the requested biologic require pre-treatment scores. Scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places, as indicated above.

Please provide reason if a switch to a different biologic agent is requested:

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Will the patient be maintained on methotrexate in combination with the requested biologic?

☐ YES ☐ NO (If not, please specify reason):

Please provide the following information for all NEW requests:

Previous medications utilized: Dose, duration and response is required for ALL THREE of the following:

☐ Methotrexate PO:

☐ Methotrexate SC or IM:

☐ DMARD other than MTX (specify agent):

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection of this information, please contact the Co-chairs of the Alberta Blue Cross Privacy Steering Committee at 780-498-8108 or 780-498-8597, 10009 - 108 Street, Edmonton AB, T5J 3C5.

Select Quinolones Special Authorization Request Form

On the reverse is the official *Select Quinolones Special Authorization Request Form* (ABC 30966).

- All requests for ciprofloxacin, levofloxacin, moxifloxacin or ofloxacin must be submitted using the *Select Quinolones Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

SELECT QUINOLONES*

*ciprofloxacin/levofloxacin/moxifloxacin/ofloxacin

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed. Incomplete requests CANNOT BE EXPEDITED.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION:				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO. OR PROFESSIONAL REGISTRATION NO.			**YOUR FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED**	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Only the following conditions may be authorized for coverage.
Drug Requested and Condition requiring quinolone treatment: Please check the boxes that apply to your patient.

☐ CIPROFLOXACIN

Respiratory Tract Infection:
- ☐ End stage COPD with or without bronchiectasis, where there has been documentation of previous *Pseudomonas aeruginosa* colonization/infection
- ☐ Pneumonic illness in cystic fibrosis

Genitourinary Tract Infection:
- ☐ Urinary Tract Infection
- ☐ Prostatitis
- ☐ Prophylaxis of urinary tract surgical procedures
- ☐ Gonococcal infection

Skin & Soft Tissue / Bone & Joint Infection:
- ☐ Malignant / invasive otitis externa
- ☐ Bone / joint infection due to gram-negative organism(s)
- ☐ Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole, e.g. diabetic foot infection, decubitus ulcers

Gastrointestinal Tract Infection:
- ☐ Bacterial gastroenteritis where antimicrobial therapy is indicated
- ☐ Typhoid fever (enteric fever)
- ☐ Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole, e.g. intra-abdominal infections

Other:
- ☐ Prophylaxis of adult contacts of cases of invasive meningococcal disease
- ☐ Therapy / step-down therapy of hospital acquired gram-negative infections
- ☐ Empiric therapy of febrile neutropenia in combination with other appropriate agents
- ☐ Exception case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references, i.e. AMA CPGs or Bugs & Drugs

⬇

Please specify details: _____

- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases

☐ LEVOFLOXACIN ☐ MOXIFLOXACIN

- ☐ Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy
- ☐ Community acquired pneumonia in patients with co morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking)
- ☐ Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy
- ☐ Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with β–lactam (penicillin & cephalosporin) allergy
- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases.

☐ OFLOXACIN

- ☐ Pelvic inflammatory disease
- ☐ Epididymo-orchitis/epididymitis most likely due to enteric organisms
- ☐ For the treatment of Chlamydial infection
- ☐ For the treatment of Gonococcal infection
- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5**	**FAX: 780-498-8384** in Edmonton **1-877-828-4106** toll-free all other areas

ONCE YOU HAVE CONFIRMED YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

BACKGROUND INFORMATION REGARDING SELECT QUINOLONE SPECIAL AUTHORIZATION PROCESS

Optional Special Authorization introduced for quinolones

At the request of Alberta Health and Wellness, Alberta Employment and Immigration, Alberta Seniors and Community Supports and Alberta Children and Youth Services, Alberta Blue Cross will apply new criteria effective September 15, 2005 for coverage of select quinolone antibiotics covered through their drug benefit programs:

- **ciprofloxacin, levofloxacin, moxifloxacin, and ofloxacin.**

Norfloxacin continues to be eligible for coverage as an unrestricted benefit.

Rationale

These criteria are the result of a comprehensive evidence-based review undertaken as an initiative of the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics through the Review of Benefit Status (ROBS) process. This review examined systemic antimicrobial agents currently covered via the Alberta Health and Wellness Drug Benefit List. The mandate of the review was to encourage optimal utilization and to help prevent antimicrobial resistance. The review was conducted according to the established ROBS process, and included systematic reviews of the medical literature and analysis of current utilization patterns. External Alberta physicians and pharmacists with expertise in the treatment of infectious diseases provided advice and assistance for this review process. Information and experience from other provincial jurisdictions that have undertaken similar antimicrobial reviews were also taken into consideration in this review.

The review was completed in accordance with pre-determined guiding principles that sought to allow optimal practice to proceed, ensuring optimal use and helping prevent resistance, while at the same time being unencumbered by undue paperwork and unnecessary restrictions.

Role of Physicians

In conjunction with these new criteria, physicians have two options by which patients may be eligible for coverage of these specific antimicrobial products. This offers a streamlined alternative to traditional Special Authorization.

1) Physicia ns can register to be a designated prescriber. Registration allows for patients to receive coverage of quinolones **without Special Authorization** as long as the prescription is written for one of the criteria for coverage set out in the *Alberta Health and Wellness Drug Benefit List*. These criteria are attached for your reference. *Should a designated physician wish to prescribe one of the select quinolones outside the coverage criteria, they may do so but must indicate this on the prescription; however, patients will not be eligible for payment under the government-sponsored program for such prescriptions and the patient may choose to receive the product at their expense*.

2) **Physicians who choose not to register will be considered 'non-designated prescribers'**.
   - Such physicians **will be required to apply for Special Authorization** on the patient's behalf.
   - A patient's claims for prescriptions written by non-designated physicians will be subject to a first fill forgiveness rule. This means the first claim will be paid but subsequent claims for the same active ingredient (irrespective of strength, route and form) within a 90 day period will require Special Authorization.
   - Special authorization requests must be submitted using the *Select Quinolones Special Authorization Request Form*. If the appropriate sections of this request form are completed *and* coverage criteria are met, the request will be processed within approximately 6 to 18 hours of receiving the request. Subsequent claims will be rejected unless Special Authorization is granted.

To register to become a designated prescriber
please return your completed registration by FAX to 1-877-305-9911.

For more information, please contact

Clinical Drug Services and Evaluation, Alberta Blue Cross, at 780-498-8368.

ALBERTA BLUE CROSS®

Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form

On the reverse is the official *Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form* (ABC 31086).

- All requests for alendronate, raloxifene, risedronate or synthetic calcitonin salmon for Osteoporosis must be submitted using the *Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ALENDRONATE / RALOXIFENE / RISEDRONATE / SYNTHETIC CALCITONIN SALMON FOR OSTEOPOROSIS

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
PRESCRIBER SURNAME / FIRST NAME / INITIAL	PHONE:	FAX:	
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.	Fax number must be provided with each request submitted	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

☐ **NEW** **Please provide the following information for NEW requests:**

Indicate which drug is requested (check ONE box)*:

- ☐ Alendronate (10mg, 70mg, 70mg + 5600U vitamin D3)
- ☐ Raloxifene
- ☐ Risedronate
- ☐ Synthetic Calcitonin Salmon

*Coverage **cannot** be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when intended **for use as combination therapy**.

Diagnosis:

- ☐ For the treatment of Osteoporosis
- ☐ Osteopenia
- ☐ Bone pain secondary to: _____
- ☐ Other, please specify: _____

Has the patient experienced FRACTURES related to the diagnosis? ☐ NO ☐ YES

Information regarding previous etidronate (Didronel or Didrocal) use:

☐ Etidronate HAS been utilized.

Nature of response to etidronate:
- ☐ Lack of response (i.e. demonstrated as a > 2% loss in bone mineral density in one year)
- ☐ Intolerance
- ☐ Other (please specify):_____

☐ Etidronate has NOT been utilized:
- ☐ Contraindication. Please elaborate:_____
- ☐ Other reason(s) etidronate was NOT tried (please specify):_____

Additional information relating to request:

☐ **RENEWAL**

This product is eligible for auto-renewal for the treatment of osteoporosis. A Special Authorization renewal request is required only if the Special Authorization approval for the treatment of osteoporosis has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).

Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

ALBERTA BLUE CROSS®

ALENDRONATE / RALOXIFENE / RISEDRONATE / SYNTHETIC CALCITONIN SALMON FOR OSTEOPOROSIS

SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for Coverage:

ALENDRONATE (10mg, 70mg, 70mg + 5600U vitamin D3 oral tablets)**
RALOXIFENE
RISEDRONATE Special Authorization Criteria for OSTEOPOROSIS**

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization for may be granted for 6 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2 % loss in bone mineral density in one year). Special authorization may be granted for 6 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

These products are eligible for auto-renewal for the treatment of osteoporosis.

**Please note: alendronate and risedronate also have Special Authorization criteria for Paget's disease. Please refer to the Alberta Health and Wellness Drug Benefit List for alendronate and risedronate's other criteria for the indication of Paget's disease.

http://www.health.alberta.ca/AHCIP/drug-benefit-list.html

SYNTHETIC CALCITONIN SALMON Nasal Spray Special Authorization Criteria:

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a >2% loss in bone mineral density in one year). Special authorization may be granted for 6 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

This product is eligible for auto-renewal.

Celecoxib Special Authorization Request Form

On the reverse is the official *Celebrex Special Authorization Request Form* (ABC 31140).

- All requests for celecoxib must be submitted using the *Celecoxib Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 401-1150 in Edmonton and area
  1-888-401-1150 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

CELECOXIB
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.		Fax number must be provided with each request submitted	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Criteria for Coverage of CELECOXIB

For patients who are at high risk of upper gastrointestinal (GI) complications due to a proven history of prior complicated GI events (e.g. GI perforation, obstruction or major bleeding), OR

For patients who have a documented history of ulcers proven radiographically and/or endoscopically.

Special authorization may be granted for 6 months.

This product is eligible for auto-renewal.

☐ **NEW** **Please provide the following information for NEW requests (check ALL that apply):**

1) Is this patient at high risk of upper GI complications? ☐ Yes ☐ No

2) Does this patient have a documented history of ulcers? ☐ Yes ☐ No

Additional information relating to request:

☐ **RENEWAL**

This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).

Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** **FOR CELECOXIB REQUESTS ONLY:** • FAX: **780-401-1150** in Edmonton • **1-888-401-1150** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

THIS SECTION IS FOR ALBERTA BLUE CROSS USE ONLY

Filgrastim/Pegfilgrastim Special Authorization Request Form

On the reverse is the official *Filgrastim/Pegfilgrastim Special Authorization Request Form* (ABC 31150)

- All requests for filgrastim or pegfilgrastim must be submitted using the *Filgrastim/Pegfilgrastim Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

FILGRASTIM/PEGFILGRASTIM
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Indicate which drug is requested (check ONE box):

☐ **FILGRASTIM** **(complete Section I or II)**

☐ **PEGFILGRASTIM** **(complete Section I only)**

Criteria for Coverage of FILGRASTIM	**Criteria for Coverage of PEGFILGRASTIM**
To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-neoplastic drugs with curative intent. This drug must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates). For the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization, following induction and consolidation treatment for acute myeloid leukemia. This drug must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates). To increase neutrophil counts and to reduce the incidence and duration of infection in patients with a diagnosis of congenital, cyclic or idiopathic neutropenia. This drug must be prescribed by the Directors of Divisions of Hematology in tertiary care centres (or their designates). For the treatment of patients undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy when prescribed by a designated prescriber. *Please note for the first criterion:* ***Coverage cannot be considered for palliative patients.***	To decrease the incidence of infection, as manifested by febrile neutropenia, in patients 18 years of age and older with non-myeloid malignancies receiving myelosuppressive anti-neoplastic drugs with curative intent. This drug product must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates). *Please note:* ***Coverage cannot be considered for palliative patients.***

Section I (Filgrastim requests for the first criterion and all pegfilgrastim requests, check ALL that apply)

Please **SPECIFY** the type of cancer being treated with chemotherapy for curative intent: _____

AND

Please provide the indication for which the drug is requested:

☐ patient has febrile neutropenia

☐ patient had febrile neutropenia from a previous cycle of the same chemotherapy

☐ patient will be undergoing a *high dose* or *aggressive* chemotherapy where febrile neutropenia is very likely to occur

☐ other, please **SPECIFY**: _____

Section II (Filgrastim requests for other criteria, check ALL that apply)

Please provide the indication for which filgrastim is requested:

☐ patient has neutropenia AND a diagnosis of ☐ congenital, cyclic or idiopathic neutropenia OR ☐ acute myeloid leukemia

☐ other, please **SPECIFY**: _____

☐ patient is undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy

Additional information relating to request:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **(780) 498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Fentanyl Special Authorization Request Form

On the reverse is the official *Fentanyl Special Authorization Request Form* (ABC 31169).

- All requests for fentanyl or fentanyl citrate must be submitted using the *Fentanyl Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

FENTANYL
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				COVERAGE TYPE
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION

PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

☐ CPSA ☐ ACO
☐ CARNA ☐ ADA+C
☐ ACP ☐ Other

REGISTRATION NO.

Fax number must be provided with each request submitted

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

CRITERIA FOR COVERAGE OF FENTANYL

Fentanyl Injection

For the treatment of persistent, severe chronic pain in those patients who cannot swallow, or who are intolerant of, morphine and/or hydromorphone, if not contraindicated. Special authorization may be granted for 6 months.

This product is eligible for auto-renewal.

Fentanyl Patch

For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who cannot swallow. Special authorization may be granted for 6 months.

For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who require opioid therapy at a total daily dose of at least 60 mg/day oral morphine equivalents. Patients must have tried and not been able to tolerate at least two discrete courses of therapy with two of the following agents: morphine, hydromorphone and oxycodone, if not contraindicated. Special authorization may be granted for 6 months.

This product is eligible for auto-renewal.

☐ **NEW** **Please provide the following information for all NEW requests:**

Product(s) requested: ☐ **FENTANYL INJECTION** ☐ **FENTANYL PATCH**

Nature of the patient's pain: ☐ Persistent, severe chronic pain ☐ Other, please elaborate:

For FENTANYL PATCH requests:

Patients must have tried at least <u>two discrete courses</u>* of therapy with <u>two</u> of the required agents: morphine, hydromorphone and oxycodone.

* A *discrete course* is defined as a separate treatment course, which may involve more than one agent, used at one time to manage the patient's condition.

<u>Treatment course 1</u>: MEDICATION used & RESPONSE to each drug (or CONTRAINDICATIONS to drug):

☐ morphine _____
☐ hydromorphone _____
☐ oxycodone _____
☐ other (specify) _____

<u>Treatment course 2:</u> MEDICATION used & RESPONSE to each drug (or CONTRAINDICATIONS to drug):

☐ morphine _____
☐ hydromorphone _____
☐ oxycodone _____
☐ other (specify) _____

For FENTANYL INJECTION requests:

Previous MEDICATION used & RESPONSE to each drug (or CONTRAINDICATIONS to drug):

☐ morphine _____
☐ hydromorphone _____

If patient is unable to swallow, please provide information regarding <u>specific reasons</u> patient is unable take oral medications:

Additional information relating to request:

☐ **RENEWAL**

This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has <u>not</u> made a claim for the drug product during the Approval Period).
Please indicate response to therapy:

PRESCRIBER 'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation 10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **780 498-8384** Edmonton · **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form

On the reverse is the official *Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form* (ABC 31192).

- All requests for adalimumab, etanercept, infliximab or ustekinumab for Plaque Psoriasis must be submitted using the *Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request

.

ALBERTA BLUE CROSS®

ADALIMUMAB/ETANERCEPT/INFLIXIMAB/USTEKINUMAB for Plaque Psoriasis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
DERMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:	Indicate requested drug:	Current Weight (Kg):	Dosage:
☐ Plaque Psoriasis ☐ Other (specify): _____	☐ Adalimumab ☐ Etanercept ☐ Infliximab ☐ Ustekinumab		Dosing Frequency:

Location:
Significant involvement of face, palms of the hands, soles of the feet or genital region: ☐ YES ☐ NO

Scores:	Please provide reason if a switch to a different biologic agent is requested:
PASI_____ Date_____ DLQI_____ Date_____	Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Please provide the following information for all NEW requests:

Previous medications/therapies utilized: Dose, duration and response is required for the following:

☐ Methotrexate PO:

☐ Methotrexate SC or IM:

☐ Cyclosporine:

☐ Phototherapy:

Additional information relating to request
(e.g. reasons why any of the above therapies were not tried):

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780- 498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis Special Authorization Request Form

On the reverse is the official *Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis Special Authorization Request Form* (ABC 31195).

- All requests for adalimumab, etanercept or infliximab for Ankylosing Spondylitis must be submitted using the *Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ADALIMUMAB/ETANERCEPT/INFLIXIMAB for Ankylosing Spondylitis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION			**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL	PHONE:	FAX:	
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:	**Current weight (kg):**	**Indicate requested drug:**	**Dosage:**
☐ Ankylosing Spondylitis (meeting modified NY criteria) ☐ Other (please **SPECIFY**): _____		☐ Adalimumab ☐ Etanercept ☐ Infliximab	**Dosing frequency:**

Please provide the following information for all NEW requests:

Previous medications utilized:

Have two or more NSAIDs been tried for a minimum of 4 weeks each at maximum tolerated or recommended doses?

☐ Yes (please **SPECIFY** below) ☐ No

	Please **SPECIFY** the NSAID	Please **SPECIFY** the dose, duration, and response
NSAID #1:		
NSAID #2:		

Other, please **SPECIFY**:

Please provide the following information for all NEW* requests:

BASDAI #1	Date:
BASDAI #2:	Date:
Spinal Pain VAS #1 (cm):	Date:
Spinal Pain VAS #2 (cm):	Date:

* New requests for patients currently maintained on the requested biologic require pre-treatment scores. Scores 1 and 2 for each parameter must be at least 8 weeks apart.

Please provide the following information for all RENEWAL requests:

BASDAI	Date:
Spinal pain VAS (cm)	Date:

Please provide reason if a switch to a different biologic agent is requested:

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Additional information relating to request:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX: 780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection of this information, please contact the Co-chairs of the Alberta Blue Cross Privacy Steering Committee at 780-498-8108 or 780-498-8597, 10009 - 108 Street, Edmonton AB, T5J 3C5.

Adalimumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form

On the reverse is the official *Adalimumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* (ABC 31200).

- All requests for adalimumab for Moderately to Severely Active Crohn's Disease or infliximab for Moderately to Severely Active Crohn's/Fistulizing Crohn's Disease must be submitted using the *Adalimumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

-

ALBERTA BLUE CROSS®

ADALIMUMAB for Crohn's / INFLIXIMAB for Crohn's / Fistulizing Crohn's Disease SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
GASTROENTEROLOGY SPECIALIST SURNAME FIRST NAME INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:
- ☐ Moderately to Severely Active Crohn's
- ☐ Fistulizing Crohn's
- ☐ Other (specify) _____

Indicate requested drug:
- ☐ Adalimumab Dose:_____ Frequency:_____ Date of last dose:_____
- ☐ Infliximab Dose:_____ Frequency:_____ Date of last dose:_____

Current weight (kg):_____

For INITIAL request, please indicate if the drug is requested for
- ☐ NEW patient who has never been treated with the requested drug by any health care provider
- ☐ EXISTING patient who is being treated, or have previously been treated with the requested drug

Please provide reason if a switch to a different biologic agent or change in dose is requested:

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Infliximab For Fistulizing Crohn's Disease:

INITIAL request:

Dose, duration and response is required for all medications previously utilized:

Azathioprine:

6-mercaptopurine:

Antibiotics (specify the drug name):

NEW patient:

Does the patient have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite previous therapy:

☐ Yes ☐ No

EXISTING patient:

Please indicate response to treatment with infliximab:

- ☐ Closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline.
- ☐ Incomplete response (specify):

Adalimumab or Infliximab For Moderately to Severely Active Crohn's Disease:

INITIAL request:

Dose, duration and response is required for all medications previously utilized:

Azathioprine:

6-mercaptopurine:

Methotrexate:

Mesalamine:

Glucocorticoid(s) (specify drug name):

For ALL requests for Moderately to Severely Active Crohn's Disease, please provide

Modified Harvey-Bradshaw Index score: _____

Date of score: _____

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Abatacept/Rituximab for Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Abatacept/Rituximab for Rheumatoid Arthritis Special Authorization Request Form* (ABC 31205).

- All requests for abatacept or rituximab for Rheumatoid Arthritis must be submitted using the *Abatacept/Rituximab for Rheumatoid Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ABATACEPT/RITUXIMAB for Rheumatoid Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER **INFORMATION**			
RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:	Requested drug:	Current weight (kg):	Dosage:
☐ Rheumatoid Arthritis ☐ Other (specify)	☐ Abatacept ☐ Rituximab		Dosing Frequency:

Scores:*

DAS28 Score _____

OR

☐ ACR20 (Abatacept renewals only)

Date: _____

AND

HAQ Score _____

Date: _____

RITUXIMAB only: Requests for Re-treatment after 2 dose course

Date of initial dose of the previous course of therapy:

_____

Response Scores 16-24 weeks after initial dose of previous course of therapy:

DAS28 Score _____ Date: _____

AND HAQ Score _____ Date: _____

Current scores:

DAS28 Score _____ Date: _____

AND HAQ Score _____ Date: _____

Please provide reason if a switch from abatacept to rituximab is requested, or vice versa:

Date of last dose:

_____

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

* New requests for patients currently maintained on the requested biologic also require pre-treatment scores. Scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places.

Will the patient be maintained on methotrexate in combination with rituximab, or; methotrexate or another DMARD in combination with abatacept? ☐ YES ☐ NO (If not, please specify reason):

Please provide the following information for all NEW requests:

Previous medications/therapies utilized: Dose, duration and response is required for ALL FIVE of the following:

☐ Methotrexate PO:

☐ Methotrexate SC or IM:

☐ Methotrexate with another DMARD other than leflunomide (specify agent)

☐ Leflunomide:

☐ Anti-TNF therapy:

☐ Date of last dose of most recent Anti-TNF therapy and name of product:

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780 498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Imiquimod Special Authorization Request Form

On the reverse is the official *Imiquimod Special Authorization Request Form* (ABC 31222).

- All requests for imiquimod must be submitted using the *Imiquimod Special Authorization **Request Form*** **only.**
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

IMIQUIMOD
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other		REGISTRATION NO.	Fax number must be provided with each request submitted	
STREET ADDRESS	CITY		PROVINCE	POSTAL CODE

Criteria for Coverage of IMIQUIMOD

For the treatment of Actinic Keratosis located on the head and neck in patients who have failed treatment with cryotherapy (where appropriate) and 5-fluorouracil (5-FU). Special authorization may be granted for 6 months. This product is eligible for auto-renewal.

☐ **NEW** **Please provide the following information for NEW requests (check ALL that apply):**

Diagnosis:

☐ Actinic Keratosis → Area affected:

☐ Head or neck ☐ Other (specify): _____

☐ Other (specify):

Previous medications/therapies utilized:

Please indicate if the following medication/therapy have been tried and the response:

1) cryotherapy: ☐ Yes → Response:

☐ Lack of response ☐ Intolerance ☐ Other (specify):_____

☐ No → ☐ Not appropriate ☐ Other (specify):_____

AND

2) 5-fluorouracil (5-FU): ☐ Yes→ Response:

☐ Lack of response ☐ Intolerance ☐ Other (specify):_____

☐ No (specify reason, if applicable): _____

Additional information relating to request

☐ **RENEWAL**

This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).
Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Dutasteride/Finasteride Special Authorization Request Form

On the reverse is the official *Dutasteride/Finasteride Special Authorization Request Form* (ABC 31257).

- All requests for dutasteride or finasteride must be submitted using the *Dutasteride/Finasteride Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

DUTASTERIDE/FINASTERIDE SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.		Fax number must be provided with each request submitted	
STREET ADDRESS	CITY		PROVINCE	POSTAL CODE

Indicate which drug is requested (check one box): ☐ Dutasteride ☐ Finasteride

Criteria for Coverage of DUTASTERIDE / FINASTERIDE

For the treatment of benign prostatic hyperplasia in patients who are poor surgical risks or who have enlarged prostates and have moderate to severe symptoms suggestive of obstruction.
Special authorization may be granted for 6 months. This product is eligible for auto-renewal.

☐ **NEW Please provide the following information for NEW requests (Section 1, AND Section 2 or 3 must be completed):**

Section 1: Diagnosis:

☐ Benign Prostatic Hyperplasia ☐ Other (specify): _____

Section 2: Surgical Risk:

Is the patient a poor surgical risk? → ☐ no ☐ yes

If yes, please **specify** any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:

Has this patient had surgical intervention (TURP) for this condition in the past?
☐ yes ☐ no

Section 3: Enlarged Prostate:

Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction?

☐ yes

☐ no

Additional information relating to request

☐ **RENEWAL**

This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).

Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Risperidone Prolonged Release Injection Special Authorization Request Form

On the reverse is the official *Risperidone Prolonged Release Injection Special Authorization Request Form* (ABC 31258).

- All requests for risperidone prolonged release injection must be submitted using the *Risperidone Prolonged Release Injection Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

RISPERIDONE PROLONGED RELEASE INJECTION SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.		Fax number must be provided with each request submitted	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Criteria for Coverage of RISPERIDONE PROLONGED RELEASE INJECTION

For the management of the manifestations of schizophrenia and related psychotic disorders in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success AND who meet at least two of three of the following criteria:
-Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
-Is refractory to trials of at least two other antipsychotic therapies (Note: one trial must include a first generation antipsychotic agent); OR
-Possesses clinical evidence of previous successful treatment with risperidone therapy.

Special Authorization may be granted for six months.

☐ **NEW Please provide the following information for NEW requests:**

Diagnosis: ☐ schizophrenia or related psychotic disorder ☐ other, please specify

Compliance Issues: Does this patient demonstrate a pattern of significant non-compliance that compromises therapeutic success?

☐ Yes ☐ No If no, please elaborate:

Previous drug therapy (CHECK ALL THAT APPLY): In order to comply with the above criteria, check **<u>at least two</u>** of the following:

☐ Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product

☐ Is refractory to trials of at least two other antipsychotic therapies (Note: one trial must include a first generation antipsychotic agent)

☐ Possesses clinical evidence of previous successful treatment with risperidone therapy

Additional information relating to request

☐ **RENEWAL**
This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has <u>not</u> made a claim for the drug product during the Approval Period).

Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Abatacept for Juvenile Idiopathic Arthritis Special Authorization Request Form

On the reverse is the official *Abatacept for Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 31291).

- All requests for abatacept for Juvenile Idiopathic Arthritis must be submitted using the *Abatacept for Juvenile Idiopathic Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ABATACEPT for Juvenile Idiopathic Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER **INFORMATION**			
RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:	Current weight (kg):	Dosage:
☐ Polyarticular Juvenile Idiopathic Arthritis ☐ Other (specify)		Dosing Frequency:

Current JRA30 FLARE score (provide for ALL requests)	**JRA30 RESPONSE score at 16 to 20 weeks after first dose of previous abatacept treatment (provide for RETREATMENT requests)**
Date of assessment:_____	Date of assessment:_____
1. Rheumatologist global assessment (0-10) _____	1. Rheumatologist global assessment (0-10) _____
2. Patient global assessment (0-10) _____	2. Patient global assessment (0-10) _____
3. No. of active joints* _____	3. No. of active joints* _____
4. No. of joints with LROM _____	4. No. of joints with LROM _____
5. CHAQ (0-3) _____	5. CHAQ (0-3) _____
6. ESR (mm/hr) _____ or CRP _____	6. ESR (mm/hr) _____ or CRP _____
*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both.	*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both.

Please provide the following information for all NEW requests:

Previous medications utilized: Dose, duration and response is required:

☐ DMARD(s) (specify agents):

☐ Etanercept:

☐ Other (specify agent) :

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780 498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Montelukast/Zafirlukast Special Authorization Request Form

On the reverse is the official *Montelukast/Zafirlukast Special Authorization Request Form* (ABC 31313).

- All requests for montelukast or zafirlukast must be submitted using the *Montelukast/Zafirlukast Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

MONTELUKAST/ZAFIRLUKAST
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment and Immigration ☐ Alberta Children and Youth Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION				
PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NO.		Fax number must be provided with each request submitted	
STREET ADDRESS	CITY		PROVINCE	POSTAL CODE

Indicate which drug is requested (check one box): ☐ **Montelukast** (5mg + 10mg) ☐ **Zafirlukast** (20mg)

Criteria for Coverage of MONTELUKAST / ZAFIRLUKAST

For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:

a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, OR

b) cannot operate inhaler devices.

For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists.

Special authorization for both criteria may be granted for 6 months. This product is eligible for auto-renewal.

Note: Refer to the Alberta Health and Wellness Drug Benefit List for Restricted Benefit coverage of patients 2 to 18 years of age inclusive for Montelukast and 12 to 18 years of age inclusive for Zafirlukast.

☐ **NEW Please provide the following information for NEW requests (Section 1, AND Section 2 or 3 must be completed):**

Section 1: Indication:

☐ Prophylaxis and chronic treatment of asthma (If yes, proceed to Section 2A or 2B only).
☐ Prophylaxis of exercise-induced bronchoconstriction (If yes, proceed to Section 3 only).
☐ Other (specify): _____

Section 2: Prophylaxis and chronic treatment of asthma:

A. Previous Medication Use:

Is the patient maintained on inhaled glucocorticosteroids?
☐ Yes ☐ No (If no, specify reason):_____

Is the patient on a long-acting beta 2 agonist (e.g. salmeterol or formoterol)?
☐ Yes → Response: ☐Persistent symptoms
☐ Other (specify)_____
☐ No (If no, specify reason):_____

B. Use of Inhaler Device

Please indicate if the patient has difficulty using an inhaler device:
☐ Yes (Please elaborate on the nature of the difficulty)_____
_____
☐ No

Section 3: Prophylaxis of exercise induced bronchoconstriction:

Does this patient have tachyphylaxis with long-acting beta 2 agonists? ☐ Yes ☐ No ☐ Other (specify): _____

Additional information relating to request:

☐**RENEWAL**: This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).

Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

SECTION 2

Multiple Sclerosis (MS) Drug Coverage

MULTIPLE SCLEROSIS (MS) DRUG COVERAGE

Selected drug products used in the treatment of relapsing multiple sclerosis (MS) may be considered for coverage for patients covered under Alberta government-sponsored drug programs. For further information regarding eligibility for Alberta government-sponsored drug programs, refer to the Introduction section of the List.

In order to be eligible for Multiple Sclerosis (MS) Drug Coverage, an individual must:

- have valid Alberta government-sponsored drug coverage;
- meet specific clinical criteria according to *Multiple Sclerosis (MS) Drug Coverage* program requirements;
- have a Multiple Sclerosis (MS) Drug Coverage Application form(s) submitted on their behalf to Alberta Blue Cross by any "MS Neurologist" identified by the Alberta Multiple Sclerosis (MS) Drug Review Panel, and
- have their Application approved by the Review Panel.

Clinical Criteria to be considered for Coverage

To be considered for coverage of Avonex, Betaseron, Copaxone, and Rebif, patients must be assessed by an "MS Neurologist" and meet the following clinical criteria:

- have a diagnosis of clinically definite relapsing-remitting multiple sclerosis:
    - have had at least two attacks/exacerbations of MS during the previous two years. (An attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Attacks must be separated by a period of at least one month.)
    - are ambulatory with or without aid (i.e. a cane or walker).

OR to be considered for coverage of Betaseron:

- have a diagnosis of secondary progressive multiple sclerosis with relapses:
    - have had at least two attacks/exacerbations of MS during the previous two years. (An attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 72 hours in the absence of fever, not associated with withdrawal from steroids, and preceded by stability for at least one month. Attacks must be separated by a period of at least one month.)
    - have an EDSS score of less than or equal to 5.5.

To be considered for coverage of Tysabri, see the clinical criteria as listed in the Drug Products Under Multiple Sclerosis (MS) Drug Coverage Program section 2.5 – 2.7.

Contraindications to Coverage

In addition to meeting the above clinical criteria, the patient must have none of the following contraindications:

- Significant illness likely to alter compliance or substantially reduce life expectancy.

- Active, severe depression: in the absence of a depression waiver from a psychologist or psychiatrist. The depression waiver must accompany the Multiple Sclerosis (MS) Drug Coverage Application form(s) for patients with active, severe depression.
- Planned or current pregnancy, nursing women.

Contraindications for Tysabri, refer to section 2.6.

Alberta Multiple Sclerosis (MS) Drug Review Panel

The Alberta Multiple Sclerosis (MS) Drug Review Panel is an external review panel composed of neurologists and other health professionals with expertise in MS, appointed by the Minister of Health and Wellness.

The Review Panel's functions include:

- making recommendations to Alberta Health and Wellness on *Multiple Sclerosis (MS) Drug Coverage* program requirements, including maintenance of the eligibility criteria;
- identifying "MS Neurologists" for the purposes of this program, and;
- reviewing applications for *Multiple Sclerosis (MS) Drug Coverage*.

Process for Multiple Sclerosis (MS) Drug Coverage

Participating "MS Neurologists" must complete a separate Multiple Sclerosis (MS) Drug Coverage Application form(s) for each patient. The completed application may be forwarded to Alberta Blue Cross by mail or by facsimile.

Alberta Blue Cross, in providing administrative support to the Review Panel, receives and screens each application for completeness, then forwards it to the Review Panel for assessment. Alberta Blue Cross responds to applicants on the Review Panel's behalf. After an application is assessed by the Review Panel, Alberta Blue Cross notifies the "MS Neurologist" and the patient by letter of the Review Panel's decision.

If the patient is approved for *Multiple Sclerosis (MS) Drug Coverage* an MS Nurse (a nurse with extensive knowledge of MS and MS therapies) will provide the patient with education regarding: (i) potential benefits and limitations of therapy, (ii) side-effects, (iii) how drug administration will be taught, (iv) how the patient will be followed, (v) how the patient can access help or information, (vi) how the treatment will be reimbursed and the requirements for reimbursement, (vii) indications for treatment to possibly be discontinued, and (viii) what should be reported and to whom. The MS Nurse will also ensure that the prescribing neurologist is aware of the timelines for the necessary ongoing follow-up to ensure safe and appropriate ongoing use of therapies.

A new Multiple Sclerosis (MS) Drug Coverage Application form(s) must be completed by an "MS Neurologist" to review coverage if the patient requires a different Multiple Sclerosis (MS) Drug and for renewal requests.

To be eligible for *Multiple Sclerosis (MS) Drug Coverage*, prescriptions must be written by an "MS Neurologist" identified by the Review Panel. Regular monitoring of patients during the first year of therapy is needed in order to ensure the appropriate treatment option and dose, and to minimize the potential for wastage. Therefore, prescription quantities are limited to a one-month supply for the first year of therapy. This also applies to drug changes and to patients new or transferring to this program. Once the patient has been stabilized on a drug and dosage while on Alberta government-sponsored drug coverage for one year and received program renewal authorization, up to 100 days' supply may be dispensed at a time.

Government will not be responsible for reimbursement of costs associated with wastage or improper storage of the drug.

Prior approval must be granted to ensure coverage. Approval is granted for a specific period, to a maximum of 12 months unless otherwise indicated. If continued treatment is necessary, it is the responsibility of the patient and “MS Neurologist” to re-apply for drug coverage prior to the expiry date of the authorization period.

Completed Multiple Sclerosis (MS) Drug Coverage Application forms should be directed by mail or FAX to:

Clinical Drug Services and Evaluation
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

(780) 498-8384 in Edmonton and area
1-877-828-4106 toll-free for all other areas

ALBERTA BLUE CROSS®

AVONEX/BETASERON/COPAXONE/REBIF/TYSABRI

MS DRUG COVERAGE APPLICATION

Applicant must be covered on an Alberta Government sponsored drug program.

PATIENT INFORMATION:

Patient Surname	First Name	Middle Initial	Sex M / F	Date of Birth Year / Month / Day	Alberta Personal Health Number

Street Address	City	Province	Postal Code

Telephone Number	Coverage Type: ☐ Alberta Blue Cross ☐ Alberta Children and Youth Services ☐ Alberta Employment and Immigration ☐ Alberta Seniors and Community Supports ☐ Other
	Identification/Client/Coverage No:

Contact Person Name: (If applicable)	Telephone Number:

MS NEUROLOGIST INFORMATION:

MS Neurologist Surname	First Name	Middle Initial	College of Physicians and Surgeons Registration No

Street Address	City	Province	Postal Code

Telephone Number	Fax Number	Last Consult Date

Date Form Completed	MS Neurologist's Signature

MS NURSE INFORMATION:

MS Nurse Surname	First Name	MS Nurse Signature	Telephone Number	Fax Number

FOR INTERNAL USE ONLY - to be completed by Alberta Blue Cross

MS PANEL DECISION

SIGNATURE & DATE:

NOTE:

Section 1 (Pages 1-3) of this form must be submitted for all requests.

Section 2 (Pages 4, 5) of this form is submitted in addition to section 1 for Tysabri new requests*.

Section 3 (Page 6) of this form is submitted in addition to section 1 for Tysabri renewals.

***For patients new to the program but already on Tysabri, additional information is required; see section 3.**

Please Mail this request to:	Or Fax to:	**Case Number**
Alberta Blue Cross, Clinical Drug Services & Evaluation **10009-108 Street NW, Edmonton, Alberta T5J 3C5**	**Alberta Blue Cross, Clinical Drug Services & Evaluation** **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas	

Notice to Applicant: The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection of this information, please contact the Co-chairs of the Alberta Blue Cross Privacy Steering Committee at 780-498-8108 or 780-498-8597, 10009 - 108 Street, Edmonton AB, T5J 3C5.

ALBERTA BLUE CROSS®

AVONEX/BETASERON/COPAXONE/REBIF/TYSABRI
MS DRUG COVERAGE APPLICATION

Section 1: Complete for ALL MS Drug applications

Patient's Alberta Personal Health Number (only) _____

TREATMENT REQUESTED[1] (Check only one box and indicate dosage - must be completed for each request)

❑ **Avonex/Avonex PS** (Interferon beta-1a)	❑ **Betaseron** (Interferon beta-1b)	❑ **Copaxone** (Glatiramer Acetate)	❑ **Rebif** (Interferon beta-1a)	❑ **Tysabri** (natalizumab)	Dosage and Frequency Requested:

Planned Start Date _____

❑ New to Program: start upon approval/bridging ❑ New to Program: on drug already ❑ Drug change ❑ Renewal

PREVIOUS MS DISEASE MODIFYING TREATMENT (must be completed for each request)

DRUG	DATE STARTED	DATE STOPPED	REASON DRUG STOPPED*

* Examples of reasons drug may be stopped: lack of efficacy, intolerability, non-compliance, pregnancy, financial reasons, interferon antibody positive

ELIGIBILITY CRITERIA (complete if new to program or if off all disease modifying therapy more than 6 months and must requalify)

Approval may be granted to patients who are assessed by an MS Neurologist and (1) meet the following criteria and (2) do not have the following contraindications to treatment:

	Yes
1. Have a diagnosis of definite relapsing multiple sclerosis (RRMS or SPMS) (McDonald[2] diagnostic criteria must be met. MRI reports must be enclosed to confirm MRI criteria are met.)	❑
2. Have had at least two attacks/exacerbations of MS during the last two years, or in the two years prior to starting MS disease modifying therapy[3]. A gadolinium enhancing MRI lesion at least 3 months before or after an attack may substitute for one attack	❑
3. Ambulatory Status:	
a. Able to walk with or without aid if relapsing-remitting MS; or	❑
b. Able to walk 100 m without an aid (EDSS ≤ 5.5) if secondary progressive MS with relapses	❑

Contraindications (does the patient have any of the following?):

1. Significant illness likely to alter compliance or substantially reduce life expectancy	**No** ❑
2. Planned or current pregnancy, or nursing	**No** ❑
3. a. Active, severe depression; or	**No** ❑
b. Active, severe depression; waiver from a psychologist or psychiatrist attached[4]	**Yes** ❑
4. Progression without relapse[5]	**No** ❑

OTHER CLINICAL DATA (must be completed for each request)

Age:	Gender ❑ Male ❑ Female	Date of onset: _____/_____(Year/Month)[6]

Current Prescribed Medications:

Allergies:

1. Only Betaseron is funded for patients with SPMS starting therapy.
2. McDonald Criteria (Ann Neurol 2001; 50:121-127) Summary: patients must meet one of the following conditions:
   a) 2 attacks confirmed by objective findings and evidence of 2 clinically objective lesions.
   b) 2 attacks confirmed by objective findings, and 1 clinically objective lesion, and either dissemination in space by MRI as below *or at least* 2 MRI lesions and CSF oligoclonal bands or increased IgG index.
   c) 1 attack confirmed by objective findings, and 2 clinically objective lesion sites, and dissemination in time by MRI.
   d) 1 attack confirmed by objective findings, and 1 clinically objective lesion, and dissemination in space by MRI [*or* 2 MRI lesions and + CSF] and dissemination in time by MRI.
   Dissemination in space by MRI: (3 of 4 of the following): 1) 1 gd+ lesion or 9 T2 hyperintense lesions (cord or brain); 2) 1 infratentorial lesion; 3) 1 juxtacortical lesion; 4) 3 periventricular lesions
   Dissemination in time by MRI: Either 1) a gd+ lesion on an MRI at least 3 (or more) months after an attack, at a different site; or, 2) a new T2 lesion at least 3 months after scan that was completed at least 3 months after the initial documented attack, at a different site.
3. In RRMS an attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, and not associated with withdrawal from steroids. In SPMS it is more difficult to differentiate attacks from disease fluctuation; therefore, attacks must meet these criteria, must have lasted at least 72 hours, and new neurologic deficits must have been documented by a physician. Attacks must be separated by a period of at least one month.
4. Required prior to approval for all patients who have not been on treatment for at least 6 months.
5. Progression is worsening neurologic impairment not due to residual deficits from attacks.
6. Consider onset as the time of first convincing MS symptoms. This would include episodes such as transverse myelitis or optic neuritis, but not (in most cases) non-specific symptoms such as dizziness, visual blurring or fatigue.

Case Number _____

ALBERTA BLUE CROSS®

AVONEX/BETASERON/COPAXONE/REBIF/TYSABRI

MS DRUG COVERAGE APPLICATION

Section 1: Complete for ALL MS Drug applications

Patient's Alberta Personal Health Number (only) _____

QUALIFYING ATTACKS (complete if new to program or if off disease modifying therapy more than 6 months and must requalify)

DATE OF ATTACK ONSET (Year/Month/Day)	MRI ATTACK EQUIVALENT (Y/N)	SEVERITY[1]	RECOVERY	FUNCTIONAL SYSTEMS INVOLVED	OBJECTIVE CHANGES **(SPMS ONLY)**
Most recent attack: Year / Month / Day	❑ Yes ❑ No	❑ Mild ❑ Moderate ❑ Severe ❑ Very Severe	❑ None ❑ Incomplete ❑ Complete	❑ Pyramidal ❑ Cerebellar ❑ Bowel/bladder ❑ Cognitive/cerebral ❑ Sensory ❑ Brain Stem ❑ Visual	❑ Yes ❑ No
Previous attack: Year / Month / Day	❑ Yes ❑ No	❑ Mild ❑ Moderate ❑ Severe ❑ Very Severe	❑ None ❑ Incomplete ❑ Complete	❑ Pyramidal ❑ Cerebellar ❑ Bowel/bladder ❑ Cognitive/cerebral ❑ Sensory ❑ Brain Stem ❑ Visual	❑ Yes ❑ No

BASELINE AND FOLLOW-UP DATA (must be completed for each request)

	PRE DRUG	CURRENT if on drug	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
Date[2] (Year / Month / Day)							
EDSS							
Pyramidal							
Cerebellar							
Brain Stem							
Visual Score							
Sensory							
Bowel/Bladder							
Cognitive							
# of attacks during 2 yrs prior to baseline assessment							
# of attacks since last form completed (renewals)							
Relapse at time of assessment (Yes or No)							
Progressive course (Yes or No)							
Interferon antibodies (Yes, No, Not applicable, or Unknown)							

1. Severity: Mild - symptoms present but no change in function; Moderate - requires modification or more time to carry out activity; Severe - unable to carry out usual activity; Very Severe - requires others to provide personal care for them.
2. Date of examination must be 0-6 months preceding this request, or if already on drug, from the most recent annual assessment.

Case Number _____

Section 2: Complete for NEW Tysabri requests

Patient's Alberta Personal Health Number (only)

Yes
Patient has previously been demonstrated to have at least **nine** T2 hyperintense lesions on brain MRI…… ❑

If this application is submitted more than 6 months after the last 12 month treatment failure window, please complete the following to confirm ongoing inflammatory disease:

Since the last treatment failure window ended, the applicant has continued to have active inflammatory MS defined as an average of one or more relapses or one gadolinium enhancing T1 lesion on MRI per year (number of years is rounded to the nearest whole number). At least 50% of inflammatory events must have been relapses. (Append supporting brain MRI reports)

Date of year onset:	Relapse date:	MRI date:

Patient has demonstrated **EITHER**:

I. Intolerance to interferon-beta (Avonex, Rebif, or Betaseron): ❑

'Intolerance' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of DMT. Describe the intolerance in detail below (or attach letter):

OR

II. Failure to respond to **interferon-beta (Avonex, Rebif, or Betaseron):**

Within the 12 month treatment period from _____ to _____ the following statements are true:

a. The patient reported adherence to the interferon-beta at the standard dose defined as receiving 80% of prescribed dosing ❑

b. The patient experienced onset of one or more on-treatment clinical relapses at least 3 months after initiating full dose interferon-beta and this relapse was accompanied by new neurologic deficits that persisted for at least 3 months: ❑

Date of relapse onset: _____

Residual deficit (detected at least 3 months after onset of the relapse):_____

_____

c. Evidence of ongoing inflammatory MS disease activity as demonstrated by **either**:

The occurrence of at least one additional clinical relapse at least 1 month after initiating full dose interferon-beta and this relapse was accompanied by new neurologic deficits that persisted for at least one month: ❑

Date of relapse onset: _____

Residual deficit (detected at least 1 month after onset of the relapse):_____

_____

Or

Evidence of active inflammatory MS disease activity on brain or spine MRI that clearly started/ occurred during treatment with DMT and that was not associated with the qualifying clinical relapse. This may include one of the following: ❑

- A gadolinium enhancing T1 lesion on MRI at least 3 months after initiating full dose interferon beta and not within 3 months of the relapse described in b or c (above) (append MRI report)
- The appearance of 2 or more new, or newly enlarging, T2 hyperintense lesions, greater than 3 mm in size* (append MRI report)

*This requires comparison of 2 brain MRI scans completed within the 12-month treatment failure window. The baseline scan must have been undertaken at least 1 month after starting DMT. No clinical relapses may occur during the interval between the 2 comparison scans if that relapse is being used to confirm treatment failure. The second MRI report must include evidence that the 2 scans were directly compared, the dates of both scans, and a clear statement indicating that 2 or more new, or newly enlarging, T2 lesions at least 3 mm in size are present on the second scan.

Case Number

ALBERTA BLUE CROSS®

AVONEX/BETASERON/COPAXONE/REBIF/TYSABRI
MS DRUG COVERAGE APPLICATION

Section 2: Complete for NEW Tysabri requests

Patient's Alberta Personal Health Number (only) _____

Patient has demonstrated **EITHER**: **Yes**

I. Intolerance to **glatiramer acetate (Copaxone):** ☐

'Intolerance' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of DMT. Describe the intolerance in detail below (or attach letter):

_____

_____

_____

OR

II. Failure to respond to **glatiramer acetate (Copaxone):**

Within the 12 month treatment period from _____ to _____ the following statements are true:

d. The patient reported adherence to the glatiramer acetate at the standard dose defined as receiving 80% of prescribed dosing ☐

e. The patient experienced onset of one or more on-treatment clinical relapses at least 3 months after initiating full dose glatiramer acetate and this relapse was accompanied by new neurologic deficits that persisted for at least 3 months ☐

Date of relapse onset: _____

Residual deficit (detected at least 3 months after onset of the relapse):_____

_____

f. Evidence of ongoing inflammatory MS disease activity as demonstrated by **either**:

The occurrence of at least one additional clinical relapse at least 1 month after initiating full dose glatiramer acetate and this relapse was accompanied by new neurologic deficits that persisted for at least one month ☐

Date of relapse onset: _____

Residual deficit (detected at least 1 month after onset of the relapse): _____

_____

Or

Evidence of active inflammatory MS disease activity on brain or spine MRI that clearly started/ occurred during treatment with DMT and that was not associated with the qualifying clinical relapse. This may include one of the following: ☐

- A gadolinium enhancing T1 lesion on MRI at least 3 months after initiating full dose glatiramer acetate and not within 3 months of the relapse described in e or f (above) (append MRI report)
- The appearance of 2 or more new, or newly enlarging, T2 hyperintense lesions, greater than 3 mm in size* (append MRI report)

Contraindications (does the patient have any of the following?): **No**

1. Any evidence of disease progression independent of relapses…….. ☐
2. Immune compromise due to immunosuppressant or anti-neoplastic therapy or due to immunodeficiency (HIV, leukemia, lymphoma, etc) ☐
3. History of progressive multifocal leukoencephalopathy (PML)…… ☐
4. Concurrent malignancy…….. ☐
5. Pregnancy or anticipated pregnancy within the next year…… ☐

*This requires comparison of 2 brain MRI scans completed within the 12-month treatment failure window. The baseline scan must have been undertaken at least 1 month after starting DMT. No clinical relapses may occur during the interval between the 2 comparison scans if that relapse is being used to confirm treatment failure. The second MRI report must include evidence that the 2 scans were directly compared, the dates of both scans, and a clear statement indicating that 2 or more new, or newly enlarging, T2 lesions at least 3 mm in size are present on the second scan.

Case Number _____

ALBERTA BLUE CROSS®

AVONEX/BETASERON/COPAXONE/REBIF/TYSABRI
MS DRUG COVERAGE APPLICATION

Section 3: Complete for Tysabri RENEWAL requests

Patient's Alberta Personal Health Number (only) _____

For patients new to the program who are already on Tysabri: Complete the * questions in addition to section 1 and 2
For continued coverage beyond the initial 6 doses: Complete the following with every renewal

	Yes
The patient must be assessed by an MS Neurologist after the initial 5 or 6 doses to determine response, then at 12 months, then annually. The MS Neurologist must confirm that the patient is a 'responder' according to the following criteria:	
The patient initiated treatment within 2 months of approval (complete only at first 6 month assessment)	❑
The patient has not missed any doses, or delayed any doses by more than 1 week with the exception of medically authorized delays (Rationale for such delays must be justified in a narrative. Only serious medical conditions are acceptable)	❑
*There has been at least a 50% reduction in the relapse rate over the entire Tysabri treatment period compared with the 2 years prior to treatment:	❑

*Dates of onset of each relapse that occurred **during the 2 years prior to initiation of Tysabri**:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

*Dates of onset of each relapse that occurred **during each year of Tysabri treatment**:

1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____ 10) _____ 11) _____ 12) _____

If a clinical relapse occurred 3 or more months earlier, brain MRI after 5 or 6 doses shows no evidence of gadolinium enhancing disease activity (unless the patient experienced 5 or more relapses over the 2 years prior to initiation of Tysabri). (Complete this question only at first 6 month assessment) (Append MRI report)	Yes ❑ N/A ❑
Brain MRI scans with gadolinium were completed every 6 months to monitor disease activity and safety. There was no evidence of gadolinium enhancing disease activity on 2 consecutive scans, or on 2 out of any 3 consecutive scans, or on any scan completed within 9 to 12 months of a relapse. (append all MRI reports, in chronological order, completed since Tysabri initiated)	Yes ❑

At the first 12-month renewal (required at 6 months if already on Tysabri for 6 months at the time of the application).
There must be evidence that neutralizing antibodies to Tysabri are absent. This requires an initial test be completed between 6 to 8 months:

Are neutralizing antibodies **absent** at 6 to 8 months?

Yes ☐ If Yes: no further testing is required

No ☐ If No: Are neutralizing antibodies **absent** on repeat testing after an additional 3 months? Yes ❑ No ❑

Contraindications (does the patient have any of the following?):	**No**
1. Any evidence of disease progression independent of relapses…….	❑
2. Immune compromise due to immunosuppressant or anti-neoplastic therapy or due to immunodeficiency (HIV, leukemia, lymphoma, etc.)	❑
3. History of progressive multifocal leukoencephalopathy (PML)……	❑
4. Concurrent malignancy……..	❑
5. Pregnancy or anticipated pregnancy within the next year……	❑

Case Number _____

Drug Products Under *Multiple Sclerosis (MS) Drug Coverage* Program

GLATIRAMER ACETATE

The following drug products may be considered for coverage under the Multiple Sclerosis (MS) Drug Coverage program for patients who have a diagnosis of relapsing-remitting multiple sclerosis, and who participate in Alberta government-sponsored drug programs.

20 MG / SYR INJECTION SYRINGE			
00002245619	COPAXONE	TMP	$ 46.4400

INTERFERON BETA-1A

The following drug products may be considered for coverage under the Multiple Sclerosis (MS) Drug Coverage program for patients who have a diagnosis of relapsing-remitting multiple sclerosis, and who participate in Alberta government-sponsored drug programs.

6 MIU / VIAL INJECTION			
00002237770	AVONEX (30 MCG)	BIO	$ 393.2961
44 MCG / ML INJECTION CARTRIDGE			
00002318253	REBIF (1.5 ML CARTRIDGE)	SRO	$ 247.2500
88 MCG / ML INJECTION CARTRIDGE			
00002318261	REBIF (1.5 ML CARTRIDGE)	SRO	$ 301.0000
6 MIU / SYR INJECTION SYRINGE			
00002269201	AVONEX PS (30 MCG/ 0.5 ML SYR)	BIO	$ 393.2961
22 MCG / SYR INJECTION SYRINGE			
00002237319	REBIF (0.5 ML SYRINGE)	SRO	$ 123.6250
44 MCG / SYR INJECTION SYRINGE			
00002237320	REBIF (0.5 ML SYRINGE)	SRO	$ 150.5000

INTERFERON BETA-1A/ INTERFERON BETA-1A

The following drug products may be considered for coverage under the Multiple Sclerosis (MS) Drug Coverage program for patients who have a diagnosis of relapsing-remitting multiple sclerosis, and who participate in Alberta government-sponsored drug programs.

8.8 MCG / SYR * 22 MCG / SYR INJECTION SYRINGE			
00002281708	REBIF (INITIATION PACK)	SRO	$ 123.6250

INTERFERON BETA-1B

The following drug product may be considered for coverage under the Multiple Sclerosis (MS) Drug Coverage program for patients who have a diagnosis of relapsing-remitting multiple sclerosis OR secondary progressive multiple sclerosis with relapses, and who participate in Alberta government-sponsored drug programs.

9.6 MIU / VIAL INJECTION			
00002169649	BETASERON (0.3 MG)	BHP	$ 113.0700

NATALIZUMAB

"Special authorization coverage may be provided for the treatment of relapsing remitting Multiple Sclerosis (RRMS) to reduce the frequency of clinical exacerbations, to decrease the number and volume of active brain lesions identified on magnetic resonance imaging (MRI) scans and to delay the progression of physical disability, in adult patients (18 years of age or older) who have active RRMS that is causing CNS injury, who have previously been demonstrated to have at least nine T2 hyperintense lesions on brain MRI, and who are refractory or intolerant to the following MS disease modifying therapies (DMTs):

- Interferon beta: Avonex 30 mcg intramuscularly once weekly, OR Betaseron 0.25 mg subcutaneously every other day, OR Rebif 44 mcg subcutaneously three times per week (22 mcg if the higher dose is not tolerated);
AND
- Glatiramir acetate: Copaxone 20 mg subcutaneously daily

Refractory

When the above agents are taken at the recommended doses and for an adequate duration 'Refractory' is defined as follows:
Within a 12-month treatment failure window the patient has:
1) Been adherent to the DMT (i.e. greater than 80% of approved doses taken);

AND

2) Experienced the onset of at least 1 definite on-treatment clinical relapse (which must have started at least 3 months after the patient had been receiving full dose DMT and must have been accompanied by residual neurologic deficits on examination that persisted for at least 3 months after the relapse began);

AND

3a) Experienced a second clinical relapse (which may have begun as early as 1 month after the patient started full dose DMT and must have been accompanied by new neurologic deficits on examination that persisted for at least 1 month after the relapse began. Relapses must be separated by at least 30 days),

OR

3b) Evidence of active inflammatory MS disease activity on brain or spine MRI that clearly started/occurred during treatment with DMT and that was not associated with a clinical relapse.
- MRI evidence may be a definite gadolinium enhancing T1 lesion (not questionable faint enhancement) that was present on an MRI obtained at least 3 months after initiation of DMT and not within 3 months of a relapse; OR
- The appearance of 2 or more new, or newly enlarging, T2 hyperintense lesions, greater than 3 mm in size. This requires comparison of 2 brain MRI scans completed within the 12-month treatment failure window. The baseline scan must have been undertaken at least 1 month after starting DMT. No clinical relapses may occur during the interval between the 2 comparison scans if that relapse is being used to confirm treatment failure. The second MRI report must include evidence that the 2 scans were directly compared, the dates of both scans, and a clear statement indicating that 2 or more new, or newly enlarging, T2 lesions at least 3 mm in size are present on the second scan.

Intolerant

'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of DMT.

Coverage

NATALIZUMAB

For coverage, this drug must be prescribed by a Specialist in Neurology who has been identified by the Alberta MS Drug Review Panel ("MS Neurologist").

Initial Coverage

- The patient must apply for possible Tysabri coverage within 6 months of a 12-month treatment failure window as defined above; OR they must have continued to experience at least one relapse per year since the end of the treatment failure window (50% of relapses may be replaced by gadolinium enhancing lesions on brain MRI if they occur at least 3 months before or after a relapse). During this time approved DMT may have been used at any time.
- Initial coverage may be approved for 6 doses of 300 mg administered every 4 weeks.
- Patients will be limited to receiving 1 dose of Tysabri per prescription at their pharmacy.
- Coverage will not be approved when any DMT or other immunosuppressive therapy is to be used in combination with Tysabri (except corticosteroids which can be used for up to 12 weeks during Tysabri initiation in patients with coexisting Crohn's Disease or similar situation).
- Patients who have failed Tysabri will not be eligible for a subsequent trial of Tysabri except in exceptional circumstances.

Contraindications

Coverage will not be approved if any of the following contraindications exist:
- Any evidence of disease progression independent of relapses.
- Being immune compromised due to immunosuppressant or antineoplastic therapy or due to immunodeficiency (HIV, leukemia, lymphoma, etc).
- History of progressive multifocal leukoencephalopathy (PML).
- Concurrent malignancy.
- Pregnancy or anticipated pregnancy within the next year.

Continued Coverage to 12 months

For continued coverage beyond 6 doses, the patient must meet the following criteria:
1) The patient must be assessed by an MS Neurologist after the initial 5 or 6 doses to determine response.
2) The MS Neurologist must confirm in writing that the patient is a 'responder' that meets all of the following criteria:
- There has been at least a 50% reduction in the relapse rate over the entire Tysabri treatment period compared with the 2 years prior to treatment;
- Brain MRI after 5 or 6 doses shows no evidence of gadolinium enhancing disease activity if a clinical relapse occurred 3 or more months earlier unless the patient experienced 5 or more relapses over the 2 years prior to initiation of Tysabri.
- The patient initiated treatment within 2 months of approval; they have not missed any doses, or delayed any doses by more than 1 week with the exception of medically authorized delays (rationale for such delays must be justified in a narrative, only serious medical conditions are acceptable).
- None of the contraindications identified above exist.

Following this assessment, continued coverage may be approved for maintenance therapy of 300 mg every 4 weeks for a period of 6 months.

Antibody Testing

At the first 12-month renewal there must be evidence that neutralizing antibodies to Tysabri are absent. This requires an initial test between 6 to 8 months. If neutralizing antibodies are absent no further testing is required. If neutralizing antibodies are present, testing must be repeated in 3 months.

Ongoing Coverage

Thereafter, ongoing coverage for periods of 12 months may be considered only if the following

NATALIZUMAB

criteria are met at the end of each 12-month period:
1) The patient must be assessed by an MS Neurologist at least every 12 months.
2) The MS Neurologist must confirm in writing that the patient is a 'responder' that meets all of the following criteria:
- There has been at least a 50% reduction in the relapse rate over the entire Tysabri treatment period compared with the 2 years prior to treatment;
- Brain MRI scans must be completed every 6 months to monitor disease activity and safety. There must be no evidence of gadolinium enhancing disease activity on 2 consecutive scans, or on 2 out of any 3 consecutive scans, or on any scan completed within 9 to 12 months of a relapse.
- The patient has not missed any doses, or delayed any doses by more than 1 week, with the exception of medically authorized delays (rationale for such delays must be justified in a narrative, only serious medical conditions are acceptable).
- None of the contraindications identified above exist."

The following drug product may be considered for coverage under the Multiple Sclerosis (MS) Drug Coverage program for patients who participate in Alberta government-sponsored drug programs.

20 MG / ML INJECTION

00002286386	TYSABRI	BIO	$ 171.6391

SECTION 3

Criteria for Special Authorization of Select Drug Products

CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

The drug products listed in this section may be considered for coverage by special authorization for patients covered under Alberta Health and Wellness-sponsored drug programs. (For Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Support (AISH) clients, the special authorization criteria for coverage can be found in the Criteria for Special Authorization of Select Drug Products section of the *Alberta Employment and Immigration Drug Benefit Supplement.)*

Special Authorization Policy

DRUG PRODUCTS ELIGIBLE FOR CONSIDERATION BY SPECIAL AUTHORIZATION

Drug products may be considered for coverage by special authorization under one or more of the following circumstances, unless a specific product falls under the criteria for drug products **not** eligible for consideration by special authorization. Please see the end of this section for information regarding drug products not eligible for consideration by special authorization.

1. The drug is covered by Alberta Health and Wellness under specified criteria (listed in the following sections). Drug Products and indications other than those specified are not eligible for consideration by special authorization.
2. The drug is normally covered by another government program or agency for a specific approved clinical condition, but is needed for the treatment of a clinical condition that is not covered by that government program or agency.
3. The drug is required because other drug products listed in the *Alberta Health and Wellness Drug Benefit List* are contraindicated or inappropriate because of the clinical condition of the patient.
4. The particular brand of drug is considered essential in the care of a patient, where the LCA price policy would otherwise apply. Coverage of a specific brand may be considered where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with alternate brands in an interchangeable grouping. Coverage of a brand name product will not be considered in situations where the interchangeable grouping includes a pseudo-generic to the brand name drug.
5. A particular drug product or dosage form of a drug is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the product level. Coverage may be considered only where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with the drug product which establishes the MAC pricing.

Prior approval must be granted by Alberta Blue Cross to ensure coverage by special authorization. For those special authorization requests that are approved, the effective date for authorization is the beginning of the month in which the physician's request is received by Alberta Blue Cross.

Special authorization is granted for a defined period as indicated in each applicable special authorization drug product criteria (the "Approval Period"). If continued treatment is necessary beyond the Approval Period, it is the responsibility of the patient and physician to **re-apply for coverage prior to the expiration date of the Approved Period, unless the Auto-Renewal Process or Step Therapy Approval Process apply** (see below).

AUTO-RENEWAL PROCESS

Selected drug products are eligible for the following auto-renewal process (for eligibility, see the Special Authorization criteria for each drug product).

1. For initial approval, a special authorization request must be submitted. If approval is granted, it will be effective for the Approval Period outlined in the drug product's Special Authorization criteria
2. As long as the patient has submitted a claim for the drug product within the preceding Approval Period (example: within the preceding 6 months), approval will be automatically renewed for a further Approval Period (example: a further 6 months). There is no need for the prescriber to submit a new request as the automated real-time claims adjudication system will read the patient's claims history to determine if a claim has been made within the preceding Approval Period.
3. If the patient does not make a claim for the drug product during the Approval Period, the approval will lapse and a new special authorization request must be submitted.

STEP THERAPY APPROVAL PROCESS

Select drug products are eligible for coverage via the step therapy process, outlined below.

1. If the patient has made a claim for the First-Line* drug product(s) within the preceding 12 months, the claim for the step therapy drug will be approved.

2. The automated real-time claims adjudication system will read the patient's claims history to determine if the required First-Line* drug product(s) have been claimed within the preceding 12 months.

3. Subsequent claims for drug product(s) permitted by step therapy will continue to be approved as long as the drug product has been claimed within the preceding 12 months.

4. The regular special authorization approval process will continue to be available for step therapy approvals for those patients whose First-Line* drug claims cannot be adjudicated through the automated real-time claims adjudication system.

* A First-Line drug product includes any drug(s) or drug product(s) that, under the drug product's Special Authorization criteria, are required to be utilized before reimbursement for the drug product is permitted.

DRUG PRODUCTS NOT ELIGIBLE FOR CONSIDERATION BY SPECIAL AUTHORIZATION

The following categories of drug products are **not** eligible for special authorization:

1. Drug products **deleted** from the *List*.
2. Drug products **not yet reviewed** by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics. This applies to:
   * products where a complete submission has been received from the manufacturer and the product is under review,
   * products where an incomplete submission has been received from the manufacturer, and
   * products where the manufacturer has not made a submission for review.

   Drug products not yet reviewed may encompass new pharmaceutical products, new strengths of products already listed, reformulated products and new interchangeable (generic) products.
3. Drug products that have **completed the review** process and are **not included** on the *List.*
4. Most drugs available through Health Canada's Special Access Program.
5. Drug products when prescribed for cosmetic indications.
6. Nonprescription or over-the-counter drug products are generally not eligible.

The DBL is not a prescribing or a diagnostic tool. Prescribers should refer to drug monographs and utilize professional judgment.

Criteria for Coverage

Wording that appears within quotation marks (“ ”) in this section is the official special authorization criteria, as recommended by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health and Wellness. Wording that is not enclosed in quotation marks outlines specific information required to interpret criteria, guidelines for submitting requests and/or information regarding conditions under which coverage cannot be provided.

Products Available Through Health Canada’s Special Access Program

PEMOLINE

“For the treatment of attention deficit hyperactivity disorder where approval has been provided by Health Canada’s Special Access Program.”

37.5 MG	**ORAL TABLET**	
DIN N/A*	CYLERT	ABB
75 MG	**ORAL TABLET**	
DIN N/A*	CYLERT	ABB

**As Cylert has been withdrawn from market, the DINs are no longer valid. Where authorizations for Cylert have been granted, coverage for this product will be provided under PIN 00000999917.*

Other Products

The remaining drug products in this section are listed alphabetically according to the generic ingredient name of the drug. These products can be found on the following pages.

ABATACEPT

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate or other DMARDS, for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily), AND
- One or more anti-tumor necrosis factor (anti-TNF) therapies (e.g., etanercept, infliximab, or adalimumab) (minimum 12 week trial).

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for five doses of up to 1000 mg/dose administered at 0, 2, 4, 8 and 12 weeks.
-Patients will be limited to receiving one dose of abatacept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond five doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial five doses to determine response between 12 and 16 weeks of receiving the initial dose.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one dose of up to 1000 mg every 4 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, OR
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to

ABATACEPT

the correct number of decimal places as indicated above."

All requests (including renewal requests) for abatacept for Rheumatoid Arthritis must be completed using the Abatacept/Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 31205).

Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis (JIA) in patients 6 years of age and older who:
- Have 5 or more active joints (defined by either swelling or limitation of motion plus pain and/or tenderness), AND
- Are refractory to one or more disease modifying anti-rheumatic agents (DMARDS) conventionally used in children (minimum three month trial), AND
- Are refractory to or intolerant to etanercept (minimum 12 week trial).

'Refractory' is defined as lack of effect at the recommended doses and duration of treatments as listed above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary ("Pediatric Rheumatology Specialist").

- Coverage may be approved for six 10 mg/kg doses (maximum dose 1000 mg) at 0, 2, 4, 8, 12 and 16 weeks.
- Patients will be limited to receiving one dose of abatacept per prescription at their pharmacy.

For potential coverage for retreatment with abatacept following a disease flare, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after the initial 16 weeks, but no longer than 20 weeks after, treatment with this biologic agent to determine and document initial treatment response.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient is a responder that meets the following criteria (JRA30):
- 30% improvement from baseline in at least three of the following six response variables, with worsening of 30% or more in no more than one of the six variables. The variables include:
  i. global assessment of the severity of the disease by the Pediatric Rheumatology Specialist,
  ii. global assessment of overall well-being by the patient or parent,
  iii. number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),
  iv. number of joints with limitation of motion,
  v. functional ability based on CHAQ scores,
  vi. ESR or CRP
3) Data from all of the six variables comprising the JRA30 and the CHAQ scores must be reported.

Following assessment of and confirmation of initial treatment response, coverage for retreatment with abatacept may be approved for six 10 mg/kg doses (maximum dose 1000 mg) at 0, 2, 4, 8, 12 and 16 weeks. In order to be considered for coverage for retreatment, the patient must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist and the presence of disease flare confirmed. Disease flare is defined as worsening of at least 30% or greater in at least 3 of 6 JRA30 variables for JIA and at least 30% improvement in no more than one variable.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has had an initial treatment response (as assessed above) and that the patient has experienced a disease flare (as defined above)."

ABATACEPT

All requests (including renewal requests) for abatacept for Juvenile Idiopathic Arthritis must be completed using the Abatacept for Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 31291).

250 MG / VIAL (BASE)	INJECTION		
00002282097	ORENCIA	BMS	$ 473.0000

ADALIMUMAB

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily)

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Initial coverage may be approved for five doses as follows: An initial 40 mg dose, followed by additional 40 mg doses at 2, 4, 6 and 8 weeks after the first dose.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond five doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial five doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 40 mg every other week for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:

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1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, or
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for adalimumab for Rheumatoid Arthritis must be completed using the Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for 40 mg administered every other week for 8 weeks.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 weeks after, to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal

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place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for doses of 40 mg every other week, for a period of 12 months. Ongoing coverage may be considered if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for adalimumab for Psoriatic Arthritis must be completed using the Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis Special Authorization Request Form (ABC 30964).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for 12 weeks as follows: An initial 40 mg dose, followed by additional 40 mg doses administered every two weeks for up to 12 weeks after the first dose.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:

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1) The patient must be assessed at 12 weeks by an RA Specialist after the initial 12 weeks of therapy to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for one 40 mg dose every other week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by an RA Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for adalimumab for Ankylosing Spondylitis must be completed using the Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis Special Authorization Request Form (ABC 31195).

Moderately to Severely Active Crohn's Disease:

"Special authorization coverage may be approved for coverage of adalimumab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease in patients who meet the following criteria:

- Adalimumab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for adalimumab for coverage for the treatment of Moderately to Severely Active Crohn's Disease patients ('Specialist').
- Patients must be 18 years of age or older to be considered for coverage of adalimumab.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Prior to initiation of adalimumab therapy for New Patients:

'New Patients' are patients who have never been treated with adalimumab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of adalimumab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; AND refractory to, or dependent on, glucocorticoids: following at least one tapering dosing schedule of 40 mg/day, tapering by 5 mg each week to 20 mg, then tapering by 2.5 mg each week to zero, or similar.

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[Note: Patients who have used the above treatments in combination will not be required to be challenged with individual treatments as monotherapy]

AND
b) Immunosuppressive therapy as follows:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 3 months; OR
- Methotrexate: minimum or 15 mg/week for a minimum of 3 months.
OR
- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease

- New Patients must meet the criteria above prior to being considered for approval.
- All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

- Coverage for Induction Dosing may only be approved for New Patients (those who have never been treated with adalimumab by any health care provider).
- 'Induction Dosing' means a maximum of one 160 mg dose of adalimumab per New Patient at week 0 followed by an 80 mg dose at week 2.
- New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.
- As an interim measure, 40 mg doses of adalimumab will be provided at weeks 4, 6, 8 and 10 to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.

Maintenance Dosing:

'Maintenance Dosing' means one 40 mg dose of adalimumab per patient provided no more often than every other week starting at week 4 for a period of 12 months to:
- New Patients following the completion of Induction Dosing; OR
- Existing Patients, who are patients that are being treated, or have previously been treated, with adalimumab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:

- The New Patient must be assessed by a Specialist within 12 weeks after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease; AND
- The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's.

Maintenance Dosing for Existing Patients:

- The patient must be assessed by a Specialist annually (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's Disease; AND

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- these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 40 mg dose of adalimumab per patient provided no more often than every other week for a period of 12 months, if the following criteria are met at the end of each 12 month period:

- The New Patient or the Existing Patient must be assessed by a Specialist annually (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's Disease; AND
- For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's; OR
- For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score."

All requests (including renewal requests) for adalimumab for Moderately to Severely Active Crohn's Disease must be completed using the Adalimumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Special Authorization Request Form (ABC 31200).

Plaque Psoriasis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved for an initial dose of 80 mg, followed by one 40 mg dose every other week beginning one week after the first dose, for a total of nine doses.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for

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which it is being prescribed.

For continued coverage beyond nine doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial nine doses to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, OR
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every other week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for adalimumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 31192).

40 MG / SYR INJECTION SYRINGE

00002258595	HUMIRA	ABB	$	761.1430

ALENDRONATE SODIUM

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization may be granted for 6 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2% loss in bone mineral density in one year). Special authorization for this criteria may be granted for 6 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

"For the treatment of Paget's disease. Special Authorization for this criteria may be granted to a maximum of 6 months."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

All requests for alendronate sodium for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form (ABC 31086).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

10 MG ORAL TABLET

00002248728	**APO-ALENDRONATE**	**APX**	$	**1.1057**
00002270129	**MYLAN-ALENDRONATE**	**MYP**	$	**1.1057**
00002247373	**NOVO-ALENDRONATE**	**TEV**	$	**1.1057**
00002288087	**SANDOZ ALENDRONATE**	**SDZ**	$	**1.1057**
00002201011	FOSAMAX	MFC	$	1.9946

40 MG ORAL TABLET

00002258102	**CO ALENDRONATE**	**COB**	$	**2.6097**
00002201038	FOSAMAX	MFC	$	4.0743

ALENDRONATE SODIUM

70 MG ORAL TABLET

00002248730	**APO-ALENDRONATE**	**APX**	$	**5.5750**
00002258110	**CO ALENDRONATE**	**COB**	$	**5.5750**
00002286335	**MYLAN-ALENDRONATE**	**MYP**	$	**5.5750**
00002261715	**NOVO-ALENDRONATE**	**TEV**	$	**5.5750**
00002299712	**PHL-ALENDRONATE-FC**	**PHH**	$	**5.5750**
00002284006	**PMS-ALENDRONATE-FC**	**PMS**	$	**5.5750**
00002275279	**RATIO-ALENDRONATE**	**RPH**	$	**5.5750**
00002288109	**SANDOZ ALENDRONATE**	**SDZ**	$	**5.5750**
00002245329	FOSAMAX	MFC	$	10.0575

ALENDRONATE SODIUM/ VITAMIN D3

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2% loss in bone mineral density in one year)."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

"Special authorization for these criteria may be granted for 6 months."

All requests for alendronate sodium/vitamin D3 must be completed using the Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form (ABC 31086).

The following product(s) are eligible for auto-renewal.

70 MG * 5,600 UNIT ORAL TABLET

00002314940	FOSAVANCE	MFC	$	4.4250

ALFUZOSIN HCL

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): DOXAZOSIN OR TERAZOSIN

"For the treatment of the symptoms of benign prostatic hyperplasia (BPH) in patients who are unresponsive to a six-week trial with a non-selective alpha-blocker (e.g., terazosin) or in whom non-selective alpha-blockers are not tolerated or are contraindicated."

"Special authorization may be granted for 24 months"

10 MG ORAL SUSTAINED-RELEASE TABLET

00002315866	**APO-ALFUZOSIN**	**APX**	$	**0.5980**
00002304678	**SANDOZ ALFUZOSIN**	**SDZ**	$	**0.5980**
00002245565	XATRAL	SAV	$	1.0678

ALMOTRIPTAN MALATE

(Refer to 28:32.28 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using almotriptan malate prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

The following product(s) are eligible for auto-renewal.

6.25 MG (BASE) ORAL TABLET				
00002248128	AXERT	MCL	$	13.9217
12.5 MG (BASE) ORAL TABLET				
00002248129	AXERT	MCL	$	13.9217

AMPICILLIN

"For the treatment of infections caused by susceptible Shigella and Salmonella."

250 MG ORAL CAPSULE				
00000020877	NOVO-AMPICILLIN	TEV	$	0.3180
500 MG ORAL CAPSULE				
00000020885	NOVO-AMPICILLIN	TEV	$	0.6166

ANAKINRA

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) in whom other biologics are contraindicated or in patients who have experienced serious adverse events while on other biologics and who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4-month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Initial coverage may be approved for one 100 mg dose administered daily for 8 weeks.
- Patients will be limited to receiving a one-month supply of anakinra per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks but no longer than 12 weeks after treatment to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 100 mg dose administered once daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;

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2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for anakinra must be completed using the Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

100 MG / SYR INJECTION SYRINGE

00002245913	KINERET	BVM	$	51.4936

AZITHROMYCIN

"For the prevention of disseminated Mycobacterium avium complex disease in patients with advanced HIV infection or other immunocompromised conditions.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

600 MG ORAL TABLET

00002256088	**CO AZITHROMYCIN**	**COB**	$	**7.1161**
00002261642	**PMS-AZITHROMYCIN**	**PMS**	$	**7.1161**
00002231143	ZITHROMAX	PFI	$	12.7453

BUDESONIDE

"For the treatment of inflammatory bowel disease (e.g. Crohn's, ulcerative colitis, ulcerative ileitis, etc.). This drug product must be prescribed by a specialist in Gastroenterology, Internal Medicine or Pediatrics (or by a specialist in General Surgery on a case-by-case basis, in geographic areas where access to these specialties is not available).

Special authorization may be granted for 12 months."

The following product(s) are eligible for auto-renewal.

3 MG ORAL CONTROLLED-RELEASE CAPSULE

00002229293	ENTOCORT	AZC	$	1.6383

BUSERELIN ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

The following product(s) are eligible for auto-renewal.

1 MG / ML (BASE) NASAL SOLUTION

00002225158	SUPREFACT INTRANASAL	SAV	$	8.0496

1 MG / ML (BASE) INJECTION

00002225166	SUPREFACT	SAV	$	11.4712

6.3 MG (BASE) INJECTION IMPLANT

00002228955	SUPREFACT DEPOT	SAV	$	778.9504

CABERGOLINE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): BROMOCRIPTINE

"For the treatment of hyperprolactinemia in patients who are intolerant to or who have failed bromocriptine. Special authorization may be granted for 24 months."

0.5 MG ORAL TABLET				
00002301407	**CO CABERGOLINE**	**COB**	$	**8.8550**
00002242471	DOSTINEX	PAL	$	13.0691

CASPOFUNGIN

"For esophageal candidiasis in patients who are intolerant to fluconazole and itraconazole, or who have failed both agents as evidenced by significant clinical deterioration due to the fungal infection during a course of therapy or no resolution after a full course of therapy."

50 MG / VIAL INJECTION				
00002244265	CANCIDAS	MFC	$	222.0000
70 MG / VIAL INJECTION				
00002244266	CANCIDAS	MFC	$	222.0000

CEFADROXIL

"For the treatment of skin and skin structure infections."

500 MG ORAL CAPSULE				
00002240774	**APO-CEFADROXIL**	**APX**	$	**0.8421**
00002235134	**NOVO-CEFADROXIL**	**TEV**	$	**0.8421**

CELECOXIB

"1) For patients who are at high risk of upper gastrointestinal (GI) complications due to a proven history of prior complicated GI events (e.g. GI perforation, obstruction or major bleeding) or

2) For patients who have a documented history of ulcers proven radiographically and/or endoscopically.

Special authorization for both criteria may be granted for 6 months."

All requests for celecoxib must be completed using the Celecoxib Special Authorization Request Form (ABC 31140).

The following product(s) are eligible for auto-renewal.

100 MG ORAL CAPSULE				
00002239941	CELEBREX	PFI	$	0.7008
200 MG ORAL CAPSULE				
00002239942	CELEBREX	PFI	$	1.4017

CLINDAMYCIN PHOSPHATE/ BENZOYL PEROXIDE

"For the treatment of severe acne as defined by scarring acne.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

1 % (BASE) * 5 % TOPICAL GEL				
00002248472	BENZACLIN	SAV	$	0.9180

CLOPIDOGREL BISULFATE

(Refer to 20:12.18 of the Alberta Health and Wellness Drug Benefit List for one month of coverage, following the first intravascular stent placement, when prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery.)

"For the prevention of thrombosis, for one month, when prescribed following intravascular bare metal stent placement. Patients who have received one month of coverage via the Limited Restricted Benefit will not be eligible for additional coverage under this criterion." **

"For the prevention of thrombosis, for up to 12 months, when prescribed following intravascular drug eluting stent (DES) placement. Patients who have received one month of coverage via the Limited Restricted Benefit may be eligible for an additional 11 months of coverage (i.e., up to 12 months of coverage) following the submission of a special authorization request." **

"For the prevention of cerebrovascular (e.g. stroke, TIA) and non-cerebrovascular ischemic events in patients who have a contraindication to ASA. Special authorization for this criterion may be granted for 24 months."

"For use in patients who have experienced a non-cerebrovascular ischemic event while on ASA. Special authorization for this criterion may be granted for 24 months."

"For use in patients who have experienced a cerebrovascular ischemic event (e.g. stroke, TIA) while on dipyridamole/ASA (Aggrenox) or for whom dipyridamole/ASA (Aggrenox) is contraindicated. Special authorization for this criterion may be granted for 24 months."

"Coverage will not be considered when clopidogrel and dipyridamole/ASA are intended for use in combination."

** Special Authorization for post-stent coverage is required when the prescriber prescribing the medication is not a designated prescriber, for treatment after repeat stents, or for continued coverage of up to 12 months following intravascular drug eluting stent (DES) placement.

In order to comply with the first and second criteria, information is required regarding the date, type of stent, and stenting procedure. In order to comply with the third criterion, information is required as to why ASA cannot be used. In order to comply with the fourth criterion, information is required regarding the type of ischemic event experienced while on ASA. In order to comply with the fifth criterion, information is required regarding the type of ischemic event experienced while on dipyridamole/ASA (Aggrenox) and/or why dipyridamole/ASA (Aggrenox) cannot be used.

All requests for clopidogrel bisulfate must be completed using the Clopidogrel Special Authorization Request Form (ABC 30786).

75 MG (BASE) ORAL TABLET				
00002238682	PLAVIX	SAV	$	2.5775

CYCLOSPORINE

"For the treatment of severe psoriasis in those patients where other standard therapy has failed. This drug product must be prescribed by a specialist in Dermatology."

"For the treatment of severe rheumatoid arthritis in patients who are unable to tolerate or have failed an adequate trial of methotrexate. This drug product must be prescribed by a specialist in Rheumatology (or by a Specialist in Internal Medicine with an interest in Rheumatology on a case-by-case basis, in geographic areas where access to this specialty is not available)."

"For the treatment of steroid dependent and steroid resistant nephrotic syndrome. Consideration will be given where cyclosporine is used for the induction and maintenance of remissions or for the maintenance of steroid induced remissions. This drug product must be prescribed by a specialist in Pediatrics or Nephrology."

"Special authorization for all criteria may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

10 MG ORAL CAPSULE				
00002237671	NEORAL	NOV	$	0.6706
25 MG ORAL CAPSULE				
00002247073	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**1.2500**
00002150689	NEORAL	NOV	$	1.5588
50 MG ORAL CAPSULE				
00002247074	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**2.5000**
00002150662	NEORAL	NOV	$	3.0390
100 MG ORAL CAPSULE				
00002242821	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**5.0000**
00002150670	NEORAL	NOV	$	6.0802
100 MG / ML ORAL SOLUTION				
00002244324	**APO-CYCLOSPORINE**	**APX**	$	**3.7708**
00002150697	NEORAL	NOV	$	5.4047

CYPROTERONE ACETATE

"When prescribed for non-cancer, non-cosmetic indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

The following product(s) are eligible for auto-renewal.

50 MG ORAL TABLET				
00000704431	**ANDROCUR**	**PMS**	$	**1.4085**
00002245898	**APO-CYPROTERONE**	**APX**	$	**1.4085**
00002229723	**MYLAN-CYPROTERONE**	**MYP**	$	**1.4085**
100 MG / ML INJECTION				
00000704423	ANDROCUR DEPOT	PMS	$	25.5966

DANAPAROID SODIUM

"For the treatment of patients with heparin-induced thrombocytopenia."

1,250 UNIT / ML INJECTION				
00002129043	ORGARAN	ORG	$	32.7583

DARBEPOETIN

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<100 g/L). Hemoglobin levels should be maintained within 100 - 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin > 100 mcg/L and transferrin saturation > 20%."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Aranesp should be reduced by about 25%."

In order to comply with the second criterion: if the patient has iron overload the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the first criterion, renewal requests may be considered if the patient's hemoglobin is < 120 g/L while on Aranesp.

For the second criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on Aranesp.

All requests for darbepoetin must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 30888).

10 MCG / SYR INJECTION SYRINGE			
00002246354	ARANESP (0.4 ML SYRINGE)	AMG	$ 28.8100
20 MCG / SYR INJECTION SYRINGE			
00002246355	ARANESP (0.5 ML SYRINGE)	AMG	$ 57.6200
100 MCG / ML INJECTION SYRINGE			
00002246357	ARANESP (0.3/ 0.4/ 0.5 ML SYR)	AMG	$ 288.1000
For this product - pricing has been established on a per millilitre basis.			
200 MCG / ML INJECTION SYRINGE			
00002246358	ARANESP (0.3/ 0.4/ 0.5/ 0.65 ML SYR)	AMG	$ 576.2000
For this product - pricing has been established on a per millilitre basis.			
500 MCG / ML INJECTION SYRINGE			
00002246360	ARANESP (0.3/0.4/0.6/1.0 ML SYR)	AMG	$ 1483.5000
For this product - pricing has been established on a per millilitre basis.			

DARIFENACIN HYDROBROMIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): OXYBUTYNIN

"For patients who are intolerant to oxybutynin.

Special authorization may be granted for 24 months."

7.5 MG (BASE) ORAL EXTENDED-RELEASE TABLET			
00002273217	ENABLEX	NOV	$ 1.5695
15 MG (BASE) ORAL EXTENDED-RELEASE TABLET			
00002273225	ENABLEX	NOV	$ 1.5695

DEFERASIROX

"For patients who require iron chelation therapy but in whom deferoxamine is contraindicated.

Special authorization may be granted for 6 months.

Information is required regarding the contraindication to use of deferoxamine. Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, concomitant bleeding disorders, or risk of bleeding due to anticoagulation."

The following product(s) are eligible for auto-renewal.

125 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION				
00002287420	EXJADE	NOV	$	10.6471
250 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION				
00002287439	EXJADE	NOV	$	21.2946
500 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION				
00002287447	EXJADE	NOV	$	42.5896

DONEPEZIL HCL

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Initial special authorization for new patients may be granted for a maximum of 12 weeks. Continued special authorization coverage may be granted for a maximum of 24 months.

In order to be considered for coverage beyond the initial 12-week authorization, those patients with an MMSE score of 10 or higher may be eligible for continued coverage provided their MMSE score has not dropped by more than 3 points during the 12-week period."

All requests (including renewal requests) for donepezil HCl must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 30776).

For each request, an updated MMSE score and the date on which the exam was administered must be provided. The MMSE score must be within 3 months of the time of the application (including renewal requests).

Renewal requests for patients where the updated MMSE score is greater than 26 while on this drug, may also be considered.

5 MG ORAL TABLET				
00002232043	ARICEPT	PFI	$	4.9451
10 MG ORAL TABLET				
00002232044	ARICEPT	PFI	$	4.9451

DULOXETINE HYDROCHLORIDE

"For patients with diabetes for the treatment of diabetic peripheral neuropathic pain.

Special authorization may be granted for 6 months."

In order to comply with the above criterion, information is required regarding current therapies utilized for the treatment of diabetes.

The following product(s) are eligible for auto-renewal.

30 MG (BASE) ORAL DELAYED RELEASE CAPSULE				
00002301482	CYMBALTA	LIL	$	1.9634
60 MG (BASE) ORAL DELAYED RELEASE CAPSULE				
00002301490	CYMBALTA	LIL	$	3.9264

DUTASTERIDE

"For the treatment of benign prostatic hyperplasia in patients who are poor surgical risks or who have enlarged prostates and have moderate to severe symptoms suggestive of obstruction.

Special authorization may be granted for 6 months"

Information is required regarding the medical condition(s) or circumstances by which this patient would be deemed a poor surgical risk.

All requests (including renewal requests) for dutasteride must be completed using the Dutasteride/Finasteride Special Authorization Request Form (ABC 31257).

The following product(s) are eligible for auto-renewal.

0.5 MG ORAL CAPSULE				
00002247813	AVODART	GSK	$	1.7813

EPOETIN ALFA

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%. Patients may be granted a maximum allowable dose of 40,000 IU per week."

In order to comply with this criterion, if the patient has iron overload the prescriber must state this in the request, or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests, if applicable.

Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Eprex."

All requests for epoetin alfa must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 30888).

30,000 UNIT / SYR INJECTION SYRINGE				
00002288680	EPREX	JOI	$	431.9888
40,000 UNIT / SYR INJECTION SYRINGE				
00002240722	EPREX	JOI	$	431.9888

EPOETIN ALFA

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (< 100 g/L). Hemoglobin levels should be maintained within 100 - 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin > 100 mcg/L and transferrin saturation > 20%."

"For the treatment of anemia in AZT-treated/HIV infected patients."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%."

In order to comply with the third criterion: if the patient has iron overload the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the first criterion, renewal requests may be considered if the patient's hemoglobin is < 120 g/L while on Eprex.

For the third criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on Eprex.

All requests for epoetin alfa must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 30888).

20,000 UNIT / ML INJECTION			
00002206072	EPREX	JOI	$ 287.9925
1,000 UNIT / SYR INJECTION SYRINGE			
00002231583	EPREX (0.5 ML SYRINGE)	JOI	$ 15.3188
2,000 UNIT / SYR INJECTION SYRINGE			
00002231584	EPREX (0.5 ML SYRINGE)	JOI	$ 30.6375
3,000 UNIT / SYR INJECTION SYRINGE			
00002231585	EPREX (0.3 ML SYRINGE)	JOI	$ 45.9563
4,000 UNIT / SYR INJECTION SYRINGE			
00002231586	EPREX (0.4 ML SYRINGE)	JOI	$ 61.2750
5,000 UNIT / SYR INJECTION SYRINGE			
00002243400	EPREX (0.5 ML SYRINGE)	JOI	$ 76.5938
6,000 UNIT / SYR INJECTION SYRINGE			
00002243401	EPREX (0.6 ML SYRINGE)	JOI	$ 91.9125
8,000 UNIT / SYR INJECTION SYRINGE			
00002243403	EPREX (0.8 ML SYRINGE)	JOI	$ 122.5500
10,000 UNIT / SYR INJECTION SYRINGE			
00002231587	EPREX (1 ML SYRINGE)	JOI	$ 153.1875
20,000 UNIT / SYR INJECTION SYRINGE			
00002243239	EPREX (0.5 ML SYRINGE)	JOI	$ 287.9925

ERTAPENEM

"For therapy of complicated polymicrobial skin and skin structure infections."

"For the therapy of community-acquired intra-abdominal infections."

"For culture & susceptibility directed therapy against infections with Enterobacteriaceae producing AmpC or extended-spectrum beta-lactamases (ESBLs) where there is resistance to first line agents."

"For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. Also, where applicable, the specialist in Infectious Diseases that recommended this drug is required.

1 G / VIAL	INJECTION			
00002247437	INVANZ	MFC	$	49.9500

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Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:

- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4-month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Initial coverage may be approved for 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 weeks after treatment to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 50 mg per week, for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:

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1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for etanercept for Rheumatoid Arthritis must be completed using the Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

Juvenile Rheumatoid Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile rheumatoid arthritis (JRA) in patients 4 years of age and older who:
- Have 5 or more active joints (defined by either swelling or limitation of motion plus pain and/or tenderness), AND
- Are refractory to one or more disease modifying anti-rheumatic agents (DMARDS) conventionally used in children (minimum three month trial).

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness and its agent, throughout the special authorization approval period (Pediatric RA Specialist). The patient or patient's guardian must also provide all consents and authorizations required to permit the Pediatric RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the Pediatric RA Specialist does not continually, actively and consistently participate in the Study.

- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of Enbrel per prescription at their pharmacy.

For continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric RA Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
2) The Pediatric RA Specialist must confirm in writing that the patient is a responder that meets the following criteria (JRA30):
- 30% improvement from baseline in at least three of the following six response variables, with worsening of 30% or more in no more than one of the six variables. The variables include:
  i. global assessment of the severity of the disease by the Pediatric RA Specialist,
  ii. global assessment of overall well-being by the patient or parent,
  iii. number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),
  iv. number of joints with limitation of motion,
  v. functional ability based on CHAQ scores,
  vi. ESR or CRP
3) Data from all of the six variables comprising the JRA30 and the CHAQ scores must be

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reported in each request

Following this assessment, continued coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of twelve months. After twelve months, in order to be considered for continued coverage, the patient must be re-assessed every twelve months by a Pediatric RA Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric RA Specialist to determine response, and
2) The Pediatric RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the JRA30,
3) Data from all of the six variables comprising the JRA30 and the CHAQ scores must be reported in each request.

Once a child with JRA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for etanercept for Juvenile Rheumatoid Arthritis must be completed using the Etanercept for Juvenile Rheumatoid Arthritis Special Authorization Request Form (ABC 30948).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12

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weeks after treatment to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 50 mg per week, for a period of 12 months. Ongoing coverage may be considered if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis Special Authorization Request Form (ABC 30964).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for 50 mg per week for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for

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which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed at week 12 by an RA Specialist after the initial twelve weeks of therapy to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by an RA Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for etanercept for Ankylosing Spondylitis must be completed using the Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis Special Authorization Request Form (ABC 31195).

Plaque Psoriasis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

-Initial coverage may be approved for up to 100 mg per week for 12 weeks.
-Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 12 weeks of therapy to determine response.

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2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, OR
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI

Following this assessment, continued coverage may be considered for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 31192).

25 MG / VIAL INJECTION				
00002242903	ENBREL	AMG	$	201.6745
50 MG / SYR INJECTION SYRINGE				
00002274728	ENBREL	AMG	$	403.3490

Note: 1 x 50 mg syringe is interchangeable with 2 x 25 mg vials

EZETIMIBE

"For the treatment of hypercholesterolemia in patients who are intolerant to statins or in whom a statin is contraindicated and who are at high cardiovascular risk*; or

For the treatment of hypercholesterolemia when used in combination with a statin in patients failing to achieve target LDL with a statin at maximum tolerable dose or maximum recommended dose as per respective product monograph and who are at high cardiovascular risk*:

* High cardiovascular risk is defined as possessing one of the following:
1) Pre-existing cardiovascular disease and/or cerebrovascular disease, or
2) Diabetes, or
3) Familial hypercholesterolemia, or
4) Greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool, or
5) Three or more of the following risk factors:
- Family history of premature cardiovascular disease
- Smoking
- Hypertension
- Obesity
- Glucose intolerance
- Renal disease.

Special authorization for these criteria may be granted for 6 months."

All requests for ezetimibe must be completed using the Ezetimibe Special Authorization Request Form (ABC 30925).

The following product(s) are eligible for auto-renewal.

10 MG ORAL TABLET				
00002247521	EZETROL	MFC	$	1.7248

FENTANYL

"For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who cannot swallow. Special authorization may be granted for 6 months."

"For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who require opioid therapy at a total daily dose of at least 60 mg/day oral morphine equivalents. Patients must have tried and not been able to tolerate at least two discrete courses of therapy with two of the following agents: morphine, hydromorphone and oxycodone, if not contraindicated. Special authorization may be granted for 6 months."

Information is required regarding previous medications utilized and the patient's response to therapy. Also, information regarding the number of discrete (separate) courses of these medications is required. A discrete course is defined as a separate treatment course, which may involve more than 1 agent, used at one time to manage the patient's condition.

All requests for fentanyl must be completed using the Fentanyl Special Authorization Request Form (ABC 31169).

(Please note: The following fentanyl products are benefits not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

The following product(s) are eligible for auto-renewal.

12 MCG/HR TRANSDERMAL PATCH				
00002330105	**RAN-FENTANYL MATRIX**	**RAN**	$	**2.6861**
00002311925	**RATIO-FENTANYL**	**RPH**	$	**2.6861**
00002327112	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**2.6861**
00002280345	DURAGESIC 12	JOI	$	4.7966
25 MCG/HR TRANSDERMAL PATCH				
00002314630	**NOVO-FENTANYL**	**TEV**	$	**5.9500**
00002249391	**RAN-FENTANYL**	**RAN**	$	**5.9500**
00002330113	**RAN-FENTANYL MATRIX**	**RAN**	$	**5.9500**
00002282941	**RATIO-FENTANYL**	**RPH**	$	**5.9500**
00002327120	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**5.9500**
00001937383	DURAGESIC 25	JOI	$	11.2359
50 MCG/HR TRANSDERMAL PATCH				
00002314649	**NOVO-FENTANYL**	**TEV**	$	**11.2000**
00002249413	**RAN-FENTANYL**	**RAN**	$	**11.2000**
00002330121	**RAN-FENTANYL MATRIX**	**RAN**	$	**11.2000**
00002282968	**RATIO-FENTANYL**	**RPH**	$	**11.2000**
00002327147	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**11.2000**
00001937391	DURAGESIC 50	JOI	$	21.1431
75 MCG/HR TRANSDERMAL PATCH				
00002314657	**NOVO-FENTANYL**	**TEV**	$	**15.7500**
00002249421	**RAN-FENTANYL**	**RAN**	$	**15.7500**
00002330148	**RAN-FENTANYL MATRIX**	**RAN**	$	**15.7500**
00002282976	**RATIO-FENTANYL**	**RPH**	$	**15.7500**
00002327155	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**15.7500**
00001937405	DURAGESIC 75	JOI	$	29.7366
100 MCG/HR TRANSDERMAL PATCH				
00002314665	**NOVO-FENTANYL**	**TEV**	$	**19.6000**
00002249448	**RAN-FENTANYL**	**RAN**	$	**19.6000**
00002330156	**RAN-FENTANYL MATRIX**	**RAN**	$	**19.6000**
00002282984	**RATIO-FENTANYL**	**RPH**	$	**19.6000**
00002327163	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**19.6000**
00001937413	DURAGESIC 100	JOI	$	37.0144

FENTANYL CITRATE

"For the treatment of persistent, severe chronic pain in those patients who cannot swallow, or who are intolerant of, morphine and/or hydromorphone, if not contraindicated. Special authorization may be granted for 6 months."

Information is required regarding previous medications utilized and the patient's response to therapy. Information should include the use of agents such as morphine and/or hydromorphone, if not contraindicated for the patient.

All requests for fentanyl citrate must be completed using the Fentanyl Special Authorization Request Form (ABC 31169).

(Please note: The following fentanyl citrate product is a benefit not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

The following product(s) are eligible for auto-renewal.

0.05 MG / ML (BASE)	INJECTION			
00000888346	FENTANYL CITRATE	HSP	$	1.7250

FILGRASTIM

"To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppresive anti-neoplastic drugs with curative intent. This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates)."

"For the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization following induction and consolidation treatment for acute myeloid leukemia. This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates)."

"To increase neutrophil counts and to reduce the incidence and duration of infection in patients with a diagnosis of congenital, cyclic or idiopathic neutropenia. This drug product must be prescribed by the Directors of Divisions of Hematology in tertiary care centres (or their designates)."

"For the treatment of patients undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy when prescribed by a designated prescriber."

All requests for filgrastim must be completed using the Filgrastim/Pegfilgrastim Special Authorization Request Form (ABC 31150).

Please note for the first criterion: Coverage cannot be considered for palliative patients.

0.3 MG / ML	INJECTION			
00001968017	NEUPOGEN	AMG	$	200.8295

FINASTERIDE

"For the treatment of benign prostatic hyperplasia in patients who are poor surgical risks or who have enlarged prostates and have moderate to severe symptoms suggestive of obstruction.

Special authorization may be granted for 6 months."

Information is required regarding the medical condition(s) or circumstances by which this patient would be deemed a poor surgical risk.

All requests (including renewal requests) for finasteride must be completed using the Dutasteride/Finasteride Special Authorization Request Form (ABC 31257).

The following product(s) are eligible for auto-renewal.

5 MG ORAL TABLET

00002010909	PROSCAR	MFC	$	1.8530

FLUCONAZOLE

"For susceptible infections in immunocompromised patients (e.g. patients with AIDS, cancer, or transplant patients)."

10 MG / ML ORAL SUSPENSION

00002024152	DIFLUCAN	PFI	$	1.0465

FLUTAMIDE

"When prescribed for non-cancer, non-cosmetic indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

The following product(s) are eligible for auto-renewal.

250 MG ORAL TABLET

00002230104	**PMS-FLUTAMIDE**	**PMS**	$	**1.2027**
00002238560	APO-FLUTAMIDE	APX	$	1.3530
00000637726	EUFLEX	SCH	$	1.3530
00002230089	NOVO-FLUTAMIDE	TEV	$	1.3530

GALANTAMINE HYDROBROMIDE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Initial special authorization for new patients may be granted for a maximum of 12 weeks. Continued special authorization coverage may be granted for a maximum of 24 months.

In order to be considered for coverage beyond the initial 12-week authorization, those patients with an MMSE score of 10 or higher may be eligible for continued coverage provided their MMSE score has not dropped by more than 3 points during the 12-week period."

All requests (including renewal requests) for galantamine hydrobromide must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 30776).

For each request, an updated MMSE score and the date on which the exam was administered must be provided. The MMSE score must be within 3 months of the time of the application (including renewal requests).

Renewal requests for patients where the updated MMSE score is greater than 26 while on this drug, may also be considered.

8 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE			
00002266717	REMINYL ER	JOI	$ 5.3600
16 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE			
00002266725	REMINYL ER	JOI	$ 5.3600
24 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE			
00002266733	REMINYL ER	JOI	$ 5.3600

GOSERELIN ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

The following product(s) are eligible for auto-renewal.

3.6 MG / SYR (BASE) INJECTION SYRINGE			
00002049325	ZOLADEX	AZC	$ 410.3812
10.8 MG / SYR (BASE) INJECTION SYRINGE			
00002225905	ZOLADEX LA	AZC	$ 1169.5785

IMIPENEM MONOHYDRATE/ CILASTATIN SODIUM

"For the treatment of:

1) "Second-line therapy of intra-abdominal sepsis where there is failure of first-line therapy (e.g. ampicillin + gentamicin + metronidazole), as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy or

2) Second-line therapy of severe polymicrobial skin and skin structure infections (e.g. limb threatening diabetic foot) or

3) Empiric therapy of mixed synergistic necrotizing gangrene (Fournier's gangrene) or

4) Therapy of severe ventilator-associated pneumonia where Pseudomonas and Staphylococcus aureus coverage is needed or

5) Second-line therapy of infections due to gram-negative organisms producing inducible beta-lactamases (i.e. Enterobacter spp., Citrobacter freundii complex, Serratia spp., Morganella spp., Providencia spp., Proteus vulgaris, Proteus penneri and some Hafnia spp.) or extended spectrum beta-lactamases where there is resistance to first-line agents (trimethoprim/sulfamethoxazole, ciprofloxacin and aminoglycosides) or

6) For use in other Health Canada approved indications in consultation with a specialist in Infectious Diseases."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. Also, where applicable, the specialist in Infectious Diseases that recommended this drug is required.

250 MG / VIAL (BASE)	*** 250 MG / VIAL (BASE)**	**INJECTION**			
00000717274	PRIMAXIN		MFC	$	13.0400
500 MG / VIAL (BASE)	*** 500 MG / VIAL (BASE)**	**INJECTION**			
00000717282	PRIMAXIN		MFC	$	24.3800

IMIQUIMOD

"For the treatment of Actinic Keratosis located on the head and neck in patients who have failed treatment with cryotherapy (where appropriate) and 5-fluorouracil (5-FU).

Special authorization may be granted for 6 months."

All requests for imiquimod must be completed using the Imiquimod Special Authorization Request Form (ABC 31222).

The following product(s) are eligible for auto-renewal.

50 MG/G / G	**TOPICAL**	**CREAM**			
00002239505	ALDARA		GRC	$	52.1142

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Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:

- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily)

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Initial coverage may be approved for three doses as follows: An initial dose of 3 mg/kg, followed by additional 3 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 3 mg/kg dose every 8 weeks for a period of 12 months [Note: For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg and/or treating as often as every 4 weeks]. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to

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therapy as indicated by:
- confirmation of maintenance of ACR20, OR
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for infliximab for Rheumatoid Arthritis must be completed using the Adalimumab/Anakinra/Etanercept/Infliximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease:

"Special authorization coverage may be approved for coverage of infliximab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease and/or treatment of Fistulizing Crohn's Disease in patients who meet the following criteria:

- Infliximab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for infliximab for coverage for the treatment of Moderately to Severely Active Crohn's Disease and/or Fistulizing Crohn's Disease patients (`Specialist').
- Patients must be 18 years of age or older to be considered for coverage of infliximab.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Prior to initiation of infliximab therapy for New Patients:

'New Patients' are patients who have never been treated with infliximab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; AND refractory to, or dependent on, glucocorticoids:
following at least one tapering dosing schedule of 40 mg/day, tapering by 5 mg each week to 20 mg, then tapering by 2.5 mg each week to zero, or similar;

[Note: Patients who have used the above treatments in combination will not be required to be challenged with individual treatments as monotherapy]

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AND
b) Immunosuppressive therapy as follows:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 3 months; OR
- Methotrexate: minimum or 15 mg/week for a minimum of 3 months.
OR
- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Fistulizing Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite:

a) A course of an appropriate dose of antibiotic therapy (e.g. ciprofloxacin or metronidazole) for a minimum of 3 weeks; AND
b) Immunosuppressive therapy:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 6 weeks; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 6 weeks; OR
- Immunosuppressive therapy discontinued at less than 6 weeks due to serious adverse effects or reactions.

[Note: Patients who have used the above treatments in combination for the treatment of Fistulizing Crohn's will not be required to be challenged with individual treatments as monotherapy]

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease AND/OR Fistulizing Crohn's Disease

- New Patients must meet the criteria above prior to being considered for approval.
- All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

- Coverage for Induction Dosing may only be approved for New Patients (those who have never been treated with infliximab by any health care provider).
- 'Induction Dosing' means a maximum of one 5 mg/kg dose of infliximab per New Patient at each 0, 2 and 6 weeks (for a maximum total of three doses).
- New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.

Maintenance Dosing:

'Maintenance Dosing' means one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months to:
- New Patients following the completion of Induction Dosing; OR
- Existing Patients, who are patients that are being treated, or have previously been treated, with infliximab.

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Maintenance Dosing for New Patients after Completion of Induction Dosing:

- The New Patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND
- The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's and/or confirm closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

Maintenance Dosing for Existing Patients:

- The patient must be assessed by a Specialist at least 4 to 8 weeks after the day the last dose of infliximab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND

- these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

(For existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for existing patients with Fistulizing Crohn's who respond then lose their response, the dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months, if the following criteria are met at the end of each 12 month period:

- The New Patient or the Existing Patient must be assessed by a Specialist at least 4 to 6 weeks after the day the last dose of infliximab was administered to the patient and prior to the administration of the next dose to obtain a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND
- For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; OR
- For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

(For new and existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for new and existing patients with Fistulizing Crohn's who respond then lose their response, the maintenance dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)"

All requests (including renewal requests) for infliximab for Moderately to Severely Active Crohn's

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Disease and Fistulizing Crohn's Disease must be completed using the Adalimumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 31200).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms and improvement in physical function of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for three doses as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for one 5 mg/kg dose of infliximab every 6 to 8 weeks for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by an RA Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for infliximab for Ankylosing Spondylitis must be completed using the Adalimumab/Etanercept/Infliximab for Ankylosing Spondylitis Special Authorization Request Form (ABC 31195).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active

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arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for three doses as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 5 mg/kg dose every 8 weeks, for a period of 12 months. Ongoing coverage may be considered if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for infliximab for Psoriatic Arthritis must be completed

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using the Adalimumab/Etanercept/Infliximab for Psoriatic Arthritis Special Authorization Request Form (ABC 30964).

Plaque Psoriasis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond three doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial three doses to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, or
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 5 mg/kg dose of infliximab every 8 weeks for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for infliximab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 31192).

100 MG / VIAL	INJECTION		
00002244016	REMICADE	SCH	$ 940.0000

IPRATROPIUM BROMIDE

"For use in patients with manual dexterity problems or visual limitations who are unable to prepare a dose of the drug using the multi-dose solution."

"For use in patients who are hypersensitive to preservatives contained in multi-dose solutions."

"Special authorization for both criteria may be granted for 24 months."

Information is required regarding the nature of the difficulties experienced by the patient in preparing a dose using the multi-dose preparation; or the nature of the patient's hypersensitivity to the preservatives contained in the multi-dose solution.

The following product(s) are eligible for auto-renewal.

125 MCG / ML INHALATION UNIT DOSE SOLUTION				
00002231135	**PMS-IPRATROPIUM**	**PMS**	$	**0.3775**
00002097176	**RATIO-IPRATROPIUM UDV**	**RPH**	$	**0.3775**
250 MCG / ML INHALATION UNIT DOSE SOLUTION				
00002216221	**MYLAN-IPRATROPIUM STERINEBS**	**MYP**	$	**0.7550**
00002231244	**PMS-IPRATROPIUM (1ML)**	**PMS**	$	**0.7550**
00002231245	**PMS-IPRATROPIUM (2ML)**	**PMS**	$	**0.7550**
00002097168	**RATIO-IPRATROPIUM UDV**	**RPH**	$	**0.7550**

ITRACONAZOLE

"For the treatment of oral and/or esophageal candidiasis in immunocompromised patients who are intolerant to fluconazole, or who have failed fluconazole as evidenced by significant clinical deterioration due to the fungal infection during a course of therapy or no resolution after a full course of therapy."

10 MG / ML ORAL SOLUTION				
00002231347	SPORANOX	JOI	$	0.8417

LANREOTIDE ACETATE

"For the treatment of acromegaly when prescribed by or in consultation with a Specialist in Internal Medicine.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

60 MG / SYR INJECTION SYRINGE			
00002283395	SOMATULINE AUTOGEL (0.3 ML SYRINGE)	TCI	$ 1102.0000
90 MG / SYR INJECTION SYRINGE			
00002283409	SOMATULINE AUTOGEL (0.3 ML SYRINGE)	TCI	$ 1470.0000
120 MG / SYR INJECTION SYRINGE			
00002283417	SOMATULINE AUTOGEL (0.5 ML SYRINGE)	TCI	$ 1840.0000

LEUPROLIDE ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

The following product(s) are eligible for auto-renewal.

3.75 MG / VIAL INJECTION			
00000884502	LUPRON DEPOT	ABB	$ 337.4000
5 MG / ML INJECTION			
00000727695	LUPRON	ABB	$ 67.6464
7.5 MG / VIAL INJECTION			
00000836273	LUPRON DEPOT	ABB	$ 387.9700
11.25 MG / VIAL INJECTION			
00002239834	LUPRON DEPOT	ABB	$ 1005.2600
22.5 MG / VIAL INJECTION			
00002230248	LUPRON DEPOT	ABB	$ 1071.0000

LEVOCARNITINE

"For the treatment of primary carnitine deficiency. Information is required regarding the ratio of acyl:free carnitine and total plasma carnitine levels."

"For the treatment of patients with an inborn error of metabolism that results in secondary carnitine deficiency. Information is required regarding the patient's diagnosis."

"Special authorization may be granted for 6 months."

In order to comply with the first criteria: Information is required regarding pre-treatment acyl:free carnitine and total plasma carnitine levels.

The following product(s) are eligible for auto-renewal.

330 MG ORAL TABLET			
00002144328	CARNITOR	PPC	$ 1.2583
100 MG / ML ORAL SOLUTION			
00002144336	CARNITOR	PPC	$ 0.3811
200 MG / ML INJECTION			
00002144344	CARNITOR	PPC	$ 12.0480

LINEZOLID

"For the treatment of:

1) Vancomycin-resistant enterococcus infections or

2) Methicillin-resistant Staphylococcus aureus (MRSA)/methicillin-resistant coagulase-negative Staphylococcus infections in patients who are unresponsive to or intolerant of vancomycin or

3) Susceptible organisms in patients severely intolerant or allergic to all other appropriate alternatives (e.g. beta-lactam antibiotics, clindamycin, trimethoprim/sulfamethoxazole and vancomycin) or to facilitate patient discharge from hospital where it otherwise would not be possible.

This product must be prescribed in consultation with a specialist in Infectious Diseases in all instances."

In order to comply with the above criteria, information is required regarding the type of infection and organisms involved. Information is also required regarding previous antibiotic therapy that has been utilized and the patient's response to therapy and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. The specialist in Infectious Diseases that recommended this drug is also required.

600 MG ORAL TABLET				
00002243684	ZYVOXAM	PFI	$	76.1648

MEGESTROL ACETATE

"For the treatment of non-cancer indications (e.g. cachexia in HIV/AIDS patients and cancer patients) in patients who cannot swallow tablets.

Special authorization may be granted for 6 months."

(Please note: The above megestrol acetate product is a benefit not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

The following product(s) are eligible for auto-renewal.

40 MG / ML ORAL SUSPENSION				
00002168979	MEGACE OS	BMS	$	1.5660

MEGESTROL ACETATE

"For the treatment of non-cancer indications (e.g. cachexia in HIV/AIDS patients and cancer patients).

Special authorization may be granted for 6 months."

(Please note: The above megestrol acetate products are benefits not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

The following product(s) are eligible for auto-renewal.

40 MG ORAL TABLET				
00002195917	**APO-MEGESTROL**	**APX**	$	**1.0073**
00002185415	**NU-MEGESTROL**	**NXP**	$	**1.0073**
160 MG ORAL TABLET				
00002195925	**APO-MEGESTROL**	**APX**	$	**4.2630**
00002185423	**NU-MEGESTROL**	**NXP**	$	**4.2630**

MEROPENEM

1) "As an alternative to imipenem for severe polymicrobial infections involving gram-negative organisms resistant to first-line agents in patients with documented seizure disorder/CNS abnormality or

2) As an alternative agent for severe polymicrobial infections involving gram-negative organisms resistant to first-line agents and to imipenem but susceptible to meropenem or

3) Therapy of meningitis due to gram-negative organisms producing inducible beta-lactamases (i.e. Enterobacter spp., Citrobacter freundii complex, Serratia spp., Morganella spp., Providencia spp., Proteus vulgaris, Proteus penneri and some Hafnia spp.) or

4) For treatment of CNS infections due to gram-negative organisms that are resistant to third-generation cephalosporins but are susceptible to meropenem or

5) Therapy for infections involving multi-resistant Pseudomonas aeruginosa, where there is documented susceptibility to meropenem (i.e. cannot assume meropenem susceptibility from imipenem susceptibility), in patients with documented seizure disorder/CNS abnormality or

6) For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. Also, where applicable, the specialist in Infectious Diseases that recommended this drug is required.

500 MG / VIAL INJECTION				
00002218488	MERREM	AZC	$	26.1762
1 G / VIAL INJECTION				
00002218496	MERREM	AZC	$	52.3525

METHYLPREDNISOLONE ACETATE/ ALUMINUM CHLORHYDROXIDE COMPLEX/ SULFUR

"For the treatment of acne rosacea and seborrheic dermatitis.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

2.5 MG / ML * 100 MG / ML * 50 MG / ML TOPICAL LOTION				
00000252395	MEDROL ACNE	PFI	$	0.1915

METHYLPREDNISOLONE ACETATE/ NEOMYCIN SULFATE/ ALUMINUM CHLORHYDROXIDE COMPLEX/ SULFUR

"For the treatment of severe acne as defined by scarring acne."

"For the treatment of acne rosacea and seborrheic dermatitis."

"Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

2.5 MG / ML * 2.5 MG / ML * 100 MG / ML * 50 MG / ML TOPICAL LOTION				
00000195057	NEO-MEDROL ACNE	PFI	$	0.2748

MODAFINIL

"For the treatment of documented narcolepsy. This drug product must be prescribed by a specialist in Neurology or Psychiatry, or a sleep specialist affiliated with a recognized level 1 lab.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

100 MG ORAL TABLET				
00002285398	**APO-MODAFINIL**	**APX**	$	**0.9293**
00002239665	ALERTEC	SHB	$	1.2721

MONTELUKAST SODIUM

(Refer to 48:10.24 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 6 to 18 years of age inclusive).

"For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:
a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, or
b) cannot operate inhaler devices."

"For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists."

"Special authorization for both criteria may be granted for 6 months."

In order to comply with the first criteria, information should indicate either
a) current use of inhaled steroids and contraindications or poor response to long-acting beta 2 agonists (e.g. salmeterol or formoterol) or,
b) the nature of the patient's difficulties with using inhaler devices.

In order to comply with the second criteria, information should include the nature of the patient's response to long-acting beta 2 agonists (e.g. salmeterol or formoterol).

All requests (including renewal requests) for montelukast must be completed using the Montelukast/Zafirlukast Special Authorization Request Form (ABC 31313).

The following product(s) are eligible for auto-renewal.

10 MG (BASE) ORAL TABLET				
00002238217	SINGULAIR	MFC	$	2.3413
5 MG (BASE) ORAL CHEWABLE TABLET				
00002238216	SINGULAIR	MFC	$	1.5910

NARATRIPTAN HCL

(Refer to 28:32.28 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using naratriptan hydrochloride prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

The following product(s) are eligible for auto-renewal.

1 MG (BASE) ORAL TABLET				
00002237820	AMERGE	GSK	$	14.9224
2.5 MG (BASE) ORAL TABLET				
00002237821	AMERGE	GSK	$	15.7246

OCTREOTIDE ACETATE

"For control of symptoms in patients with metastatic carcinoid and vasoactive intestinal peptide-secreting tumors (VIPomas) when prescribed by or in consultation with a Specialist in Internal Medicine, Palliative Care or General Surgery."

"For the treatment of acromegaly when prescribed by or in consultation with a Specialist in Internal Medicine."

"For the treatment of intractable diarrhea which has not responded to less costly therapy [e.g. associated with (secondary to) AIDS, intra-abdominal fistulas, short bowel syndrome]. Treatment for these indications must be prescribed by or in consultation with a Specialist in, Internal Medicine, Palliative Care, or General Surgery."

"Special authorization may be granted for 6 months."

In order to comply with the third criterion, information is required regarding previous medications utilized and the patient's response to therapy.

The following product(s) are eligible for auto-renewal.

50 MCG / ML (BASE) INJECTION			
00002248639	**OCTREOTIDE ACETATE OMEGA**	**OMG**	**$ 3.0040**
00000839191	SANDOSTATIN	NOV	$ 5.3643
100 MCG / ML (BASE) INJECTION			
00002248640	**OCTREOTIDE ACETATE OMEGA**	**OMG**	**$ 5.6708**
00000839205	SANDOSTATIN	NOV	$ 10.1265
200 MCG / ML (BASE) INJECTION			
00002248642	**OCTREOTIDE ACETATE OMEGA**	**OMG**	**$ 10.9082**
00002049392	SANDOSTATIN	NOV	$ 19.4790
500 MCG / ML (BASE) INJECTION			
00002248641	**OCTREOTIDE ACETATE OMEGA**	**OMG**	**$ 26.6506**
00000839213	SANDOSTATIN	NOV	$ 47.5903
10 MG / VIAL (BASE) INJECTION			
00002239323	SANDOSTATIN LAR	NOV	$ 1356.0802
20 MG / VIAL (BASE) INJECTION			
00002239324	SANDOSTATIN LAR	NOV	$ 1751.9920
30 MG / VIAL (BASE) INJECTION			
00002239325	SANDOSTATIN LAR	NOV	$ 2247.7927

PAPAVERINE HCL

"For the relief of cerebral or peripheral ischemia with arterial spasm.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

32.5 MG / ML INJECTION			
00000009881	PAPAVERINE HCL	SDZ	$ 1.6389

PEGFILGRASTIM

"To decrease the incidence of infection, as manifested by febrile neutropenia, in patients 18 years of age and older with non-myeloid malignancies receiving myelosuppressive antineoplastic drugs with curative intent. This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates)."

All requests for pegfilgrastim must be completed using the Filgrastim/Pegfilgrastim Special Authorization Request Form (ABC 31150).

Please note: Coverage cannot be considered for palliative patients.

6 MG / SYR INJECTION SYRINGE			
00002249790	NEULASTA (0.6 ML SYRINGE)	AMG	$ 2686.4250

PEGINTERFERON ALFA-2A

(Refer to 08:18.20 of the Alberta Health and Wellness Drug Benefit List for coverage of peginterferon alfa-2a for the treatment of Chronic Hepatitis B.)

Chronic Hepatitis C

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease, who qualify for treatment with Pegasys RBV (peginterferon alfa-2a/ribavirin) but who are intolerant to ribavirin.

All Chronic Hepatitis C Patients Prior to Initiation of Therapy:

- To determine treatment duration and prognosis, HCV genotype testing is required for all patients.
- At least three weeks before anticipated start date of therapy, please submit to Alberta Blue Cross a Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form (ABC 30944), along with appropriate lab results. In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

All Chronic Hepatitis C Patients (with the Exception of Advanced Fibrosis or Cirrhosis Patients):

Prior to initiation of therapy:

- Patients must have a baseline serum sample stored for future viral load testing in the event that the week 12 HCV RNA test is positive.

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients may receive an initial approval for 14 weeks of coverage.

At 12 weeks of treatment:

- HCV RNA testing is required for all patients at the 12th week of treatment.
- If the HCV RNA test is positive, viral load testing is required on the previously stored baseline serum sample, and the 12 week serum sample, for evaluation of continued coverage.

Renewal approval period (for patients meeting criteria):

- Patients who respond to therapy, as measured by a reduction of viral load by at least 2 logs (100 fold) or HCV RNA not detected at 12 weeks, may be approved for an additional 34 weeks of coverage (total 48 weeks).

All Chronic Hepatitis C Patients with Advanced Fibrosis or Cirrhosis:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients with advanced fibrosis or cirrhosis may receive approval for 48 weeks of coverage.

Consideration for therapy in chronic hepatitis C patients who have previously received therapy:

- Consideration for therapy in patients who have previously received therapy may be given for patients who meet at least one of the following criteria:

- Advanced fibrosis or cirrhosis.
- Patients who have relapsed following non-pegylated interferon/ribavarin combination therapy."

In order to comply with this criterion: Confirmation of the diagnosis of chronic hepatitis C and

PEGINTERFERON ALFA-2A

presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of a liver biopsy. All requests for peginterferon alfa-2a for Chronic Hepatitis C must be completed using the Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form (ABC 30944). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

180 MCG / ML INJECTION			
00002248078	PEGASYS	HLR	$ 425.5300
180 MCG / SYR INJECTION SYRINGE			
00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	$ 425.5300

PEGINTERFERON ALFA-2A/ RIBAVIRIN

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease.

Prior to initiation of Pegasys RBV therapy:

- To determine treatment duration and prognosis, HCV genotype testing is required for all patients.
- At least three (3) weeks before anticipated start date of therapy, please submit a Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form (ABC 30932) along with appropriate lab results to Alberta Blue Cross.

All Patients (with the Exception of Post-Liver Transplant Patients and Advanced Fibrosis or Cirrhosis Patients):

Prior to initiation of Pegasys RBV therapy:

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection must have a baseline serum sample stored for future viral load testing in the event that the week 12 HCV RNA test is positive.

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection, may receive an initial approval for 14 weeks of coverage.
- Genotype 2 or 3 patients may receive initial and maximal approval for 24 weeks of coverage. These patients will not be eligible for continued approval.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of coverage. These patients will not be eligible for continued approval.

At 12 weeks of treatment:

- HCV RNA testing is required for all Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection at the 12th week of treatment.
- If the HCV RNA test is positive, viral load testing is required on the previously stored baseline serum sample and the 12th week serum sample for evaluation of continued coverage.

Renewal approval period (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who respond to therapy as measured by a negative HCV RNA status at 12 weeks, may be approved for an additional 34 weeks of coverage (i.e. total 48 weeks).
- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who achieve a reduction in viral load by at least 2 logs (100 fold) but do not possess negative HCV RNA status at week 12 may be approved for an additional 14 weeks of coverage. Patients should be retested for HCV RNA status at 24 weeks:
- Patients who respond to therapy, as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 20 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Post-Liver Transplant Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients may receive an initial approval for 26 weeks of coverage.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of coverage. These patients will not be eligible for continued approval.

At 24 weeks of treatment:

PEGINTERFERON ALFA-2A/ RIBAVIRIN

- HCV RNA testing is required for all Genotype 1 and Genotype 2 or 3 patients at the 24th week of treatment.

Renewal approval period (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients who respond to therapy as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 22 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Advanced Fibrosis or Cirrhosis Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients with advanced fibrosis or cirrhosis may receive approval for 48 weeks of coverage.

Consideration for therapy in ALL patients (including post-liver transplant patients) who have previously received therapy:

- Consideration for therapy in patients who have previously received therapy may be given for patients who meet at least one of the following criteria:
- Advanced fibrosis or cirrhosis.
- Patients who have relapsed following non-pegylated interferon/ribavarin combination therapy.
- Patients who have failed to respond to or relapsed following interferon monotherapy."

Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of liver biopsy. All requests for peginterferon alfa-2a/ribavirin must be completed using the Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form (ABC 30932). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

180 MCG * 200 MG INJECTION SYRINGE/TABLET			
00002253429	PEGASYS RBV (KIT)	HLR	$ 425.5300
180 MCG * 200 MG INJECTION VIAL/TABLET			
00002253410	PEGASYS RBV (KIT)	HLR	$ 425.5300

PEGINTERFERON ALFA-2B

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease who are 18 years of age or older with documented evidence of intolerance or contraindication to ribavirin."

Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of liver biopsy. Specific information is required regarding why ribavirin cannot be used. All requests for peginterferon alpha-2b for Chronic Hepatitis C must be completed using the Peginterferon Alfa-2b for Chronic Hepatitis C Special Authorization Request Form (ABC 30933). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to the completed form.

74 MCG / VIAL INJECTION			
00002242966	UNITRON-PEG	SCH	$ 395.8500
118.4 MCG / VIAL INJECTION			
00002242967	UNITRON-PEG	SCH	$ 395.8500
177.6 MCG / VIAL INJECTION			
00002242968	UNITRON-PEG	SCH	$ 395.8500

PEGINTERFERON ALFA-2B

222 MCG / VIAL INJECTION

00002242969	UNITRON-PEG	SCH	$ 395.8500

PEGINTERFERON ALFA-2B/ RIBAVIRIN

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease.

Prior to initiation of Pegetron therapy:

- To determine treatment duration and prognosis, HCV genotype testing is required for all patients.
- At least three (3) weeks before anticipated start date of therapy, please submit a Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form (ABC 30932) along with appropriate lab results to Alberta Blue Cross.

All Patients (with the Exception of Post-Liver Transplant Patients and Advanced Fibrosis or Cirrhosis Patients):

Prior to initiation of Pegetron therapy:

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection must have a baseline serum sample stored for future viral load testing in the event that the week 12 HCV RNA test is positive.

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection, may receive an initial approval for 14 weeks of coverage.
- Genotype 2 or 3 patients may receive initial and maximal approval for 24 weeks of coverage. These patients will not be eligible for continued approval.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of coverage. These patients will not be eligible for continued approval.

At 12 weeks of treatment:

- HCV RNA testing is required for all Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection at the 12th week of treatment.
- If the HCV RNA test is positive, viral load testing is required on the previously stored baseline serum sample and the 12th week serum sample for evaluation of continued coverage.

Renewal approval period (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who respond to therapy as measured by a negative HCV RNA status at 12 weeks, may be approved for an additional 34 weeks of coverage (i.e. total 48 weeks).
- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who achieve a reduction in viral load by at least 2 logs (100 fold) but do not possess negative HCV RNA status at week 12 may be approved for an additional 14 weeks of coverage. Patients should be retested for HCV RNA status at 24 weeks:
- Patients who respond to therapy, as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 20 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Post-Liver Transplant Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients may receive an initial approval for 26 weeks of coverage.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of coverage. These patients will not be eligible for continued approval.

At 24 weeks of treatment:

PEGINTERFERON ALFA-2B/ RIBAVIRIN

- HCV RNA testing is required for all Genotype 1 and Genotype 2 or 3 patients at the 24th week of treatment.

Renewal approval period (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients who respond to therapy as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 22 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Advanced Fibrosis or Cirrhosis Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients with advanced fibrosis or cirrhosis may receive approval for 48 weeks of coverage.

Consideration for therapy in ALL patients (including post-liver transplant patients) who have previously received therapy:

- Consideration for therapy in patients who have previously received therapy may be given for patients who meet at least one of the following criteria:
- Advanced fibrosis or cirrhosis.
- Patients who have relapsed following non-pegylated interferon/ribavarin combination therapy.
- Patients who have failed to respond to or relapsed following interferon monotherapy."

Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of liver biopsy. All requests for peginterferon alfa-2b/ribavirin must be completed using the Peginterferon Alfa-2a+Ribavirin/Peginterferon Alfa-2b+Ribavirin Special Authorization Request Form (ABC 30932). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

50 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246026	PEGETRON (KIT)	SCH	$ 752.2000
80 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246027	PEGETRON (KIT)	SCH	$ 752.2000
100 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246028	PEGETRON (KIT)	SCH	$ 752.2000
120 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246029	PEGETRON (KIT)	SCH	$ 831.1800
150 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246030	PEGETRON (KIT)	SCH	$ 831.1800
80 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254581	PEGETRON REDIPEN (KIT)	SCH	$ 752.2000
100 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254603	PEGETRON REDIPEN (KIT)	SCH	$ 752.2000
120 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254638	PEGETRON REDIPEN (KIT)	SCH	$ 831.1800
150 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254646	PEGETRON REDIPEN (KIT)	SCH	$ 831.1800

PIOGLITAZONE HCL

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN

"For the treatment of Type 2 diabetes in patients who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of metformin or who are intolerant to metformin (e.g. dermatologic reactions) or for whom the product is contraindicated."

Special authorization may be granted for 24 months.

15 MG (BASE) ORAL TABLET				
00002302942	**APO-PIOGLITAZONE**	**APX**	$	**1.3201**
00002302861	**CO PIOGLITAZONE**	**COB**	$	**1.3201**
00002326477	**MINT-PIOGLITAZONE**	**MPI**	$	**1.3201**
00002298279	**MYLAN-PIOGLITAZONE**	**MYP**	$	**1.3201**
00002274914	**NOVO-PIOGLITAZONE**	**TEV**	$	**1.3201**
00002307669	**PHL-PIOGLITAZONE**	**PHH**	$	**1.3201**
00002303124	**PMS-PIOGLITAZONE**	**PMS**	$	**1.3201**
00002301423	**RATIO-PIOGLITAZONE**	**RPH**	$	**1.3201**
00002297906	**SANDOZ PIOGLITAZONE**	**SDZ**	$	**1.3201**
00002242572	ACTOS	TAK	$	2.4207
30 MG (BASE) ORAL TABLET				
00002302950	**APO-PIOGLITAZONE**	**APX**	$	**1.8495**
00002302888	**CO PIOGLITAZONE**	**COB**	$	**1.8495**
00002326485	**MINT-PIOGLITAZONE**	**MPI**	$	**1.8495**
00002298287	**MYLAN-PIOGLITAZONE**	**MYP**	$	**1.8495**
00002274922	**NOVO-PIOGLITAZONE**	**TEV**	$	**1.8495**
00002307677	**PHL-PIOGLITAZONE**	**PHH**	$	**1.8495**
00002303132	**PMS-PIOGLITAZONE**	**PMS**	$	**1.8495**
00002301431	**RATIO-PIOGLITAZONE**	**RPH**	$	**1.8495**
00002297914	**SANDOZ PIOGLITAZONE**	**SDZ**	$	**1.8495**
00002242573	ACTOS	TAK	$	3.3913
45 MG (BASE) ORAL TABLET				
00002302977	**APO-PIOGLITAZONE**	**APX**	$	**2.7808**
00002302896	**CO PIOGLITAZONE**	**COB**	$	**2.7808**
00002326493	**MINT-PIOGLITAZONE**	**MPI**	$	**2.7808**
00002298295	**MYLAN-PIOGLITAZONE**	**MYP**	$	**2.7808**
00002274930	**NOVO-PIOGLITAZONE**	**TEV**	$	**2.7808**
00002307723	**PHL-PIOGLITAZONE**	**PHH**	$	**2.7808**
00002303140	**PMS-PIOGLITAZONE**	**PMS**	$	**2.7808**
00002301458	**RATIO-PIOGLITAZONE**	**RPH**	$	**2.7808**
00002297922	**SANDOZ PIOGLITAZONE**	**SDZ**	$	**2.7808**
00002242574	ACTOS	TAK	$	5.0993

PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM

For the treatment of:

1) "Second-line therapy of intra-abdominal sepsis where there are serious adverse events due to first-line therapy or documented failure of first-line therapy (e.g. ampicillin + gentamicin + metronidazole), as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy or

2) Second-line therapy of severe polymicrobial skin and skin structure infections (e.g. limb threatening diabetic foot) or

3) Therapy of severe ventilator-associated pneumonia where Pseudomonas and Staphylococcus aureus coverage is needed."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient.

2 G / VIAL (BASE) * 250 MG / VIAL (BASE) INJECTION				
00002308444	PIPERACILLIN AND TAZOBACTAM	APX	$	9.6120
00002299623	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ	$	9.6120
00002170817	TAZOCIN	WAY	$	12.8162
3 G / VIAL (BASE) * 375 MG / VIAL (BASE) INJECTION				
00002308452	PIPERACILLIN AND TAZOBACTAM	APX	$	14.4180
00002299631	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ	$	14.4180
00002170795	TAZOCIN	WAY	$	19.2242
4 G / VIAL (BASE) * 500 MG / VIAL (BASE) INJECTION				
00002308460	PIPERACILLIN AND TAZOBACTAM	APX	$	19.2250
00002299658	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ	$	19.2250
00002170809	TAZOCIN	WAY	$	25.6334

QUINAGOLIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): BROMOCRIPTINE

"For the treatment of hyperprolactinemia in patients who are intolerant to or who have failed bromocriptine. Special authorization may be granted for 24 months."

0.075 MG ORAL TABLET				
00002223767	NORPROLAC	FEI	$	1.1718
0.15 MG ORAL TABLET				
00002223775	NORPROLAC	FEI	$	1.7523

RALOXIFENE HCL

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization for this criteria may be granted for 6 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2% loss in bone mineral density in one year). Special authorization for this criteria may be granted for 6 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

All requests for raloxifene HCl must be completed using the Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form (ABC 31086).

The following product(s) are eligible for auto-renewal.

60 MG ORAL TABLET

00002279215	**APO-RALOXIFENE**	**APX**	$	**1.1038**
00002312298	**NOVO-RALOXIFENE**	**TEV**	$	**1.1038**
00002239028	EVISTA	LIL	$	1.9711

RIFABUTIN

"For the prevention of disseminated Mycobacterium avium complex disease in patients with advanced HIV infection or other immunocompromised conditions.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

150 MG ORAL CAPSULE

00002063786	MYCOBUTIN	PFI	$	4.2051

RILUZOLE

"For use in patients who have probable or definite diagnosis of amyotrophic lateral sclerosis (ALS) as defined by World Federation of Neurology (WFN) criteria who have a vital capacity of >60% predicted and do not have a tracheostomy for invasive ventilation. This drug must be prescribed by a Specialist in Neurology."

"Patients who previously received Rilutek and were not eligible for the Phase IV study can also be considered for coverage if they meet the special authorization criteria."

"Coverage cannot be renewed once the patient has a tracheostomy for the purpose of invasive ventilation or has a vital capacity of <60% predicted."

50 MG ORAL TABLET

00002242763	RILUTEK	SAV	$	10.2225

RISEDRONATE SODIUM

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization may be granted for 6 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2% loss in bone mineral density in one year). Special authorization for this criteria may be granted for 6 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

"For the treatment of Paget's disease. Special Authorization for this criteria may be granted to a maximum of 2 months. Renewal requests may be considered following an observation period of at least 2 months."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

All requests for risedronate sodium for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form (ABC 31086).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

5 MG ORAL TABLET				
00002242518	ACTONEL	WCC	$	1.9995
30 MG ORAL TABLET				
00002239146	ACTONEL	WCC	$	12.9645
35 MG ORAL TABLET				
00002246896	ACTONEL	WCC	$	10.7043

RISPERIDONE

"For the management of the manifestations of schizophrenia and related psychotic disorders in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success AND who meet at least two of three of the following criteria:
- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
- Is refractory to trials of at least two other antipsychotic therapies (Note: one trial must include a first generation antipsychotic agent); OR
- Possesses clinical evidence of previous successful treatment with risperidone therapy.

Special Authorization may be granted for six months."

All requests (including renewal requests) for risperidone prolonged release injection must be completed using the Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 31258).

The following product(s) are eligible for auto-renewal.

25 MG / VIAL INJECTION				
00002255707	RISPERDAL CONSTA	JOI	$	168.2913
37.5 MG / VIAL INJECTION				
00002255723	RISPERDAL CONSTA	JOI	$	252.4315
50 MG / VIAL INJECTION				
00002255758	RISPERDAL CONSTA	JOI	$	336.5718

RITUXIMAB

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) with a DAS28 Score of greater than or equal to 5.1 at the time of the initial request who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily); AND
- One anti-tumor necrosis factor (anti-TNF) therapy (e.g., etanercept, infliximab or adalimumab) (minimum 12 week trial).

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for two doses of 1000 mg/dose administered at 0 and 2 weeks.
- Patients will be limited to receiving one dose of rituximab per prescription at their pharmacy.
- Patients must have discontinued etanercept for a period of greater than or equal to 4 weeks prior to initiating therapy with rituximab. Patients must have discontinued infliximab or adalimumab for a period of greater than or equal to 8 weeks prior to initiating therapy with rituximab.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For coverage for an additional two-dose course of therapy, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the previous course of therapy, between 16 and 24 weeks after receiving the initial dose of the previous course of therapy, to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- An improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above, AND
3) The patient must have experienced a subsequent loss of effect as defined by a worsening greater than or equal to 0.6 in the DAS28 score AND possess a DAS28 score of greater than or equal to 3.2 to receive an additional two-dose course of therapy.

Subsequent courses of therapy cannot be considered prior to 24 weeks elapsing from the initial dose of the previous course of therapy."

All requests (including renewal requests) for rituximab for Rheumatoid Arthritis must be completed using the Abatacept/Rituximab for Rheumatoid Arthritis Special Authorization

RITUXIMAB

Request Form (ABC 31205).

10 MG / ML INJECTION				
00002241927	RITUXAN	HLR	$	48.7083

RIVASTIGMINE HYDROGEN TARTRATE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Initial special authorization for new patients may be granted for a maximum of 12 weeks. Continued special authorization coverage may be granted for a maximum of 24 months.

In order to be considered for coverage beyond the initial 12-week authorization, those patients with an MMSE score of 10 or higher may be eligible for continued coverage provided their MMSE score has not dropped by more than 3 points during the 12-week period."

All requests (including renewal requests) for rivastigmine hydrogen tartrate must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 30776).

For each request, an updated MMSE score and the date on which the exam was administered must be provided. The MMSE score must be within 3 months of the time of the application (including renewal requests).

Renewal requests for patients where the updated MMSE score is greater than 26 while on this drug, may also be considered.

1.5 MG (BASE) ORAL CAPSULE				
00002324563	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**1.2605**
00002242115	EXELON	NOV	$	2.8013
3 MG (BASE) ORAL CAPSULE				
00002324571	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**1.2605**
00002242116	EXELON	NOV	$	2.8013
4.5 MG (BASE) ORAL CAPSULE				
00002324598	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**1.2605**
00002242117	EXELON	NOV	$	2.8013
6 MG (BASE) ORAL CAPSULE				
00002336758	**APO-RIVASTIGMINE**	**APX**	$	**1.2605**
00002332833	**MYLAN-RIVASTIGMINE**	**MYP**	$	**1.2605**
00002306026	**NOVO-RIVASTIGMINE**	**TEV**	$	**1.2605**
00002306069	**PMS-RIVASTIGMINE**	**PMS**	$	**1.2605**
00002311313	**RATIO-RIVASTIGMINE**	**RPH**	$	**1.2605**
00002324601	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**1.2605**
00002242118	EXELON	NOV	$	2.8013
2 MG / ML (BASE) ORAL SOLUTION				
00002245240	EXELON	NOV	$	1.4728

RIZATRIPTAN BENZOATE

(Refer to 28:32.28 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using rizatriptan benzoate prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

The following product(s) are eligible for auto-renewal.

5 MG (BASE) ORAL TABLET				
00002240520	MAXALT	MFC	$	14.7167
10 MG (BASE) ORAL TABLET				
00002240521	MAXALT	MFC	$	14.7167
5 MG (BASE) ORAL WAFER				
00002240518	MAXALT RPD	MFC	$	14.7167
10 MG (BASE) ORAL WAFER				
00002240519	MAXALT RPD	MFC	$	14.7167

ROSIGLITAZONE MALEATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN

"For the treatment of Type 2 diabetes in patients who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of metformin or who are intolerant to metformin (e.g. dermatologic reactions) or for whom the product is contraindicated."

Special authorization may be granted for 24 months.

2 MG (BASE) ORAL TABLET				
00002241112	AVANDIA	GSK	$	1.4787
4 MG (BASE) ORAL TABLET				
00002241113	AVANDIA	GSK	$	2.3203
8 MG (BASE) ORAL TABLET				
00002241114	AVANDIA	GSK	$	3.3180

ROSIGLITAZONE MALEATE/ METFORMIN HCL

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN

"For the treatment of Type 2 diabetes in patients who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of metformin."

Special authorization may be granted for 24 months.

1 MG (BASE) * 500 MG ORAL TABLET				
00002247085	AVANDAMET	GSK	$	0.6903
2 MG (BASE) * 500 MG ORAL TABLET				
00002247086	AVANDAMET	GSK	$	1.2482
2 MG (BASE) * 1,000 MG ORAL TABLET				
00002248440	AVANDAMET	GSK	$	1.3633
4 MG (BASE) * 500 MG ORAL TABLET				
00002247087	AVANDAMET	GSK	$	1.7142
4 MG (BASE) * 1,000 MG ORAL TABLET				
00002248441	AVANDAMET	GSK	$	1.8637

SOLIFENACIN SUCCINATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): OXYBUTYNIN

"For patients who are intolerant to oxybutynin.

Special authorization may be granted for 24 months."

5 MG ORAL TABLET				
00002277263	VESICARE	ASP	$	1.6125
10 MG ORAL TABLET				
00002277271	VESICARE	ASP	$	1.6125

SOMATROPIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of a diagnostic insulin tolerance test. Growth hormone values less than 3 mcg/litre during hypoglycemia are indicative of severe growth hormone deficiency.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

6 MG / VIAL INJECTION				
00002243077	HUMATROPE	LIL	$	294.0210
12 MG / VIAL INJECTION				
00002243078	HUMATROPE	LIL	$	588.0420

SOMATROPIN R-DNA ORIGIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of a diagnostic insulin tolerance test. Growth hormone values less than 3 mcg/litre during hypoglycemia are indicative of severe growth hormone deficiency.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

3.3 MG / VIAL INJECTION			
☒ 00002325063	OMNITROPE	SDZ	$ 111.6567
☒ 00002215136	SAIZEN	SRO	$ 155.7675
5 MG / VIAL INJECTION			
00002237971	SAIZEN	SRO	$ 233.8340
6.7 MG / ML INJECTION			
00002325071	OMNITROPE	SDZ	$ 223.3133
8.8 MG / VIAL INJECTION			
00002272083	SAIZEN	SRO	$ 374.1322

SULFUR/ SULFACETAMIDE SODIUM

"For the treatment seborrheic dermatitis and bacterial folliculitis.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

5 % * 10 % TOPICAL LOTION			
00002220407	SULFACET-R	SAV	$ 0.9910

SUMATRIPTAN HEMISULFATE

(Refer to 28:32.28 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using sumatriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

The following product(s) are eligible for auto-renewal.

5 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY			
00002230418	IMITREX	GSK	$ 15.1467
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY			
00002230420	IMITREX	GSK	$ 15.5875

SUMATRIPTAN SUCCINATE

(Refer to 28:32.28 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using sumatriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

The following product(s) are eligible for auto-renewal.

50 MG (BASE) ORAL TABLET				
00002268388	**APO-SUMATRIPTAN**	**APX**	$	**8.9364**
00002257890	**CO SUMATRIPTAN**	**COB**	$	**8.9364**
00002268914	**MYLAN-SUMATRIPTAN**	**MYP**	$	**8.9364**
00002286823	**NOVO-SUMATRIPTAN DF**	**TEV**	$	**8.9364**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**8.9364**
00002271583	**RATIO-SUMATRIPTAN**	**RPH**	$	**8.9364**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**8.9364**
00002212153	IMITREX DF	GSK	$	15.9579
100 MG (BASE) ORAL TABLET				
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**9.8442**
00002257904	**CO SUMATRIPTAN**	**COB**	$	**9.8442**
00002268922	**MYLAN-SUMATRIPTAN**	**MYP**	$	**9.8442**
00002239367	**NOVO-SUMATRIPTAN**	**TEV**	$	**9.8442**
00002286831	**NOVO-SUMATRIPTAN DF**	**TEV**	$	**9.8442**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**9.8442**
00002271591	**RATIO-SUMATRIPTAN**	**RPH**	$	**9.8442**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**9.8442**
00002212161	IMITREX DF	GSK	$	17.5789
6 MG / SYR (BASE) INJECTION SYRINGE				
00002212188	IMITREX (0.5 ML)	GSK	$	47.3968

SYNTHETIC CALCITONIN SALMON (SALCATONIN)

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a >2% loss in bone mineral density in one year). Special authorization may be granted for 6 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

All requests for synthetic calcitonin salmon must be completed using the Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form (ABC 31086).

The following product(s) are eligible for auto-renewal.

200 IU / DOSE NASAL METERED DOSE SPRAY				
00002247585	**APO-CALCITONIN**	**APX**	$	**1.7254**
00002261766	**SANDOZ CALCITONIN NS**	**SDZ**	$	**1.7254**
00002240775	MIACALCIN	NOV	$	2.2506

TACROLIMUS

"For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30 % of body surface area."

"Special authorization for all criteria may be granted for 6 months."

Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the first criteria, information is also required regarding the area(s) affected. In order to comply with the second criteria, information is also required regarding the percentage body surface area affected.

The following product(s) are eligible for auto-renewal.

0.1 % TOPICAL OINTMENT

00002244148	PROTOPIC	ASP	$	2.4730

TACROLIMUS

"For use in patients 2 to 15 years of age inclusive with atopic dermatitis who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 2 to 15 years of age inclusive with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids."

"For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30 % of body surface area."

"Special authorization for all criteria may be granted for 6 months."

Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the third criteria, information is also required regarding the area(s) affected. In order to comply with the fourth criteria, information is also required regarding the percentage body surface area affected.

The following product(s) are eligible for auto-renewal.

0.03 % TOPICAL OINTMENT

00002244149	PROTOPIC	ASP	$	2.3110

TELITHROMYCIN

"For the treatment of community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy."

In order to comply with the above criterion, information is required regarding the type of infection and organisms involved, previous antibiotic therapy that has been utilized and the patient's response to therapy. Information is also required regarding the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient.

400 MG ORAL TABLET

00002247520	KETEK	SAV	$	3.4905

TESTOSTERONE

"For use in males for the treatment of congenital and acquired primary and secondary hypogonadism."

"Coverage cannot be considered when used for the treatment of androgen decline in the aging male (ADAM)."

"Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

12.2 MG TRANSDERMAL PATCH

00002239653	ANDRODERM (2.5 MG/DAY)	PAL	$	1.9391

24.3 MG TRANSDERMAL PATCH

00002245972	ANDRODERM (5 MG/DAY)	PAL	$	3.8783

TESTOSTERONE UNDECANOATE

"For use in males for the treatment of congenital and acquired primary and secondary hypogonadism."

"Coverage cannot be considered when used for the treatment of androgen decline in the aging male (ADAM)."

"Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

40 MG ORAL CAPSULE

00000782327	ANDRIOL	ORG	$	0.9400

TETRABENAZINE

"For the treatment of hyperkinetic movement disorders when prescribed by specialists in Neurology, Psychiatry, or Geriatric Medicine.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

25 MG ORAL TABLET

00002199270	NITOMAN	BOV	$	6.6435

TIZANIDINE HCL

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): DIAZEPAM OR BACLOFEN

"For the treatment of spasticity in patients with documented evidence of intolerance or lack of response to diazepam or baclofen. Special authorization is granted for 24 months."

4 MG (BASE) ORAL TABLET				
00002259893	**APO-TIZANIDINE**	**APX**	$	**0.4129**
00002272059	**MYLAN-TIZANIDINE**	**MYP**	$	**0.4129**
00002239170	ZANAFLEX	PAL	$	0.7395

TOLTERODINE L-TARTRATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): OXYBUTYNIN

"For patients who are intolerant to oxybutynin."

"Special authorization may be granted for 24 months."

2 MG ORAL EXTENDED-RELEASE CAPSULE				
00002244612	DETROL LA	PFI	$	1.9624
4 MG ORAL EXTENDED-RELEASE CAPSULE				
00002244613	DETROL LA	PFI	$	1.9624

TRETINOIN

"For the treatment of severe acne as defined by scarring acne.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

0.05 % TOPICAL CREAM				
00000443794	RETIN-A	JJI	$	0.4016
0.1 % TOPICAL CREAM				
00000870021	RETIN-A	JJI	$	0.4016
0.01 % TOPICAL GEL				
00001926462	**VITAMIN A ACID**	**SAV**	$	**0.3053**
00000870013	RETIN-A	JJI	$	0.4016
0.025 % TOPICAL GEL				
00001926470	**VITAMIN A ACID**	**SAV**	$	**0.3053**
00000443816	RETIN-A	JJI	$	0.4016
0.05 % TOPICAL GEL				
00001926489	VITAMIN A ACID	SAV	$	0.3053

TROSPIUM CHLORIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): OXYBUTYNIN

"For patients who are intolerant to oxybutynin."

"Special authorization may be granted for 24 months."

20 MG ORAL TABLET

00002275066	TROSEC	SPC	$	0.8063

USTEKINUMAB

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory to or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved for three doses of 45 mg at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial16 weeks of therapy to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, OR
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for 45 mg every 12 weeks for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for ustekinumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 31192).

45 MG / VIAL INJECTION

00002320673	STELARA	JOI	$ 4515.0000

VALGANCICLOVIR HCL

"For the treatment of cytomegalovirus (CMV) retinitis in patients with acquired immunodeficiency syndrome (AIDS)."
"Special authorization may be granted for 12 months."

"For the prevention of CMV disease in solid organ transplant patients at risk (i.e. risk is defined as donor +ve/recipient -ve for CMV or recipient +ve post-active treatment of CMV disease with IV
ganciclovir)."
"Special authorization may be granted for 100 days."

450 MG (BASE) ORAL TABLET				
00002245777	VALCYTE	HLR	$	24.0908

VANCOMYCIN HCL

"For the treatment of:

1) Clostridium difficile enteritis if there is clinical deterioration or documented failure on metronidazole therapy. Documented failure is defined as no clinical improvement after 5 days of therapy or

2) Laboratory confirmed relapse of Clostridium difficile enteritis with symptoms after 2 courses of metronidazole therapy or

3) Clostridium difficile enteritis if there is documented or impending toxic megacolon or

4) Clostridium difficile enteritis if there is intolerance or side effects to metronidazole therapy."

125 MG (BASE) ORAL CAPSULE				
00000800430	VANCOCIN	IRO	$	7.9805
250 MG (BASE) ORAL CAPSULE				
00000788716	VANCOCIN	IRO	$	15.9604

VORICONAZOLE

"For the treatment of invasive aspergillosis for post-hospital discharge only."

"For treatment of culture proven invasive candidiasis with documented resistance to fluconazole."

"This medication must be prescribed in consultation with a specialist in Infectious Diseases."

50 MG ORAL TABLET				
00002256460	VFEND	PFI	$	12.8093
200 MG ORAL TABLET				
00002256479	VFEND	PFI	$	51.2157
200 MG / VIAL INJECTION				
00002256487	VFEND	PFI	$	150.9515

ZAFIRLUKAST

(Refer to 48:10.24 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 12 to 18 years of age inclusive).

"For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:

a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, or

b) cannot operate inhaler devices."

"For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists."

"Special authorization for both criteria may be granted for 6 months."

In order to comply with the first criteria, information should indicate either a) current use of inhaled steroids and contraindications or poor response to long-acting beta 2 agonists (e.g. salmeterol or formoterol) or, b) the nature of the patient's difficulties with using inhaler devices. In order to comply with the second criteria, information should include the nature of the patient's response to long-acting beta 2 agonists (e.g. salmeterol or formoterol).

All requests (including renewal requests) for zafirlukast must be completed using the Montelukast/Zafirlukast Special Authorization Request Form (ABC 31313).

The following product(s) are eligible for auto-renewal.

20 MG ORAL TABLET

00002236606	ACCOLATE	AZC	$	0.7749

ZOLEDRONIC ACID

"For the treatment of Paget's disease. Special Authorization for this criterion may be granted for one dose per 12 month period."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

0.05 MG / ML INJECTION

00002269198	ACLASTA	NOV	$	7.2111

ZOLEDRONIC ACID

"For the treatment of tumor-induced hypercalcemia in patients with documented evidence of intolerance or lack of response to clodronate or pamidronate. Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

0.8 MG / ML INJECTION

00002248296	ZOMETA CONCENTRATE	NOV	$	119.1272

ZOLMITRIPTAN

(Refer to 28:32.28 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using zolmitriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

The following product(s) are eligible for auto-renewal.

2.5 MG ORAL TABLET				
00002238660	ZOMIG	AZC	$	14.3333
2.5 MG ORAL DISPERSIBLE TABLET				
00002243045	ZOMIG RAPIMELT	AZC	$	14.3405
5 MG / DOSE NASAL UNIT DOSE SPRAY				
00002248993	ZOMIG	AZC	$	14.3333

SECTION 3A

Criteria for Optional Special Authorization of Select Drug Products

CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

The drug products listed in this section may be considered for coverage by optional special authorization for patients covered under Alberta Health and Wellness-sponsored drug programs. (For Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients, the optional special authorization criteria for coverage can be found in the Criteria for Optional Special Authorization of Select Drug Products section of the *Alberta Employment and Immigration Drug Benefit Supplement*.)

Criteria for Coverage

Wording that appears within quotation marks (“ ”) in this section is the official optional special authorization criteria, as recommended by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health and Wellness. Wording that is not enclosed in quotation marks outlines specific information required to interpret criteria, guidelines for submitting requests and/or information regarding conditions under which coverage cannot be provided.

Role of the Prescribers

In conjunction with the criteria, prescribers have two options by which patients may be eligible for coverage of these select optional special authorization drug products.

1) Prescribers can register to be a *designated prescriber*. Registration allows for patients to receive coverage of select drug products **without special authorization** as long as the prescription is written for one of the criteria for coverage set out in this section. Should a designated prescriber wish to prescribe one of the select drug products outside the coverage criteria, they may do so but must indicate this on the prescription; however, patients will not be eligible for payment under the Alberta government-sponsored program for such prescription and the patient may choose to receive the product at their expense. The registration form may be found on the previous page.

2) Prescribers who choose not to register will be considered *non-designated prescribers*. Such prescribers **will be required to apply for special authorization** on the patient’s behalf.

ALBERTA GOVERNMENT SPONSORED DRUG BENEFIT PROGRAMS
OPTIONAL SPECIAL AUTHORIZATION

REGISTRATION FOR DESIGNATED PRESCRIBER STATUS
for *Alberta Health and Wellness Drug Benefit List* Claim Coverage

Select Quinolone Antibiotics
ciprofloxacin, levofloxacin, moxifloxacin, ofloxacin

Please complete all sections of this form
and return it by fax to Alberta Blue Cross

Registrations will be accepted on an ongoing basis

PRESCRIBER SURNAME	FIRST NAME	INITIAL	OFFICE PHONE:	FAX:

OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.
OR PROFESSIONAL REGISTRATION NO.

I have reviewed the criteria for coverage of select quinolone products, and I agree to abide with these criteria as updated from time to time in the Optional Special Authorization section of the *Alberta Health and Wellness Drug Benefit List* for coverage under the program.

SIGNATURE OF PRESCRIBER (required): ✗ _____ **DATE:** _____

The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection of this information, please contact the Co-chairs of the Alberta Blue Cross Privacy Steering Committee at 780-498-8108 or 780-498-8597, 10009 - 108 Street, Edmonton AB, T5J 3C5.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-305-9911

Criteria For Optional Special Authorization Of Select Drug Products

Patient claims for select quinolone prescriptions written by a non-designated prescriber will be subject to a first forgiveness rule, meaning the first claim will be paid. Subsequent claims for the same product (irrespective of strength, route and form) within a 90-day period would require the prescriber to apply for special authorization for coverage on the patientís behalf.

CIPROFLOXACIN

"For the treatment of:

1) Respiratory Tract Infections:
-end stage COPD with or without bronchiectasis, where there has been documentation of previous Pseudomonas aeruginosa colonization/infection or
- pneumonic illness in cystic fibrosis; or

2) Genitourinary Tract Infections:
- urinary tract infections,
- prostatitis,
- prophylaxis of urinary tract surgical procedures or
- gonococcal infections; or

3) Skin and Soft Tissue/Bone and Joint Infections:
- malignant/invasive otitis externa,
- bone/joint infections due to gram negative organisms or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. diabetic foot infection, decubitus ulcers; or

4) Gastrointestinal Tract Infections:
- bacterial gastroenteritis where antimicrobial therapy is indicated,
- typhoid fever (enteric fever), or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. intra-abdominal infections; or

5) Other:
- prophylaxis of adult contacts of cases of invasive meningococcal disease,
- therapy/step-down therapy of hospital acquired gram negative infections,
- empiric therapy of febrile neutropenia in combination with other appropriate agents or
- exceptional case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references i.e. AMA CPGs or Bugs and Drugs.
- for use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for ciprofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

100 MG / ML	ORAL	SUSPENSION			
00002237514	CIPRO		BAI	$	0.6001

CIPROFLOXACIN HCL

"For the treatment of

1) Respiratory Tract Infections:
- end stage COPD with or without bronchiectasis, where there has been documentation of previous Pseudomonas aeruginosa colonization/infection; or
- pneumonic illness in cystic fibrosis; or

2) Genitourinary Tract Infections:
- urinary tract infections; or
- prostatitis; or
- prophylaxis of urinary tract surgical procedures; or
- gonococcal infections; or

3) Skin and Soft Tissue/Bone and Joint Infections:
- malignant/invasive otitis externa; or
- bone/joint infections due to gram negative organisms; or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. diabetic foot infection, decubitus ulcers; or

4) Gastrointestinal Tract Infections:
- bacterial gastroenteritis where antimicrobial therapy is indicated; or
- typhoid fever (enteric fever); or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. intra-abdominal infections; or

5) Other:
- prophylaxis of adult contacts of cases of invasive meningococcal disease; or
- therapy/step-down therapy of hospital acquired gram negative infections; or
- empiric therapy of febrile neutropenia in combination with other appropriate agents; or
- exceptional case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references i.e. AMA CPGs or Bugs and Drugs; or
- for use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for Ciprofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

250 MG (BASE) ORAL TABLET

00002229521	**APO-CIPROFLOX**	**APX**	$	**1.3992**
00002332132	**CIPROFLOXACIN**	**RAN**	$	**1.3992**
00002247339	**CO CIPROFLOXACIN**	**COB**	$	**1.3992**
00002317427	**MINT-CIPROFLOXACIN**	**MPI**	$	**1.3992**
00002245647	**MYLAN-CIPROFLOXACIN**	**MYP**	$	**1.3992**
00002161737	**NOVO-CIPROFLOXACIN**	**TEV**	$	**1.3992**
00002248437	**PMS-CIPROFLOXACIN**	**PMS**	$	**1.3992**
00002303728	**RAN-CIPROFLOX**	**RAN**	$	**1.3992**
00002267934	**RAN-CIPROFLOXACIN**	**RAN**	$	**1.3992**
00002246825	**RATIO-CIPROFLOXACIN**	**RPH**	$	**1.3992**
00002248756	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**1.3992**
00002155958	CIPRO	BAI	$	2.6598

CIPROFLOXACIN HCL

500 MG (BASE) ORAL TABLET

00002229522	**APO-CIPROFLOX**	**APX**	$	**1.5786**
00002332140	**CIPROFLOXACIN**	**RAN**	$	**1.5786**
00002247340	**CO CIPROFLOXACIN**	**COB**	$	**1.5786**
00002317435	**MINT-CIPROFLOXACIN**	**MPI**	$	**1.5786**
00002245648	**MYLAN-CIPROFLOXACIN**	**MYP**	$	**1.5786**
00002161745	**NOVO-CIPROFLOXACIN**	**TEV**	$	**1.5786**
00002248438	**PMS-CIPROFLOXACIN**	**PMS**	$	**1.5786**
00002303736	**RAN-CIPROFLOX**	**RAN**	$	**1.5786**
00002267942	**RAN-CIPROFLOXACIN**	**RAN**	$	**1.5786**
00002246826	**RATIO-CIPROFLOXACIN**	**RPH**	$	**1.5786**
00002248757	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**1.5786**
00002155966	CIPRO	BAI	$	3.0009

750 MG (BASE) ORAL TABLET

00002229523	**APO-CIPROFLOX**	**APX**	$	**2.9774**
00002332159	**CIPROFLOXACIN**	**RAN**	$	**2.9774**
00002247341	**CO CIPROFLOXACIN**	**COB**	$	**2.9774**
00002317443	**MINT-CIPROFLOXACIN**	**MPI**	$	**2.9774**
00002245649	**MYLAN-CIPROFLOXACIN**	**MYP**	$	**2.9774**
00002161753	**NOVO-CIPROFLOXACIN**	**TEV**	$	**2.9774**
00002248439	**PMS-CIPROFLOXACIN**	**PMS**	$	**2.9774**
00002303744	**RAN-CIPROFLOX**	**RAN**	$	**2.9774**
00002267950	**RAN-CIPROFLOXACIN**	**RAN**	$	**2.9774**
00002246827	**RATIO-CIPROFLOXACIN**	**RPH**	$	**2.9774**
00002248758	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**2.9774**
00002155974	CIPRO	BAI	$	5.4952

LEVOFLOXACIN

"To be prescribed according to ONE of the following criteria:

For the treatment of

1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

2) Community acquired pneumonia in patients with co-morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking); or

3) Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

4) Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with beta-lactam (penicillin and cephalosporin) allergy; or

5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for Levofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

250 MG ORAL TABLET				
00002284707	**APO-LEVOFLOXACIN**	**APX**	$	**2.8494**
00002315424	**CO LEVOFLOXACIN**	**COB**	$	**2.8494**
00002313979	**MYLAN-LEVOFLOXACIN**	**MYP**	$	**2.8494**
00002248262	**NOVO-LEVOFLOXACIN**	**TEV**	$	**2.8494**
00002284677	**PMS-LEVOFLOXACIN**	**PMS**	$	**2.8494**
00002298635	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**2.8494**
500 MG ORAL TABLET				
00002284715	**APO-LEVOFLOXACIN**	**APX**	$	**3.2153**
00002315432	**CO LEVOFLOXACIN**	**COB**	$	**3.2153**
00002313987	**MYLAN-LEVOFLOXACIN**	**MYP**	$	**3.2153**
00002248263	**NOVO-LEVOFLOXACIN**	**TEV**	$	**3.2153**
00002284685	**PMS-LEVOFLOXACIN**	**PMS**	$	**3.2153**
00002298643	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**3.2153**
750 MG ORAL TABLET				
00002325942	**APO-LEVOFLOXACIN**	**APX**	$	**5.6889**
00002315440	**CO LEVOFLOXACIN**	**COB**	$	**5.6889**
00002285649	**NOVO-LEVOFLOXACIN**	**TEV**	$	**5.6889**
00002298651	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**5.6889**
00002246804	LEVAQUIN	JOI	$	10.1588

MOXIFLOXACIN HCL

"To be prescribed according to ONE of the following criteria:

For the treatment of

1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

2) Community acquired pneumonia in patients with co-morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking); or

3) Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

4) Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with beta-lactam (penicillin and cephalosporin) allergy; or

5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for Moxifloxacin HCl must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

400 MG (BASE) ORAL TABLET				
00002242965	AVELOX	BAI	$	6.1648

OFLOXACIN

"To be prescribed according to ONE of the following criteria:

For the treatment of

1) Pelvic inflammatory disease; or

2) Epididymo-orchitis/epididymitis most likely due to enteric organisms; or

3) Chlamydia infection; or

4) Gonococcal infection; or

5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for Ofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

200 MG ORAL TABLET				
00002231529	**APO-OFLOX**	**APX**	$	**1.3041**
00002243474	**NOVO-OFLOXACIN**	**TEV**	$	**1.3041**
300 MG ORAL TABLET				
00002231531	**APO-OFLOX**	**APX**	$	**1.5323**
00002243475	**NOVO-OFLOXACIN**	**TEV**	$	**1.5323**
400 MG ORAL TABLET				
00002231532	APO-OFLOX	APX	$	1.5323

SECTION 4

Rare Diseases Drug Coverage Program

RARE DISEASES DRUG COVERAGE PROGRAM

Selected drug products used in the treatment of rare diseases may be considered for coverage for individuals covered under Alberta government-sponsored drug programs. The Minister of Health and Wellness makes the final decisions regarding coverage under this Program, and may list a drug product under this section when the Minister considers it in the public interest to do so.[1].

RARE DISEASES DRUG COVERAGE

In order to be eligible for the Rare Diseases Drug Coverage Program, an individual must:

- have Alberta government-sponsored drug coverage;
- be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five years unless:
    - the individual is less than five years of age at the date of the application, then the individual's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years;

    OR

    - the individual has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for a drug product listed in this section in the province of origin by a provincial or territorial government sponsored drug plan, and the individual has been registered in the Alberta Health Care Insurance Plan (the individual must provide supporting documentation from the province of origin to prove prior coverage).
- meet the clinical criteria for a rare disease drug product published on the *List*;
- have a *Rare Diseases Drug Coverage* Application form ("Application") submitted on their behalf to Alberta Blue Cross by the individual's "Rare Disease Specialist";
- have the Application reviewed and approved for coverage by the Alberta Rare Diseases Clinical Review Panel ("Review Panel")
- complete the required forms, and consent to and acknowledge that
    - approval for initial and continued coverage is conditional upon clinical outcomes;
    - regular monitoring of the individual's clinical outcomes will be required, and
    - that coverage will be discontinued if there is inadequate response or the individual's condition deteriorates as outlined in the withdrawal criteria established in relation to a specific rare diseases drug product and/or as assessed by the Review Panel.

Contraindications

In addition to meeting the above criteria, the individual must not have the following contraindications:

- Significant illness, not including one of the rare diseases, likely to substantially alter or reduce life expectancy**.**

[1] Section 1 of the AHWDBL does not apply to the Rare Diseases Drug Coverage Program

Rare Diseases Drugs Eligible for Coverage

Drug products approved by Health Canada for the treatment of Rare Diseases may be considered for coverage in accordance with this section.

Rare Diseases are genetic, lysosmal storage disorders occurring at a rate of less than one per 50,000 for the Canadian population for a specific disease (as determined by Alberta Health and Wellness).

As of April 1, 2009, drug products for the treatment of the following rare diseases are currently under consideration for coverage:

- Gaucher's disease
- Fabry disease
- MPS-I (Hurler/Hurler Scheie)
- Hunter disease
- Pompe disease

Alberta Rare Diseases Clinical Review Panel

The Alberta Rare Diseases Clinical Review Panel ("Review Panel") is a review panel composed of specialists treating rare diseases and other health professionals with clinical expertise, appointed by the Minister of Health and Wellness.

The Review Panel's functions include:

- Providing advice to Alberta Health and Wellness regarding the Rare Diseases Drug Coverage Program;
- Reviewing and applying clinical knowledge and skills to individual applications for Rare Diseases Drug Coverage; and
- Providing advice to the Expert Committee on Drug Evaluation and Therapeutics regarding drug products under consideration for coverage under this section, clinical criteria for rare diseases drug products and identifying appropriate "Rare Disease Specialists".

Process for Rare Diseases Drug Coverage

Participating "Rare Disease Specialists" must complete a Rare Diseases Drug Coverage Application form for each individual. The form must be the one specific to the rare diseases drug product being requested. The completed application may be forwarded to Alberta Blue Cross by mail or by facsimile.

To be considered for Rare Diseases Drug Coverage, the "Rare Disease Specialist" must confirm the individual (or individual's parent/guardian/legal representative) has been provided with information regarding the Rare Diseases Drug Coverage Program and have completed the required forms.

Alberta Blue Cross, in providing administrative support to the Review Panel, receives and screens each application for completeness, then forwards to Alberta Health and Wellness to confirm that the individual

has met the Alberta Health Care Insurance Plan registration requirement (please see above). Once it has been confirmed that the individual meets the Alberta Health Care Insurance Plan registration requirement, Alberta Blue Cross forwards the application to the Review Panel for assessment. Alberta Blue Cross responds to applicants on the Review Panel's behalf. After an application has been assessed by the Review Panel, Alberta Blue Cross notifies the individual's "Rare Disease Specialist" and the individual or individual's parent/guardian/legal representative by letter of the Review Panel's decision. Eligibility will be effective the date coverage is approved by the Review Panel.

Renewals require a new drug product specific Rare Diseases Drug Coverage Application form that is completed by a "Rare Disease Specialist".

To be eligible for Rare Diseases Drug Coverage, prescriptions must be written by a "Rare Disease Specialist" as identified by the eligibility criteria for the drug product. To avoid wastage, prescription quantities are limited to a one-month supply. Extended quantity and vacation supplies are not permitted. Out-of-country claims will only be reimbursed in accordance with standard rules and regulations; individuals should verify with Alberta Blue Cross these rules and regulations prior to obtaining drug products out of the country.

Government will not be responsible for reimbursement of costs associated with wastage or improper storage of rare diseases drug products.

Prior approval must be granted to ensure coverage. Approval is granted for a specific period, to a maximum of 12 months. If continued treatment is necessary, it is the responsibility of the individual or individual's parent/guardian/legal representative and the "Rare Disease Specialist" to re-apply for drug product coverage prior to the expiry date of the authorization period.

PART 2

Pharmacologic – Therapeutic Classification of Drugs

04:00

Antihistamine Drugs

04:00 ANTIHISTAMINE DRUGS

04:04.04 FIRST GENERATION ANTIHISTAMINES (ETHANOLAMINE DERIVATIVES)

DIPHENHYDRAMINE HCL

50 MG / ML INJECTION				
00000596612	DIPHENHYDRAMINE	SDZ	$	3.7630

04:00 ANTIHISTAMINE DRUGS

04:04.12 FIRST GENERATION ANTIHISTAMINES (PHENOTHIAZINE DERIVATIVES)

PROMETHAZINE HCL

25 MG / ML (BASE) INJECTION				
00000567434	PROMETHAZINE	SDZ	$	1.0135

TRIMEPRAZINE TARTRATE

2.5 MG (BASE) ORAL TABLET				
00001926306	PANECTYL	ERF	$	0.2856
5 MG (BASE) ORAL TABLET				
00001926292	PANECTYL	ERF	$	0.3503

04:00 ANTIHISTAMINE DRUGS

04:92 OTHER ANTIHISTAMINES

KETOTIFEN FUMARATE

1 MG (BASE) ORAL TABLET				
00002230730	**NOVO-KETOTIFEN**	**TEV**	$	**0.6335**
00000577308	ZADITEN	PAL	$	0.7943
0.2 MG / ML (BASE) ORAL SYRUP				
00002176084	NOVO-KETOTIFEN	TEV	$	0.1334

08:00

Anti-Infective Agents

08:00 ANTI-INFECTIVE AGENTS

08:08 ANTHELMINTICS

MEBENDAZOLE

100 MG ORAL CHEWABLE TABLET				
00000556734	VERMOX	JOI	$	3.9560

08:00 ANTI-INFECTIVE AGENTS

08:12.02 ANTIBACTERIALS (AMINOGLYCOSIDES)

GENTAMICIN SULFATE

40 MG / ML (BASE) INJECTION				
00002242652	GENTAMICIN	SDZ	$	2.6902

TOBRAMYCIN SULFATE

60 MG / ML (BASE) INHALATION SOLUTION				
00002239630	TOBI	NOV	$	10.8844
10 MG / ML (BASE) INJECTION				
00002241209	TOBRAMYCIN	SDZ	$	2.1615
40 MG / ML (BASE) INJECTION				
00002241210	TOBRAMYCIN	SDZ	$	2.9974

08:00 ANTI-INFECTIVE AGENTS

08:12.06.04 ANTIBACTERIALS CEPHALOSPORINS (FIRST GENERATION CEPHALOSPORINS)

CEFAZOLIN SODIUM

500 MG / VIAL (BASE) INJECTION				
00002308932	**CEFAZOLIN**	**SDZ**	$	**4.0000**
00002108119	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**4.0000**
1 G / VIAL (BASE) INJECTION				
00002297205	**CEFAZOLIN**	**APX**	$	**6.0000**
00002308959	**CEFAZOLIN**	**SDZ**	$	**6.0000**
00002108127	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**6.0000**
10 G / VIAL (BASE) INJECTION				
00002297213	**CEFAZOLIN**	**APX**	$	**56.0000**
00002308967	**CEFAZOLIN**	**SDZ**	$	**56.0000**
00002108135	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**56.0000**

CEPHALEXIN

250 MG ORAL TABLET				
00000768723	**APO-CEPHALEX**	**APX**	$	**0.2250**
00000583413	**NOVO-LEXIN**	**TEV**	$	**0.2250**
00000865877	**NU-CEPHALEX**	**NXP**	$	**0.2250**
500 MG ORAL TABLET				
00000768715	**APO-CEPHALEX**	**APX**	$	**0.4500**
00000583421	**NOVO-LEXIN**	**TEV**	$	**0.4500**
00000865885	**NU-CEPHALEX**	**NXP**	$	**0.4500**
250 MG ORAL CAPSULE				
00000342084	NOVO-LEXIN	TEV	$	0.2257
500 MG ORAL CAPSULE				
00000342114	NOVO-LEXIN	TEV	$	0.4514

08:00 ANTI-INFECTIVE AGENTS

08:12.06.04 ANTIBACTERIALS
CEPHALOSPORINS
(FIRST GENERATION CEPHALOSPORINS)

CEPHALEXIN

25 MG / ML ORAL SUSPENSION				
00000342106	NOVO-LEXIN	TEV	$	0.0845
50 MG / ML ORAL SUSPENSION				
00000342092	NOVO-LEXIN	TEV	$	0.1327

08:00 ANTI-INFECTIVE AGENTS

08:12.06.08 ANTIBACTERIALS
CEPHALOSPORINS
(SECOND GENERATION CEPHALOSPORINS)

CEFPROZIL

250 MG ORAL TABLET				
00002292998	**APO-CEFPROZIL**	**APX**	$	**0.9703**
00002332035	**CEFPROZIL**	**RAN**	$	**0.9703**
00002293528	**RAN-CEFPROZIL**	**RAN**	$	**0.9703**
00002302179	**SANDOZ CEFPROZIL**	**SDZ**	$	**0.9703**
00002163659	CEFZIL	BMS	$	1.7327
500 MG ORAL TABLET				
00002293005	**APO-CEFPROZIL**	**APX**	$	**1.9025**
00002332043	**CEFPROZIL**	**RAN**	$	**1.9025**
00002293536	**RAN-CEFPROZIL**	**RAN**	$	**1.9025**
00002302187	**SANDOZ CEFPROZIL**	**SDZ**	$	**1.9025**
00002163667	CEFZIL	BMS	$	3.3974
25 MG / ML ORAL SUSPENSION				
00002303426	**SANDOZ CEFPROZIL**	**SDZ**	$	**0.0948**
00002163675	CEFZIL	BMS	$	0.1693
50 MG / ML ORAL SUSPENSION				
00002293951	**APO-CEFPROZIL**	**APX**	$	**0.1896**
00002332027	**CEFPROZIL**	**RAN**	$	**0.1896**
00002293579	**RAN-CEFPROZIL**	**RAN**	$	**0.1896**
00002303434	**SANDOZ CEFPROZIL**	**SDZ**	$	**0.1896**
00002163683	CEFZIL	BMS	$	0.3386

CEFUROXIME AXETIL

250 MG (BASE) ORAL TABLET				
00002244393	**APO-CEFUROXIME**	**APX**	$	**0.9745**
00002242656	**RATIO-CEFUROXIME**	**RPH**	$	**0.9745**
00002212277	CEFTIN	GSK	$	1.7401
500 MG (BASE) ORAL TABLET				
00002244394	**APO-CEFUROXIME**	**APX**	$	**1.9304**
00002242657	**RATIO-CEFUROXIME**	**RPH**	$	**1.9304**
00002212285	CEFTIN	GSK	$	3.4472

08:00 ANTI-INFECTIVE AGENTS

08:12.06.12 ANTIBACTERIALS
CEPHALOSPORINS
(THIRD GENERATION CEPHALOSPORINS)

CEFIXIME

400 MG ORAL TABLET			
00000868981	SUPRAX	SAV	$ 3.6872
20 MG / ML ORAL SUSPENSION			
00000868965	SUPRAX	SAV	$ 0.4288

CEFOTAXIME SODIUM

500 MG / VIAL (BASE) INJECTION			
00002225085	CLAFORAN	SAV	$ 6.4500
1 G / VIAL (BASE) INJECTION			
00002225093	CLAFORAN	SAV	$ 9.8900
2 G / VIAL (BASE) INJECTION			
00002225107	CLAFORAN	SAV	$ 19.7800

CEFTAZIDIME

1 G / VIAL INJECTION			
00002212218	FORTAZ	GSK	$ 24.2821
2 G / VIAL INJECTION			
00002212226	FORTAZ	GSK	$ 47.7418
6 G / VIAL INJECTION			
00002212234	FORTAZ	GSK	$ 143.2940

CEFTRIAXONE SODIUM

0.25 G / VIAL (BASE) INJECTION			
00002292866	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$ **7.5250**
00000657387	ROCEPHIN	HLR	$ 12.1324
1 G / VIAL (BASE) INJECTION			
00002292270	CEFTRIAXONE FOR INJECTION USP	SDZ	$ 23.8000
00002292874	CEFTRIAXONE FOR INJECTION USP	APX	$ 23.8000
00000657417	ROCEPHIN	HLR	$ 38.3775
2 G / VIAL (BASE) INJECTION			
00002292289	**CEFTRIAXONE FOR INJECTION USP**	**SDZ**	$ **46.9000**
00002292882	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$ **46.9000**

08:00 ANTI-INFECTIVE AGENTS

08:12.08 ANTIBACTERIALS
(CHLORAMPHENICOL)

CHLORAMPHENICOL SODIUM SUCCINATE

1 G / VIAL (BASE) INJECTION			
00000312363	CHLOROMYCETIN	ERF	$ 19.4080

08:00 ANTI-INFECTIVE AGENTS

08:12.12.04 ANTIBACTERIALS MACROLIDES (ERYTHROMYCINS)

ERYTHROMYCIN

250 MG ORAL TABLET				
00000682020	APO-ERYTHRO BASE	APX	$	0.1828
250 MG ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000726672	**APO-ERYTHRO E-C**	**APX**	$	**0.3900**
00000607142	ERYC	PFI	$	0.5191
333 MG ORAL CAPSULE (ENTERIC-COATED PELLET)				
00001925938	**APO-ERYTHRO E-C**	**APX**	$	**0.4332**
00000873454	ERYC	PFI	$	0.5767

ERYTHROMYCIN ESTOLATE

50 MG / ML (BASE) ORAL SUSPENSION				
00000262595	NOVO-RYTHRO ESTOLATE	TEV	$	0.1212

ERYTHROMYCIN ETHYLSUCCINATE

600 MG (BASE) ORAL TABLET				
00000637416	APO-ERYTHRO-ES	APX	$	0.3363
40 MG / ML (BASE) ORAL SUSPENSION				
00000605859	NOVO-RYTHRO EES	TEV	$	0.0923
80 MG / ML (BASE) ORAL SUSPENSION				
00000652318	NOVO-RYTHRO EES	TEV	$	0.1398

ERYTHROMYCIN STEARATE

250 MG ORAL TABLET				
00000545678	APO-ERYTHRO-S	APX	$	0.2118
500 MG ORAL TABLET				
00000688568	APO-ERYTHRO-S	APX	$	0.5425

08:00 ANTI-INFECTIVE AGENTS

08:12.12.92 ANTIBACTERIALS MACROLIDES (OTHER MACROLIDES)

AZITHROMYCIN

250 MG ORAL TABLET				
00002247423	**APO-AZITHROMYCIN**	**APX**	$	**2.9650**
00002255340	**CO AZITHROMYCIN**	**COB**	$	**2.9650**
00002278359	**MYLAN-AZITHROMYCIN**	**MYP**	$	**2.9650**
00002267845	**NOVO-AZITHROMYCIN**	**TEV**	$	**2.9650**
00002278588	**PHL-AZITHROMYCIN**	**PHH**	$	**2.9650**
00002261634	**PMS-AZITHROMYCIN**	**PMS**	$	**2.9650**
00002275287	**RATIO-AZITHROMYCIN**	**RPH**	$	**2.9650**
00002265826	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**2.9650**
00002212021	ZITHROMAX	PFI	$	5.3106
20 MG / ML ORAL SUSPENSION				
00002315157	**NOVO-AZITHROMYCIN**	**TEV**	$	**0.6410**
00002274388	**PMS-AZITHROMYCIN**	**PMS**	$	**0.6410**
00002332388	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.6410**
00002223716	ZITHROMAX	PFI	$	1.1480

08:00 ANTI-INFECTIVE AGENTS

08:12.12.92 ANTIBACTERIALS
MACROLIDES
(OTHER MACROLIDES)

AZITHROMYCIN

40 MG / ML ORAL SUSPENSION				
00002315165	**NOVO-AZITHROMYCIN**	**TEV**	$	**0.9083**
00002274396	**PMS-AZITHROMYCIN**	**PMS**	$	**0.9083**
00002332396	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.9083**
00002223724	ZITHROMAX	PFI	$	1.6267

CLARITHROMYCIN

250 MG ORAL TABLET				
00001984853	BIAXIN BID	ABB	$	1.6487
500 MG ORAL TABLET				
00002248857	**MYLAN-CLARITHROMYCIN**	**MYP**	$	**1.8249**
00002247574	**PMS-CLARITHROMYCIN**	**PMS**	$	**1.8249**
00002247819	**RATIO-CLARITHROMYCIN**	**RPH**	$	**1.8249**
00002266547	**SANDOZ CLARITHROMYCIN**	**SDZ**	$	**1.8249**
00002126710	BIAXIN BID	ABB	$	3.2587
500 MG ORAL EXTENDED-RELEASE TABLET				
00002244756	BIAXIN XL	ABB	$	2.5144
25 MG / ML ORAL SUSPENSION				
00002146908	BIAXIN	ABB	$	0.2842
50 MG / ML ORAL SUSPENSION				
00002244641	BIAXIN	ABB	$	0.5674

08:00 ANTI-INFECTIVE AGENTS

08:12.16.04 ANTIBACTERIALS
PENICILLINS
(NATURAL PENICILLINS)

PENICILLIN G SODIUM

1,000,000 IU / VIAL INJECTION				
00001930672	PENICILLIN G SODIUM	TEV	$	2.4072
5,000,000 IU / VIAL INJECTION				
00000883751	PENICILLIN G SODIUM	TEV	$	5.1153
10,000,000 IU / VIAL INJECTION				
00001930680	PENICILLIN G SODIUM	TEV	$	8.9267

PENICILLIN V POTASSIUM

300 MG ORAL TABLET				
00000642215	**APO-PEN-VK**	**APX**	$	**0.0710**
00000021202	**NOVO-PEN-VK**	**TEV**	$	**0.0710**
00000717568	**NU-PEN-VK**	**NXP**	$	**0.0710**
25 MG / ML ORAL LIQUID				
00000642223	APO-PEN-VK	APX	$	0.0535
60 MG / ML ORAL LIQUID				
00000642231	**APO-PEN-VK**	**APX**	$	**0.0618**
00000391603	**NOVO-PEN-VK**	**TEV**	$	**0.0618**

08:00 ANTI-INFECTIVE AGENTS

08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE

125 MG (BASE) ORAL CHEWABLE TABLET				
00002036347	NOVAMOXIN	TEV	$	0.4180
250 MG (BASE) ORAL CHEWABLE TABLET				
00002036355	NOVAMOXIN	TEV	$	0.6156
250 MG (BASE) ORAL CAPSULE				
00000628115	**APO-AMOXI**	**APX**	$	**0.1750**
00002238171	**MYLAN-AMOXILLIN**	**MYP**	$	**0.1750**
00000406724	**NOVAMOXIN**	**TEV**	$	**0.1750**
00000865567	**NU-AMOXI**	**NXP**	$	**0.1750**
00002230243	**PMS-AMOXICILLIN**	**PMS**	$	**0.1750**
500 MG (BASE) ORAL CAPSULE				
00000628123	**APO-AMOXI**	**APX**	$	**0.3417**
00002238172	**MYLAN-AMOXILLIN**	**MYP**	$	**0.3417**
00000406716	**NOVAMOXIN**	**TEV**	$	**0.3417**
00000865575	**NU-AMOXI**	**NXP**	$	**0.3417**
00002230244	**PMS-AMOXICILLIN**	**PMS**	$	**0.3417**
25 MG / ML (BASE) ORAL SUSPENSION				
00000452149	**NOVAMOXIN**	**TEV**	$	**0.0352**
00000628131	APO-AMOXI	APX	$	0.0353
00001934171	NOVAMOXIN SUGAR-REDUCED	TEV	$	0.0353
00000865540	NU-AMOXI	NXP	$	0.0353
00002230245	PMS-AMOXICILLIN	PMS	$	0.0353
50 MG / ML (BASE) ORAL SUSPENSION				
00000628158	**APO-AMOXI**	**APX**	$	**0.0540**
00000452130	**NOVAMOXIN**	**TEV**	$	**0.0540**
00001934163	**NOVAMOXIN SUGAR-REDUCED**	**TEV**	$	**0.0540**
00000865559	**NU-AMOXI**	**NXP**	$	**0.0540**
00002230246	**PMS-AMOXICILLIN**	**PMS**	$	**0.0540**

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM

250 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002243350	APO-AMOXI CLAV	APX	$	0.9375
500 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002243351	**APO-AMOXI CLAV**	**APX**	$	**0.8911**
00002243771	**RATIO-ACLAVULANATE**	**RPH**	$	**0.8911**
00001916858	CLAVULIN-500F	GSK	$	1.5912
875 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002245623	**APO-AMOXI CLAV**	**APX**	$	**1.2610**
00002248138	**NOVO-CLAVAMOXIN**	**TEV**	$	**1.2610**
00002247021	**RATIO-ACLAVULANATE**	**RPH**	$	**1.2610**
00002238829	CLAVULIN-875	GSK	$	2.3868
25 MG / ML (BASE) * 6.25 MG / ML (BASE) ORAL SUSPENSION				
00002244646	**RATIO-ACLAVULANATE 125F**	**RPH**	$	**0.0704**
00001916882	CLAVULIN-125F	GSK	$	0.1258
40 MG / ML (BASE) * 5.7 MG / ML (BASE) ORAL SUSPENSION				
00002238831	CLAVULIN-200	GSK	$	0.1548
50 MG / ML (BASE) * 12.5 MG / ML (BASE) ORAL SUSPENSION				
00002243987	**APO-AMOXI CLAV**	**APX**	$	**0.1211**
00002244647	**RATIO-ACLAVULANATE 250F**	**RPH**	$	**0.1211**
00001916874	CLAVULIN-250F	GSK	$	0.2162

08:00 ANTI-INFECTIVE AGENTS

08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM

80 MG / ML (BASE) * 11.4 MG / ML (BASE) ORAL SUSPENSION				
00002288559	**APO-AMOXI CLAV**	**APX**	$	**0.1969**
00002238830	CLAVULIN-400	GSK	$	0.2959

AMPICILLIN SODIUM

250 MG / VIAL (BASE) INJECTION				
00000872644	AMPICILLIN SODIUM	TEV	$	2.0561
500 MG / VIAL (BASE) INJECTION				
00000872652	AMPICILLIN SODIUM	TEV	$	2.1564
1 G / VIAL (BASE) INJECTION				
00001933345	AMPICILLIN SODIUM	TEV	$	3.6108
2 G / VIAL (BASE) INJECTION				
00001933353	AMPICILLIN SODIUM	TEV	$	7.2216

08:00 ANTI-INFECTIVE AGENTS

08:12.16.12 ANTIBACTERIALS
PENICILLINS
(PENICILLINASE-RESISTANT PENICILLINS)

CLOXACILLIN SODIUM

250 MG (BASE) ORAL CAPSULE				
00000618292	**APO-CLOXI**	**APX**	$	**0.1850**
00000337765	**NOVO-CLOXIN**	**TEV**	$	**0.1850**
00000717584	**NU-CLOXI**	**NXP**	$	**0.1850**
500 MG (BASE) ORAL CAPSULE				
00000618284	**APO-CLOXI**	**APX**	$	**0.3675**
00000337773	**NOVO-CLOXIN**	**TEV**	$	**0.3675**
00000717592	**NU-CLOXI**	**NXP**	$	**0.3675**
25 MG / ML (BASE) ORAL LIQUID				
00000644633	**APO-CLOXI**	**APX**	$	**0.0450**
00000337757	**NOVO-CLOXIN**	**TEV**	$	**0.0450**
00000717630	**NU-CLOXI**	**NXP**	$	**0.0450**
500 MG / VIAL (BASE) INJECTION				
00001912429	CLOXACILLIN SODIUM	TEV	$	4.5737
1 G / VIAL (BASE) INJECTION				
00001975447	CLOXACILLIN SODIUM	TEV	$	5.6218
2 G / VIAL (BASE) INJECTION				
00001912410	CLOXACILLIN SODIUM	TEV	$	7.3369

08:00 ANTI-INFECTIVE AGENTS

08:12.18 ANTIBACTERIALS (QUINOLONES)

NORFLOXACIN

400 MG ORAL TABLET				
00002269627	**CO NORFLOXACIN**	**COB**	$	**1.2204**
00002246596	**PMS-NORFLOXACIN**	**PMS**	$	**1.2204**
00002229524	APO-NORFLOX	APX	$	1.3716
00002237682	NOVO-NORFLOXACIN	TEV	$	1.3716

08:00 ANTI-INFECTIVE AGENTS

08:12.20 ANTIBACTERIALS (SULFONAMIDES)

SULFAMETHOXAZOLE/ TRIMETHOPRIM

100 MG * 20 MG ORAL TABLET				
00000445266	APO-SULFATRIM	APX	$	0.0911
400 MG * 80 MG ORAL TABLET				
00000445274	**APO-SULFATRIM**	**APX**	$	**0.0482**
00000510637	**NOVO-TRIMEL**	**TEV**	$	**0.0482**
00000865710	**NU-COTRIMOX**	**NXP**	$	**0.0482**
800 MG * 160 MG ORAL TABLET				
00000445282	**APO-SULFATRIM DS**	**APX**	$	**0.1221**
00000510645	**NOVO-TRIMEL DS**	**TEV**	$	**0.1221**
00000865729	**NU-COTRIMOX DS**	**NXP**	$	**0.1221**
40 MG / ML * 8 MG / ML ORAL SUSPENSION				
00000726540	NOVO-TRIMEL	TEV	$	0.0911
80 MG / ML * 16 MG / ML INJECTION				
00000550086	SEPTRA	GSK	$	1.3831

SULFASALAZINE

500 MG ORAL TABLET				
00000598461	**PMS-SULFASALAZINE**	**PMS**	$	**0.2122**
00002064480	SALAZOPYRIN	PFI	$	0.2700
500 MG ORAL ENTERIC-COATED TABLET				
00000598488	**PMS-SULFASALAZINE**	**PMS**	$	**0.3232**
00002064472	SALAZOPYRIN EN-TABS	PFI	$	0.4253

08:00 ANTI-INFECTIVE AGENTS

08:12.24 ANTIBACTERIALS (TETRACYCLINES)

DOXYCYCLINE HYCLATE

100 MG (BASE) ORAL TABLET				
00000874256	**APO-DOXY**	**APX**	$	**0.5860**
00000860751	**DOXYCIN**	**MYP**	$	**0.5860**
00002158574	**NOVO-DOXYLIN**	**TEV**	$	**0.5860**
00002289466	**PMS-DOXYCYCLINE**	**PMS**	$	**0.5860**
100 MG (BASE) ORAL CAPSULE				
00000740713	**APO-DOXY**	**APX**	$	**0.5860**
00000817120	**DOXYCIN**	**MYP**	$	**0.5860**
00000725250	**NOVO-DOXYLIN**	**TEV**	$	**0.5860**
00002044668	**NU-DOXYCYCLINE**	**NXP**	$	**0.5860**
00002289539	**PMS-DOXYCYCLINE**	**PMS**	$	**0.5860**
00000024368	VIBRAMYCIN	PFI	$	1.8274

MINOCYCLINE HCL

50 MG (BASE) ORAL CAPSULE				
00002294419	**PMS-MINOCYCLINE**	**PMS**	$	**0.4445**
00002084090	APO-MINOCYCLINE	APX	$	0.5350
00002230735	MYLAN-MINOCYCLINE	MYP	$	0.5350
00002108143	NOVO-MINOCYCLINE	TEV	$	0.5350
00001914138	RATIO-MINOCYCLINE	RPH	$	0.5350
00002237313	SANDOZ MINOCYCLINE	SDZ	$	0.5350
100 MG (BASE) ORAL CAPSULE				
00002294427	**PMS-MINOCYCLINE**	**PMS**	$	**0.8889**
00002084104	APO-MINOCYCLINE	APX	$	1.0332
00002230736	MYLAN-MINOCYCLINE	MYP	$	1.0332
00002108151	NOVO-MINOCYCLINE	TEV	$	1.0332
00001914146	RATIO-MINOCYCLINE	RPH	$	1.0332
00002237314	SANDOZ MINOCYCLINE	SDZ	$	1.0332

TETRACYCLINE HCL

250 MG ORAL CAPSULE				
00000580929	**APO-TETRA**	**APX**	$	**0.0657**
00000717606	**NU-TETRA**	**NXP**	$	**0.0657**

08:00 ANTI-INFECTIVE AGENTS

08:12.28.16 ANTIBACTERIALS MISCELLANEOUS ANTIBACTERIALS (GLYCOPEPTIDES)

VANCOMYCIN HCL

500 MG / VIAL (BASE) INJECTION				
00002241820	PMS-VANCOMYCIN	PMS	$	31.1432
1 G / VIAL (BASE) INJECTION				
00002241821	PMS-VANCOMYCIN	PMS	$	59.1670

08:00 ANTI-INFECTIVE AGENTS

08:12.28.20 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(LINCOMYCINS)

CLINDAMYCIN HCL

150 MG (BASE) ORAL CAPSULE				
00002245232	**APO-CLINDAMYCIN**	**APX**	$	**0.4890**
00002258331	**MYLAN-CLINDAMYCIN**	**MYP**	$	**0.4890**
00002241709	**NOVO-CLINDAMYCIN**	**TEV**	$	**0.4890**
00002294826	**PMS-CLINDAMYCIN**	**PMS**	$	**0.4890**
00000030570	DALACIN C	PFI	$	1.0118
300 MG (BASE) ORAL CAPSULE				
00002245233	**APO-CLINDAMYCIN**	**APX**	$	**0.9780**
00002258358	**MYLAN-CLINDAMYCIN**	**MYP**	$	**0.9780**
00002241710	**NOVO-CLINDAMYCIN**	**TEV**	$	**0.9780**
00002294834	**PMS-CLINDAMYCIN**	**PMS**	$	**0.9780**
00002182866	DALACIN C	PFI	$	2.0235

CLINDAMYCIN PALMITATE HCL

15 MG / ML (BASE) ORAL SOLUTION				
00000225851	DALACIN C PALMITATE	PFI	$	0.1336

CLINDAMYCIN PHOSPHATE

150 MG / ML (BASE) INJECTION				
00002230535	CLINDAMYCIN (60 & 120 ML)	SDZ	$	3.2585
00002230540	CLINDAMYCIN	SDZ	$	3.3250
00000260436	DALACIN C PHOSPHATE	PFI	$	4.3289

08:00 ANTI-INFECTIVE AGENTS

08:12.28.28 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(POLYMYXINS)

COLISTIMETHATE SODIUM

150 MG / VIAL INJECTION				
00002244849	COLISTIMETHATE FOR INJECTION	STM	$	33.8088

08:00 ANTI-INFECTIVE AGENTS

08:14.04 ANTIFUNGALS
(ALLYLAMINES)

TERBINAFINE HCL

250 MG (BASE) ORAL TABLET				
00002239893	**APO-TERBINAFINE**	**APX**	$	**2.5243**
00002254727	**CO TERBINAFINE**	**COB**	$	**2.5243**
00002242503	**MYLAN-TERBINAFINE**	**MYP**	$	**2.5243**
00002240346	**NOVO-TERBINAFINE**	**TEV**	$	**2.5243**
00002240807	**PMS-TERBINAFINE**	**PMS**	$	**2.5243**
00002294273	**PMS-TERBINAFINE**	**PMS**	$	**2.5243**
00002262177	**SANDOZ TERBINAFINE**	**SDZ**	$	**2.5243**
00002031116	LAMISIL	NOV	$	4.5734

08:00 ANTI-INFECTIVE AGENTS

08:14.08 ANTIFUNGALS (AZOLES)

FLUCONAZOLE

50 MG ORAL TABLET				
00002281260	**CO FLUCONAZOLE**	**COB**	$	**2.9186**
00002245643	**PMS-FLUCONAZOLE**	**PMS**	$	**2.9186**
00002237370	APO-FLUCONAZOLE	APX	$	3.1266
00002245292	MYLAN-FLUCONAZOLE	MYP	$	3.1266
00002236978	NOVO-FLUCONAZOLE	TEV	$	3.1266
100 MG ORAL TABLET				
00002281279	**CO FLUCONAZOLE**	**COB**	$	**5.1776**
00002245644	**PMS-FLUCONAZOLE**	**PMS**	$	**5.1776**
00002237371	APO-FLUCONAZOLE	APX	$	5.5466
00002245293	MYLAN-FLUCONAZOLE	MYP	$	5.5466
00002236979	NOVO-FLUCONAZOLE	TEV	$	5.5466
150 MG ORAL CAPSULE				
00002241895	**APO-FLUCONAZOLE-150**	**APX**	$	**8.7632**
00002323419	**CO FLUCONAZOLE**	**COB**	$	**8.7632**
00002245697	**MYLAN-FLUCONAZOLE**	**MYP**	$	**8.7632**
00002282348	**PMS-FLUCONAZOLE**	**PMS**	$	**8.7632**
00002141442	DIFLUCAN	PFI	$	15.6953
2 MG / ML INJECTION				
00002247749	**FLUCONAZOLE OMEGA**	**OMG**	$	**0.3187**
00000891835	DIFLUCAN	PFI	$	0.5707

ITRACONAZOLE

100 MG ORAL CAPSULE				
00002047454	SPORANOX	JOI	$	4.2946

KETOCONAZOLE

200 MG ORAL TABLET				
00002237235	**APO-KETOCONAZOLE**	**APX**	$	**1.1835**
00002231061	**NOVO-KETOCONAZOLE**	**TEV**	$	**1.1835**
00002122197	**NU-KETOCON**	**NXP**	$	**1.1835**

08:00 ANTI-INFECTIVE AGENTS

08:14.28 ANTIFUNGALS (POLYENES)

AMPHOTERICIN B

50 MG / VIAL INJECTION				
00000029149	FUNGIZONE IV	BMS	$	69.2070

NYSTATIN

500,000 UNIT ORAL TABLET				
00002194198	RATIO-NYSTATIN	RPH	$	0.2407
100,000 UNIT / ML ORAL SUSPENSION				
00000792667	**PMS-NYSTATIN**	**PMS**	$	**0.0520**
00002194201	RATIO-NYSTATIN	RPH	$	0.0521

08:00 ANTI-INFECTIVE AGENTS

08:16.92 ANTIMYCOBACTERIALS

(MISCELLANEOUS ANTIMYCOBACTERIALS)

DAPSONE

100 MG ORAL TABLET

00002041510	DAPSONE	NTI	$	1.4405

08:00 ANTI-INFECTIVE AGENTS

08:18.08.20 ANTIVIRALS

ANTIRETROVIRALS

(NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS)

LAMIVUDINE

RESTRICTED BENEFIT - This product is a benefit when initiated by a Specialist in Internal Medicine or a designated prescriber.

100 MG ORAL TABLET

00002239193	HEPTOVIR	GSK	$	5.0620

TENOFOVIR DISOPROXIL FUMARATE

RESTRICTED BENEFIT - This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber.

300 MG (BASE) ORAL TABLET

00002247128	VIREAD	GIL	$	18.4148

08:00 ANTI-INFECTIVE AGENTS

08:18.20 ANTIVIRALS

(INTERFERONS)

PEGINTERFERON ALFA-2A

RESTRICTED BENEFIT - This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber. (For eligibility for the treatment of chronic hepatitis C refer to Criteria for Special Authorization of Select Drug Products of the List and Criteria for Special Authorization of Select Drug Products of the Alberta Employment and Immigration Drug Benefit Supplement for Alberta Employment and Immigration, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

180 MCG / ML INJECTION

00002248078	PEGASYS	HLR	$	425.5300

180 MCG / SYR INJECTION SYRINGE

00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	$	425.5300

08:00 ANTI-INFECTIVE AGENTS

08:18.32 ANTIVIRALS

(NUCLEOSIDES AND NUCLEOTIDES)

ACYCLOVIR

200 MG ORAL TABLET				
00002207621	**APO-ACYCLOVIR**	**APX**	$	**0.7702**
00002242784	**MYLAN-ACYCLOVIR**	**MYP**	$	**0.7702**
00002285959	**NOVO-ACYCLOVIR**	**TEV**	$	**0.7702**
00002078627	**RATIO-ACYCLOVIR**	**RPH**	$	**0.7702**
00000634506	ZOVIRAX	GSK	$	1.3754
400 MG ORAL TABLET				
00002207648	**APO-ACYCLOVIR**	**APX**	$	**1.5519**
00002242463	**MYLAN-ACYCLOVIR**	**MYP**	$	**1.5519**
00002285967	**NOVO-ACYCLOVIR**	**TEV**	$	**1.5519**
00002197413	**NU-ACYCLOVIR**	**NXP**	$	**1.5519**
00002078635	**RATIO-ACYCLOVIR**	**RPH**	$	**1.5519**
00001911627	ZOVIRAX	GSK	$	2.7712
800 MG ORAL TABLET				
00002207656	**APO-ACYCLOVIR**	**APX**	$	**2.8557**
00002242464	**MYLAN-ACYCLOVIR**	**MYP**	$	**2.8557**
00002285975	**NOVO-ACYCLOVIR**	**TEV**	$	**2.8557**
00002197421	**NU-ACYCLOVIR**	**NXP**	$	**2.8557**
00002078651	**RATIO-ACYCLOVIR**	**RPH**	$	**2.8557**
00001911635	ZOVIRAX	GSK	$	5.4494
40 MG / ML ORAL SUSPENSION				
00000886157	ZOVIRAX	GSK	$	0.2693

ADEFOVIR DIPIVOXIL

RESTRICTED BENEFIT - This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber.

10 MG ORAL TABLET				
00002247823	HEPSERA	GIL	$	24.2706

ENTECAVIR

RESTRICTED BENEFIT - This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber.

0.5 MG ORAL TABLET				
00002282224	BARACLUDE	BMS	$	22.0000

GANCICLOVIR SODIUM

500 MG / VIAL (BASE) INJECTION				
00002162695	CYTOVENE	HLR	$	44.3060

VALACYCLOVIR

500 MG ORAL TABLET				
00002295822	**APO-VALACYCLOVIR (CAPLET)**	**APX**	$	**2.0422**
00002298457	**PMS-VALACYCLOVIR (CAPLET)**	**PMS**	$	**2.0422**
00002219492	VALTREX (CAPLET)	GSK	$	3.6472

08:00 ANTI-INFECTIVE AGENTS

08:30.04 ANTIPROTOZOALS (AMEBICIDES)

IODOQUINOL

210 MG ORAL TABLET				
00001997769	DIODOQUIN	GLE	$	0.6541
650 MG ORAL TABLET				
00001997750	DIODOQUIN	GLE	$	0.8111

08:00 ANTI-INFECTIVE AGENTS

08:30.08 ANTIPROTOZOALS (ANTIMALARIALS)

CHLOROQUINE PHOSPHATE

250 MG ORAL TABLET				
00000021261	NOVO-CHLOROQUINE	TEV	$	0.3322

HYDROXYCHLOROQUINE SULFATE

200 MG ORAL TABLET				
00002246691	**APO-HYDROXYQUINE**	**APX**	$	**0.3301**
00002252600	**MYLAN-HYDROXYCHLOROQUINE**	**MYP**	$	**0.3301**
00002017709	PLAQUENIL SULFATE	SAV	$	0.6335

PRIMAQUINE PHOSPHATE

15 MG (BASE) ORAL TABLET				
00002017776	PRIMAQUINE PHOSPHATE	SAV	$	0.4105

PYRIMETHAMINE

25 MG ORAL TABLET				
00000004774	DARAPRIM	GSK	$	1.4272

QUININE SULFATE

200 MG ORAL CAPSULE				
00002254514	**APO-QUININE**	**APX**	$	**0.2390**
00000021008	**NOVO-QUININE**	**TEV**	$	**0.2390**
300 MG ORAL CAPSULE				
00002254522	**APO-QUININE**	**APX**	$	**0.3750**
00000021016	**NOVO-QUININE**	**TEV**	$	**0.3750**

08:00 ANTI-INFECTIVE AGENTS

08:30.92 ANTIPROTOZOALS (MISCELLANEOUS ANTIPROTOZOALS)

ATOVAQUONE

150 MG / ML ORAL SUSPENSION				
00002217422	MEPRON	GSK	$	2.7546

METRONIDAZOLE

250 MG ORAL TABLET				
00000545066	APO-METRONIDAZOLE	APX	$	0.0595
5 MG / ML INJECTION				
00000870420	**FLAGYL**	**BAX**	$	**0.0240**
00000649074	**METRONIDAZOLE**	**HSP**	$	**0.0240**

08:00 ANTI-INFECTIVE AGENTS

08:36 URINARY ANTI-INFECTIVES

NITROFURANTOIN

50 MG ORAL TABLET				
00000319511	APO-NITROFURANTOIN	APX	$	0.1670
100 MG ORAL TABLET				
00000312738	APO-NITROFURANTOIN	APX	$	0.2227
50 MG ORAL CAPSULE (MACROCRYSTALS)				
00002231015	NOVO-FURANTOIN	TEV	$	0.3300
100 MG ORAL CAPSULE (MACROCRYSTALS)				
00002231016	NOVO-FURANTOIN	TEV	$	0.6326
100 MG ORAL CAPSULE (MACROCRYSTALS/MONOHYDRATE)				
00002063662	MACROBID	WCC	$	0.7421

TRIMETHOPRIM

100 MG ORAL TABLET				
00002243116	APO-TRIMETHOPRIM	APX	$	0.2566
200 MG ORAL TABLET				
00002243117	APO-TRIMETHOPRIM	APX	$	0.5273

10:00

Antineoplastic Agents

10:00 ANTINEOPLASTIC AGENTS

10:00

METHOTREXATE

2.5 MG ORAL TABLET				
00002182963	**APO-METHOTREXATE**	**APX**	$	**0.6325**
00002244798	**RATIO-METHOTREXATE SODIUM**	**RPH**	$	**0.6325**
00002170698	METHOTREXATE	WAY	$	0.6799
10 MG ORAL TABLET				
00002182750	METHOTREXATE	HSP	$	2.4600

METHOTREXATE SODIUM

25 MG / ML (BASE) INJECTION				
00002182955	METHOTREXATE SOD.(UNPRESERVED)	HSP	$	4.3574
25 MG / ML (BASE) INJECTION				
00002182777	METHOTREXATE SOD. (PRESERVED)	HSP	$	8.0000

12:00

Autonomic Drugs

12:00 AUTONOMIC DRUGS

12:04 PARASYMPATHOMIMETIC (CHOLINERGIC) AGENTS

NEOSTIGMINE BROMIDE

15 MG ORAL TABLET

00000869945	PROSTIGMIN	VCL	$	0.4698

PILOCARPINE HCL

5 MG ORAL TABLET

00002216345	SALAGEN	PFI	$	1.1774

PYRIDOSTIGMINE BROMIDE

60 MG ORAL TABLET

00000869961	MESTINON	VCL	$	0.4617

180 MG ORAL SUSTAINED-RELEASE TABLET

00000869953	MESTINON-SR	VCL	$	1.0102

12:00 AUTONOMIC DRUGS

12:08.08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS / ANTISPASMODICS)

ATROPINE SULFATE

0.4 MG / ML INJECTION

00000392782	ATROPINE SULFATE	SDZ	$	1.5311

0.6 MG / ML INJECTION

00000392693	ATROPINE SULFATE	SDZ	$	1.5311

DICYCLOMINE HCL

10 MG ORAL TABLET

00002103087	BENTYLOL	AXC	$	0.1156

20 MG ORAL TABLET

00002103095	BENTYLOL	AXC	$	0.2182

2 MG / ML ORAL SYRUP

00002102978	BENTYLOL	AXC	$	0.0619

10 MG / ML INJECTION

00000392812	DICYCLOMINE HYDROCHLORIDE	SDZ	$	3.2536

GLYCOPYRROLATE

0.2 MG / ML INJECTION

00002039508	GLYCOPYRROLATE	SDZ	$	3.4611

HYOSCINE BUTYLBROMIDE

10 MG ORAL TABLET

00000363812	BUSCOPAN	BOE	$	0.3222

20 MG / ML INJECTION

00000363839	BUSCOPAN	BOE	$	4.3000

IPRATROPIUM BROMIDE

20 MCG / DOSE METERED DOSE AEROSOL

00002247686	ATROVENT HFA	BOE	$	0.0917

250 MCG / ML INHALATION SOLUTION

00002231136	**PMS-IPRATROPIUM**	**PMS**	$	**0.5051**
00002126222	APO-IPRAVENT	APX	$	0.5530
00002239131	MYLAN-IPRATROPIUM	MYP	$	0.5530
00002210479	NOVO-IPRAMIDE	TEV	$	0.5530

12:00 AUTONOMIC DRUGS

12:08.08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS / ANTISPASMODICS)

IPRATROPIUM BROMIDE

0.03 % NASAL SPRAY

00002239627	**PMS-IPRATROPIUM**	**PMS**	$	**0.5561**
00002163705	ATROVENT	BOE	$	0.9930

IPRATROPIUM BROMIDE/ SALBUTAMOL SULFATE

0.2 MG / ML * 1 MG / ML (BASE) INHALATION SOLUTION

00002243789	**RATIO-IPRA SAL UDV**	**RPH**	$	**0.3377**
00002231675	COMBIVENT UDV	BOE	$	0.6030

TIOTROPIUM BROMIDE MONOHYDRATE

18 MCG INHALATION CAPSULE

00002246793	SPIRIVA	BOE	$	2.1000

12:00 AUTONOMIC DRUGS

12:12.04 SYMPATHOMIMETIC (ADRENERGIC) AGENTS (ALPHA-ADRENERGIC AGONISTS)

MIDODRINE HCL

2.5 MG ORAL TABLET

00002278677	APO-MIDODRINE	APX	$	0.3378

5 MG ORAL TABLET

00002278685	APO-MIDODRINE	APX	$	0.5630

12:00 AUTONOMIC DRUGS

12:12.08.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS BETA-ADRENERGIC AGONISTS (SELECTIVE BETA 2-ADRENERGIC AGONISTS)

BUDESONIDE/ FORMOTEROL FUMARATE DIHYDRATE

100 MCG / DOSE * 6 MCG / DOSE METERED INHALATION POWDER

00002245385	SYMBICORT 100 TURBUHALER	AZC	$	0.5375

200 MCG / DOSE * 6 MCG / DOSE METERED INHALATION POWDER

00002245386	SYMBICORT 200 TURBUHALER	AZC	$	0.6988

FORMOTEROL FUMARATE

12 MCG INHALATION CAPSULE

00002230898	FORADIL	NOV	$	0.8412

FORMOTEROL FUMARATE DIHYDRATE

6 MCG / DOSE METERED INHALATION POWDER

00002237225	OXEZE TURBUHALER	AZC	$	0.5859

12 MCG / DOSE METERED INHALATION POWDER

00002237224	OXEZE TURBUHALER	AZC	$	0.7802

ORCIPRENALINE SULFATE

2 MG / ML ORAL SYRUP

00002236783	APO-ORCIPRENALINE	APX	$	0.0574

12:00 AUTONOMIC DRUGS

12:12.08.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS BETA-ADRENERGIC AGONISTS (SELECTIVE BETA 2-ADRENERGIC AGONISTS)

SALBUTAMOL

100 MCG / DOSE METERED DOSE AEROSOL				
00002245669	**APO-SALVENT CFC FREE**	**APX**	$	**0.0325**
00002241497	**VENTOLIN HFA**	**GSK**	$	**0.0325**
00002244914	RATIO-SALBUTAMOL HFA	RPH	$	0.0387

SALBUTAMOL SULFATE

2 MG (BASE) ORAL TABLET				
00002146843	APO-SALVENT	APX	$	0.1274
4 MG (BASE) ORAL TABLET				
00002146851	APO-SALVENT	APX	$	0.2134
400 MCG / ML (BASE) ORAL LIQUID				
00002091186	PMS-SALBUTAMOL	PMS	$	0.0487
0.5 MG / ML (BASE) INHALATION SOLUTION				
00002208245	**PMS-SALBUTAMOL**	**PMS**	$	**0.1165**
00002239365	RATIO-SALBUTAMOL UNIT DOSE P.F	RPH	$	0.1492
1 MG / ML (BASE) INHALATION SOLUTION				
00001926934	**MYLAN-SALBUTAMOL STERINEBS P.F.**	**MYP**	$	**0.2434**
00002208229	**PMS-SALBUTAMOL**	**PMS**	$	**0.2434**
00001986864	**RATIO-SALBUTAMOL SULF U.D.P.F.**	**RPH**	$	**0.2434**
00002213419	VENTOLIN NEBULES P.F.	GSK	$	0.4444
5 MG / ML (BASE) INHALATION SOLUTION				
00002232987	**MYLAN-SALBUTAMOL**	**MYP**	$	**0.5900**
00002069571	**PMS-SALBUTAMOL**	**PMS**	$	**0.5900**
00000860808	**RATIO-SALBUTAMOL**	**RPH**	$	**0.5900**
00002154412	**SANDOZ SALBUTAMOL**	**SDZ**	$	**0.5900**
00002213486	VENTOLIN	GSK	$	1.0782
2 MG / ML (BASE) INHALATION UNIT DOSE SOLUTION				
00002173360	**MYLAN-SALBUTAMOL STERINEBS P.F.**	**MYP**	$	**0.4622**
00002208237	**PMS-SALBUTAMOL POLYNEB**	**PMS**	$	**0.4622**
00002239366	**RATIO-SALBUTAMOL UNI DOSE P.F.**	**RPH**	$	**0.4622**
00002213427	VENTOLIN NEBULES P.F.	GSK	$	0.8441

SALMETEROL XINAFOATE

50 MCG / DOSE (BASE) METERED INHALATION POWDER				
00002231129	SEREVENT DISKUS	GSK	$	1.0051
50 MCG / DOSE (BASE) INHALATION DISK				
00002214261	SEREVENT	GSK	$	4.0205

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

25 MCG / DOSE (BASE) * 125 MCG / DOSE METERED DOSE AEROSOL				
00002245126	ADVAIR 125	GSK	$	0.8599
25 MCG / DOSE (BASE) * 250 MCG / DOSE METERED DOSE AEROSOL				
00002245127	ADVAIR 250	GSK	$	1.2208
50 MCG / DOSE (BASE) * 100 MCG / DOSE METERED INHALATION POWDER				
00002240835	ADVAIR 100 DISKUS	GSK	$	1.4367
50 MCG / DOSE (BASE) * 250 MCG / DOSE METERED INHALATION POWDER				
00002240836	ADVAIR 250 DISKUS	GSK	$	1.7198
50 MCG / DOSE (BASE) * 500 MCG / DOSE METERED INHALATION POWDER				
00002240837	ADVAIR 500 DISKUS	GSK	$	2.4415

12:00 AUTONOMIC DRUGS

12:12.08.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS BETA-ADRENERGIC AGONISTS (SELECTIVE BETA 2-ADRENERGIC AGONISTS)

TERBUTALINE SULFATE

0.5 MG / DOSE METERED INHALATION POWDER

00000786616	BRICANYL TURBUHALER	AZC	$	0.0790

12:00 AUTONOMIC DRUGS

12:12.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS (ALPHA- AND BETA-ADRENERGIC AGONISTS)

EPINEPHRINE

0.15 MG / SYR INJECTION SYRINGE

☒ 00002268205	TWINJECT AUTO INJECTOR	PAL	$	81.0000
☒ 00000578657	EPIPEN JR	KNG	$	88.8165

0.3 MG / SYR INJECTION SYRINGE

☒ 00002247310	TWINJECT AUTO INJECTOR	PAL	$	81.0000
☒ 00000509558	EPIPEN	KNG	$	88.8165

EPINEPHRINE HCL

1 MG / ML INJECTION

00000155357	ADRENALIN	ERF	$	0.5930

12:00 AUTONOMIC DRUGS

12:16 SYMPATHOLYTIC (ADRENERGIC BLOCKING) AGENTS

DIHYDROERGOTAMINE MESYLATE

4 MG / ML NASAL SPRAY

00002228947	MIGRANAL	STM	$	10.6605

1 MG / ML INJECTION

00002241163	**DIHYDROERGOTAMINE MESYLATE**	**SDZ**	$	**3.7200**
00000027243	DIHYDROERGOTAMINE (DHE)	STM	$	3.9918

ERGOLOID MESYLATES

1 MG ORAL TABLET

00000176176	HYDERGINE	STM	$	1.0477

ERGOTAMINE TARTRATE/ CAFFEINE

1 MG * 100 MG ORAL TABLET

00000176095	CAFERGOT	NOV	$	0.8519

12:00 AUTONOMIC DRUGS

12:20.04 SKELETAL MUSCLE RELAXANTS

(CENTRALLY ACTING SKELETAL MUSCLE RELAXANTS)

CYCLOBENZAPRINE HCL

RESTRICTED BENEFIT - Coverage is limited to 126 tablets per plan participant per year as an adjunct to rest and physical therapy for the treatment of acute muscle spasm.

10 MG ORAL TABLET

00002249359	**PHL-CYCLOBENZAPRINE**	**PHH**	$	**0.3731**
00002212048	**PMS-CYCLOBENZAPRINE**	**PMS**	$	**0.3731**
00002177145	APO-CYCLOBENZAPRINE	APX	$	0.3765
00002231353	MYLAN-CYCLOBENZAPRINE	MYP	$	0.3765
00002080052	NOVO-CYCLOPRINE	TEV	$	0.3765
00002171848	NU-CYCLOBENZAPRINE	NXP	$	0.3765
00002236506	RATIO-CYCLOBENZAPRINE	RPH	$	0.3765

12:00 AUTONOMIC DRUGS

12:20.08 SKELETAL MUSCLE RELAXANTS

(DIRECT-ACTING SKELETAL MUSCLE RELAXANTS)

DANTROLENE SODIUM

25 MG ORAL CAPSULE

00001997602	DANTRIUM	JHP	$	0.3780

100 MG ORAL CAPSULE

00001997653	DANTRIUM	JHP	$	0.7684

12:00 AUTONOMIC DRUGS

12:20.12 SKELETAL MUSCLE RELAXANTS

(GABA-DERIVATIVE SKELETAL MUSCLE RELAXANTS)

BACLOFEN

10 MG ORAL TABLET

00002139332	**APO-BACLOFEN**	**APX**	$	**0.2911**
00002088398	**MYLAN-BACLOFEN**	**MYP**	$	**0.2911**
00002136090	**NU-BACLO**	**NXP**	$	**0.2911**
00002236963	**PHL-BACLOFEN**	**PHH**	$	**0.2911**
00002063735	**PMS-BACLOFEN**	**PMS**	$	**0.2911**
00002236507	**RATIO-BACLOFEN**	**RPH**	$	**0.2911**
00000455881	LIORESAL	NOV	$	0.6878

20 MG ORAL TABLET

00002139391	**APO-BACLOFEN**	**APX**	$	**0.5667**
00002088401	**MYLAN-BACLOFEN**	**MYP**	$	**0.5667**
00002136104	**NU-BACLO**	**NXP**	$	**0.5667**
00002236964	**PHL-BACLOFEN**	**PHH**	$	**0.5667**
00002063743	**PMS-BACLOFEN**	**PMS**	$	**0.5667**
00002236508	**RATIO-BACLOFEN**	**RPH**	$	**0.5667**
00000636576	LIORESAL D.S.	NOV	$	1.3386

0.05 MG / ML INJECTION

00002131048	LIORESAL INTRATHECAL	NOV	$	14.2180

0.5 MG / ML INJECTION

00002131056	LIORESAL INTRATHECAL	NOV	$	10.6538

2 MG / ML INJECTION

00002131064	LIORESAL INTRATHECAL	NOV	$	42.6152

20:00

Blood Formation, Coagulation and Thrombosis

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:04.04 ANTIANEMIA DRUGS
(IRON PREPARATIONS)

IRON DEXTRAN COMPLEX

50 MG / ML INJECTION

☒ 00002221780	INFUFER	SDZ	$	14.8253
☒ 00002205963	DEXIRON	MYP	$	14.9500

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.08 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(COUMARIN DERIVATIVES)

NICOUMALONE

1 MG ORAL TABLET

00000010383	SINTROM	PAL	$	0.4857

4 MG ORAL TABLET

00000010391	SINTROM	PAL	$	1.5271

WARFARIN SODIUM

1 MG ORAL TABLET

00002242924	**APO-WARFARIN**	**APX**	$	**0.1747**
00002244462	**MYLAN-WARFARIN**	**MYP**	$	**0.1747**
00002265273	**NOVO-WARFARIN**	**TEV**	$	**0.1747**
00002242680	**TARO-WARFARIN**	**TAR**	$	**0.1747**
00001918311	COUMADIN	BMS	$	0.3129

2 MG ORAL TABLET

00002242925	**APO-WARFARIN**	**APX**	$	**0.1847**
00002244463	**MYLAN-WARFARIN**	**MYP**	$	**0.1847**
00002265281	**NOVO-WARFARIN**	**TEV**	$	**0.1847**
00002242681	**TARO-WARFARIN**	**TAR**	$	**0.1847**
00001918338	COUMADIN	BMS	$	0.3309

2.5 MG ORAL TABLET

00002242926	**APO-WARFARIN**	**APX**	$	**0.1479**
00002244464	**MYLAN-WARFARIN**	**MYP**	$	**0.1479**
00002265303	**NOVO-WARFARIN**	**TEV**	$	**0.1479**
00002242682	**TARO-WARFARIN**	**TAR**	$	**0.1479**
00001918346	COUMADIN	BMS	$	0.2649

3 MG ORAL TABLET

00002245618	**APO-WARFARIN**	**APX**	$	**0.2290**
00002287498	**MYLAN-WARFARIN**	**MYP**	$	**0.2290**
00002265311	**NOVO-WARFARIN**	**TEV**	$	**0.2290**
00002242683	**TARO-WARFARIN**	**TAR**	$	**0.2290**
00002240205	COUMADIN	BMS	$	0.4102

4 MG ORAL TABLET

00002242927	**APO-WARFARIN**	**APX**	$	**0.2290**
00002244465	**MYLAN-WARFARIN**	**MYP**	$	**0.2290**
00002265338	**NOVO-WARFARIN**	**TEV**	$	**0.2290**
00002242684	**TARO-WARFARIN**	**TAR**	$	**0.2290**
00002007959	COUMADIN	BMS	$	0.4102

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.08 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(COUMARIN DERIVATIVES)

WARFARIN SODIUM

5 MG ORAL TABLET				
00002242928	**APO-WARFARIN**	**APX**	$	**0.1482**
00002244466	**MYLAN-WARFARIN**	**MYP**	$	**0.1482**
00002265346	**NOVO-WARFARIN**	**TEV**	$	**0.1482**
00002242685	**TARO-WARFARIN**	**TAR**	$	**0.1482**
00001918354	COUMADIN	BMS	$	0.2654
6 MG ORAL TABLET				
00002242686	TARO-WARFARIN	TAR	$	0.2954
7.5 MG ORAL TABLET				
00002242697	TARO-WARFARIN	TAR	$	0.3174
10 MG ORAL TABLET				
00002242929	**APO-WARFARIN**	**APX**	$	**0.2659**
00002244467	**MYLAN-WARFARIN**	**MYP**	$	**0.2659**
00002242687	**TARO-WARFARIN**	**TAR**	$	**0.2659**
00001918362	COUMADIN	BMS	$	0.4762

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.16 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(HEPARINS)

DALTEPARIN SODIUM

10,000 IU / ML INJECTION				
00002132664	FRAGMIN	PFI	$	16.8203
25,000 IU / ML INJECTION				
00002231171	FRAGMIN	PFI	$	42.0508
2,500 IU / SYR INJECTION SYRINGE				
00002132621	FRAGMIN (0.2 ML SYRINGE)	PFI	$	5.3264
25,000 IU / ML INJECTION SYRINGE				
00002132648	FRAGMIN (0.2-0.72 ML SYR)	PFI	$	53.2643
For this product - pricing has been established on a per millilitre basis.				

ENOXAPARIN SODIUM

100 MG / ML INJECTION				
00002236564	LOVENOX	SAV	$	22.0375
30 MG / SYR INJECTION SYRINGE				
00002012472	LOVENOX (0.3 ML SYRINGE)	SAV	$	6.6543
100 MG / ML INJECTION SYRINGE				
00002236883	LOVENOX (0.4 - 1 ML SYRINGE)	SAV	$	22.0375
For this product - pricing has been established on a per millilitre basis.				
150 MG / ML INJECTION SYRINGE				
00002242692	LOVENOX HP (0.8ML/1ML SYRINGE)	SAV	$	33.0562
For this product - pricing has been established on a per millilitre basis.				

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.16 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(HEPARINS)

HEPARIN SODIUM

1,000 UNIT / ML INJECTION				
00000453811	HEPARIN LEO	LEO	$	0.4075
00000740519	HEPALEAN	ORG	$	0.9368
10,000 UNIT / ML INJECTION				
00000579718	**HEPARIN LEO**	**LEO**	$	**1.9420**
00000740497	HEPALEAN	ORG	$	2.2116
25,000 UNIT / ML INJECTION				
00000453781	HEPARIN LEO	LEO	$	8.0381
10 UNIT / ML INJECTION LOCK FLUSH				
00000725323	HEPARIN LOCK FLUSH	HSP	$	0.2750
100 UNIT / ML INJECTION LOCK FLUSH				
00000725315	**HEPARIN LOCK FLUSH**	**HSP**	$	**0.2820**
00000727520	HEPARIN LEO	LEO	$	0.3467

NADROPARIN CALCIUM

9,500 IU / ML INJECTION SYRINGE				
00002236913	FRAXIPARINE (.3-1ML SYR)	GSK	$	9.8137
For this product - pricing has been established on a per millilitre basis.				
19,000 IU / ML INJECTION SYRINGE				
00002240114	FRAXIPARINE FORTE (.6-1ML SYR)	GSK	$	19.6274
For this product - pricing has been established on a per millilitre basis.				

TINZAPARIN SODIUM

10,000 IU / ML INJECTION				
00002167840	INNOHEP	LEO	$	17.2000
20,000 IU / ML INJECTION				
00002229515	INNOHEP	LEO	$	34.9375
10,000 IU / ML INJECTION SYRINGE				
00002229755	INNOHEP (0.35/0.45 ML SYR)	LEO	$	17.3505
For this product - pricing has been established on a per millilitre basis.				
20,000 IU / ML INJECTION SYRINGE				
00002231478	INNOHEP (0.5/0.7/0.9 ML SYR)	LEO	$	35.4320
For this product - pricing has been established on a per millilitre basis.				

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.92 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(MISCELLANEOUS ANTICOAGULANTS)

FONDAPARINUX SODIUM

2.5 MG / SYR INJECTION SYRINGE				
00002245531	ARIXTRA (0.5 ML SYRINGE)	GSK	$	16.5894

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.92 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(MISCELLANEOUS ANTICOAGULANTS)

RIVAROXABAN

RESTRICTED BENEFIT - This product is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total hip replacement or total knee replacement surgery. Coverage is restricted to two 14-day courses of therapy per patient per year.

10 MG ORAL TABLET

00002316986	XARELTO	BAI	$	9.5243

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.18 ANTITHROMBOTIC AGENTS
(PLATELET AGGREGATION INHIBITORS)

CLOPIDOGREL BISULFATE

LIMITED RESTRICTED BENEFIT - This product is a benefit for patients for the prevention of thrombosis, following intravascular stent placement, when prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery. This benefit is limited to one month of coverage for the first stent placement only. (For eligibility for repeat stents, other indications, or continued coverage up to 12 months following intravascular drug eluting stent (DES) placement refer to Criteria for Special Authorization of Select Drug Products of the List and Criteria for Special Authorization of Select Drug Products of the Alberta Employment and Immigration Drug Benefit Supplement for Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients.)

75 MG ORAL TABLET

00002238682	PLAVIX	SAV	$	2.5775

DIPYRIDAMOLE/ ASA

200 MG * 25 MG ORAL CAPSULE

00002242119	AGGRENOX	BOE	$	0.8230

TICLOPIDINE HCL

250 MG ORAL TABLET

00002237701	**APO-TICLOPIDINE**	**APX**	$	**0.6885**
00002239744	**MYLAN-TICLOPIDINE**	**MYP**	$	**0.6885**
00002236848	**NOVO-TICLOPIDINE**	**TEV**	$	**0.6885**
00002237560	**NU-TICLOPIDINE**	**NXP**	$	**0.6885**
00002243587	**SANDOZ TICLOPIDINE**	**SDZ**	$	**0.6885**

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:24 HEMORRHEOLOGIC AGENTS

PENTOXIFYLLINE

400 MG ORAL SUSTAINED-RELEASE TABLET

00002230090	**APO-PENTOXIFYLLINE SR**	**APX**	$	**0.3837**
00002230401	**NU-PENTOXIFYLLINE-SR**	**NXP**	$	**0.3837**
00001968432	**RATIO-PENTOXIFYLLINE**	**RPH**	$	**0.3837**
00002221977	TRENTAL	SAV	$	0.8380

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:28.16 ANTIHEMORRHAGIC AGENTS (HEMOSTATICS)

TRANEXAMIC ACID

500 MG ORAL TABLET

00002064405	CYKLOKAPRON	PFI	$	1.2395

24:00

Cardiovascular Drugs

24:00 CARDIOVASCULAR DRUGS

24:04.04.04 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS IA ANTIARRYTHMICS)

DISOPYRAMIDE

100 MG ORAL CAPSULE				
00002224801	RYTHMODAN	SAV	$	0.2873
150 MG ORAL CAPSULE				
00002224828	RYTHMODAN	SAV	$	0.4061

PROCAINAMIDE HCL

250 MG ORAL SUSTAINED-RELEASE TABLET				
00000638692	PROCAN SR	ERF	$	0.3811
500 MG ORAL SUSTAINED-RELEASE TABLET				
00000638676	PROCAN SR	ERF	$	0.5391
750 MG ORAL SUSTAINED-RELEASE TABLET				
00000638684	PROCAN SR	ERF	$	0.8680

24:00 CARDIOVASCULAR DRUGS

24:04.04.08 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS IB ANTIARRYTHMICS)

MEXILETINE HCL

100 MG ORAL CAPSULE				
00002230359	NOVO-MEXILETINE	TEV	$	0.8451
200 MG ORAL CAPSULE				
00002230360	NOVO-MEXILETINE	TEV	$	1.1317

24:00 CARDIOVASCULAR DRUGS

24:04.04.12 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS IC ANTIARRYTHMICS)

FLECAINIDE ACETATE

50 MG ORAL TABLET				
00002275538	**APO-FLECAINIDE**	**APX**	$	**0.3956**
00001966197	TAMBOCOR	GRC	$	0.5686
100 MG ORAL TABLET				
00002275546	**APO-FLECAINIDE**	**APX**	$	**0.7912**
00001966200	TAMBOCOR	GRC	$	1.1374

24:00 CARDIOVASCULAR DRUGS

24:04.04.12 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS IC ANTIARRYTHMICS)

PROPAFENONE HCL

150 MG ORAL TABLET				
00002243324	**APO-PROPAFENONE**	**APX**	$	**0.4275**
00002243727	**PMS-PROPAFENONE**	**PMS**	$	**0.4275**
00000603708	RYTHMOL	ABB	$	1.1297
300 MG ORAL TABLET				
00002243325	**APO-PROPAFENONE**	**APX**	$	**0.7537**
00002243728	**PMS-PROPAFENONE**	**PMS**	$	**0.7537**
00000603716	RYTHMOL	ABB	$	1.9913

24:00 CARDIOVASCULAR DRUGS

24:04.04.20 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS III ANTIARRYTHMICS)

AMIODARONE HCL

100 MG ORAL TABLET				
00002292173	PMS-AMIODARONE	PMS	$	0.6830
200 MG ORAL TABLET				
00002246194	**APO-AMIODARONE**	**APX**	$	**1.2394**
00002240604	**MYLAN-AMIODARONE**	**MYP**	$	**1.2394**
00002239835	**NOVO-AMIODARONE**	**TEV**	$	**1.2394**
00002242472	**PMS-AMIODARONE**	**PMS**	$	**1.2394**
00002240071	**RATIO-AMIODARONE**	**RPH**	$	**1.2394**
00002243836	**SANDOZ AMIODARONE**	**SDZ**	$	**1.2394**
00002036282	CORDARONE	WAY	$	2.2133

24:00 CARDIOVASCULAR DRUGS

24:04.08 CARDIAC DRUGS
(CARDIOTONIC AGENTS)

DIGOXIN

0.0625 MG ORAL TABLET				
00002242321	LANOXIN	PMS	$	0.2402
0.125 MG ORAL TABLET				
00002242322	LANOXIN	PMS	$	0.2402
0.25 MG ORAL TABLET				
00002242323	LANOXIN	PMS	$	0.2402
0.05 MG / ML ORAL ELIXIR				
00002242320	LANOXIN PEDIATRIC	PMS	$	0.3929
0.05 MG / ML INJECTION				
00002048272	DIGOXIN PEDIATRIC	SDZ	$	6.4819
0.25 MG / ML INJECTION				
00002048264	DIGOXIN	SDZ	$	2.7823

24:00 CARDIOVASCULAR DRUGS

24:06.04 ANTILIPEMIC AGENTS

(BILE ACID SEQUESTRANTS)

CHOLESTYRAMINE RESIN

4 G ORAL POWDER PACKET				
00000890960	**PMS-CHOLESTYRAMINE LIGHT**	**PMS**	$	**1.3470**
00002210320	**PMS-CHOLESTYRAMINE REGULAR**	**PMS**	$	**1.3470**

COLESTIPOL HCL

1 G ORAL TABLET				
00002132680	COLESTID	PFI	$	0.2769
5 G ORAL POWDER PACKET				
00000642975	**COLESTID**	**PFI**	$	**0.9902**
00002132699	**COLESTID ORANGE**	**PFI**	$	**0.9902**

24:00 CARDIOVASCULAR DRUGS

24:06.06 ANTILIPEMIC AGENTS

(FIBRIC ACID DERIVATIVES)

BEZAFIBRATE

400 MG ORAL SUSTAINED-RELEASE TABLET				
00002083523	BEZALIP	ACV	$	1.8748

FENOFIBRATE

100 MG ORAL TABLET				
00002246859	**APO-FENO-SUPER**	**APX**	$	**0.6511**
00002289083	**NOVO-FENOFIBRATE-S**	**TEV**	$	**0.6511**
00002288044	**SANDOZ FENOFIBRATE S**	**SDZ**	$	**0.6511**
00002241601	LIPIDIL SUPRA	SLO	$	1.1627
67 MG ORAL CAPSULE				
00002243180	**APO-FENO-MICRO**	**APX**	$	**0.4325**
00002243551	**NOVO-FENOFIBRATE MICRONIZED**	**TEV**	$	**0.4325**
100 MG ORAL CAPSULE				
00002225980	**APO-FENOFIBRATE**	**APX**	$	**0.6105**
00002223600	**NU-FENOFIBRATE**	**NXP**	$	**0.6105**
200 MG ORAL CAPSULE				
00002273551	**PMS-FENOFIBRATE MICRO**	**PMS**	$	**1.0414**
00002239864	APO-FENO-MICRO	APX	$	1.0890
00002240210	MYLAN-FENOFIBRATE MICRO	MYP	$	1.0890
00002243552	NOVO-FENOFIBRATE MICRONIZED	TEV	$	1.0890
00002250039	RATIO-FENOFIBRATE MC	RPH	$	1.0890
00002146959	LIPIDIL MICRO	SLO	$	1.1707
160 MG ORAL CAPSULE/TABLET				
00002246860	**APO-FENO-SUPER (TABLET)**	**APX**	$	**0.7502**
00002289091	**NOVO-FENOFIBRATE-S (TABLET)**	**TEV**	$	**0.7502**
00002288052	**SANDOZ FENOFIBRATE S (TABLET)**	**SDZ**	$	**0.7502**
00002241602	LIPIDIL SUPRA (TABLET)	SLO	$	1.3397

24:00 CARDIOVASCULAR DRUGS

24:06.06 ANTILIPEMIC AGENTS (FIBRIC ACID DERIVATIVES)

GEMFIBROZIL

600 MG ORAL TABLET				
00001979582	**APO-GEMFIBROZIL**	**APX**	$	**0.6208**
00002230476	**MYLAN-GEMFIBROZIL**	**MYP**	$	**0.6208**
00002142074	**NOVO-GEMFIBROZIL**	**TEV**	$	**0.6208**
00002058464	**NU-GEMFIBROZIL**	**NXP**	$	**0.6208**
00002230183	**PMS-GEMFIBROZIL**	**PMS**	$	**0.6208**
00000659606	LOPID	PFI	$	1.1120
300 MG ORAL CAPSULE				
00001979574	**APO-GEMFIBROZIL**	**APX**	$	**0.2964**
00002185407	**MYLAN-GEMFIBROZIL**	**MYP**	$	**0.2964**
00002241704	**NOVO-GEMFIBROZIL**	**TEV**	$	**0.2964**
00002058456	**NU-GEMFIBROZIL**	**NXP**	$	**0.2964**
00002239951	**PMS-GEMFIBROZIL**	**PMS**	$	**0.2964**
00000599026	LOPID	PFI	$	0.5555

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS (HMG-COA REDUCTASE INHIBITORS)

ATORVASTATIN CALCIUM

10 MG (BASE) ORAL TABLET				
00002230711	LIPITOR	PFI	$	1.7888
20 MG (BASE) ORAL TABLET				
00002230713	LIPITOR	PFI	$	2.2360
40 MG (BASE) ORAL TABLET				
00002230714	LIPITOR	PFI	$	2.4037
80 MG (BASE) ORAL TABLET				
00002243097	LIPITOR	PFI	$	2.4037

FLUVASTATIN SODIUM

80 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002250527	LESCOL XL	NOV	$	1.5495
20 MG (BASE) ORAL CAPSULE				
00002061562	LESCOL	NOV	$	0.9148
40 MG (BASE) ORAL CAPSULE				
00002061570	LESCOL	NOV	$	1.2845

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS (HMG-COA REDUCTASE INHIBITORS)

LOVASTATIN

20 MG ORAL TABLET				
00002220172	**APO-LOVASTATIN**	**APX**	$	**1.0907**
00002248572	**CO LOVASTATIN**	**COB**	$	**1.0907**
00002243127	**MYLAN-LOVASTATIN**	**MYP**	$	**1.0907**
00002246542	**NOVO-LOVASTATIN**	**TEV**	$	**1.0907**
00002246013	**PMS-LOVASTATIN**	**PMS**	$	**1.0907**
00002267969	**RAN-LOVASTATIN**	**RAN**	$	**1.0907**
00002245822	**RATIO-LOVASTATIN**	**RPH**	$	**1.0907**
00002247056	**SANDOZ LOVASTATIN**	**SDZ**	$	**1.0907**
00000795860	MEVACOR	MFC	$	1.9675
40 MG ORAL TABLET				
00002220180	**APO-LOVASTATIN**	**APX**	$	**2.0117**
00002248573	**CO LOVASTATIN**	**COB**	$	**2.0117**
00002243129	**MYLAN-LOVASTATIN**	**MYP**	$	**2.0117**
00002246543	**NOVO-LOVASTATIN**	**TEV**	$	**2.0117**
00002246014	**PMS-LOVASTATIN**	**PMS**	$	**2.0117**
00002267977	**RAN-LOVASTATIN**	**RAN**	$	**2.0117**
00002245823	**RATIO-LOVASTATIN**	**RPH**	$	**2.0117**
00002247057	**SANDOZ LOVASTATIN**	**SDZ**	$	**2.0117**
00000795852	MEVACOR	MFC	$	3.5939

PRAVASTATIN SODIUM

10 MG ORAL TABLET				
00002317451	**MINT-PRAVASTATIN**	**MPI**	$	**0.5337**
00000893749	PRAVACHOL	BMS	$	0.9530
20 MG ORAL TABLET				
00002317478	**MINT-PRAVASTATIN**	**MPI**	$	**0.6296**
00000893757	PRAVACHOL	BMS	$	1.1243
40 MG ORAL TABLET				
00002317486	**MINT-PRAVASTATIN**	**MPI**	$	**0.7584**
00002222051	PRAVACHOL	BMS	$	1.3543

ROSUVASTATIN CALCIUM

5 MG (BASE) ORAL TABLET				
00002265540	CRESTOR	AZC	$	1.3868
10 MG (BASE) ORAL TABLET				
00002247162	CRESTOR	AZC	$	1.4620
20 MG (BASE) ORAL TABLET				
00002247163	CRESTOR	AZC	$	1.8275
40 MG (BASE) ORAL TABLET				
00002247164	CRESTOR	AZC	$	2.1392

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS

(HMG-COA REDUCTASE INHIBITORS)

SIMVASTATIN

5 MG ORAL TABLET

00002247011	**APO-SIMVASTATIN**	**APX**	$	**0.5670**
00002248103	**CO SIMVASTATIN**	**COB**	$	**0.5670**
00002331020	**JAMP-SIMVASTATIN**	**JPC**	$	**0.5670**
00002246582	**MYLAN-SIMVASTATIN**	**MYP**	$	**0.5670**
00002250144	**NOVO-SIMVASTATIN**	**TEV**	$	**0.5670**
00002281546	**PHL-SIMVASTATIN**	**PHH**	$	**0.5670**
00002269252	**PMS-SIMVASTATIN**	**PMS**	$	**0.5670**
00002329131	**RAN-SIMVASTATIN**	**RAN**	$	**0.5670**
00002331969	**SIMVASTATIN**	**RAN**	$	**0.5670**
00000884324	ZOCOR	MFC	$	1.0225

10 MG ORAL TABLET

00002247012	**APO-SIMVASTATIN**	**APX**	$	**1.1214**
00002248104	**CO SIMVASTATIN**	**COB**	$	**1.1214**
00002331039	**JAMP-SIMVASTATIN**	**JPC**	$	**1.1214**
00002246583	**MYLAN-SIMVASTATIN**	**MYP**	$	**1.1214**
00002250152	**NOVO-SIMVASTATIN**	**TEV**	$	**1.1214**
00002281554	**PHL-SIMVASTATIN**	**PHH**	$	**1.1214**
00002269260	**PMS-SIMVASTATIN**	**PMS**	$	**1.1214**
00002329158	**RAN-SIMVASTATIN**	**RAN**	$	**1.1214**
00002247068	**RATIO-SIMVASTATIN**	**RPH**	$	**1.1214**
00002247828	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.1214**
00002331985	**SIMVASTATIN**	**RAN**	$	**1.1214**
00000884332	ZOCOR	MFC	$	2.0232

20 MG ORAL TABLET

00002247013	**APO-SIMVASTATIN**	**APX**	$	**1.3860**
00002248105	**CO SIMVASTATIN**	**COB**	$	**1.3860**
00002331047	**JAMP-SIMVASTATIN**	**JPC**	$	**1.3860**
00002246737	**MYLAN-SIMVASTATIN**	**MYP**	$	**1.3860**
00002250160	**NOVO-SIMVASTATIN**	**TEV**	$	**1.3860**
00002281562	**PHL-SIMVASTATIN**	**PHH**	$	**1.3860**
00002269279	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002329166	**RAN-SIMVASTATIN**	**RAN**	$	**1.3860**
00002247069	**RATIO-SIMVASTATIN**	**RPH**	$	**1.3860**
00002247830	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.3860**
00002331993	**SIMVASTATIN**	**RAN**	$	**1.3860**
00000884340	ZOCOR	MFC	$	2.5004

40 MG ORAL TABLET

00002247014	**APO-SIMVASTATIN**	**APX**	$	**1.3860**
00002248106	**CO SIMVASTATIN**	**COB**	$	**1.3860**
00002331055	**JAMP-SIMVASTATIN**	**JPC**	$	**1.3860**
00002246584	**MYLAN-SIMVASTATIN**	**MYP**	$	**1.3860**
00002250179	**NOVO-SIMVASTATIN**	**TEV**	$	**1.3860**
00002281570	**PHL-SIMVASTATIN**	**PHH**	$	**1.3860**
00002269287	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002329174	**RAN-SIMVASTATIN**	**RAN**	$	**1.3860**
00002247070	**RATIO-SIMVASTATIN**	**RPH**	$	**1.3860**
00002247831	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.3860**
00002332000	**SIMVASTATIN**	**RAN**	$	**1.3860**
00000884359	ZOCOR	MFC	$	2.5004

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS
(HMG-COA REDUCTASE INHIBITORS)

SIMVASTATIN

80 MG ORAL TABLET

00002247015	**APO-SIMVASTATIN**	**APX**	$	**1.3860**
00002248107	**CO SIMVASTATIN**	**COB**	$	**1.3860**
00002331063	**JAMP-SIMVASTATIN**	**JPC**	$	**1.3860**
00002246585	**MYLAN-SIMVASTATIN**	**MYP**	$	**1.3860**
00002250187	**NOVO-SIMVASTATIN**	**TEV**	$	**1.3860**
00002281589	**PHL-SIMVASTATIN**	**PHH**	$	**1.3860**
00002269295	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002329182	**RAN-SIMVASTATIN**	**RAN**	$	**1.3860**
00002247071	**RATIO-SIMVASTATIN**	**RPH**	$	**1.3860**
00002247833	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.3860**
00002332019	**SIMVASTATIN**	**RAN**	$	**1.3860**
00002240332	ZOCOR	MFC	$	2.5004

24:00 CARDIOVASCULAR DRUGS

24:08.16 HYPOTENSIVE AGENTS
(CENTRAL ALPHA-AGONISTS)

CLONIDINE HCL

0.1 MG ORAL TABLET

00000868949	**APO-CLONIDINE**	**APX**	$	**0.1765**
00002046121	**NOVO-CLONIDINE**	**TEV**	$	**0.1765**
00001913786	**NU-CLONIDINE**	**NXP**	$	**0.1765**
00000259527	CATAPRES	BOE	$	0.1853

0.2 MG ORAL TABLET

00000868957	**APO-CLONIDINE**	**APX**	$	**0.3149**
00002046148	**NOVO-CLONIDINE**	**TEV**	$	**0.3149**
00001913220	**NU-CLONIDINE**	**NXP**	$	**0.3149**
00000291889	CATAPRES	BOE	$	0.3306

METHYLDOPA

125 MG ORAL TABLET

00000360252	APO-METHYLDOPA	APX	$	0.0989

250 MG ORAL TABLET

00000360260	APO-METHYLDOPA	APX	$	0.1433

500 MG ORAL TABLET

00000426830	APO-METHYLDOPA	APX	$	0.2537

24:00 CARDIOVASCULAR DRUGS

24:08.20 HYPOTENSIVE AGENTS
(DIRECT VASODILATORS)

DIAZOXIDE

100 MG ORAL CAPSULE

00000503347	PROGLYCEM	SCH	$	1.5723

24:00 CARDIOVASCULAR DRUGS

24:08.20 HYPOTENSIVE AGENTS (DIRECT VASODILATORS)

HYDRALAZINE HCL

10 MG ORAL TABLET				
00000441619	**APO-HYDRALAZINE**	**APX**	$	**0.1026**
00000759465	**NOVO-HYLAZIN**	**TEV**	$	**0.1026**
00001913204	**NU-HYDRAL**	**NXP**	$	**0.1026**
25 MG ORAL TABLET				
00000441627	**APO-HYDRALAZINE**	**APX**	$	**0.2314**
00002004828	**NU-HYDRAL**	**NXP**	$	**0.2314**
50 MG ORAL TABLET				
00000441635	**APO-HYDRALAZINE**	**APX**	$	**0.2770**
00000759481	**NOVO-HYLAZIN**	**TEV**	$	**0.2770**
00002004836	**NU-HYDRAL**	**NXP**	$	**0.2770**

MINOXIDIL

2.5 MG ORAL TABLET				
00000514497	LONITEN	PFI	$	0.3689
10 MG ORAL TABLET				
00000514500	LONITEN	PFI	$	0.8132

24:00 CARDIOVASCULAR DRUGS

24:08.24.08 HYPOTENSIVE AGENTS DIURETICS (LOOP DIURETICS)

FUROSEMIDE

20 MG ORAL TABLET				
00000396788	**APO-FUROSEMIDE**	**APX**	$	**0.0445**
00000337730	**NOVO-SEMIDE**	**TEV**	$	**0.0445**
00002224690	LASIX	SAV	$	0.0901
40 MG ORAL TABLET				
00000362166	**APO-FUROSEMIDE**	**APX**	$	**0.0670**
00000337749	**NOVO-SEMIDE**	**TEV**	$	**0.0670**
00002224704	LASIX	SAV	$	0.1382
80 MG ORAL TABLET				
00000707570	**APO-FUROSEMIDE**	**APX**	$	**0.1220**
00000765953	**NOVO-SEMIDE**	**TEV**	$	**0.1220**
500 MG ORAL TABLET				
00002224755	LASIX SPECIAL	SAV	$	3.1034
10 MG / ML ORAL SOLUTION				
00002224720	LASIX	SAV	$	0.2837
10 MG / ML INJECTION				
00000527033	FUROSEMIDE	SDZ	$	0.7116

24:00 CARDIOVASCULAR DRUGS

24:08.44.08 HYPOTENSIVE AGENTS
RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS
(ANGIOTENSIN II RECEPTOR ANTAGONISTS)

OLMESARTAN MEDOXOMIL

20 MG ORAL TABLET				
00002318660	OLMETEC	SCH	$	0.9900
40 MG ORAL TABLET				
00002318679	OLMETEC	SCH	$	0.9900

OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE

20 MG * 12.5 MG ORAL TABLET				
00002319616	OLMETEC PLUS	SCH	$	0.9900
40 MG * 12.5 MG ORAL TABLET				
00002319624	OLMETEC PLUS	SCH	$	0.9900
40 MG * 25 MG ORAL TABLET				
00002319632	OLMETEC PLUS	SCH	$	0.9900

24:00 CARDIOVASCULAR DRUGS

24:12.08 VASODILATING AGENTS
(NITRATES AND NITRITES)

ISOSORBIDE DINITRATE

10 MG ORAL TABLET				
00000441686	APO-ISDN	APX	$	0.0365
30 MG ORAL TABLET				
00000441694	APO-ISDN	APX	$	0.0857
5 MG ORAL SUBLINGUAL TABLET				
00000670944	APO-ISDN	APX	$	0.0621
20 MG ORAL SUSTAINED-RELEASE TABLET				
00000740721	CEDOCARD-SR	PAL	$	0.4195

ISOSORBIDE-5-MONONITRATE

60 MG ORAL EXTENDED-RELEASE TABLET				
00002272830	**APO-ISMN**	**APX**	$	**0.3973**
00002301288	**PMS-ISMN**	**PMS**	$	**0.3973**
00002126559	IMDUR	AZC	$	0.7095

NITROGLYCERIN

0.3 MG ORAL SUBLINGUAL TABLET				
00000037613	NITROSTAT	PFI	$	0.1234
0.6 MG ORAL SUBLINGUAL TABLET				
00000037621	NITROSTAT	PFI	$	0.1234
0.4 MG / DOSE SUBLINGUAL METERED DOSE SPRAY				
00002238998	**RHO-NITRO PUMPSPRAY**	**SDZ**	$	**0.0421**
00002231441	NITROLINGUAL PUMPSPRAY	SAV	$	0.0752
2 % TOPICAL OINTMENT				
00001926454	NITROL	PAL	$	0.6100
0.2 MG/HR TRANSDERMAL PATCH				
☒ 00001911910	NITRO-DUR 0.2	SCH	$	0.5667
☒ 00002230732	TRINIPATCH 0.2	PAL	$	0.5667
☒ 00002162806	MINITRAN 0.2	GRC	$	0.6274
☒ 00000584223	TRANSDERM-NITRO 0.2	NOV	$	0.6805

24:00 CARDIOVASCULAR DRUGS

24:12.08 VASODILATING AGENTS (NITRATES AND NITRITES)

NITROGLYCERIN

0.4 MG/HR TRANSDERMAL PATCH				
☒ 00001911902	NITRO-DUR 0.4	SCH	$	0.6400
☒ 00002230733	TRINIPATCH 0.4	PAL	$	0.6400
☒ 00002163527	MINITRAN 0.4	GRC	$	0.7087
☒ 00000852384	TRANSDERM-NITRO 0.4	NOV	$	0.7686
0.6 MG/HR TRANSDERMAL PATCH				
☒ 00001911929	NITRO-DUR 0.6	SCH	$	0.6400
☒ 00002230734	TRINIPATCH 0.6	PAL	$	0.6400
☒ 00002163535	MINITRAN 0.6	GRC	$	0.7090
☒ 00002046156	TRANSDERM-NITRO 0.6	NOV	$	0.7686
0.8 MG/HR TRANSDERMAL PATCH				
00002011271	NITRO-DUR 0.8	SCH	$	1.1100

24:00 CARDIOVASCULAR DRUGS

24:12.92 VASODILATING AGENTS (MISCELLANEOUS VASODILATING AGENTS)

ALPROSTADIL

500 MCG / ML INJECTION				
00000559253	PROSTIN VR	PFI	$	254.6156

DIPYRIDAMOLE

25 MG ORAL TABLET				
00000895644	APO-DIPYRIDAMOLE (FC)	APX	$	0.2633
50 MG ORAL TABLET				
00000895652	**APO-DIPYRIDAMOLE (FC)**	**APX**	$	**0.2932**
00000067393	PERSANTINE	BOE	$	0.3879
75 MG ORAL TABLET				
00000895660	**APO-DIPYRIDAMOLE (FC)**	**APX**	$	**0.4397**
00000452092	PERSANTINE	BOE	$	0.5224

NYLIDRIN HCL

6 MG ORAL TABLET				
00001926713	ARLIDIN	ERF	$	0.5013

24:00 CARDIOVASCULAR DRUGS

24:16 SCLEROSING AGENTS

SODIUM TETRADECYL SULFATE

1 % INJECTION				
00000511234	TROMBOJECT	OMG	$	3.3000
3 % INJECTION				
00000511226	TROMBOJECT	OMG	$	3.6000

24:00 CARDIOVASCULAR DRUGS

24:20 ALPHA-ADRENERGIC BLOCKING AGENTS

DOXAZOSIN MESYLATE

1 MG (BASE) ORAL TABLET				
00002240588	**APO-DOXAZOSIN**	**APX**	$	**0.3410**
00002240498	**MYLAN-DOXAZOSIN**	**MYP**	$	**0.3410**
00002242728	**NOVO-DOXAZOSIN**	**TEV**	$	**0.3410**
00002244527	**PMS-DOXAZOSIN**	**PMS**	$	**0.3410**
00001958100	CARDURA	PFI	$	0.6108
2 MG (BASE) ORAL TABLET				
00002240589	**APO-DOXAZOSIN**	**APX**	$	**0.4091**
00002240499	**MYLAN-DOXAZOSIN**	**MYP**	$	**0.4091**
00002242729	**NOVO-DOXAZOSIN**	**TEV**	$	**0.4091**
00002244528	**PMS-DOXAZOSIN**	**PMS**	$	**0.4091**
00001958097	CARDURA	PFI	$	0.7326
4 MG (BASE) ORAL TABLET				
00002240590	**APO-DOXAZOSIN**	**APX**	$	**0.5319**
00002240500	**MYLAN-DOXAZOSIN**	**MYP**	$	**0.5319**
00002242730	**NOVO-DOXAZOSIN**	**TEV**	$	**0.5319**
00002244529	**PMS-DOXAZOSIN**	**PMS**	$	**0.5319**
00001958119	CARDURA	PFI	$	0.9527

PRAZOSIN HCL

1 MG (BASE) ORAL TABLET				
00000882801	**APO-PRAZO**	**APX**	$	**0.2055**
00001934198	**NOVO-PRAZIN**	**TEV**	$	**0.2055**
00001913794	**NU-PRAZO**	**NXP**	$	**0.2055**
2 MG (BASE) ORAL TABLET				
00000882828	**APO-PRAZO**	**APX**	$	**0.2791**
00001934201	**NOVO-PRAZIN**	**TEV**	$	**0.2791**
00001913808	**NU-PRAZO**	**NXP**	$	**0.2791**
5 MG (BASE) ORAL TABLET				
00000882836	**APO-PRAZO**	**APX**	$	**0.3806**
00001934228	**NOVO-PRAZIN**	**TEV**	$	**0.3806**
00001913816	**NU-PRAZO**	**NXP**	$	**0.3806**

TAMSULOSIN HCL

0.4 MG ORAL EXTENDED-RELEASE TABLET				
00002270102	FLOMAX CR	BOE	$	0.6000
0.4 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002294885	**RAN-TAMSULOSIN**	**RAN**	$	**0.5464**
00002294265	**RATIO-TAMSULOSIN**	**RPH**	$	**0.5464**
00002331780	**TAMSULOSIN**	**RAN**	$	**0.5464**
00002298570	MYLAN-TAMSULOSIN	MYP	$	0.6000
00002281392	NOVO-TAMSULOSIN	TEV	$	0.6000
00002295121	SANDOZ TAMSULOSIN	SDZ	$	0.6000

24:00 CARDIOVASCULAR DRUGS

24:20 ALPHA-ADRENERGIC BLOCKING AGENTS

TERAZOSIN HCL

1 MG (BASE) ORAL TABLET				
00002234502	**APO-TERAZOSIN**	**APX**	$	**0.3490**
00002230805	**NOVO-TERAZOSIN**	**TEV**	$	**0.3490**
00002233047	**NU-TERAZOSIN**	**NXP**	$	**0.3490**
00002243518	**PMS-TERAZOSIN**	**PMS**	$	**0.3490**
00002218941	**RATIO-TERAZOSIN**	**RPH**	$	**0.3490**
00000818658	HYTRIN	ABB	$	0.6991
2 MG (BASE) ORAL TABLET				
00002234503	**APO-TERAZOSIN**	**APX**	$	**0.4436**
00002230806	**NOVO-TERAZOSIN**	**TEV**	$	**0.4436**
00002233048	**NU-TERAZOSIN**	**NXP**	$	**0.4436**
00002243519	**PMS-TERAZOSIN**	**PMS**	$	**0.4436**
00002218968	**RATIO-TERAZOSIN**	**RPH**	$	**0.4436**
00000818682	HYTRIN	ABB	$	0.8887
5 MG (BASE) ORAL TABLET				
00002234504	**APO-TERAZOSIN**	**APX**	$	**0.6025**
00002230807	**NOVO-TERAZOSIN**	**TEV**	$	**0.6025**
00002233049	**NU-TERAZOSIN**	**NXP**	$	**0.6025**
00002243520	**PMS-TERAZOSIN**	**PMS**	$	**0.6025**
00002218976	**RATIO-TERAZOSIN**	**RPH**	$	**0.6025**
00000818666	HYTRIN	ABB	$	1.2069
10 MG (BASE) ORAL TABLET				
00002234505	**APO-TERAZOSIN**	**APX**	$	**0.8820**
00002230808	**NOVO-TERAZOSIN**	**TEV**	$	**0.8820**
00002233050	**NU-TERAZOSIN**	**NXP**	$	**0.8820**
00002243521	**PMS-TERAZOSIN**	**PMS**	$	**0.8820**
00002218984	**RATIO-TERAZOSIN**	**RPH**	$	**0.8820**
00000818674	HYTRIN	ABB	$	1.7666

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL HCL

100 MG (BASE) ORAL TABLET				
00002147602	**APO-ACEBUTOLOL**	**APX**	$	**0.1630**
00002237721	**MYLAN-ACEBUTOLOL**	**MYP**	$	**0.1630**
00002237885	**MYLAN-ACEBUTOLOL (TYPE S)**	**MYP**	$	**0.1630**
00002204517	**NOVO-ACEBUTOLOL**	**TEV**	$	**0.1630**
00002165546	**NU-ACEBUTOLOL**	**NXP**	$	**0.1630**
00001910140	**RHOTRAL**	**SDZ**	$	**0.1630**
00002257599	**SANDOZ ACEBUTOLOL**	**SDZ**	$	**0.1630**
00001926543	SECTRAL	SAV	$	0.3552
200 MG (BASE) ORAL TABLET				
00002147610	**APO-ACEBUTOLOL**	**APX**	$	**0.2440**
00002237722	**MYLAN-ACEBUTOLOL**	**MYP**	$	**0.2440**
00002237886	**MYLAN-ACEBUTOLOL (TYPE S)**	**MYP**	$	**0.2440**
00002204525	**NOVO-ACEBUTOLOL**	**TEV**	$	**0.2440**
00002165554	**NU-ACEBUTOLOL**	**NXP**	$	**0.2440**
00001910159	**RHOTRAL**	**SDZ**	$	**0.2440**
00002257602	**SANDOZ ACEBUTOLOL**	**SDZ**	$	**0.2440**
00001926551	SECTRAL	SAV	$	0.5328

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL HCL

400 MG (BASE) ORAL TABLET

00002147629	**APO-ACEBUTOLOL**	**APX**	$	**0.4848**
00002237723	**MYLAN-ACEBUTOLOL**	**MYP**	$	**0.4848**
00002237887	**MYLAN-ACEBUTOLOL (TYPE S)**	**MYP**	$	**0.4848**
00002204533	**NOVO-ACEBUTOLOL**	**TEV**	$	**0.4848**
00002165562	**NU-ACEBUTOLOL**	**NXP**	$	**0.4848**
00001910167	**RHOTRAL**	**SDZ**	$	**0.4848**
00002257610	**SANDOZ ACEBUTOLOL**	**SDZ**	$	**0.4848**
00001926578	SECTRAL	SAV	$	1.0602

ATENOLOL

25 MG ORAL TABLET

00002247182	**PHL-ATENOLOL**	**PHH**	$	**0.1730**
00002246581	**PMS-ATENOLOL**	**PMS**	$	**0.1730**
00002266660	NOVO-ATENOL	TEV	$	0.1758

50 MG ORAL TABLET

00000773689	**APO-ATENOL**	**APX**	$	**0.3460**
00002255545	**CO ATENOLOL**	**COB**	$	**0.3460**
00002146894	**MYLAN-ATENOLOL**	**MYP**	$	**0.3460**
00001912062	**NOVO-ATENOL**	**TEV**	$	**0.3460**
00002238316	**PHL-ATENOLOL**	**PHH**	$	**0.3460**
00002237600	**PMS-ATENOLOL**	**PMS**	$	**0.3460**
00002267985	**RAN-ATENOLOL**	**RAN**	$	**0.3460**
00002171791	**RATIO-ATENOLOL**	**RPH**	$	**0.3460**
00002231731	**SANDOZ ATENOLOL**	**SDZ**	$	**0.3460**
00002039532	TENORMIN	AZC	$	0.6178

100 MG ORAL TABLET

00000773697	**APO-ATENOL**	**APX**	$	**0.5687**
00002255553	**CO ATENOLOL**	**COB**	$	**0.5687**
00002147432	**MYLAN-ATENOLOL**	**MYP**	$	**0.5687**
00001912054	**NOVO-ATENOL**	**TEV**	$	**0.5687**
00002238318	**PHL-ATENOLOL**	**PHH**	$	**0.5687**
00002237601	**PMS-ATENOLOL**	**PMS**	$	**0.5687**
00002267993	**RAN-ATENOLOL**	**RAN**	$	**0.5687**
00002171805	**RATIO-ATENOLOL**	**RPH**	$	**0.5687**
00002231733	**SANDOZ ATENOLOL**	**SDZ**	$	**0.5687**
00002039540	TENORMIN	AZC	$	1.0156

ATENOLOL/ CHLORTHALIDONE

50 MG * 25 MG ORAL TABLET

00002248763	**APO-ATENIDONE**	**APX**	$	**0.3847**
00002302918	**NOVO-ATENOLTHALIDONE**	**TEV**	$	**0.3847**
00002049961	TENORETIC 50/25	AZC	$	0.6869

100 MG * 25 MG ORAL TABLET

00002248764	**APO-ATENIDONE**	**APX**	$	**0.6303**
00002302926	**NOVO-ATENOLTHALIDONE**	**TEV**	$	**0.6303**
00002049988	TENORETIC 100/25	AZC	$	1.1256

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

BISOPROLOL FUMARATE

5 MG ORAL TABLET				
00002302632	**PMS-BISOPROLOL**	**PMS**	$	**0.2120**
00002256134	APO-BISOPROLOL	APX	$	0.2205
00002267470	NOVO-BISOPROLOL	TEV	$	0.2205
00002247439	SANDOZ BISOPROLOL	SDZ	$	0.2205
10 MG ORAL TABLET				
00002302640	**PMS-BISOPROLOL**	**PMS**	$	**0.3248**
00002256177	APO-BISOPROLOL	APX	$	0.3654
00002267489	NOVO-BISOPROLOL	TEV	$	0.3654
00002247440	SANDOZ BISOPROLOL	SDZ	$	0.3654

CARVEDILOL

3.125 MG ORAL TABLET				
00002248752	**PHL-CARVEDILOL**	**PHH**	$	**0.7564**
00002245914	**PMS-CARVEDILOL**	**PMS**	$	**0.7564**
00002268027	**RAN-CARVEDILOL**	**RAN**	$	**0.7564**
00002252309	**RATIO-CARVEDILOL**	**RPH**	$	**0.7564**
00002247933	APO-CARVEDILOL	APX	$	0.8001
6.25 MG ORAL TABLET				
00002248753	**PHL-CARVEDILOL**	**PHH**	$	**0.7564**
00002245915	**PMS-CARVEDILOL**	**PMS**	$	**0.7564**
00002268035	**RAN-CARVEDILOL**	**RAN**	$	**0.7564**
00002252317	**RATIO-CARVEDILOL**	**RPH**	$	**0.7564**
00002247934	APO-CARVEDILOL	APX	$	0.8001
12.5 MG ORAL TABLET				
00002248754	**PHL-CARVEDILOL**	**PHH**	$	**0.7564**
00002245916	**PMS-CARVEDILOL**	**PMS**	$	**0.7564**
00002268043	**RAN-CARVEDILOL**	**RAN**	$	**0.7564**
00002252325	**RATIO-CARVEDILOL**	**RPH**	$	**0.7564**
00002247935	APO-CARVEDILOL	APX	$	0.8001
25 MG ORAL TABLET				
00002248755	**PHL-CARVEDILOL**	**PHH**	$	**0.6001**
00002245917	PMS-CARVEDILOL	PMS	$	0.7564
00002268051	RAN-CARVEDILOL	RAN	$	0.7564
00002252333	RATIO-CARVEDILOL	RPH	$	0.7564
00002247936	APO-CARVEDILOL	APX	$	0.8001

LABETALOL HCL

100 MG ORAL TABLET				
00002106272	TRANDATE	PAL	$	0.2556
200 MG ORAL TABLET				
00002106280	TRANDATE	PAL	$	0.4519
5 MG / ML INJECTION				
00002231689	LABETALOL HYDROCHLORIDE	SDZ	$	1.2976

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

METOPROLOL TARTRATE

25 MG ORAL TABLET				
00002246010	**APO-METOPROLOL**	**APX**	$	**0.0643**
00002248855	**PMS-METOPROLOL-L**	**PMS**	$	**0.0643**
50 MG ORAL TABLET				
00000618632	**APO-METOPROLOL**	**APX**	$	**0.1225**
00000749354	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.1225**
00002174545	**MYLAN-METOPROLOL (TYPE L)**	**MYP**	$	**0.1225**
00000842648	**NOVO-METOPROL**	**TEV**	$	**0.1225**
00000648035	**NOVO-METOPROL (FC)**	**TEV**	$	**0.1225**
00000865605	**NU-METOP**	**NXP**	$	**0.1225**
00002230803	**PMS-METOPROLOL-L**	**PMS**	$	**0.1225**
00002247875	**SANDOZ METOPROLOL (TYPE L)**	**SDZ**	$	**0.1225**
00000397423	LOPRESOR	NOV	$	0.2860
100 MG ORAL TABLET				
00000618640	**APO-METOPROLOL**	**APX**	$	**0.2223**
00000751170	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.2223**
00002174553	**MYLAN-METOPROLOL (TYPE L)**	**MYP**	$	**0.2223**
00000842656	**NOVO-METOPROL**	**TEV**	$	**0.2223**
00000648043	**NOVO-METOPROL (FC)**	**TEV**	$	**0.2223**
00000865613	**NU-METOP**	**NXP**	$	**0.2223**
00002230804	**PMS-METOPROLOL-L**	**PMS**	$	**0.2223**
00002247876	**SANDOZ METOPROLOL (TYPE L)**	**SDZ**	$	**0.2223**
00000397431	LOPRESOR	NOV	$	0.5867
100 MG ORAL SUSTAINED-RELEASE TABLET				
00002285169	**APO-METOPROLOL SR**	**APX**	$	**0.1789**
00002303396	**SANDOZ METOPROLOL SR**	**SDZ**	$	**0.1789**
00000658855	LOPRESOR SR	NOV	$	0.3203
200 MG (BASE) ORAL SUSTAINED-RELEASE TABLET				
00002285177	**APO-METOPROLOL SR**	**APX**	$	**0.3246**
00002303418	**SANDOZ METOPROLOL SR**	**SDZ**	$	**0.3246**
00000534560	LOPRESOR SR	NOV	$	0.5815
1 MG / ML (BASE) INJECTION				
00000590819	LOPRESOR	NOV	$	1.2289

NADOLOL

40 MG ORAL TABLET				
00000782505	**APO-NADOL**	**APX**	$	**0.2465**
00002126753	**NOVO-NADOLOL**	**TEV**	$	**0.2465**
80 MG ORAL TABLET				
00000782467	**APO-NADOL**	**APX**	$	**0.3515**
00002126761	**NOVO-NADOLOL**	**TEV**	$	**0.3515**
160 MG ORAL TABLET				
00000782475	APO-NADOL	APX	$	1.2046

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

PINDOLOL

5 MG ORAL TABLET				
00000755877	**APO-PINDOL**	**APX**	$	**0.2283**
00002057808	**GEN-PINDOLOL**	**MYP**	$	**0.2283**
00000869007	**NOVO-PINDOL**	**TEV**	$	**0.2283**
00000886149	**NU-PINDOL**	**NXP**	$	**0.2283**
00002231536	**PMS-PINDOLOL**	**PMS**	$	**0.2283**
00002261782	**SANDOZ PINDOLOL**	**SDZ**	$	**0.2283**
00000417270	VISKEN	NOV	$	0.5867
10 MG ORAL TABLET				
00000755885	**APO-PINDOL**	**APX**	$	**0.3965**
00002057816	**GEN-PINDOLOL**	**MYP**	$	**0.3965**
00000869015	**NOVO-PINDOL**	**TEV**	$	**0.3965**
00000886009	**NU-PINDOL**	**NXP**	$	**0.3965**
00002231537	**PMS-PINDOLOL**	**PMS**	$	**0.3965**
00002261790	**SANDOZ PINDOLOL**	**SDZ**	$	**0.3965**
00000443174	VISKEN	NOV	$	1.0019
15 MG ORAL TABLET				
00000755893	**APO-PINDOL**	**APX**	$	**0.5825**
00002057824	**GEN-PINDOLOL**	**MYP**	$	**0.5825**
00000869023	**NOVO-PINDOL**	**TEV**	$	**0.5825**
00000886130	**NU-PINDOL**	**NXP**	$	**0.5825**
00002231539	**PMS-PINDOLOL**	**PMS**	$	**0.5825**
00002261804	**SANDOZ PINDOLOL**	**SDZ**	$	**0.5825**
00000417289	VISKEN	NOV	$	1.4535

PINDOLOL/ HYDROCHLOROTHIAZIDE

10 MG * 25 MG ORAL TABLET				
00000568627	VISKAZIDE 10/25	NOV	$	0.8993
10 MG * 50 MG ORAL TABLET				
00000568635	VISKAZIDE 10/50	NOV	$	0.8993

PROPRANOLOL HCL

10 MG ORAL TABLET				
00000402788	**APO-PROPRANOLOL**	**APX**	$	**0.0192**
00000496480	**NOVO-PRANOL**	**TEV**	$	**0.0192**
00000582255	**PMS-PROPRANOLOL**	**PMS**	$	**0.0192**
20 MG ORAL TABLET				
00000663719	**APO-PROPRANOLOL**	**APX**	$	**0.0346**
00000740675	**NOVO-PRANOL**	**TEV**	$	**0.0346**
40 MG ORAL TABLET				
00000402753	**APO-PROPRANOLOL**	**APX**	$	**0.0348**
00000496499	**NOVO-PRANOL**	**TEV**	$	**0.0348**
00000582263	**PMS-PROPRANOLOL**	**PMS**	$	**0.0348**
80 MG ORAL TABLET				
00000402761	**APO-PROPRANOLOL**	**APX**	$	**0.0585**
00000496502	**NOVO-PRANOL**	**TEV**	$	**0.0585**
00000582271	**PMS-PROPRANOLOL**	**PMS**	$	**0.0585**
120 MG ORAL TABLET				
00000504335	APO-PROPRANOLOL	APX	$	0.3091
60 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042231	INDERAL-LA	WAY	$	0.5874
80 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042258	INDERAL-LA	WAY	$	0.6623

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

PROPRANOLOL HCL

120 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042266	INDERAL-LA	WAY	$	1.0196
160 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042274	INDERAL-LA	WAY	$	1.2059

SOTALOL HCL

80 MG ORAL TABLET				
00002238326	**PMS-SOTALOL**	**PMS**	$	**0.4922**
00002210428	APO-SOTALOL	APX	$	0.5932
00002270625	CO SOTALOL	COB	$	0.5932
00002229778	MYLAN-SOTALOL	MYP	$	0.5932
00002231181	NOVO-SOTALOL	TEV	$	0.5932
00002200996	NU-SOTALOL	NXP	$	0.5932
00002084228	RATIO-SOTALOL	RPH	$	0.5932
00002257831	SANDOZ SOTALOL	SDZ	$	0.5932
160 MG ORAL TABLET				
00002238327	**PMS-SOTALOL**	**PMS**	$	**0.5771**
00002167794	APO-SOTALOL	APX	$	0.6492
00002270633	CO SOTALOL	COB	$	0.6492
00002229779	MYLAN-SOTALOL	MYP	$	0.6492
00002231182	NOVO-SOTALOL	TEV	$	0.6492
00002163772	NU-SOTALOL	NXP	$	0.6492
00002084236	RATIO-SOTALOL	RPH	$	0.6492
00002257858	SANDOZ SOTALOL	SDZ	$	0.6492

TIMOLOL MALEATE

5 MG ORAL TABLET				
00000755842	**APO-TIMOL**	**APX**	$	**0.1817**
00001947796	**NOVO-TIMOL**	**TEV**	$	**0.1817**
00002044609	**NU-TIMOLOL**	**NXP**	$	**0.1817**
10 MG ORAL TABLET				
00000755850	**APO-TIMOL**	**APX**	$	**0.2835**
00001947818	**NOVO-TIMOL**	**TEV**	$	**0.2835**
00002044617	**NU-TIMOLOL**	**NXP**	$	**0.2835**
20 MG ORAL TABLET				
00000755869	**APO-TIMOL**	**APX**	$	**0.5670**
00001947826	**NOVO-TIMOL**	**TEV**	$	**0.5670**

24:00 CARDIOVASCULAR DRUGS

24:28.08 CALCIUM-CHANNEL BLOCKING AGENTS (DIHYDROPYRIDINES)

AMLODIPINE BESYLATE

2.5 MG ORAL TABLET				
00002326760	**PHL-AMLODIPINE**	**PHH**	$	**0.3328**
00002295148	**PMS-AMLODIPINE**	**PMS**	$	**0.3328**
5 MG (BASE) ORAL TABLET				
00002331934	**AMLODIPINE**	**RAN**	$	**0.6656**
00002273373	**APO-AMLODIPINE**	**APX**	$	**0.6656**
00002297485	**CO AMLODIPINE**	**COB**	$	**0.6656**
00002280132	**GD-AMLODIPINE**	**GMD**	$	**0.6656**
00002331071	**JAMP-AMLODIPINE**	**JPC**	$	**0.6656**
00002272113	**MYLAN-AMLODIPINE**	**MYP**	$	**0.6656**
00002250497	**NOVO-AMLODIPINE**	**TEV**	$	**0.6656**
00002326779	**PHL-AMLODIPINE**	**PHH**	$	**0.6656**
00002284065	**PMS-AMLODIPINE**	**PMS**	$	**0.6656**
00002321858	**RAN-AMLODIPINE**	**RAN**	$	**0.6656**
00002259605	**RATIO-AMLODIPINE**	**RPH**	$	**0.6656**
00002284383	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.6656**
00000878928	NORVASC	PFI	$	1.3778
10 MG (BASE) ORAL TABLET				
00002331942	**AMLODIPINE**	**RAN**	$	**0.9880**
00002273381	**APO-AMLODIPINE**	**APX**	$	**0.9880**
00002297493	**CO AMLODIPINE**	**COB**	$	**0.9880**
00002280140	**GD-AMLODIPINE**	**GMD**	$	**0.9880**
00002331098	**JAMP-AMLODIPINE**	**JPC**	$	**0.9880**
00002272121	**MYLAN-AMLODIPINE**	**MYP**	$	**0.9880**
00002250500	**NOVO-AMLODIPINE**	**TEV**	$	**0.9880**
00002326787	**PHL-AMLODIPINE**	**PHH**	$	**0.9880**
00002284073	**PMS-AMLODIPINE**	**PMS**	$	**0.9880**
00002321866	**RAN-AMLODIPINE**	**RAN**	$	**0.9880**
00002259613	**RATIO-AMLODIPINE**	**RPH**	$	**0.9880**
00002284391	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.9880**
00000878936	NORVASC	PFI	$	2.0453

FELODIPINE

2.5 MG ORAL EXTENDED-RELEASE TABLET				
00002057778	**PLENDIL**	**AZC**	$	**0.5469**
00002221985	RENEDIL	SAV	$	0.5699
5 MG ORAL EXTENDED-RELEASE TABLET				
00002280264	**SANDOZ FELODIPINE**	**SDZ**	$	**0.4620**
00000851779	PLENDIL	AZC	$	0.7307
00002221993	RENEDIL	SAV	$	0.7770
10 MG ORAL EXTENDED-RELEASE TABLET				
00002280272	**SANDOZ FELODIPINE**	**SDZ**	$	**0.6923**
00000851787	PLENDIL	AZC	$	1.0962
00002222000	RENEDIL	SAV	$	1.1647

NIFEDIPINE

20 MG ORAL EXTENDED-RELEASE TABLET				
00002237618	ADALAT XL	BAI	$	1.2816
30 MG ORAL EXTENDED-RELEASE TABLET				
00002155907	ADALAT XL	BAI	$	1.2816
60 MG ORAL EXTENDED-RELEASE TABLET				
00002321149	**MYLAN-NIFEDIPINE EXTENDED RELEASE**	**MYP**	$	**1.1285**
00002155990	ADALAT XL	BAI	$	1.3450

24:00 CARDIOVASCULAR DRUGS

24:28.08 CALCIUM-CHANNEL BLOCKING AGENTS (DIHYDROPYRIDINES)

NIFEDIPINE

5 MG ORAL CAPSULE				
00000725110	APO-NIFED	APX	$	0.3679
10 MG ORAL CAPSULE				
00000755907	**APO-NIFED**	**APX**	$	**0.4877**
00000865591	**NU-NIFED**	**NXP**	$	**0.4877**

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

30 MG ORAL TABLET				
00000771376	**APO-DILTIAZ**	**APX**	$	**0.2075**
00000862924	**NOVO-DILTAZEM**	**TEV**	$	**0.2075**
00000886068	**NU-DILTIAZ**	**NXP**	$	**0.2075**
60 MG ORAL TABLET				
00000771384	**APO-DILTIAZ**	**APX**	$	**0.3637**
00000862932	**NOVO-DILTAZEM**	**TEV**	$	**0.3637**
00000886076	**NU-DILTIAZ**	**NXP**	$	**0.3637**
120 MG ORAL EXTENDED-RELEASE TABLET				
00002256738	TIAZAC XC	BOV	$	0.7911
180 MG ORAL EXTENDED-RELEASE TABLET				
00002256746	TIAZAC XC	BOV	$	1.0501
240 MG ORAL EXTENDED-RELEASE TABLET				
00002256754	TIAZAC XC	BOV	$	1.3928
300 MG ORAL EXTENDED-RELEASE TABLET				
00002256762	TIAZAC XC	BOV	$	1.3928
360 MG ORAL EXTENDED-RELEASE TABLET				
00002256770	TIAZAC XC	BOV	$	1.3928
120 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002230997	**APO-DILTIAZ CD**	**APX**	$	**0.7904**
00002242538	**NOVO-DILTAZEM CD**	**TEV**	$	**0.7904**
00002231052	**NU-DILTIAZ-CD**	**NXP**	$	**0.7904**
00002229781	**RATIO-DILTIAZEM CD**	**RPH**	$	**0.7904**
00002243338	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.7904**
00002097249	CARDIZEM CD	BOV	$	1.4114
180 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002230998	**APO-DILTIAZ CD**	**APX**	$	**1.0492**
00002242539	**NOVO-DILTAZEM CD**	**TEV**	$	**1.0492**
00002231053	**NU-DILTIAZ-CD**	**NXP**	$	**1.0492**
00002229782	**RATIO-DILTIAZEM CD**	**RPH**	$	**1.0492**
00002243339	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**1.0492**
00002097257	CARDIZEM CD	BOV	$	1.8735
240 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002230999	**APO-DILTIAZ CD**	**APX**	$	**1.3916**
00002242540	**NOVO-DILTAZEM CD**	**TEV**	$	**1.3916**
00002231054	**NU-DILTIAZ-CD**	**NXP**	$	**1.3916**
00002229783	**RATIO-DILTIAZEM CD**	**RPH**	$	**1.3916**
00002243340	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**1.3916**
00002097265	CARDIZEM CD	BOV	$	2.4850

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS
(MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

300 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002229526	**APO-DILTIAZ CD**	**APX**	$	**1.7395**
00002242541	**NOVO-DILTAZEM CD**	**TEV**	$	**1.7395**
00002229784	**RATIO-DILTIAZEM CD**	**RPH**	$	**1.7395**
00002243341	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**1.7395**
00002097273	CARDIZEM CD	BOV	$	3.1063
120 MG ORAL EXTENDED-RELEASE CAPSULE				
00002291037	**APO-DILTIAZ TZ**	**APX**	$	**0.4778**
00002271605	**NOVO-DILTIAZEM HCL ER**	**TEV**	$	**0.4778**
00002245918	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.4778**
00002231150	TIAZAC	BOV	$	0.8533
180 MG ORAL EXTENDED-RELEASE CAPSULE				
00002291045	**APO-DILTIAZ TZ**	**APX**	$	**0.6471**
00002271613	**NOVO-DILTIAZEM HCL ER**	**TEV**	$	**0.6471**
00002245919	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.6471**
00002231151	TIAZAC	BOV	$	1.1556
240 MG ORAL EXTENDED-RELEASE CAPSULE				
00002291053	**APO-DILTIAZ TZ**	**APX**	$	**0.8584**
00002271621	**NOVO-DILTIAZEM HCL ER**	**TEV**	$	**0.8584**
00002245920	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.8584**
00002231152	TIAZAC	BOV	$	1.5328
300 MG ORAL EXTENDED-RELEASE CAPSULE				
00002291061	**APO-DILTIAZ TZ**	**APX**	$	**1.0572**
00002271648	**NOVO-DILTIAZEM HCL ER**	**TEV**	$	**1.0572**
00002245921	**SANDOZ DILTIAZEM T**	**SDZ**	$	**1.0572**
00002231154	TIAZAC	BOV	$	1.8878
360 MG ORAL EXTENDED-RELEASE CAPSULE				
00002291088	**APO-DILTIAZ TZ**	**APX**	$	**1.2943**
00002271656	**NOVO-DILTIAZEM HCL ER**	**TEV**	$	**1.2943**
00002245922	**SANDOZ DILTIAZEM T**	**SDZ**	$	**1.2943**
00002231155	TIAZAC	BOV	$	2.3112

VERAPAMIL HCL

80 MG ORAL TABLET				
00000782483	**APO-VERAP**	**APX**	$	**0.2735**
00002237921	**MYLAN-VERAPAMIL**	**MYP**	$	**0.2735**
00000886033	**NU-VERAP**	**NXP**	$	**0.2735**
120 MG ORAL TABLET				
00000782491	**APO-VERAP**	**APX**	$	**0.4250**
00002237922	**MYLAN-VERAPAMIL**	**MYP**	$	**0.4250**
00000886041	**NU-VERAP**	**NXP**	$	**0.4250**
120 MG ORAL SUSTAINED-RELEASE TABLET				
00002246893	**APO-VERAP SR**	**APX**	$	**0.6900**
00002210347	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.6900**
00001907123	ISOPTIN SR	ABB	$	1.2838
180 MG ORAL SUSTAINED-RELEASE TABLET				
00002246894	**APO-VERAP SR**	**APX**	$	**0.6558**
00002210355	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.6558**
00001934317	ISOPTIN SR	ABB	$	1.4497

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

VERAPAMIL HCL

240 MG ORAL SUSTAINED-RELEASE TABLET				
00002246895	**APO-VERAP SR**	**APX**	$	**0.8720**
00002210363	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.8720**
00002211920	**NOVO-VERAMIL SR**	**TEV**	$	**0.8720**
00002237791	**PMS-VERAPAMIL SR**	**PMS**	$	**0.8720**
00000742554	ISOPTIN SR	ABB	$	1.9333

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

BENAZEPRIL HCL

5 MG ORAL TABLET				
00002290332	**APO-BENAZEPRIL**	**APX**	$	**0.5577**
00000885835	LOTENSIN	NOV	$	0.8016
10 MG ORAL TABLET				
00002290340	**APO-BENAZEPRIL**	**APX**	$	**0.6595**
00000885843	LOTENSIN	NOV	$	0.9479
20 MG ORAL TABLET				
00002273918	**APO-BENAZEPRIL**	**APX**	$	**0.7567**
00000885851	LOTENSIN	NOV	$	1.0877

CAPTOPRIL

12.5 MG ORAL TABLET				
00000893595	**APO-CAPTO**	**APX**	$	**0.2120**
00002163551	**MYLAN-CAPTOPRIL**	**MYP**	$	**0.2120**
00001942964	**NOVO-CAPTORIL**	**TEV**	$	**0.2120**
00001913824	**NU-CAPTO**	**NXP**	$	**0.2120**
25 MG ORAL TABLET				
00000893609	**APO-CAPTO**	**APX**	$	**0.3000**
00000546283	**CAPOTEN**	**BMS**	$	**0.3000**
00002163578	**MYLAN-CAPTOPRIL**	**MYP**	$	**0.3000**
00001942972	**NOVO-CAPTORIL**	**TEV**	$	**0.3000**
00001913832	**NU-CAPTO**	**NXP**	$	**0.3000**
50 MG ORAL TABLET				
00000893617	**APO-CAPTO**	**APX**	$	**0.5590**
00000546291	**CAPOTEN**	**BMS**	$	**0.5590**
00002163586	**MYLAN-CAPTOPRIL**	**MYP**	$	**0.5590**
00001942980	**NOVO-CAPTORIL**	**TEV**	$	**0.5590**
00001913840	**NU-CAPTO**	**NXP**	$	**0.5590**
100 MG ORAL TABLET				
00000893625	**APO-CAPTO**	**APX**	$	**1.0395**
00002163594	**MYLAN-CAPTOPRIL**	**MYP**	$	**1.0395**
00001942999	**NOVO-CAPTORIL**	**TEV**	$	**1.0395**
00001913859	**NU-CAPTO**	**NXP**	$	**1.0395**

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

CILAZAPRIL

1 MG ORAL TABLET

00002291134	**APO-CILAZAPRIL**	**APX**	$	**0.3717**
00002283778	**MYLAN-CILAZAPRIL**	**MYP**	$	**0.3717**
00002266350	**NOVO-CILAZAPRIL**	**TEV**	$	**0.3717**
00002280442	**PMS-CILAZAPRIL**	**PMS**	$	**0.3717**
00001911465	INHIBACE	HLR	$	0.6696

2.5 MG ORAL TABLET

00002291142	**APO-CILAZAPRIL**	**APX**	$	**0.4284**
00002285215	**CO CILAZAPRIL**	**COB**	$	**0.4284**
00002283786	**MYLAN-CILAZAPRIL**	**MYP**	$	**0.4284**
00002266369	**NOVO-CILAZAPRIL**	**TEV**	$	**0.4284**
00002280450	**PMS-CILAZAPRIL**	**PMS**	$	**0.4284**
00001911473	INHIBACE	HLR	$	0.7717

5 MG ORAL TABLET

00002291150	**APO-CILAZAPRIL**	**APX**	$	**0.4977**
00002285223	**CO CILAZAPRIL**	**COB**	$	**0.4977**
00002283794	**MYLAN-CILAZAPRIL**	**MYP**	$	**0.4977**
00002266377	**NOVO-CILAZAPRIL**	**TEV**	$	**0.4977**
00002280469	**PMS-CILAZAPRIL**	**PMS**	$	**0.4977**
00001911481	INHIBACE	HLR	$	0.8967

CILAZAPRIL/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002284987	**APO-CILAZAPRIL/HCTZ**	**APX**	$	**0.5020**
00002313731	**NOVO-CILAZAPRIL/HCTZ**	**TEV**	$	**0.5020**
00002181479	INHIBACE PLUS	HLR	$	0.8964

ENALAPRIL MALEATE

2.5 MG ORAL TABLET

00002020025	**APO-ENALAPRIL**	**APX**	$	**0.4172**
00002291878	**CO ENALAPRIL**	**COB**	$	**0.4172**
00002300036	**MYLAN-ENALAPRIL**	**MYP**	$	**0.4172**
00002300680	**NOVO-ENALAPRIL**	**TEV**	$	**0.4172**
00002300079	**PMS-ENALAPRIL**	**PMS**	$	**0.4172**
00002299984	**RATIO-ENALAPRIL**	**RPH**	$	**0.4172**
00002299933	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.4172**
00002300117	**TARO-ENALAPRIL**	**TAR**	$	**0.4172**
00000851795	VASOTEC	MFC	$	0.7450

5 MG ORAL TABLET

00002019884	**APO-ENALAPRIL**	**APX**	$	**0.4935**
00002291886	**CO ENALAPRIL**	**COB**	$	**0.4935**
00002300044	**MYLAN-ENALAPRIL**	**MYP**	$	**0.4935**
00002233005	**NOVO-ENALAPRIL**	**TEV**	$	**0.4935**
00002300087	**PMS-ENALAPRIL**	**PMS**	$	**0.4935**
00002299992	**RATIO-ENALAPRIL**	**RPH**	$	**0.4935**
00002299941	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.4935**
00002300125	**TARO-ENALAPRIL**	**TAR**	$	**0.4935**
00000708879	VASOTEC	MFC	$	0.8813

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

ENALAPRIL MALEATE

10 MG ORAL TABLET

00002019892	**APO-ENALAPRIL**	**APX**	$	**0.5932**
00002291894	**CO ENALAPRIL**	**COB**	$	**0.5932**
00002300052	**MYLAN-ENALAPRIL**	**MYP**	$	**0.5932**
00002233006	**NOVO-ENALAPRIL**	**TEV**	$	**0.5932**
00002300095	**PMS-ENALAPRIL**	**PMS**	$	**0.5932**
00002300001	**RATIO-ENALAPRIL**	**RPH**	$	**0.5932**
00002299968	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.5932**
00002300133	**TARO-ENALAPRIL**	**TAR**	$	**0.5932**
00000670901	VASOTEC	MFC	$	1.0592

20 MG ORAL TABLET

00002019906	**APO-ENALAPRIL**	**APX**	$	**0.7156**
00002291908	**CO ENALAPRIL**	**COB**	$	**0.7156**
00002300060	**MYLAN-ENALAPRIL**	**MYP**	$	**0.7156**
00002233007	**NOVO-ENALAPRIL**	**TEV**	$	**0.7156**
00002300109	**PMS-ENALAPRIL**	**PMS**	$	**0.7156**
00002300028	**RATIO-ENALAPRIL**	**RPH**	$	**0.7156**
00002299976	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.7156**
00002300141	**TARO-ENALAPRIL**	**TAR**	$	**0.7156**
00000670928	VASOTEC	MFC	$	1.2779

ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002300222	NOVO-ENALAPRIL/HCTZ	TEV	$	0.6436

10 MG * 25 MG ORAL TABLET

00002300230	**NOVO-ENALAPRIL/HCTZ**	**TEV**	$	**0.6108**
00000657298	VASERETIC	MFC	$	1.0907

FOSINOPRIL SODIUM

10 MG ORAL TABLET

00002266008	**APO-FOSINOPRIL**	**APX**	$	**0.4878**
00002331004	**JAMP-FOSINOPRIL**	**JPC**	$	**0.4878**
00002262401	**MYLAN-FOSINOPRIL**	**MYP**	$	**0.4878**
00002247802	**NOVO-FOSINOPRIL**	**TEV**	$	**0.4878**
00002294524	**RAN-FOSINOPRIL**	**RAN**	$	**0.4878**
00001907107	MONOPRIL	BMS	$	0.8711

20 MG ORAL TABLET

00002266016	**APO-FOSINOPRIL**	**APX**	$	**0.5866**
00002331012	**JAMP-FOSINOPRIL**	**JPC**	$	**0.5866**
00002262428	**MYLAN-FOSINOPRIL**	**MYP**	$	**0.5866**
00002247803	**NOVO-FOSINOPRIL**	**TEV**	$	**0.5866**
00002294532	**RAN-FOSINOPRIL**	**RAN**	$	**0.5866**
00001907115	MONOPRIL	BMS	$	1.0475

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

LISINOPRIL

5 MG ORAL TABLET				
00002317397	**MINT-LISINOPRIL**	**MPI**	$	**0.3199**
00002292203	**PMS-LISINOPRIL**	**PMS**	$	**0.3199**
00000839388	PRINIVIL	MFC	$	0.5716
00002049333	ZESTRIL	AZC	$	0.5792
10 MG ORAL TABLET				
00002317400	**MINT-LISINOPRIL**	**MPI**	$	**0.3844**
00002292211	**PMS-LISINOPRIL**	**PMS**	$	**0.3844**
00000839396	PRINIVIL	MFC	$	0.6864
00002049376	ZESTRIL	AZC	$	0.6960
20 MG ORAL TABLET				
00002317419	**MINT-LISINOPRIL**	**MPI**	$	**0.4622**
00002292238	**PMS-LISINOPRIL**	**PMS**	$	**0.4622**
00000839418	PRINIVIL	MFC	$	0.8253
00002049384	ZESTRIL	AZC	$	0.8364

LISINOPRIL/ HYDROCHLOROTHIAZIDE

10 MG * 12.5 MG ORAL TABLET				
00002261979	**APO-LISINOPRIL/HCTZ**	**APX**	$	**0.5019**
00002297736	**MYLAN-LISINOPRIL HCTZ**	**MYP**	$	**0.5019**
00002301768	**NOVO-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.5019**
00002302365	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.5019**
00002103729	ZESTORETIC	AZC	$	0.8962
20 MG * 12.5 MG ORAL TABLET				
00002261987	**APO-LISINOPRIL/HCTZ**	**APX**	$	**0.6030**
00002297744	**MYLAN-LISINOPRIL HCTZ**	**MYP**	$	**0.6030**
00002301776	**NOVO-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.6030**
00002302373	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.6030**
00002045737	ZESTORETIC	AZC	$	1.0768
20 MG * 25 MG ORAL TABLET				
00002261995	**APO-LISINOPRIL/HCTZ**	**APX**	$	**0.6030**
00002297752	**MYLAN-LISINOPRIL HCTZ**	**MYP**	$	**0.6030**
00002301784	**NOVO-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.6030**
00002302381	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.6030**
00002045729	ZESTORETIC	AZC	$	1.0768
10 MG * 12.5 MG ORAL TABLET				
00002302136	**NOVO-LISINOPRIL/HCTZ (TYPE P)**	**TEV**	$	**0.3961**
00002108194	PRINZIDE	MFC	$	0.7074
20 MG * 12.5 MG ORAL TABLET				
00002302144	**NOVO-LISINOPRIL/HCTZ (TYPE P)**	**TEV**	$	**0.4760**
00000884413	PRINZIDE	MFC	$	0.8500
20 MG * 25 MG ORAL TABLET				
00002302152	NOVO-LISINOPRIL/HCTZ (TYPE P)	TEV	$	0.5793

PERINDOPRIL ERBUMINE

2 MG ORAL TABLET				
00002123274	COVERSYL	SEV	$	0.6700
4 MG ORAL TABLET				
00002123282	COVERSYL	SEV	$	0.8385
8 MG ORAL TABLET				
00002246624	COVERSYL	SEV	$	1.1739

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

PERINDOPRIL ERBUMINE/ INDAPAMIDE HEMIHYDRATE

4 MG * 1.25 MG ORAL TABLET				
00002246569	COVERSYL PLUS	SEV	$	1.0105
8 MG * 2.5 MG ORAL TABLET				
00002321653	COVERSYL PLUS HD	SEV	$	1.1739

QUINAPRIL HCL

5 MG (BASE) ORAL TABLET				
00001947664	ACCUPRIL	PFI	$	0.9212
10 MG (BASE) ORAL TABLET				
00001947672	ACCUPRIL	PFI	$	0.9212
20 MG (BASE) ORAL TABLET				
00001947680	ACCUPRIL	PFI	$	0.9212
40 MG (BASE) ORAL TABLET				
00001947699	ACCUPRIL	PFI	$	0.9212

QUINAPRIL HCL/ HYDROCHLOROTHIAZIDE

10 MG (BASE) * 12.5 MG ORAL TABLET				
00002237367	ACCURETIC 10/12.5	PFI	$	0.9210
20 MG (BASE) * 12.5 MG ORAL TABLET				
00002237368	ACCURETIC 20/12.5	PFI	$	0.9210
20 MG * 25 MG ORAL TABLET				
00002237369	ACCURETIC 20/25	PFI	$	0.9169

RAMIPRIL

1.25 MG ORAL CAPSULE/TABLET				
00002251515	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.4174**
00002295482	**CO RAMIPRIL (CAPSULE)**	**COB**	$	**0.4174**
00002331101	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.4174**
00002301148	**MYLAN-RAMIPRIL (CAPSULE)**	**MYP**	$	**0.4174**
00002295369	**PMS-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.4174**
00002332299	**RAMIPRIL (CAPSULE)**	**RAN**	$	**0.4174**
00002310503	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.4174**
00002287692	**RATIO-RAMIPRIL (CAPSULE)**	**RPH**	$	**0.4174**
00002291398	**SANDOZ RAMIPRIL (TABLET)**	**SDZ**	$	**0.4174**
00002221829	ALTACE (CAPSULE)	SAV	$	0.7453
2.5 MG ORAL CAPSULE/TABLET				
00002251531	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.4815**
00002295490	**CO RAMIPRIL (CAPSULE)**	**COB**	$	**0.4815**
00002331128	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.4815**
00002301156	**MYLAN-RAMIPRIL (CAPSULE)**	**MYP**	$	**0.4815**
00002247945	**NOVO-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.4815**
00002247917	**PMS-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.4815**
00002255316	**RAMIPRIL (CAPSULE)**	**RVP**	$	**0.4815**
00002332302	**RAMIPRIL (CAPSULE)**	**RAN**	$	**0.4815**
00002310511	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.4815**
00002287706	**RATIO-RAMIPRIL (CAPSULE)**	**RPH**	$	**0.4815**
00002291401	**SANDOZ RAMIPRIL (TABLET)**	**SDZ**	$	**0.4815**
00002221837	ALTACE (CAPSULE)	SAV	$	0.8599

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

RAMIPRIL

5 MG ORAL CAPSULE/TABLET				
00002251574	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.4815**
00002295504	**CO RAMIPRIL (CAPSULE)**	**COB**	$	**0.4815**
00002331136	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.4815**
00002301164	**MYLAN-RAMIPRIL (CAPSULE)**	**MYP**	$	**0.4815**
00002247946	**NOVO-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.4815**
00002247918	**PMS-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.4815**
00002255324	**RAMIPRIL (CAPSULE)**	**RVP**	$	**0.4815**
00002332310	**RAMIPRIL (CAPSULE)**	**RAN**	$	**0.4815**
00002310538	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.4815**
00002287714	**RATIO-RAMIPRIL (CAPSULE)**	**RPH**	$	**0.4815**
00002291428	**SANDOZ RAMIPRIL (TABLET)**	**SDZ**	$	**0.4815**
00002221845	ALTACE (CAPSULE)	SAV	$	0.8599
10 MG ORAL CAPSULE/TABLET				
00002251582	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.6100**
00002295512	**CO RAMIPRIL (CAPSULE)**	**COB**	$	**0.6100**
00002331144	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.6100**
00002301172	**MYLAN-RAMIPRIL (CAPSULE)**	**MYP**	$	**0.6100**
00002247947	**NOVO-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.6100**
00002247919	**PMS-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.6100**
00002255332	**RAMIPRIL (CAPSULE)**	**RVP**	$	**0.6100**
00002332329	**RAMIPRIL (CAPSULE)**	**RAN**	$	**0.6100**
00002310546	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.6100**
00002287722	**RATIO-RAMIPRIL (CAPSULE)**	**RPH**	$	**0.6100**
00002291436	**SANDOZ RAMIPRIL (TABLET)**	**SDZ**	$	**0.6100**
00002221853	ALTACE (CAPSULE)	SAV	$	1.0892

RAMIPRIL/ HYDROCHLOROTHIAZIDE

2.5 MG * 12.5 MG ORAL TABLET				
00002283131	ALTACE HCT	SAV	$	0.4031
5 MG * 12.5 MG ORAL TABLET				
00002283158	ALTACE HCT	SAV	$	0.4112
5 MG * 25 MG ORAL TABLET				
00002283174	ALTACE HCT	SAV	$	0.4112
10 MG * 12.5 MG ORAL TABLET				
00002283166	ALTACE HCT	SAV	$	0.5208
10 MG * 25 MG ORAL TABLET				
00002283182	ALTACE HCT	SAV	$	0.5208

TRANDOLAPRIL

0.5 MG ORAL CAPSULE				
00002231457	MAVIK	ABB	$	0.4030
1 MG ORAL CAPSULE				
00002231459	MAVIK	ABB	$	0.6901
2 MG ORAL CAPSULE				
00002231460	MAVIK	ABB	$	0.7931
4 MG ORAL CAPSULE				
00002239267	MAVIK	ABB	$	0.9785

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

CANDESARTAN CILEXETIL

8 MG ORAL TABLET				
00002239091	ATACAND	AZC	$	1.2255
16 MG ORAL TABLET				
00002239092	ATACAND	AZC	$	1.2255
32 MG ORAL TABLET				
00002311658	ATACAND	AZC	$	1.2255

CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE

16 MG * 12.5 MG ORAL TABLET				
00002244021	ATACAND PLUS	AZC	$	1.2255
32 MG * 12.5 MG ORAL TABLET				
00002332922	ATACAND PLUS	AZC	$	1.2255
32 MG * 25 MG ORAL TABLET				
00002332957	ATACAND PLUS	AZC	$	1.2255

EPROSARTAN MESYLATE

400 MG (BASE) ORAL TABLET				
00002240432	TEVETEN	SLO	$	0.7528
600 MG (BASE) ORAL TABLET				
00002243942	TEVETEN	SLO	$	1.1298

EPROSARTAN MESYLATE/ HYDROCHLOROTHIAZIDE

600 MG * 12.5 MG ORAL TABLET				
00002253631	TEVETEN PLUS	SLO	$	1.1298

IRBESARTAN

75 MG ORAL TABLET				
00002237923	AVAPRO	SAV	$	1.2097
150 MG ORAL TABLET				
00002237924	AVAPRO	SAV	$	1.2097
300 MG ORAL TABLET				
00002237925	AVAPRO	SAV	$	1.2097

IRBESARTAN/ HYDROCHLOROTHIAZIDE

150 MG * 12.5 MG ORAL TABLET				
00002241818	AVALIDE 150/12.5	SAV	$	1.2097
300 MG * 12.5 MG ORAL TABLET				
00002241819	AVALIDE 300/12.5	SAV	$	1.2097
300 MG * 25 MG ORAL TABLET				
00002280213	AVALIDE 300/25	SAV	$	1.2015

LOSARTAN POTASSIUM

25 MG ORAL TABLET				
00002182815	COZAAR	MFC	$	1.2500
50 MG ORAL TABLET				
00002182874	COZAAR	MFC	$	1.2500
100 MG ORAL TABLET				
00002182882	COZAAR	MFC	$	1.2500

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

LOSARTAN POTASSIUM/ HYDROCHLOROTHIAZIDE

50 MG * 12.5 MG ORAL TABLET				
00002230047	HYZAAR	MFC	$	1.2500
100 MG * 12.5 MG ORAL TABLET				
00002297841	HYZAAR	MFC	$	1.2135
100 MG * 25 MG ORAL TABLET				
00002241007	HYZAAR DS	MFC	$	1.2500

TELMISARTAN

40 MG ORAL TABLET				
00002240769	MICARDIS	BOE	$	1.1296
80 MG ORAL TABLET				
00002240770	MICARDIS	BOE	$	1.1296

TELMISARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET				
00002244344	MICARDIS PLUS	BOE	$	1.1296
80 MG * 25 MG ORAL TABLET				
00002318709	MICARDIS PLUS	BOE	$	1.1296

VALSARTAN

80 MG ORAL TABLET				
00002244781	DIOVAN	NOV	$	1.2719
160 MG ORAL TABLET				
00002244782	DIOVAN	NOV	$	1.2719
320 MG ORAL TABLET				
00002289504	DIOVAN	NOV	$	1.2224

VALSARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET				
00002241900	DIOVAN-HCT	NOV	$	1.2719
160 MG * 12.5 MG ORAL TABLET				
00002241901	DIOVAN-HCT	NOV	$	1.2719
160 MG * 25 MG ORAL TABLET				
00002246955	DIOVAN-HCT	NOV	$	1.2719
320 MG * 12.5 MG ORAL TABLET				
00002308908	DIOVAN-HCT	NOV	$	1.2519
320 MG * 25 MG ORAL TABLET				
00002308916	DIOVAN-HCT	NOV	$	1.2519

24:00 CARDIOVASCULAR DRUGS

24:32.20 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONISTS)

HYDROCHLOROTHIAZIDE/ SPIRONOLACTONE

25 MG * 25 MG ORAL TABLET				
00000613231	**NOVO-SPIROZINE**	**TEV**	$	**0.1057**
00000180408	ALDACTAZIDE 25	PFI	$	0.1380
50 MG * 50 MG ORAL TABLET				
00000657182	**NOVO-SPIROZINE**	**TEV**	$	**0.2236**
00000594377	ALDACTAZIDE 50	PFI	$	0.2926

SPIRONOLACTONE

25 MG ORAL TABLET				
00000613215	**NOVO-SPIROTON**	**TEV**	$	**0.1038**
00000028606	ALDACTONE	PFI	$	0.1380
100 MG ORAL TABLET				
00000613223	**NOVO-SPIROTON**	**TEV**	$	**0.2417**
00000285455	ALDACTONE	PFI	$	0.3253

28:00

Central Nervous System Agents

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08 ANALGESICS AND ANTIPYRETICS

COMPOUND PRESCRIPTION

00000999105	**COMPD- ANSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999205	**COMPD- ANSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04 ANALGESICS AND ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

COMPOUND PRESCRIPTION

TOPICAL

00000999102	COMPOUND-DICLOFENAC (TOPICAL)	XXX	$	0.0000

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999202	COMPOUND- DICLOFENAC (TOPICAL)	XXX	$	0.0000

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.24 ANALGESICS AND ANTIPYRETICS NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (SALICYLATES)

ASA

650 MG ORAL ENTERIC-COATED TABLET

00000010340	ENTROPHEN 10	PPH	$	0.0864

BUTALBITAL/ CAFFEINE/ ASA

50 MG * 40 MG * 330 MG ORAL TABLET

00000608211	RATIO-TECNAL	RPH	$	0.5811

50 MG * 40 MG * 330 MG ORAL CAPSULE

00000608238	**RATIO-TECNAL**	**RPH**	$	**0.5794**
00000226327	FIORINAL	NOV	$	1.5604

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM

75 MG ORAL SUSTAINED-RELEASE TABLET

00002158582	**NOVO-DIFENAC SR**	**TEV**	***$ 0.5706***	$ **0.5706**
00002231504	**PMS-DICLOFENAC-SR**	**PMS**	***$ 0.5706***	$ **0.5706**
00002261901	**SANDOZ DICLOFENAC SR**	**SDZ**	***$ 0.5706***	$ **0.5706**
00000782459	VOLTAREN SR	NOV	***$ 0.5706***	$ 1.2471

MAC pricing has been applied based on the LCA Price for 3 x 25 mg oral enteric-coated tablets.

100 MG ORAL SUSTAINED-RELEASE TABLET

00002048698	**NOVO-DIFENAC SR**	**TEV**	***$ 0.7608***	$ **0.7608**
00002231505	**PMS-DICLOFENAC-SR**	**PMS**	***$ 0.7608***	$ **0.7608**
00002261944	**SANDOZ DICLOFENAC SR**	**SDZ**	***$ 0.7608***	$ **0.7608**
00000590827	VOLTAREN SR	NOV	***$ 0.7608***	$ 1.7776

MAC pricing has been applied based on the LCA Price for 4 X 25 mg oral enteric-coated tablets.

25 MG ORAL ENTERIC-COATED TABLET

00002302616	**PMS-DICLOFENAC**	**PMS**	$ **0.1881**
00000839175	APO-DICLO	APX	$ 0.1902
00000808539	NOVO-DIFENAC	TEV	$ 0.1902
00000886017	NU-DICLO	NXP	$ 0.1902
00002261952	SANDOZ DICLOFENAC	SDZ	$ 0.1902

50 MG ORAL ENTERIC-COATED TABLET

00000839183	**APO-DICLO**	**APX**	***$ 0.3804***	$ **0.3804**
00000808547	**NOVO-DIFENAC**	**TEV**	***$ 0.3804***	$ **0.3804**
00002302624	**PMS-DICLOFENAC**	**PMS**	***$ 0.3804***	$ **0.3804**
00002261960	**SANDOZ DICLOFENAC**	**SDZ**	***$ 0.3804***	$ **0.3804**
00000514012	VOLTAREN	NOV	***$ 0.3804***	$ 0.8901

MAC pricing has been applied based on the LCA Price for 2 x 25 mg oral enteric-coated tablets.

50 MG RECTAL SUPPOSITORY

00002231506	**PMS-DICLOFENAC**	**PMS**	$ **0.6237**
00002241224	**SANDOZ DICLOFENAC**	**SDZ**	$ **0.6237**
00002261928	**SANDOZ DICLOFENAC**	**SDZ**	$ **0.6237**
00000632724	VOLTAREN	NOV	$ 1.3365

100 MG RECTAL SUPPOSITORY

00002231508	**PMS-DICLOFENAC**	**PMS**	$ **0.8397**
00002261936	**SANDOZ DICLOFENAC**	**SDZ**	$ **0.8397**
00000632732	VOLTAREN	NOV	$ 1.7992

DICLOFENAC SODIUM/ MISOPROSTOL

50 MG * 200 MCG ORAL TABLET

00001917056	ARTHROTEC-50	PFI	$ 0.6212

75 MG * 200 MCG ORAL TABLET

00002229837	ARTHROTEC-75	PFI	$ 0.8455

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DIFLUNISAL

250 MG ORAL TABLET				
00002039486	**APO-DIFLUNISAL**	**APX**	$	**0.5646**
00002058405	**NU-DIFLUNISAL**	**NXP**	$	**0.5646**
00002048493	NOVO-DIFLUNISAL FC	TEV	$	0.5647
500 MG ORAL TABLET				
00002039494	**APO-DIFLUNISAL**	**APX**	$	**0.7150**
00002058413	**NU-DIFLUNISAL**	**NXP**	$	**0.7150**

ETODOLAC

200 MG ORAL CAPSULE				
00002232317	APO-ETODOLAC	APX	$	0.7600
300 MG ORAL CAPSULE				
00002232318	APO-ETODOLAC	APX	$	0.7600

FLOCTAFENINE

200 MG ORAL TABLET				
00002244680	APO-FLOCTAFENINE	APX	$	0.4175
400 MG ORAL TABLET				
00002244681	APO-FLOCTAFENINE	APX	$	0.8123

FLURBIPROFEN

50 MG ORAL TABLET				
00001912046	**APO-FLURBIPROFEN**	**APX**	$	**0.2564**
00002100509	**NOVO-FLURPROFEN**	**TEV**	$	**0.2564**
00002020661	**NU-FLURBIPROFEN**	**NXP**	$	**0.2564**
00000647942	ANSAID	PFI	$	0.5524
100 MG ORAL TABLET				
00001912038	**APO-FLURBIPROFEN**	**APX**	$	**0.3508**
00002100517	**NOVO-FLURPROFEN**	**TEV**	$	**0.3508**
00002020688	**NU-FLURBIPROFEN**	**NXP**	$	**0.3508**
00000600792	ANSAID	PFI	$	0.7233

IBUPROFEN

300 MG ORAL TABLET				
00000441651	APO-IBUPROFEN	APX	$	0.0690
400 MG ORAL TABLET				
00000506052	APO-IBUPROFEN	APX	$	0.0758
600 MG ORAL TABLET				
00000629359	**NOVO-PROFEN**	**TEV**	$	**0.0465**
00000839264	**PMS-IBUPROFEN**	**PMS**	$	**0.0465**
00000585114	APO-IBUPROFEN	APX	$	0.1313
00002020726	NU-IBUPROFEN	NXP	$	0.1313

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

INDOMETHACIN

25 MG ORAL CAPSULE

00000611158	**APO-INDOMETHACIN**	**APX**	$	**0.0871**
00000337420	**NOVO-METHACIN**	**TEV**	$	**0.0871**
00000865850	**NU-INDO**	**NXP**	$	**0.0871**

50 MG ORAL CAPSULE

00000611166	**APO-INDOMETHACIN**	**APX**	$	**0.1511**
00000337439	**NOVO-METHACIN**	**TEV**	$	**0.1511**
00000865869	**NU-INDO**	**NXP**	$	**0.1511**

50 MG RECTAL SUPPOSITORY

00002231799	SANDOZ INDOMETHACIN	SDZ	$	0.8842

100 MG RECTAL SUPPOSITORY

00001934139	**RATIO-INDOMETHACIN**	**RPH**	$	**0.8920**
00002231800	**SANDOZ INDOMETHACIN**	**SDZ**	$	**0.8920**

KETOPROFEN

200 MG ORAL SUSTAINED-RELEASE TABLET

00002172577	APO-KETO SR	APX	***$ 1.3646***	$	1.3890

MAC pricing has been applied based on the price for 2 x 100 mg oral enteric-coated tablets.

50 MG ORAL ENTERIC-COATED TABLET

00000790435	APO-KETO-E	APX	$	0.3373

100 MG ORAL ENTERIC-COATED TABLET

00000842664	APO-KETO-E	APX	$	0.6823

50 MG ORAL CAPSULE

00000790427	**APO-KETO**	**APX**	$	**0.3373**
00002044633	**NU-KETOPROFEN**	**NXP**	$	**0.3373**

100 MG RECTAL SUPPOSITORY

00002015951	PMS-KETOPROFEN	PMS	$	1.0458

KETOROLAC TROMETHAMINE

10 MG ORAL TABLET

00002229080	**APO-KETOROLAC**	**APX**	$	**0.4085**
00002230201	**NOVO-KETOROLAC**	**TEV**	$	**0.4085**
00002237910	**NU-KETOROLAC**	**NXP**	$	**0.4085**
00002162660	TORADOL	HLR	$	0.7295

10 MG / ML INJECTION

00002162644	TORADOL	HLR	$	2.4058

30 MG / ML INJECTION

00002239944	KETOROLAC TROMETHAMINE	SDZ	$	3.7200

MEFENAMIC ACID

250 MG ORAL CAPSULE

00002229452	**APO-MEFENAMIC**	**APX**	$	**0.4988**
00002229569	**NU-MEFENAMIC**	**NXP**	$	**0.4988**

NABUMETONE

500 MG ORAL TABLET

00002242912	SANDOZ NABUMETONE	SDZ	$	0.3769

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

NAPROXEN

125 MG ORAL TABLET					
00000522678	APO-NAPROXEN	APX		$	0.0781
250 MG ORAL TABLET					
00000522651	**APO-NAPROXEN**	**APX**		$	**0.1068**
00000565350	**NOVO-NAPROX**	**TEV**		$	**0.1068**
00000865648	**NU-NAPROX**	**NXP**		$	**0.1068**
375 MG ORAL TABLET					
00000600806	**APO-NAPROXEN**	**APX**		$	**0.1458**
00000627097	**NOVO-NAPROX**	**TEV**		$	**0.1458**
00000865656	**NU-NAPROX**	**NXP**		$	**0.1458**
500 MG ORAL TABLET					
00000592277	**APO-NAPROXEN**	**APX**		$	**0.2110**
00000589861	**NOVO-NAPROX**	**TEV**		$	**0.2110**
00000865664	**NU-NAPROX**	**NXP**		$	**0.2110**
750 MG ORAL SUSTAINED-RELEASE TABLET					
00002177072	APO-NAPROXEN SR	APX	***$ 0.2916***	$	1.0048
00002162466	NAPROSYN SR	HLR	***$ 0.2916***	$	1.3650
MAC pricing has been applied based on the LCA price for 2 x 375 mg oral tablets.					
250 MG ORAL ENTERIC-COATED TABLET					
00002246699	APO-NAPROXEN EC	APX	***$ 0.1068***	$	0.2467
00002243312	NOVO-NAPROX EC	TEV	***$ 0.1068***	$	0.2467
00002162792	NAPROSYN E	HLR	***$ 0.1068***	$	0.4405
MAC pricing has been applied based on the LCA price for 1 x 250 mg oral tablet.					
375 MG ORAL ENTERIC-COATED TABLET					
00002246700	APO-NAPROXEN EC	APX	***$ 0.1458***	$	0.3234
00002243432	MYLAN-NAPROXEN EC	MYP	***$ 0.1458***	$	0.3234
00002243313	NOVO-NAPROX EC	TEV	***$ 0.1458***	$	0.3234
00002294702	PMS-NAPROXEN EC	PMS	***$ 0.1458***	$	0.3234
00002162415	NAPROSYN E	HLR	***$ 0.1458***	$	0.5775
MAC pricing has been applied based on the LCA price for 1 x 375 mg oral tablet.					
500 MG ORAL ENTERIC-COATED TABLET					
00002246701	APO-NAPROXEN EC	APX	***$ 0.2110***	$	0.5842
00002241024	MYLAN-NAPROXEN EC	MYP	***$ 0.2110***	$	0.5842
00002243314	NOVO-NAPROX EC	TEV	***$ 0.2110***	$	0.5842
00002294710	PMS-NAPROXEN EC	PMS	***$ 0.2110***	$	0.5842
00002162423	NAPROSYN E	HLR	***$ 0.2110***	$	1.0432
MAC pricing has been applied based on the LCA price for 1 x 500 mg oral tablet.					
25 MG / ML ORAL SUSPENSION					
00002162431	NAPROSYN	HLR		$	0.0660
500 MG RECTAL SUPPOSITORY					
00002017237	PMS-NAPROXEN	PMS		$	0.8348

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

NAPROXEN SODIUM

275 MG ORAL TABLET

00000784354	**APO-NAPRO-NA**	**APX**	$	**0.3422**
00000778389	**NOVO-NAPROX SODIUM**	**TEV**	$	**0.3422**
00002162725	ANAPROX	HLR	$	0.6576

550 MG ORAL TABLET

00001940309	**APO-NAPRO-NA DS**	**APX**	$	**0.6667**
00002026600	**NOVO-NAPROX SODIUM DS**	**TEV**	$	**0.6667**
00002162717	ANAPROX DS	HLR	$	1.2659

PIROXICAM

10 MG ORAL CAPSULE

00000642886	**APO-PIROXICAM**	**APX**	$	**0.4147**
00002171813	**GEN-PIROXICAM**	**MYP**	$	**0.4147**
00000695718	**NOVO-PIROCAM**	**TEV**	$	**0.4147**
00000865761	**NU-PIROX**	**NXP**	$	**0.4147**

20 MG ORAL CAPSULE

00000642894	**APO-PIROXICAM**	**APX**	$	**0.7158**
00000695696	**NOVO-PIROCAM**	**TEV**	$	**0.7158**
00000865788	**NU-PIROX**	**NXP**	$	**0.7158**

20 MG RECTAL SUPPOSITORY

00002154463	PMS-PIROXICAM	PMS	$	1.7335

SULINDAC

150 MG ORAL TABLET

00000778354	**APO-SULIN**	**APX**	$	**0.3824**
00000745588	**NOVO-SUNDAC**	**TEV**	$	**0.3824**
00002042576	**NU-SULINDAC**	**NXP**	$	**0.3824**

200 MG ORAL TABLET

00000778362	**APO-SULIN**	**APX**	$	**0.4840**
00000745596	**NOVO-SUNDAC**	**TEV**	$	**0.4840**
00002042584	**NU-SULINDAC**	**NXP**	$	**0.4840**

TENOXICAM

20 MG ORAL TABLET

00002230661	APO-TENOXICAM	APX	$	1.1552

TIAPROFENIC ACID

200 MG ORAL TABLET

00002136112	**APO-TIAPROFENIC**	**APX**	$	**0.3437**
00002179679	**NOVO-TIAPROFENIC**	**TEV**	$	**0.3437**

300 MG ORAL TABLET

00002136120	**APO-TIAPROFENIC**	**APX**	$	**0.4104**
00002179687	**NOVO-TIAPROFENIC**	**TEV**	$	**0.4104**
00002146886	**NU-TIAPROFENIC**	**NXP**	$	**0.4104**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

ASA/ CAFFEINE CITRATE/ CODEINE PHOSPHATE

375 MG * 30 MG * 15 MG ORAL TABLET				
00002234510	282	PPH	$	0.0721

BUTALBITAL/ CODEINE PHOSPHATE/ ASA/ CAFFEINE

50 MG * 15 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608203	**RATIO-TECNAL-C 1/4**	**RPH**	$	**0.6210**
00000176192	FIORINAL-C 1/4	NOV	$	1.6733
50 MG * 30 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608181	**RATIO-TECNAL-C 1/2**	**RPH**	$	**0.7607**
00000176206	FIORINAL-C 1/2	NOV	$	2.0491

CODEINE PHOSPHATE

15 MG ORAL TABLET				
00000593435	RATIO-CODEINE	RPH	$	0.0691
30 MG ORAL TABLET				
00000593451	RATIO-CODEINE	RPH	$	0.0833
5 MG / ML ORAL SYRUP				
00000779474	RATIO-CODEINE	RPH	$	0.0290
30 MG / ML INJECTION				
00000544884	CODEINE PHOSPHATE	SDZ	$	1.2508

CODEINE PHOSPHATE/ ACETAMINOPHEN

30 MG * 300 MG ORAL TABLET				
00000608882	RATIO-EMTEC-30	RPH	$	0.1499
60 MG * 300 MG ORAL TABLET				
00000621463	**RATIO-LENOLTEC NO.4**	**RPH**	$	**0.1605**
00002163918	TYLENOL NO. 4	JOI	$	0.2018
1.6 MG / ML * 32 MG / ML ORAL ELIXIR				
00002163942	TYLENOL WITH CODEINE	JOI	$	0.1121

CODEINE PHOSPHATE/ ACETAMINOPHEN/ CAFFEINE

15 MG * 300 MG * 15 MG ORAL TABLET				
00000653241	**RATIO-LENOLTEC NO.2**	**RPH**	$	**0.0690**
00002163934	TYLENOL NO. 2	JOI	$	0.0868
30 MG * 300 MG * 15 MG ORAL TABLET				
00000653276	**RATIO-LENOLTEC NO.3**	**RPH**	$	**0.0760**
00002163926	TYLENOL NO. 3	JOI	$	0.0955

CODEINE PHOSPHATE/ ACETAMINOPHEN/ CAFFEINE CITRATE

15 MG * 325 MG * 30 MG ORAL TABLET				
00000293504	ATASOL-15	CHD	$	0.1236
30 MG * 325 MG * 30 MG ORAL TABLET				
00000293512	ATASOL-30	CHD	$	0.1438

CODEINE PHOSPHATE/ ASA/ CAFFEINE CITRATE

30 MG * 375 MG * 30 MG ORAL TABLET				
00002238645	292	PPH	$	0.1865

CODEINE PHOSPHATE/ ASA/ MEPROBAMATE/ CAFFEINE CITRATE

15 MG * 350 MG * 200 MG * 30 MG ORAL TABLET				
00002238646	282 MEP	PPH	$	0.2328

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

COMPOUND PRESCRIPTION

00000999108	**COMPOUND NARCOTIC MIXTURES - ORAL AND INJECTION**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999208	**COMPOUND NARCOTIC MIXTURES - ORAL AND INJECTION**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

HYDROMORPHONE HCL

1 MG ORAL TABLET				
00000885444	**PMS-HYDROMORPHONE**	**PMS**	$	**0.0959**
00000705438	DILAUDID	PUR	$	0.1502
2 MG ORAL TABLET				
00000885436	**PMS-HYDROMORPHONE**	**PMS**	$	**0.1417**
00000125083	DILAUDID	PUR	$	0.2206
4 MG ORAL TABLET				
00000885401	**PMS-HYDROMORPHONE**	**PMS**	$	**0.2240**
00000125121	DILAUDID	PUR	$	0.3370
8 MG ORAL TABLET				
00000885428	**PMS-HYDROMORPHONE**	**PMS**	$	**0.3528**
00000786543	DILAUDID	PUR	$	0.5249
3 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125323	HYDROMORPH CONTIN	PUR	$	0.6998
6 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125331	HYDROMORPH CONTIN	PUR	$	1.0503
12 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125366	HYDROMORPH CONTIN	PUR	$	1.8189
18 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002243562	HYDROMORPH CONTIN	PUR	$	2.6230
24 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125382	HYDROMORPH CONTIN	PUR	$	3.3583
30 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125390	HYDROMORPH CONTIN	PUR	$	4.0227
1 MG / ML ORAL LIQUID				
00001916386	**PMS-HYDROMORPHONE**	**PMS**	$	**0.0665**
00000786535	DILAUDID	PUR	$	0.0851
2 MG / ML INJECTION				
00002145901	**HYDROMORPHONE**	**SDZ**	$	**1.1380**
00000627100	DILAUDID	PUR	$	1.2255
10 MG / ML INJECTION				
00002145928	**HYDROMORPHONE HP**	**SDZ**	$	**2.7860**
00000622133	DILAUDID-HP	PUR	$	2.9992
20 MG / ML INJECTION				
00002145936	**HYDROMORPHONE HP 20**	**SDZ**	$	**4.5100**
00002146118	DILAUDID-HP-PLUS	PUR	$	4.8536
50 MG / ML INJECTION				
00002145863	DILAUDID-XP	PUR	$	11.2822
00002146126	HYDROMORPHONE HP 50	SDZ	$	13.1500

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

HYDROMORPHONE HCL

250 MG / VIAL INJECTION				
00002085895	DILAUDID STERILE POWDER	PUR	$	75.4032
3 MG RECTAL SUPPOSITORY				
00001916394	PMS-HYDROMORPHONE	PMS	$	2.3069

MEPERIDINE HCL

50 MG ORAL TABLET				
00002138018	DEMEROL	SAV	$	0.1547
50 MG / ML INJECTION				
00000725765	MEPERIDINE HYDROCHLORIDE	SDZ	$	0.9380
75 MG / ML INJECTION				
00000725757	MEPERIDINE HYDROCHLORIDE	SDZ	$	0.9920
100 MG / ML INJECTION				
00000725749	MEPERIDINE HYDROCHLORIDE	SDZ	$	1.0459

METHADONE COMPOUND

ORAL LIQUID				
00000999995	METHADONE	XXX	$	0.0000

METHADONE HCL

1 MG ORAL TABLET				
00002247698	METADOL	PAL	$	0.1612
5 MG ORAL TABLET				
00002247699	METADOL	PAL	$	0.5371
10 MG ORAL TABLET				
00002247700	METADOL	PAL	$	0.8594
25 MG ORAL TABLET				
00002247701	METADOL	PAL	$	1.6113
1 MG / ML ORAL SOLUTION				
00002247694	METADOL	PAL	$	0.0971
10 MG / ML ORAL LIQUID				
00002241377	METADOL CONCENTRATE	PAL	$	0.3509

MORPHINE HCL

30 MG ORAL SUSTAINED-RELEASE TABLET				
00000776181	M.O.S.-SR	VCL	$	0.4833
60 MG ORAL SUSTAINED-RELEASE TABLET				
00000776203	M.O.S.-SR	VCL	$	0.8518
1 MG / ML ORAL SYRUP				
00000614491	DOLORAL 1	ATL	$	0.0144
5 MG / ML ORAL SYRUP				
00000614505	DOLORAL 5	ATL	$	0.0502
10 MG / ML ORAL SYRUP				
00000690783	RATIO-MORPHINE	RPH	$	0.1844
20 MG / ML ORAL SYRUP				
00000690791	RATIO-MORPHINE	RPH	$	0.5240

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE SULFATE

5 MG ORAL TABLET				
00000594652	**STATEX**	**PAL**	$	**0.1182**
00002009773	M.O.S. SULFATE	VCL	$	0.1183
00002014203	MS.IR	PUR	$	0.1312
10 MG ORAL TABLET				
00002009765	**M.O.S. SULFATE**	**VCL**	$	**0.1828**
00000594644	**STATEX**	**PAL**	$	**0.1828**
00002014211	MS.IR	PUR	$	0.2139
20 MG ORAL TABLET				
00002014238	MS.IR	PUR	$	0.3601
25 MG ORAL TABLET				
00002009749	**M.O.S. SULFATE**	**VCL**	$	**0.2419**
00000594636	**STATEX**	**PAL**	$	**0.2419**
30 MG ORAL TABLET				
00002014254	MS.IR	PUR	$	0.4623
50 MG ORAL TABLET				
00002009706	**M.O.S. SULFATE**	**VCL**	$	**0.3709**
00000675962	**STATEX**	**PAL**	$	**0.3709**
15 MG ORAL SUSTAINED-RELEASE TABLET				
00002302764	**NOVO-MORPHINE SR**	**TEV**	$	**0.3550**
00002245284	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**0.3550**
00002244790	**RATIO-MORPHINE SULFATE SR**	**RPH**	$	**0.3550**
00002015439	MS CONTIN	PUR	$	0.7117
30 MG ORAL SUSTAINED-RELEASE TABLET				
00002302772	**NOVO-MORPHINE SR**	**TEV**	$	**0.5486**
00002245285	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**0.5486**
00002244791	**RATIO-MORPHINE SULFATE SR**	**RPH**	$	**0.5486**
00002014297	MS CONTIN	PUR	$	1.0750
60 MG ORAL SUSTAINED-RELEASE TABLET				
00002302780	**NOVO-MORPHINE SR**	**TEV**	$	**0.9628**
00002245286	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**0.9628**
00002244792	**RATIO-MORPHINE SULFATE SR**	**RPH**	$	**0.9628**
00002014300	MS CONTIN	PUR	$	1.8942
100 MG ORAL SUSTAINED-RELEASE TABLET				
00002302799	**NOVO-MORPHINE SR**	**TEV**	$	**1.5853**
00002245287	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**1.5853**
00002014319	MS CONTIN	PUR	$	2.8875
200 MG ORAL SUSTAINED-RELEASE TABLET				
00002302802	**NOVO-MORPHINE SR**	**TEV**	$	**2.9473**
00002245288	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**2.9473**
00002014327	MS CONTIN	PUR	$	5.3686
10 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019930	M-ESLON	ETP	$	0.3120
15 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177749	M-ESLON	ETP	$	0.3601
30 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019949	M-ESLON	ETP	$	0.5375
60 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019957	M-ESLON	ETP	$	0.9546
100 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019965	M-ESLON	ETP	$	2.0535

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE SULFATE

200 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177757	M-ESLON	ETP	$	4.1065
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002242163	KADIAN	ABB	$	0.3604
20 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184435	KADIAN	ABB	$	0.7004
50 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184443	KADIAN	ABB	$	1.2875
100 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184451	KADIAN	ABB	$	2.2454
1 MG / ML ORAL SYRUP				
00000591467	STATEX	PAL	$	0.0200
5 MG / ML ORAL SYRUP				
00000591475	STATEX	PAL	$	0.0803
20 MG / ML ORAL DROPS				
00000621935	STATEX	PAL	$	0.4980
50 MG / ML ORAL DROPS				
00000705799	STATEX	PAL	$	0.9464
0.5 MG / ML INJECTION				
00002021056	MORPHINE LP EPIDURAL	SDZ	$	1.0675
1 MG / ML INJECTION				
00002021048	MORPHINE LP EPIDURAL	SDZ	$	2.1348
10 MG / ML INJECTION				
00000392588	MORPHINE SULFATE	SDZ	$	0.9704
15 MG / ML INJECTION				
00000392561	MORPHINE SULFATE	SDZ	$	0.9865
25 MG / ML INJECTION				
00000676411	MORPHINE HP 25	SDZ	$	2.7710
50 MG / ML INJECTION				
00000617288	MORPHINE HP 50	SDZ	$	3.8266
5 MG RECTAL SUPPOSITORY				
00000632228	STATEX	PAL	$	1.6690
10 MG RECTAL SUPPOSITORY				
00000632201	STATEX	PAL	$	1.8640
20 MG RECTAL SUPPOSITORY				
00000596965	STATEX	PAL	$	2.2190
30 MG RECTAL SUPPOSITORY				
00000639389	STATEX	PAL	$	2.4340

OPIUM/ BELLADONNA

65 MG * 15 MG RECTAL SUPPOSITORY				
00001901869	SANDOZ OPIUM & BELLADONNA	SDZ	$	2.4907

OXYCODONE HCL

5 MG ORAL TABLET				
00002319977	PMS-OXYCODONE	PMS	$	0.1332
10 MG ORAL TABLET				
00002319985	PMS-OXYCODONE	PMS	$	0.2283
20 MG ORAL TABLET				
00002319993	PMS-OXYCODONE	PMS	$	0.3965

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

OXYCODONE HCL

5 MG ORAL SUSTAINED-RELEASE TABLET				
00002258129	OXYCONTIN	PUR	$	0.6708
10 MG ORAL SUSTAINED-RELEASE TABLET				
00002202441	OXYCONTIN	PUR	$	0.9331
15 MG ORAL SUSTAINED-RELEASE TABLET				
00002323192	OXYCONTIN	PUR	$	1.1395
20 MG ORAL SUSTAINED-RELEASE TABLET				
00002202468	OXYCONTIN	PUR	$	1.3975
30 MG ORAL SUSTAINED-RELEASE TABLET				
00002323206	OXYCONTIN	PUR	$	1.8705
40 MG ORAL SUSTAINED-RELEASE TABLET				
00002202476	OXYCONTIN	PUR	$	2.4252
60 MG ORAL SUSTAINED-RELEASE TABLET				
00002323214	OXYCONTIN	PUR	$	3.3862
80 MG ORAL SUSTAINED-RELEASE TABLET				
00002202484	OXYCONTIN	PUR	$	4.4763
10 MG RECTAL SUPPOSITORY				
00000392480	SUPEUDOL	SDZ	$	2.2212
20 MG RECTAL SUPPOSITORY				
00000392472	SUPEUDOL	SDZ	$	2.8141

OXYCODONE HCL/ ACETAMINOPHEN

2.5 MG * 325 MG ORAL TABLET				
00001916491	PERCOCET DEMI	BMS	$	0.6013
5 MG * 325 MG ORAL TABLET				
00002324628	**APO-OXYCODONE**	**APX**	$	**0.1285**
00001916548	**ENDOCET**	**BMS**	$	**0.1285**
00002307898	**NOVO-OXYCODONE ACET**	**TEV**	$	**0.1285**
00002245758	**PMS-OXYCODONE-ACETAMINOPHEN**	**PMS**	$	**0.1285**
00000608165	**RATIO-OXYCOCET**	**RPH**	$	**0.1285**
00001916475	PERCOCET	BMS	$	0.7357

OXYCODONE HCL/ ASA

5 MG * 325 MG ORAL TABLET				
00000608157	RATIO-OXYCODAN	RPH	$	0.3703

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.12 ANALGESICS AND ANTIPYRETICS (OPIATE PARTIAL AGONISTS)

BUPRENORPHINE HCL/ NALOXONE HYDROCHLORIDE DIHYDRATE

2 MG (BASE) * 0.5 MG (BASE) ORAL SUBLINGUAL TABLET				
00002295695	SUBOXONE	SCH	$	2.6700
8 MG (BASE) * 2 MG (BASE) ORAL SUBLINGUAL TABLET				
00002295709	SUBOXONE	SCH	$	4.7300

PENTAZOCINE HCL

50 MG (BASE) ORAL TABLET				
00002137984	TALWIN	SAV	$	0.4464

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.12 ANALGESICS AND ANTIPYRETICS (OPIATE PARTIAL AGONISTS)

PENTAZOCINE LACTATE

30 MG / ML INJECTION

00002241976	TALWIN	HSP	$	1.5700

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.04 ANTICONVULSANTS (BARBITURATES)

PRIMIDONE

125 MG ORAL TABLET

00000399310	APO-PRIMIDONE	APX	$	0.0553

250 MG ORAL TABLET

00000396761	APO-PRIMIDONE	APX	$	0.0870

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.08 ANTICONVULSANTS (BENZODIAZEPINES)

CLOBAZAM

10 MG ORAL TABLET

00002244638	**APO-CLOBAZAM**	**APX**	$	**0.2153**
00002238334	**NOVO-CLOBAZAM**	**TEV**	$	**0.2153**
00002244474	**PMS-CLOBAZAM**	**PMS**	$	**0.2153**
00002238797	RATIO-CLOBAZAM	RPH	$	0.2154

CLONAZEPAM

0.25 MG ORAL TABLET

00002179660	PMS-CLONAZEPAM	PMS	$	0.0672

0.5 MG ORAL TABLET

00002177889	**APO-CLONAZEPAM**	**APX**	$	**0.1166**
00002270641	**CO CLONAZEPAM**	**COB**	$	**0.1166**
00002230950	**MYLAN-CLONAZEPAM**	**MYP**	$	**0.1166**
00002239024	**NOVO-CLONAZEPAM**	**TEV**	$	**0.1166**
00002145227	**PHL-CLONAZEPAM**	**PHH**	$	**0.1166**
00002236948	**PHL-CLONAZEPAM-R**	**PHH**	$	**0.1166**
00002048701	**PMS-CLONAZEPAM**	**PMS**	$	**0.1166**
00002207818	**PMS-CLONAZEPAM-R**	**PMS**	$	**0.1166**
00002103656	**RATIO-CLONAZEPAM**	**RPH**	$	**0.1166**
00002233960	**SANDOZ CLONAZEPAM**	**SDZ**	$	**0.1166**
00000382825	RIVOTRIL	HLR	$	0.2131

1 MG ORAL TABLET

00002270668	**CO CLONAZEPAM**	**COB**	$	**0.1860**
00002145235	**PHL-CLONAZEPAM**	**PHH**	$	**0.1860**
00002048728	**PMS-CLONAZEPAM**	**PMS**	$	**0.1860**
00002233982	**SANDOZ CLONAZEPAM**	**SDZ**	$	**0.1860**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.08 ANTICONVULSANTS (BENZODIAZEPINES)

CLONAZEPAM

2 MG ORAL TABLET				
00002177897	**APO-CLONAZEPAM**	**APX**	$	**0.2010**
00002270676	**CO CLONAZEPAM**	**COB**	$	**0.2010**
00002230951	**MYLAN-CLONAZEPAM**	**MYP**	$	**0.2010**
00002239025	**NOVO-CLONAZEPAM**	**TEV**	$	**0.2010**
00002145243	**PHL-CLONAZEPAM**	**PHH**	$	**0.2010**
00002048736	**PMS-CLONAZEPAM**	**PMS**	$	**0.2010**
00002103737	**RATIO-CLONAZEPAM**	**RPH**	$	**0.2010**
00002233985	**SANDOZ CLONAZEPAM**	**SDZ**	$	**0.2010**
00000382841	RIVOTRIL	HLR	$	0.3673

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.12 ANTICONVULSANTS (HYDANTOINS)

PHENYTOIN

50 MG ORAL CHEWABLE TABLET				
00000023698	DILANTIN INFATABS	PFI	$	0.0764
6 MG / ML ORAL SUSPENSION				
00000023442	DILANTIN-30	PFI	$	0.0421
25 MG / ML ORAL SUSPENSION				
00002250896	**TARO-PHENYTOIN**	**TAR**	$	**0.0311**
00000023450	DILANTIN-125	PFI	$	0.0497

PHENYTOIN SODIUM

30 MG ORAL CAPSULE				
00000022772	DILANTIN	PFI	$	0.0558
100 MG ORAL CAPSULE				
00000022780	DILANTIN	PFI	$	0.0775
50 MG / ML INJECTION				
00000780626	PHENYTOIN SODIUM	SDZ	$	2.5230

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.20 ANTICONVULSANTS (SUCCINIMIDES)

ETHOSUXIMIDE

250 MG ORAL CAPSULE				
00000022799	ZARONTIN	ERF	$	0.3375
50 MG / ML ORAL SYRUP				
00000023485	ZARONTIN	ERF	$	0.0675

METHSUXIMIDE

300 MG ORAL CAPSULE				
00000022802	CELONTIN	ERF	$	0.6253

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

CARBAMAZEPINE

200 MG ORAL TABLET				
00000402699	**APO-CARBAMAZEPINE**	**APX**	$	**0.0795**
00000782718	**NOVO-CARBAMAZ**	**TEV**	$	**0.0795**
00002042568	**NU-CARBAMAZEPINE**	**NXP**	$	**0.0795**
00000010405	TEGRETOL	NOV	$	0.3976
100 MG ORAL CHEWABLE TABLET				
00002231542	**PMS-CARBAMAZEPINE**	**PMS**	$	**0.0770**
00002261855	**SANDOZ CARBAMAZEPINE**	**SDZ**	$	**0.0770**
00002244403	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.0770**
00000369810	TEGRETOL	NOV	$	0.1636
200 MG ORAL CHEWABLE TABLET				
00002231540	**PMS-CARBAMAZEPINE**	**PMS**	$	**0.1520**
00002261863	**SANDOZ CARBAMAZEPINE**	**SDZ**	$	**0.1520**
00002244404	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.1520**
00000665088	TEGRETOL	NOV	$	0.3228
200 MG ORAL SUSTAINED-RELEASE TABLET				
00002241882	**MYLAN-CARBAMAZEPINE CR**	**MYP**	$	**0.1887**
00002231543	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.1887**
00002261839	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.1887**
00000773611	TEGRETOL CR	NOV	$	0.4009
400 MG ORAL SUSTAINED-RELEASE TABLET				
00002241883	**MYLAN-CARBAMAZEPINE CR**	**MYP**	$	**0.3774**
00002231544	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.3774**
00002261847	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.3774**
00000755583	TEGRETOL CR	NOV	$	0.8016
20 MG / ML ORAL SUSPENSION				
00002194333	TEGRETOL	NOV	$	0.0773

DIVALPROEX SODIUM (VALPROIC ACID EQUIV.)

125 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239698	**APO-DIVALPROEX**	**APX**	$	**0.1377**
00002265133	**MYLAN-DIVALPROEX**	**MYP**	$	**0.1377**
00002239701	**NOVO-DIVALPROEX**	**TEV**	$	**0.1377**
00002239517	**NU-DIVALPROEX**	**NXP**	$	**0.1377**
00002244138	**PMS-DIVALPROEX**	**PMS**	$	**0.1377**
00000596418	EPIVAL	ABB	$	0.2758
250 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239699	**APO-DIVALPROEX**	**APX**	$	**0.2475**
00002265141	**MYLAN-DIVALPROEX**	**MYP**	$	**0.2475**
00002239702	**NOVO-DIVALPROEX**	**TEV**	$	**0.2475**
00002239518	**NU-DIVALPROEX**	**NXP**	$	**0.2475**
00002244139	**PMS-DIVALPROEX**	**PMS**	$	**0.2475**
00000596426	EPIVAL	ABB	$	0.4957
500 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239700	**APO-DIVALPROEX**	**APX**	$	**0.4952**
00002265168	**MYLAN-DIVALPROEX**	**MYP**	$	**0.4952**
00002239703	**NOVO-DIVALPROEX**	**TEV**	$	**0.4952**
00002239519	**NU-DIVALPROEX**	**NXP**	$	**0.4952**
00002244140	**PMS-DIVALPROEX**	**PMS**	$	**0.4952**
00000596434	EPIVAL	ABB	$	0.9920

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

GABAPENTIN

100 MG ORAL CAPSULE

00002244304	**APO-GABAPENTIN**	**APX**	$	**0.2504**
00002256142	**CO GABAPENTIN**	**COB**	$	**0.2504**
00002248259	**MYLAN-GABAPENTIN**	**MYP**	$	**0.2504**
00002244513	**NOVO-GABAPENTIN**	**TEV**	$	**0.2504**
00002246314	**PHL-GABAPENTIN**	**PHH**	$	**0.2504**
00002243446	**PMS-GABAPENTIN**	**PMS**	$	**0.2504**
00002319055	**RAN-GABAPENTIN**	**RAN**	$	**0.2504**
00002260883	**RATIO-GABAPENTIN**	**RPH**	$	**0.2504**
00002084260	NEURONTIN	PFI	$	0.4485

300 MG ORAL CAPSULE

00002244305	**APO-GABAPENTIN**	**APX**	$	**0.6092**
00002256150	**CO GABAPENTIN**	**COB**	$	**0.6092**
00002248260	**MYLAN-GABAPENTIN**	**MYP**	$	**0.6092**
00002244514	**NOVO-GABAPENTIN**	**TEV**	$	**0.6092**
00002246315	**PHL-GABAPENTIN**	**PHH**	$	**0.6092**
00002243447	**PMS-GABAPENTIN**	**PMS**	$	**0.6092**
00002319063	**RAN-GABAPENTIN**	**RAN**	$	**0.6092**
00002260891	**RATIO-GABAPENTIN**	**RPH**	$	**0.6092**
00002084279	NEURONTIN	PFI	$	1.0910

400 MG ORAL CAPSULE

00002244306	**APO-GABAPENTIN**	**APX**	$	**0.7259**
00002256169	**CO GABAPENTIN**	**COB**	$	**0.7259**
00002248261	**MYLAN-GABAPENTIN**	**MYP**	$	**0.7259**
00002244515	**NOVO-GABAPENTIN**	**TEV**	$	**0.7259**
00002246316	**PHL-GABAPENTIN**	**PHH**	$	**0.7259**
00002243448	**PMS-GABAPENTIN**	**PMS**	$	**0.7259**
00002319071	**RAN-GABAPENTIN**	**RAN**	$	**0.7259**
00002260905	**RATIO-GABAPENTIN**	**RPH**	$	**0.7259**
00002084287	NEURONTIN	PFI	$	1.3002

LAMOTRIGINE

25 MG ORAL TABLET

00002245208	**APO-LAMOTRIGINE**	**APX**	$	**0.2088**
00002265494	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.2088**
00002248232	**NOVO-LAMOTRIGINE**	**TEV**	$	**0.2088**
00002246897	**PMS-LAMOTRIGINE**	**PMS**	$	**0.2088**
00002243352	**RATIO-LAMOTRIGINE**	**RPH**	$	**0.2088**
00002142082	LAMICTAL	GSK	$	0.4023

100 MG ORAL TABLET

00002245209	**APO-LAMOTRIGINE**	**APX**	$	**0.8354**
00002265508	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.8354**
00002248233	**NOVO-LAMOTRIGINE**	**TEV**	$	**0.8354**
00002246898	**PMS-LAMOTRIGINE**	**PMS**	$	**0.8354**
00002243353	**RATIO-LAMOTRIGINE**	**RPH**	$	**0.8354**
00002142104	LAMICTAL	GSK	$	1.6060

150 MG ORAL TABLET

00002245210	**APO-LAMOTRIGINE**	**APX**	$	**1.2530**
00002265516	**MYLAN-LAMOTRIGINE**	**MYP**	$	**1.2530**
00002248234	**NOVO-LAMOTRIGINE**	**TEV**	$	**1.2530**
00002246899	**PMS-LAMOTRIGINE**	**PMS**	$	**1.2530**
00002246963	**RATIO-LAMOTRIGINE**	**RPH**	$	**1.2530**
00002142112	LAMICTAL	GSK	$	2.3669

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS
(MISCELLANEOUS ANTICONVULSANTS)

LAMOTRIGINE

5 MG ORAL CHEWABLE TABLET				
00002240115	LAMICTAL	GSK	$	0.1716

LEVETIRACETAM

250 MG ORAL TABLET				
00002285924	**APO-LEVETIRACETAM**	**APX**	$	**0.9632**
00002274183	**CO LEVETIRACETAM**	**COB**	$	**0.9632**
00002296101	**PMS-LEVETIRACETAM**	**PMS**	$	**0.9632**
00002247027	KEPPRA	UCB	$	1.7200
500 MG ORAL TABLET				
00002285932	**APO-LEVETIRACETAM**	**APX**	$	**1.1739**
00002274191	**CO LEVETIRACETAM**	**COB**	$	**1.1739**
00002296128	**PMS-LEVETIRACETAM**	**PMS**	$	**1.1739**
00002247028	KEPPRA	UCB	$	2.0962
750 MG ORAL TABLET				
00002274205	**CO LEVETIRACETAM**	**COB**	$	**1.6254**
00002247029	KEPPRA	UCB	$	2.9025

TOPIRAMATE

25 MG ORAL TABLET				
00002287765	**CO TOPIRAMATE**	**COB**	$	**0.6615**
00002263351	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.6615**
00002248860	**NOVO-TOPIRAMATE**	**TEV**	$	**0.6615**
00002271184	**PHL-TOPIRAMATE**	**PHH**	$	**0.6615**
00002262991	**PMS-TOPIRAMATE**	**PMS**	$	**0.6615**
00002256827	**RATIO-TOPIRAMATE**	**RPH**	$	**0.6615**
00002260050	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.6615**
00002230893	TOPAMAX	JOI	$	1.3450
50 MG ORAL TABLET				
00002312085	PMS-TOPIRAMATE	PMS	$	1.0030
100 MG ORAL TABLET				
00002287773	**CO TOPIRAMATE**	**COB**	$	**1.2537**
00002263378	**MYLAN-TOPIRAMATE**	**MYP**	$	**1.2537**
00002248861	**NOVO-TOPIRAMATE**	**TEV**	$	**1.2537**
00002271192	**PHL-TOPIRAMATE**	**PHH**	$	**1.2537**
00002263009	**PMS-TOPIRAMATE**	**PMS**	$	**1.2537**
00002256835	**RATIO-TOPIRAMATE**	**RPH**	$	**1.2537**
00002260069	**SANDOZ TOPIRAMATE**	**SDZ**	$	**1.2537**
00002230894	TOPAMAX	JOI	$	2.5494
200 MG ORAL TABLET				
00002287781	**CO TOPIRAMATE**	**COB**	$	**1.9845**
00002263386	**MYLAN-TOPIRAMATE**	**MYP**	$	**1.9845**
00002248862	**NOVO-TOPIRAMATE**	**TEV**	$	**1.9845**
00002271206	**PHL-TOPIRAMATE**	**PHH**	$	**1.9845**
00002263017	**PMS-TOPIRAMATE**	**PMS**	$	**1.9845**
00002256843	**RATIO-TOPIRAMATE**	**RPH**	$	**1.9845**
00002267837	**SANDOZ TOPIRAMATE**	**SDZ**	$	**1.9845**
00002230896	TOPAMAX	JOI	$	3.8071
15 MG ORAL CAPSULE				
00002239907	TOPAMAX SPRINKLE	JOI	$	1.2276
25 MG ORAL CAPSULE				
00002239908	TOPAMAX SPRINKLE	JOI	$	1.2889

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS
(MISCELLANEOUS ANTICONVULSANTS)

VALPROIC ACID

250 MG ORAL CAPSULE				
00002238048	**APO-VALPROIC**	**APX**	$	**0.2584**
00002184648	**MYLAN-VALPROIC**	**MYP**	$	**0.2584**
00002100630	**NOVO-VALPROIC**	**TEV**	$	**0.2584**
00002237830	**NU-VALPROIC**	**NXP**	$	**0.2584**
00002230768	**PMS-VALPROIC ACID**	**PMS**	$	**0.2584**
00002140047	**RATIO-VALPROIC**	**RPH**	$	**0.2584**
00002239714	**SANDOZ VALPROIC**	**SDZ**	$	**0.2584**
00000443840	DEPAKENE	ABB	$	0.5204
500 MG ORAL ENTERIC-COATED CAPSULE				
00002218321	**NOVO-VALPROIC**	**TEV**	$	**0.5197**
00002229628	**PMS-VALPROIC ACID E.C.**	**PMS**	$	**0.5197**
50 MG / ML ORAL SYRUP				
00002238370	**APO-VALPROIC**	**APX**	$	**0.0577**
00002236807	**PMS-VALPROIC ACID**	**PMS**	$	**0.0577**
00002140063	**RATIO-VALPROIC**	**RPH**	$	**0.0577**
00000443832	DEPAKENE	ABB	$	0.1085

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.12 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MONOAMINE OXIDASE INHIBITORS)

MOCLOBEMIDE

100 MG ORAL TABLET				
00002232148	**APO-MOCLOBEMIDE**	**APX**	$	**0.2520**
00002239746	**NOVO-MOCLOBEMIDE**	**TEV**	$	**0.2520**
00002237111	**NU-MOCLOBEMIDE**	**NXP**	$	**0.2520**
150 MG ORAL TABLET				
00002232150	**APO-MOCLOBEMIDE**	**APX**	$	**0.3647**
00002239747	**NOVO-MOCLOBEMIDE**	**TEV**	$	**0.3647**
00002243218	**PMS-MOCLOBEMIDE**	**PMS**	$	**0.3647**
00000899356	MANERIX	MED	$	0.6512
300 MG ORAL TABLET				
00002240456	**APO-MOCLOBEMIDE**	**APX**	$	**0.7161**
00002239748	**NOVO-MOCLOBEMIDE**	**TEV**	$	**0.7161**
00002243219	**PMS-MOCLOBEMIDE**	**PMS**	$	**0.7161**
00002166747	MANERIX	MED	$	1.2788

PHENELZINE SULFATE

15 MG (BASE) ORAL TABLET				
00000476552	NARDIL	ERF	$	0.3753

TRANYLCYPROMINE SULFATE

10 MG (BASE) ORAL TABLET				
00001919598	PARNATE	GSK	$	0.3958

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.16 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(SELECTIVE SEROTONIN- AND NOREPINEPHRINE-REUPTAKE INHIBITORS)

VENLAFAXINE HCL

37.5 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002331683	**APO-VENLAFAXINE**	**APX**	$	**0.5438**
00002304317	**CO VENLAFAXINE XR**	**COB**	$	**0.5438**
00002310279	**MYLAN-VENLAFAXINE XR**	**MYP**	$	**0.5438**
00002275023	**NOVO-VENLAFAXINE XR**	**TEV**	$	**0.5438**
00002278545	**PMS-VENLAFAXINE XR**	**PMS**	$	**0.5438**
00002273969	**RATIO-VENLAFAXINE XR**	**RPH**	$	**0.5438**
00002310317	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**0.5438**
00002237279	EFFEXOR XR	WAY	$	0.9761
75 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002331691	**APO-VENLAFAXINE**	**APX**	$	**1.0876**
00002304325	**CO VENLAFAXINE XR**	**COB**	$	**1.0876**
00002310287	**MYLAN-VENLAFAXINE XR**	**MYP**	$	**1.0876**
00002275031	**NOVO-VENLAFAXINE XR**	**TEV**	$	**1.0876**
00002278553	**PMS-VENLAFAXINE XR**	**PMS**	$	**1.0876**
00002273977	**RATIO-VENLAFAXINE XR**	**RPH**	$	**1.0876**
00002310325	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**1.0876**
00002237280	EFFEXOR XR	WAY	$	1.9523
150 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002331705	**APO-VENLAFAXINE**	**APX**	$	**1.1483**
00002304333	**CO VENLAFAXINE XR**	**COB**	$	**1.1483**
00002310295	**MYLAN-VENLAFAXINE XR**	**MYP**	$	**1.1483**
00002275058	**NOVO-VENLAFAXINE XR**	**TEV**	$	**1.1483**
00002278561	**PMS-VENLAFAXINE XR**	**PMS**	$	**1.1483**
00002273985	**RATIO-VENLAFAXINE XR**	**RPH**	$	**1.1483**
00002310333	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**1.1483**
00002237282	EFFEXOR XR	WAY	$	2.0610

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

CITALOPRAM HYDROBROMIDE

10 MG (BASE) ORAL TABLET				
00002270609	PMS-CITALOPRAM	PMS	$	0.4477
20 MG (BASE) ORAL TABLET				
00002246056	**APO-CITALOPRAM**	**APX**	$	**0.7860**
00002331950	**CITALOPRAM**	**RAN**	$	**0.7860**
00002306239	**CITALOPRAM-ODAN**	**ODN**	$	**0.7860**
00002248050	**CO CITALOPRAM**	**COB**	$	**0.7860**
00002313405	**JAMP-CITALOPRAM**	**JPC**	$	**0.7860**
00002304686	**MINT-CITALOPRAM**	**MPI**	$	**0.7860**
00002246594	**MYLAN-CITALOPRAM**	**MYP**	$	**0.7860**
00002322781	**NG CITALOPRAM**	**NGP**	$	**0.7860**
00002293218	**NOVO-CITALOPRAM**	**TEV**	$	**0.7860**
00002248944	**PHL-CITALOPRAM**	**PHH**	$	**0.7860**
00002248010	**PMS-CITALOPRAM**	**PMS**	$	**0.7860**
00002285622	**RAN-CITALO**	**RAN**	$	**0.7860**
00002268000	**RAN-CITALOPRAM**	**RAN**	$	**0.7860**
00002252112	**RATIO-CITALOPRAM**	**RPH**	$	**0.7860**
00002248170	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.7860**
00002239607	CELEXA	LBC	$	1.4078
30 MG (BASE) ORAL TABLET				
00002296152	CTP 30	SPC	$	0.9406
40 MG (BASE) ORAL TABLET				
00002246057	**APO-CITALOPRAM**	**APX**	$	**0.7860**
00002331977	**CITALOPRAM**	**RAN**	$	**0.7860**
00002306247	**CITALOPRAM-ODAN**	**ODN**	$	**0.7860**
00002248051	**CO CITALOPRAM**	**COB**	$	**0.7860**
00002313413	**JAMP-CITALOPRAM**	**JPC**	$	**0.7860**
00002304694	**MINT-CITALOPRAM**	**MPI**	$	**0.7860**
00002246595	**MYLAN-CITALOPRAM**	**MYP**	$	**0.7860**
00002322803	**NG CITALOPRAM**	**NGP**	$	**0.7860**
00002293226	**NOVO-CITALOPRAM**	**TEV**	$	**0.7860**
00002248945	**PHL-CITALOPRAM**	**PHH**	$	**0.7860**
00002248011	**PMS-CITALOPRAM**	**PMS**	$	**0.7860**
00002285630	**RAN-CITALO**	**RAN**	$	**0.7860**
00002268019	**RAN-CITALOPRAM**	**RAN**	$	**0.7860**
00002252120	**RATIO-CITALOPRAM**	**RPH**	$	**0.7860**
00002248171	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.7860**
00002239608	CELEXA	LBC	$	1.4078

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

FLUOXETINE HCL

10 MG (BASE) ORAL CAPSULE				
00002216353	**APO-FLUOXETINE**	**APX**	$	**1.0807**
00002242177	**CO FLUOXETINE**	**COB**	$	**1.0807**
00002237813	**MYLAN-FLUOXETINE**	**MYP**	$	**1.0807**
00002216582	**NOVO-FLUOXETINE**	**TEV**	$	**1.0807**
00002192756	**NU-FLUOXETINE**	**NXP**	$	**1.0807**
00002223481	**PHL-FLUOXETINE**	**PHH**	$	**1.0807**
00002177579	**PMS-FLUOXETINE**	**PMS**	$	**1.0807**
00002241371	**RATIO-FLUOXETINE HYDROCHLORIDE**	**RPH**	$	**1.0807**
00002243486	**SANDOZ FLUOXETINE**	**SDZ**	$	**1.0807**
00002018985	PROZAC	LIL	$	1.9298
20 MG (BASE) ORAL CAPSULE				
00002216361	**APO-FLUOXETINE**	**APX**	$	**1.0112**
00002242178	**CO FLUOXETINE**	**COB**	$	**1.0112**
00002237814	**MYLAN-FLUOXETINE**	**MYP**	$	**1.0112**
00002216590	**NOVO-FLUOXETINE**	**TEV**	$	**1.0112**
00002192764	**NU-FLUOXETINE**	**NXP**	$	**1.0112**
00002223503	**PHL-FLUOXETINE**	**PHH**	$	**1.0112**
00002177587	**PMS-FLUOXETINE**	**PMS**	$	**1.0112**
00002241374	**RATIO-FLUOXETINE HYDROCHLORIDE**	**RPH**	$	**1.0112**
00002243487	**SANDOZ FLUOXETINE**	**SDZ**	$	**1.0112**
00000636622	PROZAC	LIL	$	1.9313
40 MG (BASE) ORAL CAPSULE				
00002245283	FXT 40	SPC	$	2.1924
4 MG / ML (BASE) ORAL LIQUID				
00002231328	APO-FLUOXETINE	APX	$	0.5859

FLUVOXAMINE MALEATE

50 MG ORAL TABLET				
00002231329	**APO-FLUVOXAMINE**	**APX**	$	**0.4952**
00002255529	**CO FLUVOXAMINE**	**COB**	$	**0.4952**
00002239953	**NOVO-FLUVOXAMINE**	**TEV**	$	**0.4952**
00002231192	**NU-FLUVOXAMINE**	**NXP**	$	**0.4952**
00002240682	**PMS-FLUVOXAMINE**	**PMS**	$	**0.4952**
00002218453	**RATIO-FLUVOXAMINE**	**RPH**	$	**0.4952**
00002247054	**SANDOZ FLUVOXAMINE**	**SDZ**	$	**0.4952**
00001919342	LUVOX	SLO	$	0.9051
100 MG ORAL TABLET				
00002231330	**APO-FLUVOXAMINE**	**APX**	$	**0.8902**
00002255537	**CO FLUVOXAMINE**	**COB**	$	**0.8902**
00002239954	**NOVO-FLUVOXAMINE**	**TEV**	$	**0.8902**
00002231193	**NU-FLUVOXAMINE**	**NXP**	$	**0.8902**
00002240683	**PMS-FLUVOXAMINE**	**PMS**	$	**0.8902**
00002218461	**RATIO-FLUVOXAMINE**	**RPH**	$	**0.8902**
00002247055	**SANDOZ FLUVOXAMINE**	**SDZ**	$	**0.8902**
00001919369	LUVOX	SLO	$	1.6268

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

PAROXETINE HCL

20 MG (BASE) ORAL TABLET				
00002240908	**APO-PAROXETINE**	**APX**	$	**1.0017**
00002262754	**CO PAROXETINE**	**COB**	$	**1.0017**
00002248013	**MYLAN-PAROXETINE**	**MYP**	$	**1.0017**
00002248557	**NOVO-PAROXETINE**	**TEV**	$	**1.0017**
00002248451	**PHL-PAROXETINE**	**PHH**	$	**1.0017**
00002247751	**PMS-PAROXETINE**	**PMS**	$	**1.0017**
00002247811	**RATIO-PAROXETINE**	**RPH**	$	**1.0017**
00002269430	**SANDOZ PAROXETINE**	**SDZ**	$	**1.0017**
00001940481	PAXIL	GSK	$	1.9410
30 MG (BASE) ORAL TABLET				
00002240909	**APO-PAROXETINE**	**APX**	$	**1.0647**
00002262762	**CO PAROXETINE**	**COB**	$	**1.0647**
00002248014	**MYLAN-PAROXETINE**	**MYP**	$	**1.0647**
00002248558	**NOVO-PAROXETINE**	**TEV**	$	**1.0647**
00002248452	**PHL-PAROXETINE**	**PHH**	$	**1.0647**
00002247752	**PMS-PAROXETINE**	**PMS**	$	**1.0647**
00002247812	**RATIO-PAROXETINE**	**RPH**	$	**1.0647**
00002254778	**SANDOZ PAROXETINE**	**SDZ**	$	**1.0647**
00002269449	**SANDOZ PAROXETINE**	**SDZ**	$	**1.0647**
00001940473	PAXIL	GSK	$	2.0622
40 MG (BASE) ORAL TABLET				
00002293749	PMS-PAROXETINE	PMS	$	2.0094

SERTRALINE HCL

25 MG (BASE) ORAL CAPSULE				
00002238280	**APO-SERTRALINE**	**APX**	$	**0.4826**
00002287390	**CO SERTRALINE**	**COB**	$	**0.4826**
00002242519	**MYLAN-SERTRALINE**	**MYP**	$	**0.4826**
00002240485	**NOVO-SERTRALINE**	**TEV**	$	**0.4826**
00002245824	**PHL-SERTRALINE**	**PHH**	$	**0.4826**
00002244838	**PMS-SERTRALINE**	**PMS**	$	**0.4826**
00002245787	**RATIO-SERTRALINE**	**RPH**	$	**0.4826**
00002245159	**SANDOZ SERTRALINE**	**SDZ**	$	**0.4826**
00002132702	ZOLOFT	PFI	$	0.8643
50 MG (BASE) ORAL CAPSULE				
00002238281	**APO-SERTRALINE**	**APX**	$	**0.9651**
00002287404	**CO SERTRALINE**	**COB**	$	**0.9651**
00002242520	**MYLAN-SERTRALINE**	**MYP**	$	**0.9651**
00002240484	**NOVO-SERTRALINE**	**TEV**	$	**0.9651**
00002245825	**PHL-SERTRALINE**	**PHH**	$	**0.9651**
00002244839	**PMS-SERTRALINE**	**PMS**	$	**0.9651**
00002245788	**RATIO-SERTRALINE**	**RPH**	$	**0.9651**
00002245160	**SANDOZ SERTRALINE**	**SDZ**	$	**0.9651**
00001962817	ZOLOFT	PFI	$	1.7286

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

SERTRALINE HCL

100 MG (BASE) ORAL CAPSULE				
00002238282	**APO-SERTRALINE**	**APX**	$	**1.0114**
00002287412	**CO SERTRALINE**	**COB**	$	**1.0114**
00002242521	**MYLAN-SERTRALINE**	**MYP**	$	**1.0114**
00002240481	**NOVO-SERTRALINE**	**TEV**	$	**1.0114**
00002245826	**PHL-SERTRALINE**	**PHH**	$	**1.0114**
00002244840	**PMS-SERTRALINE**	**PMS**	$	**1.0114**
00002245789	**RATIO-SERTRALINE**	**RPH**	$	**1.0114**
00002245161	**SANDOZ SERTRALINE**	**SDZ**	$	**1.0114**
00001962779	ZOLOFT	PFI	$	1.8114

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.24 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SEROTONIN MODULATORS)

TRAZODONE HCL

50 MG ORAL TABLET				
00002147637	**APO-TRAZODONE**	**APX**	$	**0.2214**
00000579351	**DESYREL**	**BMS**	$	**0.2214**
00002231683	**MYLAN-TRAZODONE**	**MYP**	$	**0.2214**
00002144263	**NOVO-TRAZODONE**	**TEV**	$	**0.2214**
00002165384	**NU-TRAZODONE**	**NXP**	$	**0.2214**
00001937227	**PMS-TRAZODONE**	**PMS**	$	**0.2214**
00002277344	**RATIO-TRAZODONE**	**RPH**	$	**0.2214**
75 MG ORAL TABLET				
00002237339	PMS-TRAZODONE	PMS	$	0.3279
100 MG ORAL TABLET				
00002147645	**APO-TRAZODONE**	**APX**	$	**0.3956**
00000579378	**DESYREL**	**BMS**	$	**0.3956**
00002231684	**MYLAN-TRAZODONE**	**MYP**	$	**0.3956**
00002144271	**NOVO-TRAZODONE**	**TEV**	$	**0.3956**
00002165392	**NU-TRAZODONE**	**NXP**	$	**0.3956**
00001937235	**PMS-TRAZODONE**	**PMS**	$	**0.3956**
00002277352	**RATIO-TRAZODONE**	**RPH**	$	**0.3956**
150 MG ORAL TABLET				
00002147653	**APO-TRAZODONE D**	**APX**	$	**0.5812**
00000702277	**DESYREL DIVIDOSE**	**BMS**	$	**0.5812**
00002144298	**NOVO-TRAZODONE**	**TEV**	$	**0.5812**
00002165406	**NU-TRAZODONE-D**	**NXP**	$	**0.5812**
00002277360	**RATIO-TRAZODONE**	**RPH**	$	**0.5812**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.28 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(TRICYCLICS AND OTHER NOREPINEPHRINE-REUPTAKE INHIBITORS)

AMITRIPTYLINE HCL

10 MG ORAL TABLET				
00000335053	APO-AMITRIPTYLINE	APX	$	0.0664
25 MG ORAL TABLET				
00000335061	APO-AMITRIPTYLINE	APX	$	0.1211
50 MG ORAL TABLET				
00000335088	APO-AMITRIPTYLINE	APX	$	0.2347
75 MG ORAL TABLET				
00000754129	APO-AMITRIPTYLINE	APX	$	0.3634

CLOMIPRAMINE HCL

10 MG ORAL TABLET				
00002040786	**APO-CLOMIPRAMINE**	**APX**	$	**0.1626**
00002244816	**CO CLOMIPRAMINE**	**COB**	$	**0.1626**
00000330566	ANAFRANIL	SPC	$	0.2922
25 MG ORAL TABLET				
00002040778	**APO-CLOMIPRAMINE**	**APX**	$	**0.2215**
00002244817	**CO CLOMIPRAMINE**	**COB**	$	**0.2215**
00000324019	ANAFRANIL	SPC	$	0.3981
50 MG ORAL TABLET				
00002040751	**APO-CLOMIPRAMINE**	**APX**	$	**0.4078**
00002244818	**CO CLOMIPRAMINE**	**COB**	$	**0.4078**
00000402591	ANAFRANIL	SPC	$	0.7329

DESIPRAMINE HCL

10 MG ORAL TABLET				
00002216248	**APO-DESIPRAMINE**	**APX**	$	**0.3804**
00002211939	**NU-DESIPRAMINE**	**NXP**	$	**0.3804**
25 MG ORAL TABLET				
00002216256	**APO-DESIPRAMINE**	**APX**	$	**0.3804**
00002211947	**NU-DESIPRAMINE**	**NXP**	$	**0.3804**
50 MG ORAL TABLET				
00002216264	**APO-DESIPRAMINE**	**APX**	$	**0.6704**
00002211955	**NU-DESIPRAMINE**	**NXP**	$	**0.6704**
75 MG ORAL TABLET				
00002216272	**APO-DESIPRAMINE**	**APX**	$	**0.8915**
00002211963	**NU-DESIPRAMINE**	**NXP**	$	**0.8915**

DOXEPIN HCL

10 MG (BASE) ORAL CAPSULE				
00002049996	**APO-DOXEPIN**	**APX**	$	**0.1889**
00000024325	SINEQUAN	ERF	$	0.2714
25 MG (BASE) ORAL CAPSULE				
00001913425	**NOVO-DOXEPIN**	**TEV**	$	**0.1860**
00000024333	SINEQUAN	ERF	$	0.3330
50 MG (BASE) ORAL CAPSULE				
00001913433	**NOVO-DOXEPIN**	**TEV**	$	**0.3450**
00000024341	SINEQUAN	ERF	$	0.6178

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.28 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(TRICYCLICS AND OTHER NOREPINEPHRINE-REUPTAKE INHIBITORS)

DOXEPIN HCL

75 MG (BASE) ORAL CAPSULE				
00002050021	**APO-DOXEPIN**	**APX**	$	**0.4953**
00001913441	**NOVO-DOXEPIN**	**TEV**	$	**0.4953**
00000400750	SINEQUAN	ERF	$	0.8870
100 MG (BASE) ORAL CAPSULE				
00002050048	**APO-DOXEPIN**	**APX**	$	**0.6526**
00001913468	**NOVO-DOXEPIN**	**TEV**	$	**0.6526**
00000326925	SINEQUAN	ERF	$	1.1687
150 MG (BASE) ORAL CAPSULE				
00001913476	NOVO-DOXEPIN	TEV	$	1.1304

IMIPRAMINE HCL

10 MG ORAL TABLET				
00000360201	APO-IMIPRAMINE	APX	$	0.1370
25 MG ORAL TABLET				
00000312797	APO-IMIPRAMINE	APX	$	0.2353
50 MG ORAL TABLET				
00000326852	**APO-IMIPRAMINE**	**APX**	$	**0.3807**
00000010480	TOFRANIL	NOV	$	0.5457
75 MG ORAL TABLET				
00000644579	APO-IMIPRAMINE	APX	$	0.5529

MAPROTILINE HCL

25 MG ORAL TABLET				
00002158612	NOVO-MAPROTILINE	TEV	$	0.5687
50 MG ORAL TABLET				
00002158620	NOVO-MAPROTILINE	TEV	$	1.0769
75 MG ORAL TABLET				
00002158639	NOVO-MAPROTILINE	TEV	$	1.4707

NORTRIPTYLINE HCL

10 MG (BASE) ORAL CAPSULE				
00002223511	**APO-NORTRIPTYLINE**	**APX**	$	**0.1260**
00002231781	**NOVO-NORTRIPTYLINE**	**TEV**	$	**0.1260**
00002223139	**NU-NORTRIPTYLINE**	**NXP**	$	**0.1260**
00002177692	**PMS-NORTRIPTYLINE**	**PMS**	$	**0.1260**
00000015229	AVENTYL	PHH	$	0.2265
25 MG (BASE) ORAL CAPSULE				
00002223538	**APO-NORTRIPTYLINE**	**APX**	$	**0.2546**
00002231782	**NOVO-NORTRIPTYLINE**	**TEV**	$	**0.2546**
00002223147	**NU-NORTRIPTYLINE**	**NXP**	$	**0.2546**
00002177706	**PMS-NORTRIPTYLINE**	**PMS**	$	**0.2546**
00000015237	AVENTYL	PHH	$	0.4577

TRIMIPRAMINE MALEATE

12.5 MG (BASE) ORAL TABLET				
00000740799	APO-TRIMIP	APX	$	0.2156
25 MG (BASE) ORAL TABLET				
00000740802	**APO-TRIMIP**	**APX**	$	**0.2776**
00002020602	**NU-TRIMIPRAMINE**	**NXP**	$	**0.2776**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.28 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(TRICYCLICS AND OTHER NOREPINEPHRINE-REUPTAKE INHIBITORS)

TRIMIPRAMINE MALEATE

50 MG (BASE) ORAL TABLET				
00000740810	**APO-TRIMIP**	**APX**	$	**0.5434**
00002020610	**NU-TRIMIPRAMINE**	**NXP**	$	**0.5434**
100 MG (BASE) ORAL TABLET				
00000740829	**APO-TRIMIP**	**APX**	$	**0.9273**
00002020629	**NU-TRIMIPRAMINE**	**NXP**	$	**0.9273**
75 MG (BASE) ORAL CAPSULE				
00002070987	APO-TRIMIP	APX	$	0.7314

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.92 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MISCELLANEOUS ANTIDEPRESSANTS)

BUPROPION HCL

100 MG ORAL SUSTAINED-RELEASE TABLET				
00002325373	**PMS-BUPROPION SR**	**PMS**	$	**0.3266**
00002285657	RATIO-BUPROPION SR	RPH	$	0.3365
00002275074	SANDOZ BUPROPION SR	SDZ	$	0.3733
150 MG ORAL SUSTAINED-RELEASE TABLET				
00002313421	**PMS-BUPROPION SR**	**PMS**	$	**0.5040**
00002285665	**RATIO-BUPROPION SR**	**RPH**	$	**0.5040**
00002275082	**SANDOZ BUPROPION SR**	**SDZ**	$	**0.5040**
00002237825	WELLBUTRIN SR	BOV	$	0.9191
150 MG ORAL EXTENDED-RELEASE TABLET				
00002275090	WELLBUTRIN XL	BOV	$	0.5345
300 MG ORAL EXTENDED-RELEASE TABLET				
00002275104	WELLBUTRIN XL	BOV	$	1.0691

L-TRYPTOPHAN

250 MG ORAL TABLET				
00002239326	TRYPTAN	VCL	$	0.3830
500 MG ORAL TABLET				
00002248538	**APO-TRYPTOPHAN**	**APX**	$	**0.4289**
00002240445	**PMS-TRYPTOPHAN**	**PMS**	$	**0.4289**
00002240333	**RATIO-TRYPTOPHAN**	**RPH**	$	**0.4289**
00002029456	TRYPTAN	VCL	$	0.7659
750 MG ORAL TABLET				
00002239327	TRYPTAN	VCL	$	1.1491
1 G ORAL TABLET				
00002248539	**APO-TRYPTOPHAN**	**APX**	$	**0.8579**
00002230202	**PMS-TRYPTOPHAN**	**PMS**	$	**0.8579**
00002237250	**RATIO-TRYPTOPHAN**	**RPH**	$	**0.8579**
00000654531	TRYPTAN	VCL	$	1.5320

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.92 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MISCELLANEOUS ANTIDEPRESSANTS)

L-TRYPTOPHAN

500 MG ORAL CAPSULE

00002248540	**APO-TRYPTOPHAN**	**APX**	$	**0.4289**
00002241023	**PMS-TRYPTOPHAN**	**PMS**	$	**0.4289**
00002240334	**RATIO-TRYPTOPHAN**	**RPH**	$	**0.4289**
00000718149	TRYPTAN	VCL	$	0.7659

MIRTAZAPINE

15 MG ORAL TABLET

00002273942	PMS-MIRTAZAPINE	PMS	$	0.3761

30 MG ORAL TABLET

00002286629	**APO-MIRTAZAPINE**	**APX**	$	**0.6944**
00002256118	**MYLAN-MIRTAZAPINE**	**MYP**	$	**0.6944**
00002259354	**NOVO-MIRTAZAPINE**	**TEV**	$	**0.6944**
00002252279	**PHL-MIRTAZAPINE**	**PHH**	$	**0.6944**
00002248762	**PMS-MIRTAZAPINE**	**PMS**	$	**0.6944**
00002270927	**RATIO-MIRTAZAPINE**	**RPH**	$	**0.6944**
00002250608	**SANDOZ MIRTAZAPINE**	**SDZ**	$	**0.6944**
00002243910	REMERON	ORG	$	1.2400

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

CLOZAPINE

25 MG ORAL TABLET

00002248034	**APO-CLOZAPINE**	**APX**	$	**0.6594**
00002247243	**GEN-CLOZAPINE**	**MYP**	$	**0.6594**
00000894737	CLOZARIL	NOV	$	1.0127

100 MG ORAL TABLET

00002248035	**APO-CLOZAPINE**	**APX**	$	**2.6446**
00002247244	**GEN-CLOZAPINE**	**MYP**	$	**2.6446**
00000894745	CLOZARIL	NOV	$	4.0614

OLANZAPINE

2.5 MG ORAL TABLET

00002281791	**APO-OLANZAPINE**	**APX**	$	**1.0568**
00002325659	**CO OLANZAPINE**	**COB**	$	**1.0568**
00002276712	**NOVO-OLANZAPINE**	**TEV**	$	**1.0568**
00002303116	**PMS-OLANZAPINE**	**PMS**	$	**1.0568**
00002229250	ZYPREXA	LIL	$	1.8871

5 MG ORAL TABLET

00002281805	**APO-OLANZAPINE**	**APX**	$	**2.1135**
00002325667	**CO OLANZAPINE**	**COB**	$	**2.1135**
00002276720	**NOVO-OLANZAPINE**	**TEV**	$	**2.1135**
00002303159	**PMS-OLANZAPINE**	**PMS**	$	**2.1135**
00002229269	ZYPREXA	LIL	$	3.7741

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

OLANZAPINE

7.5 MG ORAL TABLET

00002281813	**APO-OLANZAPINE**	**APX**	$	**3.1703**
00002325675	**CO OLANZAPINE**	**COB**	$	**3.1703**
00002276739	**NOVO-OLANZAPINE**	**TEV**	$	**3.1703**
00002303167	**PMS-OLANZAPINE**	**PMS**	$	**3.1703**
00002229277	ZYPREXA	LIL	$	5.6612

10 MG ORAL TABLET

00002281821	**APO-OLANZAPINE**	**APX**	$	**4.2270**
00002325683	**CO OLANZAPINE**	**COB**	$	**4.2270**
00002276747	**NOVO-OLANZAPINE**	**TEV**	$	**4.2270**
00002303175	**PMS-OLANZAPINE**	**PMS**	$	**4.2270**
00002229285	ZYPREXA	LIL	$	7.5482

15 MG ORAL TABLET

00002281848	**APO-OLANZAPINE**	**APX**	$	**6.3405**
00002325691	**CO OLANZAPINE**	**COB**	$	**6.3405**
00002276755	**NOVO-OLANZAPINE**	**TEV**	$	**6.3405**
00002303183	**PMS-OLANZAPINE**	**PMS**	$	**6.3405**
00002238850	ZYPREXA	LIL	$	11.3223

5 MG ORAL DISINTEGRATING TABLET

00002327562	**CO OLANZAPINE ODT**	**COB**	$	**1.6890**
00002303191	**PMS-OLANZAPINE ODT**	**PMS**	$	**1.6890**
00002327775	**SANDOZ OLANZAPINE ODT**	**SDZ**	$	**1.6890**
00002243086	ZYPREXA ZYDIS	LIL	$	3.7533

10 MG ORAL DISINTEGRATING TABLET

00002327570	**CO OLANZAPINE ODT**	**COB**	$	**3.3750**
00002303205	**PMS-OLANZAPINE ODT**	**PMS**	$	**3.3750**
00002327783	**SANDOZ OLANZAPINE ODT**	**SDZ**	$	**3.3750**
00002243087	ZYPREXA ZYDIS	LIL	$	7.5000

QUETIAPINE FUMARATE

25 MG (BASE) ORAL TABLET

00002313901	**APO-QUETIAPINE**	**APX**	$	**0.2975**
00002316080	**CO QUETIAPINE**	**COB**	$	**0.2975**
00002330415	**JAMP-QUETIAPINE**	**JPC**	$	**0.2975**
00002307804	**MYLAN-QUETIAPINE**	**MYP**	$	**0.2975**
00002284235	**NOVO-QUETIAPINE**	**TEV**	$	**0.2975**
00002296551	**PMS-QUETIAPINE**	**PMS**	$	**0.2975**
00002311704	**RATIO-QUETIAPINE**	**RPH**	$	**0.2975**
00002313995	**SANDOZ QUETIAPINE**	**SDZ**	$	**0.2975**
00002236951	SEROQUEL	AZC	$	0.5313

100 MG (BASE) ORAL TABLET

00002313928	**APO-QUETIAPINE**	**APX**	$	**0.7936**
00002316099	**CO QUETIAPINE**	**COB**	$	**0.7936**
00002330423	**JAMP-QUETIAPINE**	**JPC**	$	**0.7936**
00002307812	**MYLAN-QUETIAPINE**	**MYP**	$	**0.7936**
00002284243	**NOVO-QUETIAPINE**	**TEV**	$	**0.7936**
00002296578	**PMS-QUETIAPINE**	**PMS**	$	**0.7936**
00002311712	**RATIO-QUETIAPINE**	**RPH**	$	**0.7936**
00002314002	**SANDOZ QUETIAPINE**	**SDZ**	$	**0.7936**
00002236952	SEROQUEL	AZC	$	1.4172

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

QUETIAPINE FUMARATE

150 MG (BASE) ORAL TABLET				
00002284251	NOVO-QUETIAPINE	TEV	$	1.3559
200 MG (BASE) ORAL TABLET				
00002313936	**APO-QUETIAPINE**	**APX**	$	**1.5935**
00002316110	**CO QUETIAPINE**	**COB**	$	**1.5935**
00002330458	**JAMP-QUETIAPINE**	**JPC**	$	**1.5935**
00002307839	**MYLAN-QUETIAPINE**	**MYP**	$	**1.5935**
00002284278	**NOVO-QUETIAPINE**	**TEV**	$	**1.5935**
00002296594	**PMS-QUETIAPINE**	**PMS**	$	**1.5935**
00002311747	**RATIO-QUETIAPINE**	**RPH**	$	**1.5935**
00002314010	**SANDOZ QUETIAPINE**	**SDZ**	$	**1.5935**
00002236953	SEROQUEL	AZC	$	2.8455
300 MG (BASE) ORAL TABLET				
00002313944	**APO-QUETIAPINE**	**APX**	$	**2.3252**
00002316129	**CO QUETIAPINE**	**COB**	$	**2.3252**
00002330466	**JAMP-QUETIAPINE**	**JPC**	$	**2.3252**
00002307847	**MYLAN-QUETIAPINE**	**MYP**	$	**2.3252**
00002284286	**NOVO-QUETIAPINE**	**TEV**	$	**2.3252**
00002296608	**PMS-QUETIAPINE**	**PMS**	$	**2.3252**
00002311755	**RATIO-QUETIAPINE**	**RPH**	$	**2.3252**
00002314029	**SANDOZ QUETIAPINE**	**SDZ**	$	**2.3252**
00002244107	SEROQUEL	AZC	$	4.1522

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

RISPERIDONE

0.25 MG ORAL TABLET

00002282119	**APO-RISPERIDONE**	**APX**	$	**0.2615**
00002282585	**CO RISPERIDONE**	**COB**	$	**0.2615**
00002282240	**MYLAN-RISPERIDONE**	**MYP**	$	**0.2615**
00002282690	**NOVO-RISPERIDONE**	**TEV**	$	**0.2615**
00002258439	**PHL-RISPERIDONE**	**PHH**	$	**0.2615**
00002252007	**PMS-RISPERIDONE**	**PMS**	$	**0.2615**
00002280906	**RAN-RISPERIDONE**	**RAN**	$	**0.2615**
00002264757	**RATIO-RISPERIDONE**	**RPH**	$	**0.2615**
00002328305	**RBX-RISPERIDONE**	**RAN**	$	**0.2615**
00002332051	**RISPERIDONE**	**RAN**	$	**0.2615**
00002292807	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.2615**
00002303655	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.2615**
00002240551	RISPERDAL	JOI	$	0.5651

0.5 MG ORAL TABLET

00002282127	**APO-RISPERIDONE**	**APX**	$	**0.4379**
00002282593	**CO RISPERIDONE**	**COB**	$	**0.4379**
00002282259	**MYLAN-RISPERIDONE**	**MYP**	$	**0.4379**
00002264188	**NOVO-RISPERIDONE**	**TEV**	$	**0.4379**
00002258447	**PHL-RISPERIDONE**	**PHH**	$	**0.4379**
00002252015	**PMS-RISPERIDONE**	**PMS**	$	**0.4379**
00002280914	**RAN-RISPERIDONE**	**RAN**	$	**0.4379**
00002264765	**RATIO-RISPERIDONE**	**RPH**	$	**0.4379**
00002328313	**RBX-RISPERIDONE**	**RAN**	$	**0.4379**
00002332078	**RISPERIDONE**	**RAN**	$	**0.4379**
00002279495	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.4379**
00002303663	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.4379**
00002240552	RISPERDAL	JOI	$	0.9466

1 MG ORAL TABLET

00002282135	**APO-RISPERIDONE**	**APX**	$	**0.6048**
00002282607	**CO RISPERIDONE**	**COB**	$	**0.6048**
00002282267	**MYLAN-RISPERIDONE**	**MYP**	$	**0.6048**
00002264196	**NOVO-RISPERIDONE**	**TEV**	$	**0.6048**
00002258455	**PHL-RISPERIDONE**	**PHH**	$	**0.6048**
00002252023	**PMS-RISPERIDONE**	**PMS**	$	**0.6048**
00002280922	**RAN-RISPERIDONE**	**RAN**	$	**0.6048**
00002264773	**RATIO-RISPERIDONE**	**RPH**	$	**0.6048**
00002328321	**RBX-RISPERIDONE**	**RAN**	$	**0.6048**
00002332086	**RISPERIDONE**	**RAN**	$	**0.6048**
00002279800	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.6048**
00002025280	RISPERDAL	JOI	$	1.3077

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

RISPERIDONE

2 MG ORAL TABLET				
00002282143	**APO-RISPERIDONE**	**APX**	$	**1.2075**
00002282615	**CO RISPERIDONE**	**COB**	$	**1.2075**
00002282275	**MYLAN-RISPERIDONE**	**MYP**	$	**1.2075**
00002264218	**NOVO-RISPERIDONE**	**TEV**	$	**1.2075**
00002258463	**PHL-RISPERIDONE**	**PHH**	$	**1.2075**
00002252031	**PMS-RISPERIDONE**	**PMS**	$	**1.2075**
00002280930	**RAN-RISPERIDONE**	**RAN**	$	**1.2075**
00002264781	**RATIO-RISPERIDONE**	**RPH**	$	**1.2075**
00002328348	**RBX-RISPERIDONE**	**RAN**	$	**1.2075**
00002332094	**RISPERIDONE**	**RAN**	$	**1.2075**
00002279819	**SANDOZ RISPERIDONE**	**SDZ**	$	**1.2075**
00002025299	RISPERDAL	JOI	$	2.6106
3 MG ORAL TABLET				
00002282151	**APO-RISPERIDONE**	**APX**	$	**1.8113**
00002282623	**CO RISPERIDONE**	**COB**	$	**1.8113**
00002282283	**MYLAN-RISPERIDONE**	**MYP**	$	**1.8113**
00002264226	**NOVO-RISPERIDONE**	**TEV**	$	**1.8113**
00002258471	**PHL-RISPERIDONE**	**PHH**	$	**1.8113**
00002252058	**PMS-RISPERIDONE**	**PMS**	$	**1.8113**
00002280949	**RAN-RISPERIDONE**	**RAN**	$	**1.8113**
00002264803	**RATIO-RISPERIDONE**	**RPH**	$	**1.8113**
00002328364	**RBX-RISPERIDONE**	**RAN**	$	**1.8113**
00002332108	**RISPERIDONE**	**RAN**	$	**1.8113**
00002279827	**SANDOZ RISPERIDONE**	**SDZ**	$	**1.8113**
00002025302	RISPERDAL	JOI	$	3.9162
4 MG ORAL TABLET				
00002282178	**APO-RISPERIDONE**	**APX**	$	**2.4150**
00002282631	**CO RISPERIDONE**	**COB**	$	**2.4150**
00002282291	**MYLAN-RISPERIDONE**	**MYP**	$	**2.4150**
00002264234	**NOVO-RISPERIDONE**	**TEV**	$	**2.4150**
00002258498	**PHL-RISPERIDONE**	**PHH**	$	**2.4150**
00002252066	**PMS-RISPERIDONE**	**PMS**	$	**2.4150**
00002280957	**RAN-RISPERIDONE**	**RAN**	$	**2.4150**
00002264811	**RATIO-RISPERIDONE**	**RPH**	$	**2.4150**
00002328372	**RBX-RISPERIDONE**	**RAN**	$	**2.4150**
00002332116	**RISPERIDONE**	**RAN**	$	**2.4150**
00002279835	**SANDOZ RISPERIDONE**	**SDZ**	$	**2.4150**
00002025310	RISPERDAL	JOI	$	5.2218
0.5 MG ORAL DISINTEGRATING TABLET				
00002247704	RISPERDAL M-TAB	JOI	$	0.8009
1 MG ORAL DISINTEGRATING TABLET				
00002247705	RISPERDAL M-TAB	JOI	$	1.1073
2 MG ORAL DISINTEGRATING TABLET				
00002247706	RISPERDAL M-TAB	JOI	$	2.1903
3 MG ORAL DISINTEGRATING TABLET				
00002268086	RISPERDAL M-TAB	JOI	$	3.2841
4 MG ORAL DISINTEGRATING TABLET				
00002268094	RISPERDAL M-TAB	JOI	$	4.3914

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

RISPERIDONE TARTRATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 years of age and older for the management of the manifestations of schizophrenia and related psychotic disorders, as well as in severe dementia for the short-term symptomatic management of inappropriate behavior due to aggression and/or psychosis.

1 MG / ML (BASE) ORAL SOLUTION				
00002280396	**APO-RISPERIDONE**	**APX**	$	**0.7727**
00002279266	**PMS-RISPERIDONE**	**PMS**	$	**0.7727**
00002236950	RISPERDAL	JOI	$	1.4749

ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE

20 MG (BASE) ORAL CAPSULE				
00002298597	ZELDOX	PFI	$	1.7738
40 MG (BASE) ORAL CAPSULE				
00002298600	ZELDOX	PFI	$	2.0317
60 MG (BASE) ORAL CAPSULE				
00002298619	ZELDOX	PFI	$	2.0317
80 MG (BASE) ORAL CAPSULE				
00002298627	ZELDOX	PFI	$	2.0317

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.08 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(BUTYROPHENONES)

HALOPERIDOL

0.5 MG ORAL TABLET				
00000396796	**APO-HALOPERIDOL**	**APX**	$	**0.0360**
00000363685	**NOVO-PERIDOL**	**TEV**	$	**0.0360**
1 MG ORAL TABLET				
00000396818	**APO-HALOPERIDOL**	**APX**	$	**0.0614**
00000363677	**NOVO-PERIDOL**	**TEV**	$	**0.0614**
2 MG ORAL TABLET				
00000396826	**APO-HALOPERIDOL**	**APX**	$	**0.1050**
00000363669	**NOVO-PERIDOL**	**TEV**	$	**0.1050**
5 MG ORAL TABLET				
00000396834	**APO-HALOPERIDOL**	**APX**	$	**0.1487**
00000363650	**NOVO-PERIDOL**	**TEV**	$	**0.1487**
10 MG ORAL TABLET				
00000463698	**APO-HALOPERIDOL**	**APX**	$	**0.1330**
00000713449	**NOVO-PERIDOL**	**TEV**	$	**0.1330**
20 MG ORAL TABLET				
00000768820	NOVO-PERIDOL	TEV	$	0.6323
5 MG / ML INJECTION				
00000808652	HALOPERIDOL	SDZ	$	4.5178

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.08 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (BUTYROPHENONES)

HALOPERIDOL DECANOATE

50 MG / ML (BASE) INJECTION				
00002130297	HALOPERIDOL LA	SDZ	$	7.3600
100 MG / ML (BASE) INJECTION				
00002130300	HALOPERIDOL LA	SDZ	$	14.7177

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.24 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (PHENOTHIAZINES)

CHLORPROMAZINE HCL

25 MG (BASE) ORAL TABLET				
00000232823	NOVO-CHLORPROMAZINE	TEV	$	0.1734
50 MG (BASE) ORAL TABLET				
00000232807	NOVO-CHLORPROMAZINE	TEV	$	0.1983
100 MG (BASE) ORAL TABLET				
00000232831	NOVO-CHLORPROMAZINE	TEV	$	0.3313
25 MG / ML (BASE) INJECTION				
00000743518	CHLORPROMAZINE HCL	SDZ	$	0.8410

FLUPHENAZINE DECANOATE

25 MG / ML INJECTION				
00002239636	FLUPHENAZINE OMEGA	OMG	$	4.9794
100 MG / ML INJECTION				
00002242570	**FLUPHENAZINE OMEGA**	**OMG**	$	**29.7800**
00000755575	**MODECATE CONCENTRATE**	**BMS**	$	**29.7800**
00002241928	**PMS-FLUPHENAZINE DECANOATE**	**PMS**	$	**29.7800**

FLUPHENAZINE HCL

1 MG ORAL TABLET				
00000405345	APO-FLUPHENAZINE	APX	$	0.1739
2 MG ORAL TABLET				
00000410632	APO-FLUPHENAZINE	APX	$	0.2252
5 MG ORAL TABLET				
00000405361	APO-FLUPHENAZINE	APX	$	0.1720

METHOTRIMEPRAZINE HCL

25 MG / ML (BASE) INJECTION				
00001927698	NOZINAN	SAV	$	3.4400

METHOTRIMEPRAZINE MALEATE

2 MG (BASE) ORAL TABLET				
00002238403	APO-METHOPRAZINE	APX	$	0.0685
5 MG (BASE) ORAL TABLET				
00002238404	APO-METHOPRAZINE	APX	$	0.0991
25 MG (BASE) ORAL TABLET				
00002238405	APO-METHOPRAZINE	APX	$	0.2547

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.24 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (PHENOTHIAZINES)

METHOTRIMEPRAZINE MALEATE

50 MG (BASE) ORAL TABLET				
00002238406	APO-METHOPRAZINE	APX	$	0.3857

PERICYAZINE

5 MG ORAL CAPSULE				
00001926780	NEULEPTIL	ERF	$	0.1987
10 MG ORAL CAPSULE				
00001926772	NEULEPTIL	ERF	$	0.3235
20 MG ORAL CAPSULE				
00001926764	NEULEPTIL	ERF	$	0.4976
10 MG / ML ORAL DROPS				
00001926756	NEULEPTIL	ERF	$	0.3919

PERPHENAZINE

2 MG ORAL TABLET				
00000335134	APO-PERPHENAZINE	APX	$	0.0626
4 MG ORAL TABLET				
00000335126	APO-PERPHENAZINE	APX	$	0.0758
8 MG ORAL TABLET				
00000335118	APO-PERPHENAZINE	APX	$	0.0832
16 MG ORAL TABLET				
00000335096	APO-PERPHENAZINE	APX	$	0.1274

PIPOTIAZINE PALMITATE

25 MG / ML INJECTION				
00001926667	PIPORTIL L4	SAV	$	16.6625
50 MG / ML INJECTION				
00001926675	PIPORTIL L4	SAV	$	53.6425

THIOPROPERAZINE MESYLATE

10 MG (BASE) ORAL TABLET				
00001927639	MAJEPTIL	ERF	$	0.5715

TRIFLUOPERAZINE HCL

1 MG (BASE) ORAL TABLET				
00000345539	APO-TRIFLUOPERAZINE	APX	$	0.1340
2 MG (BASE) ORAL TABLET				
00000312754	APO-TRIFLUOPERAZINE	APX	$	0.1758
5 MG (BASE) ORAL TABLET				
00000312746	APO-TRIFLUOPERAZINE	APX	$	0.2328
10 MG (BASE) ORAL TABLET				
00000326836	APO-TRIFLUOPERAZINE	APX	$	0.2790
20 MG (BASE) ORAL TABLET				
00000595942	APO-TRIFLUOPERAZINE	APX	$	0.5580

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.32 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (THIOXANTHENES)

FLUPENTHIXOL DECANOATE

20 MG / ML INJECTION				
00002156032	FLUANXOL DEPOT	LBC	$	7.5961
100 MG / ML INJECTION				
00002156040	FLUANXOL DEPOT	LBC	$	37.9805

FLUPENTHIXOL DIHYDROCHLORIDE

0.5 MG ORAL TABLET				
00002156008	FLUANXOL	LBC	$	0.2624
3 MG ORAL TABLET				
00002156016	FLUANXOL	LBC	$	0.5667

THIOTHIXENE

2 MG ORAL CAPSULE				
00000024430	NAVANE	ERF	$	0.3342
5 MG ORAL CAPSULE				
00000024449	NAVANE	ERF	$	0.3719
10 MG ORAL CAPSULE				
00000024457	NAVANE	ERF	$	0.4655

ZUCLOPENTHIXOL ACETATE

50 MG / ML INJECTION				
00002230405	CLOPIXOL ACUPHASE	LBC	$	15.7658

ZUCLOPENTHIXOL DECANOATE

200 MG / ML INJECTION				
00002230406	CLOPIXOL DEPOT	LBC	$	15.7658

ZUCLOPENTHIXOL DIHYDROCHLORIDE

10 MG (BASE) ORAL TABLET				
00002230402	CLOPIXOL	LBC	$	0.4054
25 MG (BASE) ORAL TABLET				
00002230403	CLOPIXOL	LBC	$	1.0135

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.92 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (MISCELLANEOUS ANTIPSYCHOTICS)

LOXAPINE HCL

50 MG / ML (BASE) INJECTION				
00002169991	LOXAPAC	SDZ	$	6.7281

LOXAPINE SUCCINATE

2.5 MG (BASE) ORAL TABLET				
00002242868	PMS-LOXAPINE	PMS	$	0.0805
5 MG (BASE) ORAL TABLET				
00002230837	PMS-LOXAPINE	PMS	$	0.1500
10 MG (BASE) ORAL TABLET				
00002230838	PMS-LOXAPINE	PMS	$	0.2498

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.92 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(MISCELLANEOUS ANTIPSYCHOTICS)

LOXAPINE SUCCINATE

25 MG (BASE) ORAL TABLET				
00002230839	PMS-LOXAPINE	PMS	$	0.3872
50 MG (BASE) ORAL TABLET				
00002230840	PMS-LOXAPINE	PMS	$	0.5162

PIMOZIDE

2 MG ORAL TABLET				
00002245432	**APO-PIMOZIDE**	**APX**	$	**0.2279**
00000313815	ORAP	PHH	$	0.2457
4 MG ORAL TABLET				
00002245433	**APO-PIMOZIDE**	**APX**	$	**0.4136**
00000313823	ORAP	PHH	$	0.4459

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:20.04 ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS
(AMPHETAMINES)

DEXTROAMPHETAMINE SULFATE

5 MG ORAL TABLET				
00001924516	DEXEDRINE	PAL	$	0.5899
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00001924559	DEXEDRINE	PAL	$	0.8462
15 MG ORAL SUSTAINED-RELEASE CAPSULE				
00001924567	DEXEDRINE	PAL	$	1.0346

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:20.92 ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS
(MISCELLANEOUS ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS)

METHYLPHENIDATE HCL

5 MG ORAL TABLET				
00002234749	PMS-METHYLPHENIDATE	PMS	$	0.0950
10 MG ORAL TABLET				
00002249324	**APO-METHYLPHENIDATE**	**APX**	$	**0.1590**
00000584991	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.1590**
00000005606	RITALIN	NOV	$	0.3639
20 MG ORAL TABLET				
00002249332	**APO-METHYLPHENIDATE**	**APX**	$	**0.3536**
00000585009	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.3536**
00000005614	RITALIN	NOV	$	0.6358
20 MG ORAL EXTENDED-RELEASE TABLET				
00002266687	**APO-METHYLPHENIDATE SR**	**APX**	$	**0.3564**
00002320312	**SANDOZ METHYLPHENIDATE**	**SDZ**	$	**0.3564**
00000632775	RITALIN SR	NOV	$	0.6383

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.04 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BARBITURATES)

PHENOBARBITAL

15 MG ORAL TABLET				
00000178799	PMS-PHENOBARBITAL	PMS	$	0.0645
30 MG ORAL TABLET				
00000178802	PMS-PHENOBARBITAL	PMS	$	0.0767
60 MG ORAL TABLET				
00000178810	PMS-PHENOBARBITAL	PMS	$	0.1039
100 MG ORAL TABLET				
00000178829	PMS-PHENOBARBITAL	PMS	$	0.1422
5 MG / ML ORAL ELIXIR				
00000645575	PMS-PHENOBARBITAL	PMS	$	0.0860

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BENZODIAZEPINES)

ALPRAZOLAM

0.25 MG ORAL TABLET				
00000865397	**APO-ALPRAZ**	**APX**	$	**0.0760**
00002137534	**MYLAN-ALPRAZOLAM**	**MYP**	$	**0.0760**
00001913484	**NOVO-ALPRAZOL**	**TEV**	$	**0.0760**
00000548359	XANAX	PFI	$	0.2625
0.5 MG ORAL TABLET				
00000865400	**APO-ALPRAZ**	**APX**	$	**0.0920**
00002137542	**MYLAN-ALPRAZOLAM**	**MYP**	$	**0.0920**
00001913492	**NOVO-ALPRAZOL**	**TEV**	$	**0.0920**
00000548367	XANAX	PFI	$	0.3139

BROMAZEPAM

1.5 MG ORAL TABLET				
00002177153	**APO-BROMAZEPAM**	**APX**	$	**0.0693**
00002192705	**GEN-BROMAZEPAM**	**MYP**	$	**0.0693**
3 MG ORAL TABLET				
00002177161	**APO-BROMAZEPAM**	**APX**	$	**0.0882**
00002192713	**GEN-BROMAZEPAM**	**MYP**	$	**0.0882**
00002230584	**NOVO-BROMAZEPAM**	**TEV**	$	**0.0882**
00000518123	LECTOPAM	HLR	$	0.1611
6 MG ORAL TABLET				
00002177188	**APO-BROMAZEPAM**	**APX**	$	**0.1288**
00002192721	**GEN-BROMAZEPAM**	**MYP**	$	**0.1288**
00002230585	**NOVO-BROMAZEPAM**	**TEV**	$	**0.1288**
00000518131	LECTOPAM	HLR	$	0.2354

CHLORDIAZEPOXIDE HCL

5 MG ORAL CAPSULE				
00000522724	APO-CHLORDIAZEPOXIDE	APX	$	0.0679
10 MG ORAL CAPSULE				
00000522988	APO-CHLORDIAZEPOXIDE	APX	$	0.1070
25 MG ORAL CAPSULE				
00000522996	APO-CHLORDIAZEPOXIDE	APX	$	0.1658

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BENZODIAZEPINES)

CHLORDIAZEPOXIDE HCL/ CLIDINIUM BROMIDE

5 MG * 2.5 MG ORAL CAPSULE				
00000618454	**APO-CHLORAX**	**APX**	$	**0.2330**
00000115630	LIBRAX	VCL	$	0.3166

CLORAZEPATE DIPOTASSIUM

3.75 MG ORAL CAPSULE				
00000860689	APO-CLORAZEPATE	APX	$	0.1476
7.5 MG ORAL CAPSULE				
00000860700	APO-CLORAZEPATE	APX	$	0.1926
15 MG ORAL CAPSULE				
00000860697	APO-CLORAZEPATE	APX	$	0.3856

DIAZEPAM

2 MG ORAL TABLET				
00000405329	APO-DIAZEPAM	APX	$	0.0508
5 MG ORAL TABLET				
00000362158	**APO-DIAZEPAM**	**APX**	$	**0.0650**
00000013285	VALIUM	HLR	$	0.1615
10 MG ORAL TABLET				
00000405337	APO-DIAZEPAM	APX	$	0.0867
5 MG / ML INJECTION				
00000399728	DIAZEPAM	SDZ	$	0.6577
5 MG / ML INJECTION EMULSION				
00002065614	DIAZEMULS	PFI	$	1.1729

FLURAZEPAM HCL

15 MG ORAL CAPSULE				
00000521698	APO-FLURAZEPAM	APX	$	0.0810
30 MG ORAL CAPSULE				
00000521701	APO-FLURAZEPAM	APX	$	0.0930

LORAZEPAM

0.5 MG ORAL TABLET				
00000655740	**APO-LORAZEPAM**	**APX**	$	**0.0359**
00000711101	**NOVO-LORAZEM**	**TEV**	$	**0.0359**
00000728187	**PMS-LORAZEPAM**	**PMS**	$	**0.0359**
00002041413	ATIVAN	WAY	$	0.0386
1 MG ORAL TABLET				
00000655759	**APO-LORAZEPAM**	**APX**	$	**0.0447**
00000637742	**NOVO-LORAZEM**	**TEV**	$	**0.0447**
00000728195	**PMS-LORAZEPAM**	**PMS**	$	**0.0447**
00002041421	ATIVAN	WAY	$	0.0481
2 MG ORAL TABLET				
00000655767	**APO-LORAZEPAM**	**APX**	$	**0.0699**
00000637750	**NOVO-LORAZEM**	**TEV**	$	**0.0699**
00000728209	**PMS-LORAZEPAM**	**PMS**	$	**0.0699**
00002041448	ATIVAN	WAY	$	0.0751
0.5 MG ORAL SUBLINGUAL TABLET				
00002041456	ATIVAN	WAY	$	0.1153
1 MG ORAL SUBLINGUAL TABLET				
00002041464	ATIVAN	WAY	$	0.1449

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BENZODIAZEPINES)

LORAZEPAM

2 MG ORAL SUBLINGUAL TABLET

00002041472	ATIVAN	WAY	$	0.2254

MIDAZOLAM HCL

5 MG / ML (BASE) INJECTION

00002240286	MIDAZOLAM	SDZ	$	3.7253

NITRAZEPAM

5 MG ORAL TABLET

00002229654	**NITRAZADON**	**VCL**	$	**0.0731**
00002245230	APO-NITRAZEPAM	APX	$	0.0857
00002234003	SANDOZ NITRAZEPAM	SDZ	$	0.0857
00000511528	MOGADON	VCL	$	0.1535

10 MG ORAL TABLET

00002229655	**NITRAZADON**	**VCL**	$	**0.1093**
00002245231	APO-NITRAZEPAM	APX	$	0.1282
00002234007	SANDOZ NITRAZEPAM	SDZ	$	0.1282
00000511536	MOGADON	VCL	$	0.2297

OXAZEPAM

10 MG ORAL TABLET

00000402680	APO-OXAZEPAM	APX	$	0.0420

15 MG ORAL TABLET

00000402745	APO-OXAZEPAM	APX	$	0.0660

30 MG ORAL TABLET

00000402737	APO-OXAZEPAM	APX	$	0.0900

TEMAZEPAM

15 MG ORAL CAPSULE

00002225964	**APO-TEMAZEPAM**	**APX**	$	**0.1102**
00002244814	**CO TEMAZEPAM**	**COB**	$	**0.1102**
00002230095	**NOVO-TEMAZEPAM**	**TEV**	$	**0.1102**
00002229455	**PMS-TEMAZEPAM**	**PMS**	$	**0.1102**
00002273039	**PMS-TEMAZEPAM**	**PMS**	$	**0.1102**
00002243023	**RATIO-TEMAZEPAM**	**RPH**	$	**0.1102**
00000604453	RESTORIL	SPC	$	0.2049

30 MG ORAL CAPSULE

00002225972	**APO-TEMAZEPAM**	**APX**	$	**0.1326**
00002244815	**CO TEMAZEPAM**	**COB**	$	**0.1326**
00002230102	**NOVO-TEMAZEPAM**	**TEV**	$	**0.1326**
00002229456	**PMS-TEMAZEPAM**	**PMS**	$	**0.1326**
00002273047	**PMS-TEMAZEPAM**	**PMS**	$	**0.1326**
00002243024	**RATIO-TEMAZEPAM**	**RPH**	$	**0.1326**
00000604461	RESTORIL	SPC	$	0.2480

TRIAZOLAM

0.125 MG ORAL TABLET

00000808563	**APO-TRIAZO**	**APX**	$	**0.1181**
00001995227	**MYLAN-TRIAZOLAM**	**MYP**	$	**0.1181**

0.25 MG ORAL TABLET

00000808571	**APO-TRIAZO**	**APX**	$	**0.2086**
00001913506	**MYLAN-TRIAZOLAM**	**MYP**	$	**0.2086**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.92 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS

(MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS)

BUSPIRONE HCL

10 MG ORAL TABLET

00002211076	**APO-BUSPIRONE**	**APX**	$	**0.5957**
00002231492	**NOVO-BUSPIRONE**	**TEV**	$	**0.5957**
00002207672	**NU-BUSPIRONE**	**NXP**	$	**0.5957**
00002230942	**PMS-BUSPIRONE**	**PMS**	$	**0.5957**
00002237858	**RATIO-BUSPIRONE**	**RPH**	$	**0.5957**
00000603821	BUSPAR	BMS	$	1.0669

CHLORAL HYDRATE

100 MG / ML ORAL SYRUP

00000792659	PMS-CHLORAL HYDRATE	PMS	$	0.0434

HYDROXYZINE HCL

10 MG ORAL CAPSULE

00000646059	**APO-HYDROXYZINE**	**APX**	$	**0.1116**
00000738824	**NOVO-HYDROXYZIN**	**TEV**	$	**0.1116**

25 MG ORAL CAPSULE

00000646024	**APO-HYDROXYZINE**	**APX**	$	**0.1425**
00000738832	**NOVO-HYDROXYZIN**	**TEV**	$	**0.1425**

50 MG ORAL CAPSULE

00000646016	**APO-HYDROXYZINE**	**APX**	$	**0.2068**
00000738840	**NOVO-HYDROXYZIN**	**TEV**	$	**0.2068**

2 MG / ML ORAL SYRUP

00000741817	**PMS-HYDROXYZINE**	**PMS**	$	**0.0408**
00000024694	ATARAX	ERF	$	0.0551

50 MG / ML INJECTION

00000742813	HYDROXYZINE HCL	SDZ	$	4.2158

ZOPICLONE

5 MG ORAL TABLET

00002245077	**APO-ZOPICLONE**	**APX**	$	**0.2231**
00002271931	**CO ZOPICLONE**	**COB**	$	**0.2231**
00002296616	**MYLAN-ZOPICLONE**	**MYP**	$	**0.2231**
00002251450	**NOVO-ZOPICLONE**	**TEV**	$	**0.2231**
00002243426	**PMS-ZOPICLONE**	**PMS**	$	**0.2231**
00002267918	**RAN-ZOPICLONE**	**RAN**	$	**0.2231**
00002246534	**RATIO-ZOPICLONE**	**RPH**	$	**0.2231**
00002257572	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.2231**
00002216167	IMOVANE	SAV	$	1.0642

7.5 MG ORAL TABLET

00002218313	**APO-ZOPICLONE**	**APX**	$	**0.4685**
00002271958	**CO ZOPICLONE**	**COB**	$	**0.4685**
00002238596	**MYLAN-ZOPICLONE**	**MYP**	$	**0.4685**
00002251469	**NOVO-ZOPICLONE**	**TEV**	$	**0.4685**
00002228270	**NU-ZOPICLONE**	**NXP**	$	**0.4685**
00002240606	**PMS-ZOPICLONE**	**PMS**	$	**0.4685**
00002267926	**RAN-ZOPICLONE**	**RAN**	$	**0.4685**
00002242481	**RATIO-ZOPICLONE**	**RPH**	$	**0.4685**
00002008203	**RHOVANE**	**SDZ**	$	**0.4685**
00002257580	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.4685**
00001926799	IMOVANE	SAV	$	1.3438

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:28 ANTIMANIC AGENTS

LITHIUM CARBONATE

150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0532**
00002216132	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0532**
00000461733	CARBOLITH	VCL	$	0.1227
150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0532**
00002013231	LITHANE	ERF	$	0.1084
300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0533**
00002216140	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0533**
00000236683	CARBOLITH	VCL	$	0.0952
300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0533**
00000406775	LITHANE	ERF	$	0.1079
600 MG ORAL CAPSULE				
00002216159	PMS-LITHIUM CARBONATE	PMS	$	0.1364

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS (SELECTIVE SEROTONIN AGONISTS)

ALMOTRIPTAN MALATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients.)

6.25 MG (BASE) ORAL TABLET				
00002248128	AXERT	MCL	$	13.9217
12.5 MG (BASE) ORAL TABLET				
00002248129	AXERT	MCL	$	13.9217

NARATRIPTAN HCL

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products in the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients.)

1 MG (BASE) ORAL TABLET				
00002237820	AMERGE	GSK	$	14.9224
2.5 MG (BASE) ORAL TABLET				
00002237821	AMERGE	GSK	$	15.7246

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS (SELECTIVE SEROTONIN AGONISTS)

RIZATRIPTAN BENZOATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients.)

5 MG (BASE) ORAL TABLET				
00002240520	MAXALT	MFC	$	14.7167
10 MG (BASE) ORAL TABLET				
00002240521	MAXALT	MFC	$	14.7167
5 MG (BASE) ORAL WAFER				
00002240518	MAXALT RPD	MFC	$	14.7167
10 MG (BASE) ORAL WAFER				
00002240519	MAXALT RPD	MFC	$	14.7167

SUMATRIPTAN HEMISULFATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients.)

5 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230418	IMITREX	GSK	$	15.1467
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230420	IMITREX	GSK	$	15.5875

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS

(SELECTIVE SEROTONIN AGONISTS)

SUMATRIPTAN SUCCINATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients.)

50 MG (BASE) ORAL TABLET				
00002268388	**APO-SUMATRIPTAN**	**APX**	$	**8.9364**
00002257890	**CO SUMATRIPTAN**	**COB**	$	**8.9364**
00002268914	**MYLAN-SUMATRIPTAN**	**MYP**	$	**8.9364**
00002286823	**NOVO-SUMATRIPTAN DF**	**TEV**	$	**8.9364**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**8.9364**
00002271583	**RATIO-SUMATRIPTAN**	**RPH**	$	**8.9364**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**8.9364**
00002212153	IMITREX DF	GSK	$	15.9579
100 MG (BASE) ORAL TABLET				
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**9.8442**
00002257904	**CO SUMATRIPTAN**	**COB**	$	**9.8442**
00002268922	**MYLAN-SUMATRIPTAN**	**MYP**	$	**9.8442**
00002239367	**NOVO-SUMATRIPTAN**	**TEV**	$	**9.8442**
00002286831	**NOVO-SUMATRIPTAN DF**	**TEV**	$	**9.8442**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**9.8442**
00002271591	**RATIO-SUMATRIPTAN**	**RPH**	$	**9.8442**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**9.8442**
00002212161	IMITREX DF	GSK	$	17.5789
6 MG / SYR (BASE) INJECTION SYRINGE				
00002212188	IMITREX (0.5 ML)	GSK	$	47.3968

ZOLMITRIPTAN

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients.)

2.5 MG ORAL TABLET				
00002238660	ZOMIG	AZC	$	14.3333
2.5 MG ORAL DISPERSIBLE TABLET				
00002243045	ZOMIG RAPIMELT	AZC	$	14.3405
5 MG / DOSE NASAL UNIT DOSE SPRAY				
00002248993	ZOMIG	AZC	$	14.3333

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.92 ANTIMIGRAINE AGENTS
(MISCELLANEOUS ANTIMIGRAINE AGENTS)

PIZOTIFEN MALATE

0.5 MG (BASE) ORAL TABLET				
00000329320	SANDOMIGRAN	PAL	$	0.3699

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.04 ANTIPARKINSONIAN AGENTS
(ADAMANTANES)

AMANTADINE HCL

100 MG ORAL CAPSULE				
00002139200	**MYLAN-AMANTADINE**	**MYP**	$	**0.5179**
00001990403	**PMS-AMANTADINE HYDROCHLORIDE**	**PMS**	$	**0.5179**
10 MG / ML ORAL SYRUP				
00002022826	PMS-AMANTADINE HYDROCHLORIDE	PMS	$	0.0812

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.08 ANTIPARKINSONIAN AGENTS
(ANTICHOLINERGIC AGENTS)

BENZTROPINE MESYLATE

1 MG ORAL TABLET				
00000706531	PMS-BENZTROPINE	PMS	$	0.0219
2 MG ORAL TABLET				
00000587265	**PMS-BENZTROPINE**	**PMS**	$	**0.0450**
00000426857	APO-BENZTROPINE	APX	$	0.0540

ETHOPROPAZINE HCL

50 MG (BASE) ORAL TABLET				
00001927744	PARSITAN	ERF	$	0.2194

PROCYCLIDINE HCL

2.5 MG ORAL TABLET				
00000649392	PMS-PROCYCLIDINE	PMS	$	0.0585
5 MG ORAL TABLET				
00000587354	PMS-PROCYCLIDINE	PMS	$	0.0269
0.5 MG / ML ORAL ELIXIR				
00000587362	PMS-PROCYCLIDINE	PMS	$	0.0329

TRIHEXYPHENIDYL HCL

2 MG ORAL TABLET				
00000545058	APO-TRIHEX	APX	$	0.0369
5 MG ORAL TABLET				
00000545074	APO-TRIHEX	APX	$	0.0668

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.12 ANTIPARKINSONIAN AGENTS (CATECHOL-O-METHYLTRANSFERASE (COMT) INHIBITORS)

ENTACAPONE

200 MG ORAL TABLET

00002243763	COMTAN	NOV	$	1.7242

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.16 ANTIPARKINSONIAN AGENTS (DOPAMINE PRECURSORS)

LEVODOPA/ BENSERAZIDE HCL

50 MG * 12.5 MG (BASE) ORAL CAPSULE

00000522597	PROLOPA 50-12.5	HLR	$	0.2937

100 MG * 25 MG (BASE) ORAL CAPSULE

00000386464	PROLOPA 100-25	HLR	$	0.4835

200 MG * 50 MG (BASE) ORAL CAPSULE

00000386472	PROLOPA 200-50	HLR	$	0.8117

LEVODOPA/ CARBIDOPA

100 MG * 10 MG ORAL TABLET

00002195933	**APO-LEVOCARB**	**APX**	$	**0.2365**
00002244494	**NOVO-LEVOCARBIDOPA**	**TEV**	$	**0.2365**
00002182831	**NU-LEVOCARB**	**NXP**	$	**0.2365**
00000355658	SINEMET 100/10	BMS	$	0.4348

100 MG * 25 MG ORAL TABLET

00002195941	**APO-LEVOCARB**	**APX**	$	**0.3532**
00002244495	**NOVO-LEVOCARBIDOPA**	**TEV**	$	**0.3532**
00002182823	**NU-LEVOCARB**	**NXP**	$	**0.3532**
00000513997	SINEMET 100/25	BMS	$	0.6492

250 MG * 25 MG ORAL TABLET

00002195968	**APO-LEVOCARB**	**APX**	$	**0.3943**
00002244496	**NOVO-LEVOCARBIDOPA**	**TEV**	$	**0.3943**
00002182858	**NU-LEVOCARB**	**NXP**	$	**0.3943**
00000328219	SINEMET 250/25	BMS	$	0.7247

100 MG * 25 MG ORAL SUSTAINED-RELEASE TABLET

00002272873	**APO-LEVOCARB CR**	**APX**	$	**0.5126**
00002028786	SINEMET CR 100/25	BMS	$	0.7040

200 MG * 50 MG ORAL SUSTAINED-RELEASE TABLET

00000870935	SINEMET CR 200/50	BMS	$	1.2987

LEVODOPA/ CARBIDOPA/ ENTACAPONE

50 MG * 12.5 MG * 200 MG ORAL TABLET

00002305933	STALEVO	NOV	$	1.6780

100 MG * 25 MG * 200 MG ORAL TABLET

00002305941	STALEVO	NOV	$	1.6780

150 MG * 37.5 MG * 200 MG ORAL TABLET

00002305968	STALEVO	NOV	$	1.6780

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.20.04 ANTIPARKINSONIAN AGENTS
DOPAMINE RECEPTOR AGONISTS
(ERGOT-DERIVATIVE-DOPAMINE RECEPTOR AGONISTS)

BROMOCRIPTINE MESYLATE

2.5 MG (BASE) ORAL TABLET				
00002087324	**APO-BROMOCRIPTINE**	**APX**	$	**0.5453**
00002231702	**PMS-BROMOCRIPTINE**	**PMS**	$	**0.5453**
5 MG (BASE) ORAL CAPSULE				
00002230454	**APO-BROMOCRIPTINE**	**APX**	$	**0.9711**
00002236949	**PMS-BROMOCRIPTINE**	**PMS**	$	**0.9711**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.20.08 ANTIPARKINSONIAN AGENTS
DOPAMINE RECEPTOR AGONISTS
(NONERGOT-DERIVATIVE DOPAMINE RECEPTOR AGONISTS)

PRAMIPEXOLE DIHYDROCHLORIDE

0.25 MG ORAL TABLET				
00002292378	**APO-PRAMIPEXOLE**	**APX**	$	**0.5887**
00002297302	**CO PRAMIPEXOLE**	**COB**	$	**0.5887**
00002269309	**NOVO-PRAMIPEXOLE**	**TEV**	$	**0.5887**
00002290111	**PMS-PRAMIPEXOLE**	**PMS**	$	**0.5887**
00002315262	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**0.5887**
00002237145	MIRAPEX	BOE	$	1.0513
1 MG ORAL TABLET				
00002292394	**APO-PRAMIPEXOLE**	**APX**	$	**1.1776**
00002297329	**CO PRAMIPEXOLE**	**COB**	$	**1.1776**
00002269325	**NOVO-PRAMIPEXOLE**	**TEV**	$	**1.1776**
00002290146	**PMS-PRAMIPEXOLE**	**PMS**	$	**1.1776**
00002315289	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**1.1776**
00002237146	MIRAPEX	BOE	$	2.1028
1.5 MG ORAL TABLET				
00002292408	**APO-PRAMIPEXOLE**	**APX**	$	**1.1776**
00002297337	**CO PRAMIPEXOLE**	**COB**	$	**1.1776**
00002269333	**NOVO-PRAMIPEXOLE**	**TEV**	$	**1.1776**
00002290154	**PMS-PRAMIPEXOLE**	**PMS**	$	**1.1776**
00002315297	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**1.1776**
00002237147	MIRAPEX	BOE	$	2.1028

ROPINIROLE HCL

0.25 MG (BASE) ORAL TABLET				
00002316846	**CO ROPINIROLE**	**COB**	$	**0.1419**
00002326590	**PMS-ROPINIROLE**	**PMS**	$	**0.1419**
00002314037	**RAN-ROPINIROLE**	**RAN**	$	**0.1419**
00002332361	**ROPINIROLE**	**RAN**	$	**0.1419**
00002232565	REQUIP	GSK	$	0.3051
1 MG (BASE) ORAL TABLET				
00002316854	**CO ROPINIROLE**	**COB**	$	**0.5676**
00002326612	**PMS-ROPINIROLE**	**PMS**	$	**0.5676**
00002314053	**RAN-ROPINIROLE**	**RAN**	$	**0.5676**
00002332426	**ROPINIROLE**	**RAN**	$	**0.5676**
00002232567	REQUIP	GSK	$	1.2204

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.20.08 ANTIPARKINSONIAN AGENTS
DOPAMINE RECEPTOR AGONISTS
(NONERGOT-DERIVATIVE DOPAMINE RECEPTOR AGONISTS)

ROPINIROLE HCL

2 MG (BASE) ORAL TABLET				
00002316862	**CO ROPINIROLE**	**COB**	$	**0.6244**
00002326620	**PMS-ROPINIROLE**	**PMS**	$	**0.6244**
00002314061	**RAN-ROPINIROLE**	**RAN**	$	**0.6244**
00002332434	**ROPINIROLE**	**RAN**	$	**0.6244**
00002232568	REQUIP	GSK	$	1.3426
5 MG (BASE) ORAL TABLET				
00002316870	**CO ROPINIROLE**	**COB**	$	**1.7192**
00002326639	**PMS-ROPINIROLE**	**PMS**	$	**1.7192**
00002314088	**RAN-ROPINIROLE**	**RAN**	$	**1.7192**
00002332442	**ROPINIROLE**	**RAN**	$	**1.7192**
00002232569	REQUIP	GSK	$	3.6963

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.32 ANTIPARKINSONIAN AGENTS
(MONOAMINE OXIDASE B INHIBITORS)

SELEGILINE HCL

5 MG ORAL TABLET				
00002238102	**PMS-SELEGILINE**	**PMS**	$	**1.2092**
00002230641	APO-SELEGILINE	APX	$	1.2650
00002231036	MYLAN-SELEGILINE	MYP	$	1.2650
00002068087	NOVO-SELEGILINE	TEV	$	1.2650
00002230717	NU-SELEGILINE	NXP	$	1.2650

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:92 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

PIZOTIFEN MALATE

1 MG (BASE) ORAL TABLET				
00000511552	SANDOMIGRAN DS	PAL	$	0.6142

34:00

Dental Agents

34:00 DENTAL AGENTS

34:00

SODIUM FLUORIDE

2.21 MG ORAL CHEWABLE TABLET				
00000575569	FLUOR-A-DAY	PMS	$	0.0916
5.56 MG / ML ORAL DROPS				
00000610100	FLUOR-A-DAY	PMS	$	0.1831

40:00

Electrolytic, Caloric, and Water Balance

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:10 AMMONIA DETOXICANTS

LACTULOSE

667 MG / ML ORAL SYRUP

00002242814	**APO-LACTULOSE**	**APX**	$	**0.0145**
00002295881	**JAMP-LACTULOSE**	**JPC**	$	**0.0145**
00000703486	**PMS-LACTULOSE**	**PMS**	$	**0.0145**
00000854409	**RATIO-LACTULOSE**	**RPH**	$	**0.0145**

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:12 REPLACEMENT PREPARATIONS

MAGNESIUM GLUCOHEPTONATE

100 MG / ML ORAL SOLUTION

00000026697	ROUGIER MAGNESIUM	ROG	$	0.0200

MAGNESIUM GLUCONATE

500 MG ORAL TABLET

00000555126	MAGLUCATE	PMS	$	0.1231

POTASSIUM CHLORIDE (K+)

8 MEQ ORAL SUSTAINED-RELEASE TABLET

☒ 00000602884	APO-K	APX		$	0.0899
☒ 00000074225	SLOW K	NOV	***$ 0.0899***	$	0.1516

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release tablet: APO-K.

20 MEQ ORAL SUSTAINED-RELEASE TABLET

00000713376	K-DUR	SCH	$	0.1995

8 MEQ ORAL SUSTAINED-RELEASE CAPSULE

00002042304	MICRO-K EXTENCAPS	PAL	$	0.0930

POTASSIUM CHLORIDE (K+)(CL-)

1.33 MEQ / ML ORAL LIQUID

00002238604	**PMS - POTASSIUM CHLORIDE**	**PMS**	$	**0.0131**
00001918303	K-10 ORAL LIQUID	GSK	$	0.0166

POTASSIUM CITRATE (K+)

25 MEQ ORAL EFFERVESCENT TABLET

00002085992	K-LYTE	WSP	$	0.5550

SODIUM ACID PHOSPHATE/ SODIUM BICARBONATE/ POTASSIUM BICARBONATE

500 MG (BASE) * 469 MG (BASE) * 123 MG (BASE) ORAL EFFERVESCENT TABLET

00000225819	PHOSPHATE-NOVARTIS	NOV	$	0.7052

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:18.18 ION-REMOVING AGENTS (POTASSIUM-REMOVING AGENTS)

CALCIUM POLYSTYRENE SULPHONATE

ORAL POWDER

00002017741	RESONIUM CALCIUM	SAV	$	0.3650

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:18.18 ION-REMOVING AGENTS (POTASSIUM-REMOVING AGENTS)

SODIUM POLYSTYRENE SULFONATE

250 MG / ML ORAL SUSPENSION				
00000769541	PMS-SODIUM POLYSTYRENE SULF.	PMS	$	0.1247
ORAL POWDER				
00000755338	**PMS-SODIUM POLYSTYRENE SULF.**	**PMS**	$	**0.1460**
00002026961	KAYEXALATE	SAV	$	0.1889
30 G / ENM RECTAL RETENTION ENEMA				
00000769533	PMS-SOD POLYSTYR SULF (120 ML)	PMS	$	14.6639

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.16 DIURETICS (POTASSIUM-SPARING DIURETICS)

AMILORIDE HCL

5 MG ORAL TABLET				
00002249510	APO-AMILORIDE	APX	$	0.2717

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.20 DIURETICS (THIAZIDE DIURETICS)

HYDROCHLOROTHIAZIDE

25 MG ORAL TABLET				
00000326844	**APO-HYDRO**	**APX**	$	**0.0395**
00000021474	**NOVO-HYDRAZIDE**	**TEV**	$	**0.0395**
50 MG ORAL TABLET				
00000312800	**APO-HYDRO**	**APX**	$	**0.0551**
00000021482	**NOVO-HYDRAZIDE**	**TEV**	$	**0.0551**
100 MG ORAL TABLET				
00000644552	APO-HYDRO	APX	$	0.1232

HYDROCHLOROTHIAZIDE/ AMILORIDE HCL

50 MG * 5 MG ORAL TABLET				
00000784400	**APO-AMILZIDE**	**APX**	$	**0.1917**
00002257378	**MYLAN-AMILAZIDE**	**MYP**	$	**0.1917**
00001937219	**NOVAMILOR**	**TEV**	$	**0.1917**
00000886106	**NU-AMILZIDE**	**NXP**	$	**0.1917**

HYDROCHLOROTHIAZIDE/ TRIAMTERENE

25 MG * 50 MG ORAL TABLET				
00000441775	**APO-TRIAZIDE**	**APX**	$	**0.0608**
00000532657	**NOVO-TRIAMZIDE**	**TEV**	$	**0.0608**
00000865532	**NU-TRIAZIDE**	**NXP**	$	**0.0608**

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.24 DIURETICS

(THIAZIDE-LIKE DIURETICS)

CHLORTHALIDONE

50 MG ORAL TABLET

00000360279	APO-CHLORTHALIDONE	APX	$	0.1242

INDAPAMIDE HEMIHYDRATE

1.25 MG (BASE) ORAL TABLET

00002239619	**PMS-INDAPAMIDE**	**PMS**	$	**0.1668**
00002245246	APO-INDAPAMIDE	APX	$	0.1877
00002240067	MYLAN-INDAPAMIDE	MYP	$	0.1877

2.5 MG (BASE) ORAL TABLET

00002223678	**APO-INDAPAMIDE**	**APX**	$	**0.2933**
00002153483	**MYLAN-INDAPAMIDE**	**MYP**	$	**0.2933**
00002231184	**NOVO-INDAPAMIDE**	**TEV**	$	**0.2933**
00002223597	**NU-INDAPAMIDE**	**NXP**	$	**0.2933**
00002239620	**PMS-INDAPAMIDE**	**PMS**	$	**0.2933**
00000564966	LOZIDE	SEV	$	0.5238

METOLAZONE

2.5 MG ORAL TABLET

00000888400	ZAROXOLYN	SAV	$	0.2005

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:40 URICOSURIC AGENTS

PROBENECID

500 MG ORAL TABLET

00000294926	BENURYL	VCL	$	0.2025

SULFINPYRAZONE

200 MG ORAL TABLET

00000441767	**APO-SULFINPYRAZONE**	**APX**	$	**0.2997**
00002045699	**NU-SULFINPYRAZONE**	**NXP**	$	**0.2997**

48:00

Respiratory Tract Agents

48:00 RESPIRATORY TRACT AGENTS

48:10.24 ANTI-INFLAMMATORY AGENTS (LEUKOTRIENE MODIFIERS)

MONTELUKAST SODIUM

10 MG (BASE) ORAL TABLET

00002238217	SINGULAIR	MFC	$	2.3413

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients).

4 MG (BASE) ORAL CHEWABLE TABLET

00002243602	SINGULAIR	MFC	$	1.4410

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

5 MG (BASE) ORAL CHEWABLE TABLET

00002238216	SINGULAIR	MFC	$	1.5910

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients).

4 MG (BASE) ORAL GRANULE

00002247997	SINGULAIR	MFC	$	1.4410

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

ZAFIRLUKAST

RESTRICTED BENEFIT - This product is a benefit for patients 12 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to the Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment and Immigration Drug Benefit Supplement for eligibility in Alberta Employment and Immigration, Alberta Children and Youth Services and Alberta Seniors and Community Supports (AISH) clients).

20 MG ORAL TABLET

00002236606	ACCOLATE	AZC	$	0.7749

48:00 RESPIRATORY TRACT AGENTS

48:10.32 ANTI-INFLAMMATORY AGENTS (MAST-CELL STABILIZERS)

SODIUM CROMOGLYCATE

100 MG ORAL CAPSULE

00000500895	NALCROM	SAV	$	1.4694

1 % INHALATION SOLUTION

00002046113	PMS-SODIUM CROMOGLYCATE	PMS	$	0.2552

48:00 RESPIRATORY TRACT AGENTS

48:24 MUCOLYTIC AGENTS

ACETYLCYSTEINE

20 % INHALATION SOLUTION

00002243098	**ACETYLCYSTEINE**	**SDZ**	$	**0.6450**
00002091526	MUCOMYST	WSP	$	0.7200

52:00

Eye, Ear, Nose and Throat (EENT) Preparations

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:04.04 ANTI-INFECTIVES (ANTIBACTERIALS)

CIPROFLOXACIN HCL

0.3 % (BASE) OPHTHALMIC SOLUTION

00002263130	**APO-CIPROFLOX**	**APX**	$	**1.1280**
00002253933	**PMS-CIPROFLOXACIN**	**PMS**	$	**1.1280**
00001945270	CILOXAN	ALC	$	2.0855

ERYTHROMYCIN

0.5 % OPHTHALMIC OINTMENT

00001912755	PMS-ERYTHROMYCIN	PMS	$	1.2380

GENTAMICIN SULFATE

0.3 % (BASE) OPHTHALMIC SOLUTION

00000512192	**GARAMYCIN**	**SCH**	$	**0.4060**
00002229440	**SANDOZ GENTAMICIN SULFATE**	**SDZ**	$	**0.4060**

0.3 % (BASE) OPHTHALMIC OINTMENT

00000028339	**GARAMYCIN**	**SCH**	$	**1.1429**
00002230888	**SANDOZ GENTAMICIN SULFATE**	**SDZ**	$	**1.1429**

0.3 % (BASE) OTIC SOLUTION

00000512184	GARAMYCIN	SCH	$	1.0320

NEOMYCIN SULFATE/ POLYMYXIN B SULFATE/ GRAMICIDIN

0.25 % * 10,000 UNIT / ML * 0.03 MG / ML OTIC/OPHTHALMIC SOLUTION

00000807435	OPTIMYXIN PLUS	SDZ	$	0.7817

OFLOXACIN

0.3 % OPHTHALMIC SOLUTION

00002248398	**APO-OFLOXACIN**	**APX**	$	**0.9920**
00002252570	**PMS-OFLOXACIN**	**PMS**	$	**0.9920**
00002143291	OCUFLOX	ALL	$	2.6295

TOBRAMYCIN

0.3 % OPHTHALMIC SOLUTION

00002239577	**PMS-TOBRAMYCIN**	**PMS**	$	**1.0029**
00002241755	**SANDOZ TOBRAMYCIN**	**SDZ**	$	**1.0029**
00000513962	TOBREX	ALC	$	1.7909

0.3 % OPHTHALMIC OINTMENT

00000614254	TOBREX	ALC	$	2.5400

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:04.20 ANTI-INFECTIVES (ANTIVIRALS)

TRIFLURIDINE

1 % OPHTHALMIC SOLUTION

00002248529	SANDOZ TRIFLURIDINE	SDZ	$	3.2520

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08 ANTI-INFLAMMATORY AGENTS (CORTICOSTEROIDS)

BECLOMETHASONE DIPROPIONATE

50 MCG / DOSE NASAL METERED DOSE SPRAY

00002238796	**APO-BECLOMETHASONE**	**APX**	$	**0.0613**
00002172712	**MYLAN-BECLO AQ.**	**MYP**	$	**0.0613**
00002238577	**NU-BECLOMETHASONE**	**NXP**	$	**0.0613**

BUDESONIDE

100 MCG / DOSE NASAL METERED DOSE AEROSOL

00002035324	RHINOCORT TURBUHALER	AZC	$	0.1220

100 MCG / DOSE NASAL METERED DOSE SPRAY

00002230648	MYLAN-BUDESONIDE AQ	MYP	$	0.0961

CIPROFLOXACIN HCL/ DEXAMETHASONE

0.3 % * 0.1 % OTIC SUSPENSION

00002252716	CIPRODEX	ALC	$	3.6120

DEXAMETHASONE

0.1 % OPHTHALMIC SUSPENSION

00000042560	MAXIDEX	ALC	$	1.6555

0.1 % OPHTHALMIC OINTMENT

00000042579	MAXIDEX	ALC	$	2.5646

DEXAMETHASONE SODIUM PHOSPHATE

0.1 % OTIC/OPHTHALMIC SOLUTION

00000739839	SANDOZ DEXAMETHASONE SOD. PHOSPHATE	SDZ	$	1.3133

FLUNISOLIDE

0.025 % NASAL SPRAY

00002239288	APO-FLUNISOLIDE	APX	$	0.5940

FLUOROMETHOLONE

0.1 % OPHTHALMIC SUSPENSION

00002238568	PMS-FLUOROMETHOLONE	PMS	$	1.6500

0.25 % OPHTHALMIC SUSPENSION

00000707511	FML FORTE	ALL	$	2.8229

FLUOROMETHOLONE ACETATE

0.1 % OPHTHALMIC SUSPENSION

00000756784	FLAREX	ALC	$	1.8705

HYDROCORTISONE ACETATE

2.5 % OPHTHALMIC OINTMENT

00001980661	CORTAMED	SDZ	$	5.4127

MOMETASONE FUROATE

50 MCG / DOSE NASAL METERED DOSE SPRAY

00002238465	NASONEX	SCH	$	0.2021

RESTRICTED BENEFIT - This product is a benefit for patients 3 to 12 years of age inclusive for the treatment of seasonal allergic rhinitis or perennial allergic rhinitis.

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08 ANTI-INFLAMMATORY AGENTS (CORTICOSTEROIDS)

PREDNISOLONE ACETATE

0.12 % OPHTHALMIC SUSPENSION				
00001916181	**SANDOZ PREDNISOLONE ACETATE**	**SDZ**	$	**1.2650**
00000299405	PRED MILD	ALL	$	1.9307
1 % OPHTHALMIC SUSPENSION				
00000700401	**RATIO-PREDNISOLONE**	**RPH**	$	**1.9400**
00001916203	**SANDOZ PREDNISOLONE ACETATE**	**SDZ**	$	**1.9400**
00000301175	PRED FORTE	ALL	$	5.6846

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08.00 ANTI-INFLAMMATORY AGENTS CORTICOSTEROIDS (COMBINATION ANTI-INFECTIVE/CORTICOSTEROID AGENTS)

BETAMETHASONE SODIUM PHOSPHATE/ GENTAMICIN SULFATE

0.1 % (BASE) * 0.3 % (BASE) OTIC/OPHTHALMIC SOLUTION				
00000682217	**GARASONE**	**SCH**	$	**1.2813**
00002244999	**SANDOZ PENTASONE**	**SDZ**	$	**1.2813**

DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN

0.5 MG / ML * 5 MG / ML * 0.05 MG / ML OTIC/OPHTHALMIC SOLUTION				
00002247920	**SANDOZ OPTICORT**	**SDZ**	$	**1.3000**
00002224623	SOFRACORT	SAV	$	1.9215

DEXAMETHASONE/ NEOMYCIN SULFATE/ POLYMYXIN B SULFATE

1 MG / ML * 3.5 MG / ML (BASE) * 6,000 UNIT / ML OPHTHALMIC SUSPENSION				
00000042676	MAXITROL	ALC	$	2.0468
1 MG / G * 3.5 MG / G (BASE) * 6,000 UNIT / G OPHTHALMIC OINTMENT				
00000358177	MAXITROL	ALC	$	2.8533

DEXAMETHASONE/ TOBRAMYCIN

0.1 % * 0.3 % OPHTHALMIC SUSPENSION				
00000778907	TOBRADEX	ALC	$	2.1156
0.1 % * 0.3 % OPHTHALMIC OINTMENT				
00000778915	TOBRADEX	ALC	$	3.1328

FLUMETHASONE PIVALATE/ CLIOQUINOL

0.02 % * 1 % OTIC SOLUTION				
00000074454	LOCACORTEN VIOFORM	PAL	$	1.4120

PREDNISOLONE ACETATE/ SULFACETAMIDE SODIUM

0.2 % * 10 % OPHTHALMIC SUSPENSION				
00000807788	BLEPHAMIDE	ALL	$	2.8620
0.2 % * 10 % OPHTHALMIC OINTMENT				
00000307246	BLEPHAMIDE S.O.P.	ALL	$	3.6611

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.20 ANTI-INFLAMMATORY AGENTS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM

0.1 % OPHTHALMIC SOLUTION

00001940414	VOLTAREN OPHTHA	NOV	$	2.6080

KETOROLAC TROMETHAMINE

0.5 % OPHTHALMIC SOLUTION

00002245821	**APO-KETOROLAC**	**APX**	$	**2.0160**
00002247461	**RATIO-KETOROLAC**	**RPH**	$	**2.0160**
00001968300	ACULAR	ALL	$	3.6120

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:16 LOCAL ANESTHETICS

LIDOCAINE HCL

2 % ORAL LIQUID

00001968823	**LIDODAN VISCOUS**	**ODN**	$	**0.0542**
00000001686	XYLOCAINE VISCOUS	AZC	$	0.0967

PROPARACAINE HCL

0.5 % OPHTHALMIC SOLUTION

00000035076	ALCAINE	ALC	$	0.6450

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:24 MYDRIATICS

ATROPINE SULFATE

1 % OPHTHALMIC SOLUTION

00000035017	ISOPTO ATROPINE	ALC	$	0.6450

CYCLOPENTOLATE HCL

1 % OPHTHALMIC SOLUTION

00000252506	CYCLOGYL	ALC	$	0.8671

HOMATROPINE HYDROBROMIDE

2 % OPHTHALMIC SOLUTION

00000000779	ISOPTO HOMATROPINE	ALC	$	0.6557

5 % OPHTHALMIC SOLUTION

00000000787	ISOPTO HOMATROPINE	ALC	$	0.7811

TROPICAMIDE

0.5 % OPHTHALMIC SOLUTION

00000000981	MYDRIACYL	ALC	$	0.8993

1 % OPHTHALMIC SOLUTION

00000001007	MYDRIACYL	ALC	$	1.1573

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:28 MOUTHWASHES AND GARGLES

BENZYDAMINE HCL

0.15 % ORAL RINSE

00002239044	APO-BENZYDAMINE	APX	$	0.0218

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:28 MOUTHWASHES AND GARGLES

COMPOUND PRESCRIPTION

00000999109	**COMPOUND-CHLOR MOUTH RINSE (IN ANY CONCENTRATION)**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999209	**COMPOUND-CHLOR MOUTH RINSE (IN ANY CONCENTRATION)**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:32 VASOCONSTRICTORS

EPINEPHRINE HCL

1 MG / ML TOPICAL SOLUTION

00000155365	ADRENALIN	ERF	$	0.5844

PHENYLEPHRINE HCL

2.5 % OPHTHALMIC SOLUTION

00000465763	MYDFRIN	ALC	$	1.0427

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.04 ANTIGLAUCOMA AGENTS (ALPHA-ADRENERGIC AGONISTS)

BRIMONIDINE TARTRATE

0.2 % OPHTHALMIC SOLUTION

00002260077	**APO-BRIMONIDINE**	**APX**	$	**1.9869**
00002246284	**PMS-BRIMONIDINE**	**PMS**	$	**1.9869**
00002243026	**RATIO-BRIMONIDINE**	**RPH**	$	**1.9869**
00002305429	**SANDOZ BRIMONIDINE**	**SDZ**	$	**1.9869**
00002236876	ALPHAGAN	ALL	$	3.5480

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.08 ANTIGLAUCOMA AGENTS (BETA-ADRENERGIC AGENTS)

BETAXOLOL HCL

0.5 % (BASE) OPHTHALMIC SOLUTION

00002235971	SANDOZ BETAXOLOL	SDZ	$	1.8220

0.25 % (BASE) OPHTHALMIC SUSPENSION

00001908448	BETOPTIC S	ALC	$	2.4230

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.08 ANTIGLAUCOMA AGENTS (BETA-ADRENERGIC AGENTS)

LEVOBUNOLOL HCL

0.25 % OPHTHALMIC SOLUTION				
00002031159	**RATIO-LEVOBUNOLOL**	**RPH**	$	**1.1760**
00002241715	**SANDOZ LEVOBUNOLOL**	**SDZ**	$	**1.1760**
0.5 % OPHTHALMIC SOLUTION				
00002237991	**PMS-LEVOBUNOLOL**	**PMS**	$	**1.5550**
00002031167	**RATIO-LEVOBUNOLOL**	**RPH**	$	**1.5550**
00002241716	**SANDOZ LEVOBUNOLOL**	**SDZ**	$	**1.5550**
00000637661	BETAGAN	ALL	$	3.5368

TIMOLOL MALEATE

0.25 % (BASE) OPHTHALMIC SOLUTION				
00002083353	**PMS-TIMOLOL**	**PMS**	$	**1.4314**
00000755826	APO-TIMOP	APX	$	1.5500
00000893773	MYLAN-TIMOLOL	MYP	$	1.5500
00002166712	SANDOZ TIMOLOL MALEATE	SDZ	$	1.5500
0.5 % (BASE) OPHTHALMIC SOLUTION				
00000755834	**APO-TIMOP**	**APX**	$	**1.8600**
00000893781	**MYLAN-TIMOLOL**	**MYP**	$	**1.8600**
00002083345	**PMS-TIMOLOL**	**PMS**	$	**1.8600**
00002166720	**SANDOZ TIMOLOL MALEATE**	**SDZ**	$	**1.8600**
00000451207	TIMOPTIC	MFC	$	3.4700
0.25 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION				
00002171880	TIMOPTIC-XE	MFC	$	3.7040
0.5 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION				
00002171899	TIMOPTIC-XE	MFC	$	4.4320

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.12 ANTIGLAUCOMA AGENTS (CARBONIC ANHYDRASE INHIBITORS)

ACETAZOLAMIDE

250 MG ORAL TABLET				
00000545015	APO-ACETAZOLAMIDE	APX	$	0.1237

BRINZOLAMIDE

1 % OPHTHALMIC SUSPENSION				
00002238873	AZOPT	ALC	$	3.4615

DORZOLAMIDE HCL

2 % (BASE) OPHTHALMIC SOLUTION				
☒ 00002216205	TRUSOPT	MFC	$	3.7500
☒ 00002269090	TRUSOPT (PRESERVATIVE-FREE)	MFC	$	3.7550

METHAZOLAMIDE

50 MG ORAL TABLET				
00002245882	APO-METHAZOLAMIDE	APX	$	0.4817

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.20 ANTIGLAUCOMA AGENTS (MIOTICS)

CARBACHOL

1.5 % OPHTHALMIC SOLUTION				
00000000655	ISOPTO CARBACHOL	ALC	$	0.7238
3 % OPHTHALMIC SOLUTION				
00000000663	ISOPTO CARBACHOL	ALC	$	0.8707

PILOCARPINE HCL

1 % OPHTHALMIC SOLUTION				
00000000841	ISOPTO CARPINE	ALC	$	0.2199
2 % OPHTHALMIC SOLUTION				
00000000868	ISOPTO CARPINE	ALC	$	0.2537
4 % OPHTHALMIC SOLUTION				
00000000884	ISOPTO CARPINE	ALC	$	0.2866
4 % OPHTHALMIC GEL				
00000575240	PILOPINE HS	ALC	$	2.6854

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.28 ANTIGLAUCOMA AGENTS (PROSTAGLANDIN ANALOGS)

BIMATOPROST

0.03 % OPHTHALMIC SOLUTION				
00002245860	LUMIGAN	ALL	$	11.6272

LATANOPROST

0.005 % OPHTHALMIC SOLUTION				
00002231493	XALATAN	PFI	$	11.6272

TRAVOPROST

0.004 % OPHTHALMIC SOLUTION				
00002244896	**TRAVATAN**	**ALC**	$	**11.6272**
00002318008	**TRAVATAN Z**	**ALC**	$	**11.6272**

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.92 ANTIGLAUCOMA AGENTS (MISCELLANEOUS ANTIGLAUCOMA AGENTS)

BRIMONIDINE TARTRATE/ TIMOLOL MALEATE

0.2 % * 0.5 % (BASE) OPHTHALMIC SOLUTION				
00002248347	COMBIGAN	ALL	$	4.3129

DORZOLAMIDE HCL/ TIMOLOL MALEATE

2 % (BASE) * 0.5 % (BASE) OPHTHALMIC SOLUTION				
☒ 00002258692	COSOPT PRESERVATIVE-FREE	MFC	$	4.8792
☒ 00002240113	COSOPT	MFC	$	5.6820

LATANOPROST/ TIMOLOL MALEATE

0.005 % * 0.5 % (BASE) OPHTHALMIC SOLUTION				
00002246619	XALACOM	PFI	$	13.1580

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.92 ANTIGLAUCOMA AGENTS
(MISCELLANEOUS ANTIGLAUCOMA AGENTS)

TRAVOPROST/ TIMOLOL MALEATE

0.004 % * 0.5 % (BASE)	OPHTHALMIC	SOLUTION		
00002278251	DUO TRAV		ALC	$ 13.1580

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

APRACLONIDINE HCL

0.5 %	OPHTHALMIC	SOLUTION		
00002076306	IOPIDINE		ALC	$ 4.5730

RANIBIZUMAB

RESTRICTED BENEFIT - This product is a benefit when prescribed by a registered prescriber conditional to the following criteria.

"For the treatment of neovascular (wet) age-related macular degeneration (AMD) if all of the following circumstances apply to the eye to be treated:
- The best corrected visual acuity (BCVA) is between 6/12 (20/40) and 6/96 (20/320)
- There is active disease activity (choroidal neovascularization) and no permanent structural damage to the central fovea
- The lesion size is less than or equal to 12 disc areas in greatest linear dimension
- There is evidence of recent (< 3 months) presumed disease progression (blood vessel growth, as indicated by fluoroscein angiography, optical coherence tomography (OCT) or recent visual acuity changes)
- No concurrent verteporfin PDT treatment
- Injection will be by a qualified ophthalmologist with experience in intravitreal injections.

The interval between the doses should be no shorter than one month.

Treatment with ranibizumab should be continued only in people who maintain adequate response to therapy.

Ranibizumab should be discontinued if any one of the following occur:
- Reduction in BCVA in the treated eye to less than 15 letters (absolute) on 2 consecutive visits in the treated eye, attributed to AMD in the absence of other pathology,
- Reduction in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect or adverse event or both.
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three consecutive visits."

2.3 MG / VIAL	INJECTION			
00002296810	LUCENTIS		NOV	$ 1693.1250
For this product - pricing has been established on a per vial basis.				

56:00

Gastrointestinal Drugs

56:00 GASTROINTESTINAL DRUGS

56:08 ANTIDIARRHEA AGENTS

DIPHENOXYLATE HCL/ ATROPINE SULFATE

2.5 MG * 0.025 MG ORAL TABLET				
00000036323	LOMOTIL	PFI	$	0.4699

56:00 GASTROINTESTINAL DRUGS

56:14 CHOLELITHOLYTIC AGENTS

URSODIOL

250 MG ORAL TABLET				
00002273497	**PMS-URSODIOL C**	**PMS**	$	**0.8808**
00002238984	URSO	AXC	$	1.3544
500 MG ORAL TABLET				
00002273500	**PMS-URSODIOL C**	**PMS**	$	**1.6708**
00002245894	URSO DS	AXC	$	2.5689

56:00 GASTROINTESTINAL DRUGS

56:16 DIGESTANTS

LIPASE/ AMYLASE/ PROTEASE

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL TABLET				
00002230019	VIOKASE	AXC	$	0.2288
16,000 UNIT * 60,000 UNIT * 60,000 UNIT ORAL TABLET				
00002241933	VIOKASE 16	AXC	$	0.3511
8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE				
00000263818	COTAZYM	ORG	$	0.2530
4,000 UNIT * 12,000 UNIT * 12,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000789445	PANCREASE MT 4	JOI	$	0.4675
4,500 UNIT * 20,000 UNIT * 25,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00002203324	ULTRASE MS4 MICROSPHERES	AXC	$	0.2239
8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000502790	COTAZYM ECS 8	ORG	$	0.3475
10,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000789437	PANCREASE MT 10	JOI	$	1.1683
10,000 UNIT * 33,200 UNIT * 37,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00002200104	CREON 10 MINIMICROSPHERES	SLO	$	0.2927
12,000 UNIT * 39,000 UNIT * 39,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00002045834	ULTRASE MT12 MINITABLETS	AXC	$	0.4381
16,000 UNIT * 48,000 UNIT * 48,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000789429	PANCREASE MT 16	JOI	$	1.8692
20,000 UNIT * 55,000 UNIT * 55,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000821373	COTAZYM ECS 20	ORG	$	0.8975
20,000 UNIT * 65,000 UNIT * 65,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00002045869	ULTRASE MT20 MINITABLETS	AXC	$	0.7592
25,000 UNIT * 74,000 UNIT * 62,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)				
00001985205	CREON 25 MINIMICROSPHERES	SLO	$	0.9145

LIPASE/ AMYLASE/ PROTEASE/ BILE SALTS/ CELLULASE

8,000 UNIT * 30,000 UNIT * 30,000 UNIT * 65 MG * 2 MG ORAL CAPSULE				
00000456233	COTAZYM-65 B	ORG	$	0.3300

56:00 GASTROINTESTINAL DRUGS

56:22.08 ANTIEMETICS (ANTIHISTAMINES)

DIMENHYDRINATE

10 MG / ML INJECTION				
00000392731	DIMENHYDRINATE I.V.	SDZ	$	0.3063
50 MG / ML INJECTION				
00000392537	DIMENHYDRINATE I.M.	SDZ	$	1.1213

MECLIZINE HCL

25 MG ORAL CHEWABLE TABLET				
00000220442	BONAMINE	JJM	$	0.3138

PROCHLORPERAZINE

5 MG ORAL TABLET				
00000886440	APO-PROCHLORAZINE	APX	$	0.1659
10 MG ORAL TABLET				
00000886432	APO-PROCHLORAZINE	APX	$	0.2025
5 MG / ML INJECTION				
00000789747	PROCHLORPERAZINE	SDZ	$	0.8680
10 MG RECTAL SUPPOSITORY				
00000789720	SANDOZ PROCHLORPERAZINE	SDZ	$	0.8300

56:00 GASTROINTESTINAL DRUGS

56:22.20 ANTIEMETICS (5-HT3 RECEPTOR ANTAGONISTS)

DOLASETRON MESYLATE

100 MG ORAL TABLET				
00002231379	ANZEMET	SAV	$	30.7002
20 MG / ML INJECTION				
00002231380	ANZEMET	SAV	$	2.5411

GRANISETRON HCL

1 MG (BASE) ORAL TABLET				
00002308894	**APO-GRANISETRON**	**APX**	$	**13.5000**
00002185881	KYTRIL	HLR	$	19.3500

ONDANSETRON

4 MG ORAL DISINTEGRATING TABLET				
00002239372	ZOFRAN ODT	GSK	$	14.0707
8 MG ORAL DISINTEGRATING TABLET				
00002239373	ZOFRAN ODT	GSK	$	21.4699

56:00 GASTROINTESTINAL DRUGS

56:22.20 ANTIEMETICS

(5-HT3 RECEPTOR ANTAGONISTS)

ONDANSETRON HCL DIHYDRATE

4 MG (BASE) ORAL TABLET				
00002288184	**APO-ONDANSETRON**	**APX**	$	**7.5450**
00002296349	**CO ONDANSETRON**	**COB**	$	**7.5450**
00002313685	**JAMP-ONDANSETRON**	**JPC**	$	**7.5450**
00002305259	**MINT-ONDANSETRON**	**MPI**	$	**7.5450**
00002297868	**MYLAN-ONDANSETRON**	**MYP**	$	**7.5450**
00002264056	**NOVO-ONDANSETRON**	**TEV**	$	**7.5450**
00002306212	**ONDANSETRON-ODAN**	**ODN**	$	**7.5450**
00002278618	**PHL-ONDANSETRON**	**PHH**	$	**7.5450**
00002258188	**PMS-ONDANSETRON**	**PMS**	$	**7.5450**
00002312247	**RAN-ONDANSETRON**	**RAN**	$	**7.5450**
00002278529	**RATIO-ONDANSETRON**	**RPH**	$	**7.5450**
00002274310	**SANDOZ ONDANSETRON**	**SDZ**	$	**7.5450**
00002213567	ZOFRAN	GSK	$	14.4028
8 MG (BASE) ORAL TABLET				
00002288192	**APO-ONDANSETRON**	**APX**	$	**11.5166**
00002296357	**CO ONDANSETRON**	**COB**	$	**11.5166**
00002313693	**JAMP-ONDANSETRON**	**JPC**	$	**11.5166**
00002305267	**MINT-ONDANSETRON**	**MPI**	$	**11.5166**
00002297876	**MYLAN-ONDANSETRON**	**MYP**	$	**11.5166**
00002264064	**NOVO-ONDANSETRON**	**TEV**	$	**11.5166**
00002306220	**ONDANSETRON-ODAN**	**ODN**	$	**11.5166**
00002278626	**PHL-ONDANSETRON**	**PHH**	$	**11.5166**
00002258196	**PMS-ONDANSETRON**	**PMS**	$	**11.5166**
00002312255	**RAN-ONDANSETRON**	**RAN**	$	**11.5166**
00002278537	**RATIO-ONDANSETRON**	**RPH**	$	**11.5166**
00002274329	**SANDOZ ONDANSETRON**	**SDZ**	$	**11.5166**
00002213575	ZOFRAN	GSK	$	21.9773
0.8 MG / ML (BASE) ORAL SOLUTION				
00002291967	**APO-ONDANSETRON**	**APX**	$	**1.4614**
00002229639	ZOFRAN	GSK	$	2.1975
2 MG / ML (BASE) INJECTION				
00002265524	**ONDANSETRON (PRESERVATIVE FREE)**	**TEV**	$	**5.9429**
00002271761	**ONDANSETRON OMEGA (PRESERVATIVE FREE)**	**OMG**	$	**5.9429**
00002213745	ZOFRAN	GSK	$	10.6124
2 MG / ML (BASE) INJECTION				
00002265532	**ONDANSETRON (WITH PRESERVATIVE)**	**TEV**	$	**5.9429**
00002271788	**ONDANSETRON OMEGA (WITH PRESERVATIVE)**	**OMG**	$	**5.9429**
00002213745	ZOFRAN	GSK	$	10.6124

56:00 GASTROINTESTINAL DRUGS

56:22.92 ANTIEMETICS

(MISCELLANEOUS ANTIEMETICS)

APREPITANT/ APREPITANT

RESTRICTED BENEFIT - This drug product must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates).

80 MG * 125 MG ORAL CAPSULE				
00002298813	EMEND TRI-PACK	MFC	$	30.1800

56:00 GASTROINTESTINAL DRUGS

56:22.92 ANTIEMETICS
(MISCELLANEOUS ANTIEMETICS)

DOXYLAMINE SUCCINATE/ PYRIDOXINE HCL

10 MG * 10 MG ORAL SUSTAINED-RELEASE TABLET				
00000609129	DICLECTIN	DUI	$	1.2900

NABILONE

0.5 MG ORAL CAPSULE				
00002256193	CESAMET	VCL	$	3.3353
1 MG ORAL CAPSULE				
00000548375	CESAMET	VCL	$	6.6704

56:00 GASTROINTESTINAL DRUGS

56:28.12 ANTIULCER AGENTS AND ACID SUPPRESSANTS
(HISTAMINE H2-ANTAGONISTS)

CIMETIDINE

200 MG ORAL TABLET				
00000584215	**APO-CIMETIDINE**	**APX**	$	**0.0860**
00000865796	**NU-CIMET**	**NXP**	$	**0.0860**
300 MG ORAL TABLET				
00000487872	**APO-CIMETIDINE**	**APX**	$	**0.0860**
00002227444	**MYLAN-CIMETIDINE**	**MYP**	$	**0.0860**
00000582417	**NOVO-CIMETINE**	**TEV**	$	**0.0860**
00000865818	**NU-CIMET**	**NXP**	$	**0.0860**
400 MG ORAL TABLET				
00000600059	**APO-CIMETIDINE**	**APX**	$	**0.1350**
00002227452	**MYLAN-CIMETIDINE**	**MYP**	$	**0.1350**
00000603678	**NOVO-CIMETINE**	**TEV**	$	**0.1350**
00000865826	**NU-CIMET**	**NXP**	$	**0.1350**
600 MG ORAL TABLET				
00000600067	**APO-CIMETIDINE**	**APX**	$	**0.1720**
00002227460	**MYLAN-CIMETIDINE**	**MYP**	$	**0.1720**
00000603686	**NOVO-CIMETINE**	**TEV**	$	**0.1720**
00000865834	**NU-CIMET**	**NXP**	$	**0.1720**
800 MG ORAL TABLET				
00000749494	**APO-CIMETIDINE**	**APX**	$	**0.2530**
00002227479	**MYLAN-CIMETIDINE**	**MYP**	$	**0.2530**

FAMOTIDINE

20 MG ORAL TABLET				
00001953842	**APO-FAMOTIDINE**	**APX**	$	**0.5896**
00002196018	**MYLAN-FAMOTIDINE**	**MYP**	$	**0.5896**
00002022133	**NOVO-FAMOTIDINE**	**TEV**	$	**0.5896**
00002024195	**NU-FAMOTIDINE**	**NXP**	$	**0.5896**
00000710121	PEPCID	MFC	$	1.0632
40 MG ORAL TABLET				
00001953834	**APO-FAMOTIDINE**	**APX**	$	**1.0612**
00002196026	**MYLAN-FAMOTIDINE**	**MYP**	$	**1.0612**
00002022141	**NOVO-FAMOTIDINE**	**TEV**	$	**1.0612**
00002024209	**NU-FAMOTIDINE**	**NXP**	$	**1.0612**
00000710113	PEPCID	MFC	$	1.9336

56:00 GASTROINTESTINAL DRUGS

56:28.12 ANTIULCER AGENTS AND ACID SUPPRESSANTS (HISTAMINE H2-ANTAGONISTS)

NIZATIDINE

150 MG ORAL CAPSULE				
00002220156	**APO-NIZATIDINE**	**APX**	$	**0.5052**
00002246046	**GEN-NIZATIDINE**	**MYP**	$	**0.5052**
00002240457	**NOVO-NIZATIDINE**	**TEV**	$	**0.5052**
00002177714	**PMS-NIZATIDINE**	**PMS**	$	**0.5052**
00000778338	AXID	PHH	$	0.9048
300 MG ORAL CAPSULE				
00002240458	**NOVO-NIZATIDINE**	**TEV**	$	**0.9154**
00000778346	AXID	PHH	$	1.6395

RANITIDINE HCL

150 MG (BASE) ORAL TABLET				
00000828564	**NOVO-RANIDINE**	**TEV**	$	**0.1800**
00002245782	**PHL-RANITIDINE**	**PHH**	$	**0.1800**
00002242453	**PMS-RANITIDINE**	**PMS**	$	**0.1800**
00002212331	**ZANTAC**	**GSK**	$	**0.1800**
00000733059	APO-RANITIDINE	APX	$	0.4042
00002248570	CO RANITIDINE	COB	$	0.4042
00002207761	MYLAN-RANITIDINE	MYP	$	0.4042
00000865737	NU-RANIT	NXP	$	0.4042
00002336480	RAN-RANITIDINE	RAN	$	0.4042
00000828823	RATIO-RANITIDINE	RPH	$	0.4042
00002243229	SANDOZ RANITIDINE	SDZ	$	0.4042
300 MG (BASE) ORAL TABLET				
00000828556	**NOVO-RANIDINE**	**TEV**	$	**0.3600**
00002245783	**PHL-RANITIDINE**	**PHH**	$	**0.3600**
00002242454	**PMS-RANITIDINE**	**PMS**	$	**0.3600**
00002212358	**ZANTAC**	**GSK**	$	**0.3600**
00000733067	APO-RANITIDINE	APX	$	0.7787
00002248571	CO RANITIDINE	COB	$	0.7787
00002207788	MYLAN-RANITIDINE	MYP	$	0.7787
00000865745	NU-RANIT	NXP	$	0.7787
00002336502	RAN-RANITIDINE	RAN	$	0.7787
00000828688	RATIO-RANITIDINE	RPH	$	0.7787
00002243230	SANDOZ RANITIDINE	SDZ	$	0.7787
15 MG / ML (BASE) ORAL SOLUTION				
00002280833	**APO-RANITIDINE**	**APX**	$	**0.1174**
00002242940	**NOVO-RANIDINE**	**TEV**	$	**0.1174**
00002212374	ZANTAC	GSK	$	0.2241
25 MG / ML (BASE) INJECTION				
00002256711	**RANITIDINE**	**SDZ**	$	**1.2075**
00002212366	ZANTAC	GSK	$	1.5050

56:00 GASTROINTESTINAL DRUGS

56:28.28 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROSTAGLANDINS)

MISOPROSTOL

100 MCG ORAL TABLET				
00002244022	APO-MISOPROSTOL	APX	$	0.2584
200 MCG ORAL TABLET				
00002244023	APO-MISOPROSTOL	APX	$	0.4303

56:00 GASTROINTESTINAL DRUGS

56:28.32 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTECTANTS)

SUCRALFATE

1 G ORAL TABLET				
00002125250	**APO-SUCRALFATE**	**APX**	$	**0.2942**
00002045702	**NOVO-SUCRALATE**	**TEV**	$	**0.2942**
00002134829	**NU-SUCRALFATE**	**NXP**	$	**0.2942**
00002238209	**PMS-SUCRALFATE**	**PMS**	$	**0.2942**
00002100622	SULCRATE	AXC	$	0.5645
200 MG / ML ORAL SUSPENSION				
00002103567	SULCRATE SUSPENSION PLUS	AXC	$	0.1026

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

LANSOPRAZOLE

Please note: For individuals who require alternative administration (capsules to be opened and intact delayed release granules to be sprinkled on applesauce and swallowed immediately or mixed in water or apple juice and administered through a nasogastric tube) application for coverage for the Prevacid brand may be made using the Drug Special Authorization Request Form (ABC 20061), indicating a requirement for alternative administration.

15 MG ORAL DELAYED RELEASE CAPSULE				
00002293811	**APO-LANSOPRAZOLE**	**APX**	$	**1.1200**
00002280515	**NOVO-LANSOPRAZOLE**	**TEV**	$	**1.1200**
00002165503	PREVACID	ABB	$	2.0000
30 MG ORAL DELAYED RELEASE CAPSULE				
00002293838	**APO-LANSOPRAZOLE**	**APX**	$	**1.1200**
00002280523	**NOVO-LANSOPRAZOLE**	**TEV**	$	**1.1200**
00002165511	PREVACID	ABB	$	2.0000

LANSOPRAZOLE/ AMOXICILLIN TRIHYDRATE/ CLARITHROMYCIN

30 MG * 500 MG (BASE) * 500 MG ORAL TABLET/CAPSULE				
00002238525	HP-PAC (KIT)	ABB	$	82.2000

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

OMEPRAZOLE

10 MG ORAL CAPSULE/SUSTAINED RELEASE TABLET

00002329425	**MYLAN-OMEPRAZOLE (CAPSULE)**	**MYP**	$	**0.8167**
00002296438	**SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAPSULE)**	**SDZ**	$	**0.8167**
00002230737	LOSEC (SUSTAINED-RELEASE TABLET)	AZC	$	1.8812

20 MG ORAL CAPSULE/SUSTAINED RELEASE TABLET

00002245058	**APO-OMEPRAZOLE (CAPSULE)**	**APX**	$	**1.1000**
00002329433	**MYLAN-OMEPRAZOLE (CAPSULE)**	**MYP**	$	**1.1000**
00002310260	**PMS-OMEPRAZOLE (DELAYED RELEASE TABLET)**	**PMS**	$	**1.1000**
00002320851	**PMS-OMEPRAZOLE (SUSTAINED-RELEASE CAPSULE)**	**PMS**	$	**1.1000**
00002260867	**RATIO-OMEPRAZOLE (SUSTAINED-RELEASE TABLET)**	**RPH**	$	**1.1000**
00002296446	**SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAPSULE)**	**SDZ**	$	**1.1000**
00000846503	LOSEC (SUSTAINED-RELEASE CAPSULE)	AZC	$	1.1825
00002190915	LOSEC (SUSTAINED-RELEASE TABLET)	AZC	$	2.3650

PANTOPRAZOLE SODIUM SESQUIHYDRATE

40 MG (BASE) ORAL ENTERIC-COATED TABLET

00002292920	**APO-PANTOPRAZOLE**	**APX**	$	**1.2135**
00002300486	**CO PANTOPRAZOLE**	**COB**	$	**1.2135**
00002299585	**MYLAN-PANTOPRAZOLE**	**MYP**	$	**1.2135**
00002285487	**NOVO-PANTOPRAZOLE**	**TEV**	$	**1.2135**
00002309866	**PHL-PANTOPRAZOLE**	**PHH**	$	**1.2135**
00002307871	**PMS-PANTOPRAZOLE**	**PMS**	$	**1.2135**
00002305046	**RAN-PANTOPRAZOLE**	**RAN**	$	**1.2135**
00002308703	**RATIO-PANTOPRAZOLE**	**RPH**	$	**1.2135**
00002301083	**SANDOZ PANTOPRAZOLE**	**SDZ**	$	**1.2135**
00002229453	PANTOLOC	NYC	$	2.1733

RABEPRAZOLE SODIUM

10 MG ORAL ENTERIC-COATED TABLET

00002296632	**NOVO-RABEPRAZOLE**	**TEV**	$	**0.3913**
00002310805	**PMS-RABEPRAZOLE EC**	**PMS**	$	**0.3913**
00002298074	**RAN-RABEPRAZOLE**	**RAN**	$	**0.3913**
00002314177	**SANDOZ RABEPRAZOLE**	**SDZ**	$	**0.3913**

20 MG ORAL ENTERIC-COATED TABLET

00002296640	**NOVO-RABEPRAZOLE**	**TEV**	$	**0.7826**
00002310813	**PMS-RABEPRAZOLE EC**	**PMS**	$	**0.7826**
00002298082	**RAN-RABEPRAZOLE**	**RAN**	$	**0.7826**
00002314185	**SANDOZ RABEPRAZOLE**	**SDZ**	$	**0.7826**

56:00 GASTROINTESTINAL DRUGS

56:32 PROKINETIC AGENTS

DOMPERIDONE MALEATE

10 MG (BASE) ORAL TABLET				
00002268078	**RAN-DOMPERIDONE**	**RAN**	$	**0.1418**
00002236466	PMS-DOMPERIDONE	PMS	$	0.1430
00002103613	APO-DOMPERIDONE	APX	$	0.1496
00002278669	MYLAN-DOMPERIDONE	MYP	$	0.1496
00002157195	NOVO-DOMPERIDONE	TEV	$	0.1496
00002231477	NU-DOMPERIDONE	NXP	$	0.1496
00001912070	RATIO-DOMPERIDONE MALEATE	RPH	$	0.1496

METOCLOPRAMIDE HCL

5 MG ORAL TABLET				
00000842826	**APO-METOCLOP**	**APX**	$	**0.0556**
00002143275	**NU-METOCLOPRAMIDE**	**NXP**	$	**0.0556**
00002230431	**PMS-METOCLOPRAMIDE**	**PMS**	$	**0.0556**
10 MG ORAL TABLET				
00000842834	**APO-METOCLOP**	**APX**	$	**0.0583**
00002143283	**NU-METOCLOPRAMIDE**	**NXP**	$	**0.0583**
00002230432	**PMS-METOCLOPRAMIDE**	**PMS**	$	**0.0583**
1 MG / ML ORAL LIQUID				
00002230433	PMS-METOCLOPRAMIDE	PMS	$	0.0384
5 MG / ML INJECTION				
00002185431	METOCLOPRAMIDE HYDROCHLORIDE	SDZ	$	1.3316

56:00 GASTROINTESTINAL DRUGS

56:36 ANTI-INFLAMMATORY AGENTS

5-AMINOSALICYLIC ACID

500 MG ORAL SUSTAINED-RELEASE TABLET				
00002099683	PENTASA	FEI	$	0.5987
400 MG ORAL ENTERIC-COATED TABLET				
☒ 00002171929	NOVO-5 ASA	TEV	$	0.3972
☒ 00001997580	ASACOL	WCC	$	0.5590
500 MG ORAL ENTERIC-COATED TABLET				
☒ 00002112787	SALOFALK	AXC	$	0.5314
☒ 00001914030	MESASAL	GSK	$	0.6606
800 MG ORAL ENTERIC-COATED TABLET				
00002267217	ASACOL 800	WCC	$	1.0858
500 MG RECTAL SUPPOSITORY				
00002112760	SALOFALK	AXC	$	1.1745
1 G RECTAL SUPPOSITORY				
00002153564	PENTASA	FEI	$	1.7200
1,000 MG RECTAL SUPPOSITORY				
00002242146	SALOFALK	AXC	$	1.7252
1 G / ENM RECTAL ENEMA				
00002153521	PENTASA (1G/100ML)	FEI	$	3.9775
2 G / ENM RECTAL ENEMA				
00002112795	SALOFALK (2G/60G)	AXC	$	3.7842
4 G / ENM RECTAL ENEMA				
☒ 00002153556	PENTASA (4G/100 ML)	FEI	$	4.7945
☒ 00002112809	SALOFALK (4G/60G)	AXC	$	6.4263

56:00 GASTROINTESTINAL DRUGS

56:36 ANTI-INFLAMMATORY AGENTS

OLSALAZINE SODIUM

250 MG ORAL CAPSULE

00002063808	DIPENTUM	UCB	$	0.5440

56:00 GASTROINTESTINAL DRUGS

56:92 MISCELLANEOUS GI DRUGS

PINAVERIUM BROMIDE

50 MG ORAL TABLET

00001950592	DICETEL	SLO	$	0.3720

100 MG ORAL TABLET

00002230684	DICETEL	SLO	$	0.6622

TRIMEBUTINE MALEATE

100 MG ORAL TABLET

00002245663	APO-TRIMEBUTINE	APX	$	0.2690

200 MG ORAL TABLET

00002245664	**APO-TRIMEBUTINE**	**APX**	$	**0.5235**
00000803499	MODULON	AXC	$	0.6938

60:00

Gold Compounds

60:00 GOLD COMPOUNDS

60:00

AURANOFIN

3 MG ORAL CAPSULE

00001916823	RIDAURA	PAL	$	2.0047

GOLD SODIUM THIOMALATE

10 MG / ML INJECTION

00002245456	**SODIUM AUROTHIOMALATE**	**SDZ**	$	**8.8400**
00001927620	MYOCHRYSINE	SAV	$	12.3735

25 MG / ML INJECTION

00002245457	SODIUM AUROTHIOMALATE	SDZ	$	11.5586

50 MG / ML INJECTION

00002245458	**SODIUM AUROTHIOMALATE**	**SDZ**	$	**16.6500**
00001927604	MYOCHRYSINE	SAV	$	23.3064

64:00

Heavy Metal Antagonists

64:00 HEAVY METAL ANTAGONISTS

64:00

DEFEROXAMINE MESYLATE

500 MG / VIAL INJECTION				
00002241600	**DESFERRIOXAMINE MESILATE**	**HSP**	$	**8.0535**
00001981242	DESFERAL	NOV	$	14.3814
2 G / VIAL INJECTION				
00002247022	**DESFERRIOXAMINE MESILATE**	**HSP**	$	**32.3514**
00001981250	DESFERAL	NOV	$	57.7705

68:00

Hormones and Synthetic Substitutes

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:00

COMPOUND PRESCRIPTION

00000999111	**COMPOUND HORMONES (ESTROGEN PROGEST TESTOSTERONE)**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999212	**COMPOUND HORMONES (ESTROGEN PROGEST TESTOSTERONE)**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

BECLOMETHASONE DIPROPIONATE

50 MCG / DOSE METERED DOSE AEROSOL				
00002242029	QVAR CFC-FREE	GRC	$	0.1574
100 MCG / DOSE METERED DOSE AEROSOL				
00002242030	QVAR CFC-FREE	GRC	$	0.3148

BETAMETHASONE SODIUM PHOSPHATE/ BETAMETHASONE ACETATE

3 MG / ML (BASE) * 3 MG / ML INJECTION				
00000028096	CELESTONE SOLUSPAN	SCH	$	10.0246

BUDESONIDE

100 MCG / DOSE METERED INHALATION POWDER				
00000852074	PULMICORT TURBUHALER	AZC	$	0.1634
200 MCG / DOSE METERED INHALATION POWDER				
00000851752	PULMICORT TURBUHALER	AZC	$	0.3271
400 MCG / DOSE METERED INHALATION POWDER				
00000851760	PULMICORT TURBUHALER	AZC	$	0.5886
0.125 MG / ML INHALATION SUSPENSION				
00002229099	PULMICORT NEBUAMP	AZC	$	0.2218
0.25 MG / ML INHALATION SUSPENSION				
00001978918	PULMICORT NEBUAMP	AZC	$	0.4434
0.5 MG / ML INHALATION SUSPENSION				
00001978926	PULMICORT NEBUAMP	AZC	$	0.8869

CICLESONIDE

100 MCG / DOSE METERED DOSE AEROSOL				
00002285606	ALVESCO	NYC	$	0.3832
200 MCG / DOSE METERED DOSE AEROSOL				
00002285614	ALVESCO	NYC	$	0.6331

CORTISONE ACETATE

25 MG ORAL TABLET				
00000280437	CORTISONE ACETATE	VCL	$	0.3296

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

DEXAMETHASONE

0.5 MG ORAL TABLET				
00002240684	**RATIO-DEXAMETHASONE**	**RPH**	$	**0.1751**
00001964976	PMS-DEXAMETHASONE	PMS	$	0.1883
00002261081	APO-DEXAMETHASONE	APX	$	0.1970
0.75 MG ORAL TABLET				
00001964968	PMS-DEXAMETHASONE	PMS	$	0.4514
2 MG ORAL TABLET				
00002279363	PMS-DEXAMETHASONE	PMS	$	0.4124
4 MG ORAL TABLET				
00001964070	**PMS-DEXAMETHASONE**	**PMS**	$	**0.6823**
00002250055	APO-DEXAMETHASONE	APX	$	0.7673
00002240687	RATIO-DEXAMETHASONE	RPH	$	0.7673
00000489158	DEXASONE	VCL	$	0.8248

DEXAMETHASONE SODIUM PHOSPHATE

4 MG / ML (BASE) INJECTION				
00000664227	**DEXAMETHASONE SODIUM PHOSPHATE**	**SDZ**	$	**1.6900**
00001977547	**DEXAMETHASONE SODIUM PHOSPHATE**	**CYT**	$	**1.6900**
10 MG / ML (BASE) INJECTION				
00000783900	PMS-DEXAMETHASONE SODIUM PHOSP	PMS	$	1.2830
00000874582	DEXAMETHASONE SODIUM PHOSPHATE	SDZ	$	4.5600

FLUDROCORTISONE ACETATE

0.1 MG ORAL TABLET				
00002086026	FLORINEF	PAL	$	0.2356

FLUTICASONE PROPIONATE

50 MCG / DOSE METERED DOSE AEROSOL				
00002244291	FLOVENT HFA	GSK	$	0.2144
125 MCG / DOSE METERED DOSE AEROSOL				
00002244292	FLOVENT HFA	GSK	$	0.3698
250 MCG / DOSE METERED DOSE AEROSOL				
00002244293	FLOVENT HFA	GSK	$	0.7396
250 MCG / DOSE METERED INHALATION POWDER				
00002237246	FLOVENT DISKUS	GSK	$	0.7396
500 MCG / DOSE METERED INHALATION POWDER				
00002237247	FLOVENT DISKUS	GSK	$	1.4789

HYDROCORTISONE

10 MG ORAL TABLET				
00000030910	CORTEF	PFI	$	0.1612
20 MG ORAL TABLET				
00000030929	CORTEF	PFI	$	0.2910

HYDROCORTISONE SODIUM SUCCINATE

100 MG / VIAL (BASE) INJECTION				
00000872520	**HYDROCORTISONE SOD. SUCCINATE**	**TEV**	$	**2.0000**
00000030600	SOLU-CORTEF	PFI	$	3.8810
250 MG / VIAL (BASE) INJECTION				
00000872539	**HYDROCORTISONE SOD. SUCCINATE**	**TEV**	$	**3.4000**
00000030619	SOLU-CORTEF	PFI	$	6.7340
500 MG / VIAL (BASE) INJECTION				
00000878618	**HYDROCORTISONE SOD. SUCCINATE**	**TEV**	$	**5.1000**
00000030627	SOLU-CORTEF	PFI	$	9.9980

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

HYDROCORTISONE SODIUM SUCCINATE

1 G / VIAL (BASE) INJECTION				
00000878626	**HYDROCORTISONE SOD. SUCCINATE**	**TEV**	$	**8.6000**
00000030635	SOLU-CORTEF	PFI	$	16.7540

METHYLPREDNISOLONE

4 MG ORAL TABLET				
00000030988	MEDROL	PFI	$	0.3713
16 MG ORAL TABLET				
00000036129	MEDROL	PFI	$	1.0701

METHYLPREDNISOLONE ACETATE

20 MG / ML INJECTION				
00001934325	DEPO-MEDROL	PFI	$	2.5140
40 MG / ML INJECTION				
00002245400	**METHYLPREDNISOLONE ACETATE**	**SDZ**	$	**4.5000**
00000030759	DEPO-MEDROL	PFI	$	5.7405
80 MG / ML INJECTION				
00002245406	**METHYLPREDNISOLONE ACETATE**	**SDZ**	$	**8.6000**
00000030767	DEPO-MEDROL	PFI	$	10.9865
40 MG / ML INJECTION				
00002245407	**METHYLPREDNISOLONE ACETATE (P)**	**SDZ**	$	**4.3000**
00001934333	DEPO-MEDROL (PRESERVED)	PFI	$	5.4932
80 MG / ML INJECTION				
00002245408	**METHYLPREDNISOLONE ACETATE (P)**	**SDZ**	$	**6.6520**
00001934341	DEPO-MEDROL (PRESERVED)	PFI	$	8.4882

METHYLPREDNISOLONE ACETATE/ LIDOCAINE HCL

40 MG / ML * 10 MG / ML INJECTION				
00000260428	DEPO-MEDROL WITH LIDOCAINE	PFI	$	6.4300

METHYLPREDNISOLONE SODIUM SUCCINATE

40 MG / VIAL (BASE) INJECTION				
00002231893	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**3.6000**
00002063719	SOLU-MEDROL ACT-O-VIAL	PFI	$	6.4110
125 MG / VIAL (BASE) INJECTION				
00002231894	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**8.5000**
00002063727	SOLU-MEDROL ACT-O-VIAL	PFI	$	15.2200
500 MG / VIAL (BASE) INJECTION				
00002231895	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**18.6000**
00000030678	SOLU-MEDROL	PFI	$	37.3940
00002063700	SOLU-MEDROL ACT-O-VIAL	PFI	$	38.1453
1 G / VIAL (BASE) INJECTION				
00002241229	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**31.0000**
00000036137	SOLU-MEDROL	PFI	$	57.3200
00002063697	SOLU-MEDROL ACT-O-VIAL	PFI	$	58.4700

PREDNISOLONE SODIUM PHOSPHATE

1 MG / ML (BASE) ORAL LIQUID				
00002245532	**PMS-PREDNISOLONE**	**PMS**	$	**0.0684**
00002230619	PEDIAPRED	SAV	$	0.1315

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

PREDNISONE

1 MG ORAL TABLET				
00000598194	**APO-PREDNISONE**	**APX**	$	**0.1072**
00000271373	WINPRED	VCL	$	0.1113
5 MG ORAL TABLET				
00000312770	APO-PREDNISONE	APX	$	0.0401
50 MG ORAL TABLET				
00000550957	APO-PREDNISONE	APX	$	0.1735

TRIAMCINOLONE ACETONIDE

10 MG / ML INJECTION				
00002229540	**TRIAMCINOLONE ACETONIDE**	**SDZ**	$	**2.5860**
00001999761	KENALOG-10	WSD	$	3.0952
40 MG / ML INJECTION				
00001977563	**TRIAMCINOLONE ACETONIDE USP**	**CYT**	$	**5.5000**
00002229550	TRIAMCINOLONE ACETONIDE	SDZ	$	6.0000
00001999869	KENALOG-40	WSD	$	7.1903

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:08 ANDROGENS

DANAZOL

50 MG ORAL CAPSULE				
00002018144	CYCLOMEN	SAV	$	0.9313
100 MG ORAL CAPSULE				
00002018152	CYCLOMEN	SAV	$	1.3818
200 MG ORAL CAPSULE				
00002018160	CYCLOMEN	SAV	$	2.2082

NANDROLONE DECANOATE

100 MG / ML INJECTION				
00000270687	DECA-DURABOLIN	ORG	$	92.7500

TESTOSTERONE CYPIONATE

100 MG / ML INJECTION				
00002246063	**TESTOSTERONE CYPIONATE**	**SDZ**	$	**2.1300**
00000030783	DEPO-TESTOSTERONE CYPIONATE	PFI	$	2.8485

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

DESOGESTREL/ ETHINYL ESTRADIOL

0.15 MG * 0.03 MG ORAL TABLET				
00002317192	**APRI 21**	**BAR**	$	**0.4375**
00002042487	MARVELON (21 DAY)	ORG	$	0.6290
0.15 MG * 0.03 MG ORAL TABLET				
00002317206	**APRI 28**	**BAR**	$	**0.3281**
00002042479	MARVELON (28 DAY)	ORG	$	0.4717
☒ 00002042533	ORTHO-CEPT (28 DAY)	JOI	$	0.6258

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

DESOGESTREL/ ETHINYL ESTRADIOL/ DESOGESTREL/ ETHINYL ESTRADIOL/ DESOGESTREL/ ETHINYL ESTRADIOL

0.1 MG * 0.025 MG * 0.125 MG * 0.025 MG * 0.15 MG * 0.025 MG ORAL TABLET

☒ 00002257238	LINESSA 28	ORG	$	0.4467
☒ 00002272903	LINESSA 21	ORG	$	0.5956

DROSPIRENONE/ ETHINYL ESTRADIOL

3 MG * 0.03 MG ORAL TABLET

☒ 00002261731	YASMIN 28	BAI	$	0.4454
☒ 00002261723	YASMIN 21	BAI	$	0.5938

ETHYNODIOL DIACETATE/ ETHINYL ESTRADIOL

2 MG * 30 MCG ORAL TABLET

☒ 00000471526	DEMULEN 30 (28 DAY)	PFI	$	0.4997
☒ 00000469327	DEMULEN 30 (21 DAY)	PFI	$	0.6229

LEVONORGESTREL

0.75 MG ORAL TABLET

00002241674	PLAN B	DUR	$	8.6000

52 MG INTRAUTERINE INSERT

00002243005	MIRENA SYSTEM	BHP	$	347.0422

LEVONORGESTREL/ ETHINYL ESTRADIOL

100 MCG * 20 MCG ORAL TABLET

00002298538	**AVIANE 21**	**BAR**	$	**0.4636**
00002236974	ALESSE (21 DAY)	WAY	$	0.7423

150 MCG * 30 MCG ORAL TABLET

00002295946	**PORTIA 21**	**BAR**	$	**0.4636**
00002042320	MIN-OVRAL (21 DAY)	WAY	$	0.7423

100 MCG * 20 MCG ORAL TABLET

00002298546	**AVIANE 28**	**BAR**	$	**0.3477**
00002236975	ALESSE (28 DAY)	WAY	$	0.5567

150 MCG * 30 MCG ORAL TABLET

00002295954	**PORTIA 28**	**BAR**	$	**0.3477**
00002042339	MIN-OVRAL (28 DAY)	WAY	$	0.5567

LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL

50 MCG * 30 MCG * 75 MCG * 40 MCG * 125 MCG * 30 MCG ORAL TABLET

☒ 00000707503	TRIQUILAR (28 DAY)	BHP	$	0.5433
☒ 00000707600	TRIQUILAR (21 DAY)	BHP	$	0.7243

NORETHINDRONE

0.35 MG ORAL TABLET

00000037605	MICRONOR (28 DAY)	JOI	$	0.6258

NORETHINDRONE ACETATE/ ETHINYL ESTRADIOL

1 MG * 20 MCG ORAL TABLET

☒ 00000343838	MINESTRIN 1/20 (28 DAY)	PAL	$	0.4442
☒ 00000315966	MINESTRIN 1/20 (21 DAY)	PAL	$	0.5923

1.5 MG * 0.03 MG ORAL TABLET

☒ 00000353027	LOESTRIN 1.5/30 (28 DAY)	PAL	$	0.4442
☒ 00000297143	LOESTRIN 1.5/30 (21 DAY)	PAL	$	0.5923

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG ORAL TABLET

☒ 00002187094	BREVICON 0.5/35 (28 DAY)	PFI	$	0.4281
☒ 00002187086	BREVICON 0.5/35 (21 DAY)	PFI	$	0.5707
☒ 00000340731	ORTHO 0.5/35 (28 DAY)	JOI	$	0.6258
☒ 00000317047	ORTHO 0.5/35 (21 DAY)	JOI	$	0.8344

1 MG * 0.035 MG ORAL TABLET

☒ 00002199297	SELECT 1/35 (28 DAY)	PFI	$	0.2891
☒ 00002197502	SELECT 1/35 (21 DAY)	PFI	$	0.3855
☒ 00002189062	BREVICON 1/35 (28 DAY)	PFI	$	0.4281
☒ 00002189054	BREVICON 1/35 (21 DAY)	PFI	$	0.5707
☒ 00000372838	ORTHO 1/35 (28 DAY)	JOI	$	0.6258
☒ 00000372846	ORTHO 1/35 (21 DAY)	JOI	$	0.8344

NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

☒ 00002187116	SYNPHASIC (28 DAY)	PFI	$	0.3936
☒ 00002187108	SYNPHASIC (21 DAY)	PFI	$	0.5247

NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG * 0.75 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

☒ 00000602965	ORTHO 7/7/7 (28 DAY)	JOI	$	0.6258
☒ 00000602957	ORTHO 7/7/7 (21 DAY)	JOI	$	0.8344

NORGESTIMATE/ ETHINYL ESTRADIOL

0.25 MG * 0.035 MG ORAL TABLET

☒ 00001992872	CYCLEN (28 DAY)	JOI	$	0.6258
☒ 00001968440	CYCLEN (21 DAY)	JOI	$	0.8344

NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL

0.18 MG * 0.025 MG * 0.215 MG * 0.025 MG * 0.25 MG * 0.025 MG ORAL TABLET

☒ 00002258587	TRI-CYCLEN LO 28	JOI	$	0.4684
☒ 00002258560	TRI-CYCLEN LO 21	JOI	$	0.6246

0.18 MG * 0.035 MG * 0.215 MG * 0.035 MG * 0.25 MG * 0.035 MG ORAL TABLET

☒ 00002029421	TRI-CYCLEN (28 DAY)	JOI	$	0.6258
☒ 00002028700	TRI-CYCLEN (21 DAY)	JOI	$	0.8344

NORGESTREL/ ETHINYL ESTRADIOL

0.25 MG * 0.05 MG ORAL TABLET

00002043033	OVRAL (21 DAY)	WAY	$	0.7423

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.04 ESTROGENS AND ANTIESTROGENS (ESTROGENS)

CONJUGATED ESTROGENS

0.3 MG ORAL TABLET

00002043394	PREMARIN	WAY	$	0.3010

0.625 MG ORAL TABLET

00000265470	C.E.S.	VCL	$	0.1045
00002043408	PREMARIN	WAY	$	0.3010

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.04 ESTROGENS AND ANTIESTROGENS (ESTROGENS)

CONJUGATED ESTROGENS

1.25 MG ORAL TABLET				
00002043424	PREMARIN	WAY	$	0.3010
0.625 MG / G VAGINAL CREAM				
00002043440	PREMARIN	WAY	$	0.6550

CONJUGATED ESTROGENS/ MEDROXYPROGESTERONE ACETATE

0.625 MG * 2.5 MG ORAL TABLET				
00002242878	PREMPLUS	WAY	$	0.1935
0.625 MG * 5 MG ORAL TABLET				
00002242879	PREMPLUS	WAY	$	0.1935

ESTRADIOL-17B

0.5 MG ORAL TABLET				
00002225190	ESTRACE	SHB	$	0.1239
1 MG ORAL TABLET				
00002148587	ESTRACE	SHB	$	0.2392
2 MG ORAL TABLET				
00002148595	ESTRACE	SHB	$	0.4224
0.06 % TRANSDERMAL GEL				
00002238704	ESTROGEL	SCH	$	0.2993
25 MCG/DAY TRANSDERMAL PATCH				
☒ 00002245676	ESTRADOT 25 (0.39 MG/PTH)	NOV	$	2.7305
☒ 00000756849	ESTRADERM-25 (2 MG/PTH)	NOV	$	3.5731
☒ 00002247499	CLIMARA 25 (2 MG/PTH)	BHP	$	5.2863
37.5 MCG/DAY TRANSDERMAL PATCH				
00002243999	ESTRADOT 37.5 (0.585 MG/PTH)	NOV	$	2.7466
50 MCG/DAY TRANSDERMAL PATCH				
00002246967	**SANDOZ ESTRADIOL DERM 50 (4 MG/PTH)**	**SDZ**	$	**2.2300**
00002244000	ESTRADOT 50 (0.78 MG/PTH)	NOV	$	2.9347
☒ 00002231509	CLIMARA 50 (3.9 MG/PTH)	BHP	$	5.6464
75 MCG/DAY TRANSDERMAL PATCH				
00002246968	**SANDOZ ESTRADIOL DERM 75 (6 MG/PTH)**	**SDZ**	$	**2.3900**
00002244001	ESTRADOT 75 (1.17 MG/PTH)	NOV	$	3.1511
☒ 00002247500	CLIMARA 75 (5.7 MG/PTH)	BHP	$	6.0200
100 MCG/DAY TRANSDERMAL PATCH				
00002246969	**SANDOZ ESTRADIOL DERM 100 (8 MG/PTH)**	**SDZ**	$	**2.5200**
00002244002	ESTRADOT 100 (1.56 MG/PTH)	NOV	$	3.3271
☒ 00000756792	ESTRADERM-100 (8.0 MG/PTH)	NOV	$	4.3121
☒ 00002231510	CLIMARA 100 (7.8 MG/PTH)	BHP	$	6.3667
0.25 MG VAGINAL TABLET				
00002241332	VAGIFEM	NNA	$	3.0607
2 MG VAGINAL SLOW-RELEASE RING				
00002168898	ESTRING	PAL	$	62.4267

NORETHINDRONE ACETATE/ ESTRADIOL-17B

140 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH				
00002241835	ESTALIS (2.7*.62 MG/PTH)	NOV	$	3.2331
250 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH				
00002241837	ESTALIS (4.8*.51 MG/PTH)	NOV	$	3.2331

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.12 ESTROGENS AND ANTIESTROGENS (ESTROGEN AGONISTS-ANTAGONISTS)

CLOMIPHENE CITRATE

50 MG ORAL TABLET				
00000893722	**SEROPHENE**	**SRO**	$	**5.2675**
00002091879	CLOMID	SAV	$	5.8150

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.02 ANTIDIABETIC AGENTS (ALPHA-GLUCOSIDASE INHIBITORS)

ACARBOSE

50 MG ORAL TABLET				
00002190885	GLUCOBAY	BAI	$	0.2782
100 MG ORAL TABLET				
00002190893	GLUCOBAY	BAI	$	0.3853

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.04 ANTIDIABETIC AGENTS (BIGUANIDES)

METFORMIN HCL

500 MG ORAL TABLET				
00002167786	**APO-METFORMIN**	**APX**	$	**0.1216**
00002257726	**CO METFORMIN**	**COB**	$	**0.1216**
00002148765	**MYLAN-METFORMIN**	**MYP**	$	**0.1216**
00002045710	**NOVO-METFORMIN**	**TEV**	$	**0.1216**
00002162822	**NU-METFORMIN**	**NXP**	$	**0.1216**
00002223562	**PMS-METFORMIN**	**PMS**	$	**0.1216**
00002269031	**RAN-METFORMIN**	**RAN**	$	**0.1216**
00002242974	**RATIO-METFORMIN HYDROCHLORIDE**	**RPH**	$	**0.1216**
00002246820	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.1216**
00002242794	**ZYM-METFORMIN**	**ZMC**	$	**0.1216**
00002099233	GLUCOPHAGE	SAV	$	0.2875
850 MG ORAL TABLET				
00002229785	**APO-METFORMIN**	**APX**	$	**0.2040**
00002257734	**CO METFORMIN**	**COB**	$	**0.2040**
00002229656	**MYLAN-METFORMIN**	**MYP**	$	**0.2040**
00002230475	**NOVO-METFORMIN**	**TEV**	$	**0.2040**
00002229517	**NU-METFORMIN**	**NXP**	$	**0.2040**
00002242589	**PMS-METFORMIN**	**PMS**	$	**0.2040**
00002242931	**RATIO-METFORMIN HYDROCHLORIDE**	**RPH**	$	**0.2040**
00002246821	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.2040**
00002162849	GLUCOPHAGE	SAV	$	0.3642

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN ASPART

100 UNIT / ML INJECTION				
00002245397	NOVORAPID	NNA	$	2.7870
100 UNIT / ML INJECTION CARTRIDGE				
00002244353	NOVORAPID	NNA	$	3.7180

INSULIN GLULISINE (RDNA ORIGIN)

100 UNIT / ML INJECTION				
00002279460	APIDRA	SAV	$	2.5499
100 UNIT / ML INJECTION CARTRIDGE				
00002279479	APIDRA	SAV	$	3.4021
100 UNIT / ML INJECTION SYRINGE				
00002294346	APIDRA	SAV	$	3.4021

INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

100 UNIT / ML INJECTION				
☒ 00002024225	NOVOLIN GE NPH	NNA	$	2.0402
☒ 00000587737	HUMULIN N	LIL	$	2.1840
100 UNIT / ML INJECTION CARTRIDGE				
☒ 00002024268	NOVOLIN GE NPH PENFILL	NNA	$	2.6586
☒ 00001959239	HUMULIN N CARTRIDGE	LIL	$	2.8581

INSULIN HUMAN BIOSYNTHETIC (REGULAR)

100 UNIT / ML INJECTION				
☒ 00002024233	NOVOLIN GE TORONTO	NNA	$	2.0402
☒ 00000586714	HUMULIN R	LIL	$	2.1840
100 UNIT / ML INJECTION CARTRIDGE				
☒ 00002024284	NOVOLIN GE TORONTO PENFILL	NNA	$	2.6684
☒ 00001959220	HUMULIN R CARTRIDGE	LIL	$	2.8581

INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

30 UNIT / ML * 70 UNIT / ML INJECTION				
☒ 00002024217	NOVOLIN GE 30/70	NNA	$	2.0402
☒ 00000795879	HUMULIN 30/70	LIL	$	2.1840
30 UNIT / ML * 70 UNIT / ML INJECTION CARTRIDGE				
☒ 00002025248	NOVOLIN GE 30/70 PENFILL	NNA	$	2.6558
☒ 00001959212	HUMULIN 30/70 CARTRIDGE	LIL	$	2.8581
40 UNIT / ML * 60 UNIT / ML INJECTION CARTRIDGE				
00002024314	NOVOLIN GE 40/60 PENFILL	NNA	$	2.7202
50 UNIT / ML * 50 UNIT / ML INJECTION CARTRIDGE				
00002024322	NOVOLIN GE 50/50 PENFILL	NNA	$	2.7202

INSULIN LISPRO

100 UNIT / ML INJECTION				
00002229704	HUMALOG	LIL	$	2.8193
100 UNIT / ML INJECTION CARTRIDGE				
00002229705	HUMALOG	LIL	$	3.7625

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.16 ANTIDIABETIC AGENTS (MEGLITINIDES)

REPAGLINIDE

0.5 MG ORAL TABLET				
00002239924	GLUCONORM	NNA	$	0.2975
1 MG ORAL TABLET				
00002239925	GLUCONORM	NNA	$	0.3093
2 MG ORAL TABLET				
00002239926	GLUCONORM	NNA	$	0.3213

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.20 ANTIDIABETIC AGENTS (SULFONYLUREAS)

GLICLAZIDE

80 MG ORAL TABLET				
00002245247	**APO-GLICLAZIDE**	**APX**	$	**0.2242**
00002229519	**MYLAN-GLICLAZIDE**	**MYP**	$	**0.2242**
00002238103	**NOVO-GLICLAZIDE**	**TEV**	$	**0.2242**
00002294400	**PMS-GLICLAZIDE**	**PMS**	$	**0.2242**
00000765996	DIAMICRON	SEV	$	0.4004
30 MG ORAL SUSTAINED-RELEASE TABLET				
00002297795	**APO-GLICLAZIDE MR**	**APX**	$	**0.1405**
00002242987	DIAMICRON MR	SEV	$	0.1510

GLYBURIDE

2.5 MG ORAL TABLET				
00001913654	**APO-GLYBURIDE**	**APX**	$	**0.0393**
00000720933	**EUGLUCON**	**PMS**	$	**0.0393**
00000808733	**MYLAN-GLYBE**	**MYP**	$	**0.0393**
00001913670	**NOVO-GLYBURIDE**	**TEV**	$	**0.0393**
00002020734	**NU-GLYBURIDE**	**NXP**	$	**0.0393**
00002236733	**PMS-GLYBURIDE**	**PMS**	$	**0.0393**
00001900927	**RATIO-GLYBURIDE**	**RPH**	$	**0.0393**
00002248008	**SANDOZ GLYBURIDE**	**SDZ**	$	**0.0393**
00002224550	DIABETA	SAV	$	0.1379
5 MG ORAL TABLET				
00001913662	**APO-GLYBURIDE**	**APX**	$	**0.0683**
00000720941	**EUGLUCON**	**PMS**	$	**0.0683**
00000808741	**MYLAN-GLYBE**	**MYP**	$	**0.0683**
00001913689	**NOVO-GLYBURIDE**	**TEV**	$	**0.0683**
00002020742	**NU-GLYBURIDE**	**NXP**	$	**0.0683**
00002236734	**PMS-GLYBURIDE**	**PMS**	$	**0.0683**
00001900935	**RATIO-GLYBURIDE**	**RPH**	$	**0.0683**
00002248009	**SANDOZ GLYBURIDE**	**SDZ**	$	**0.0683**
00002224569	DIABETA	SAV	$	0.2469

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:22.12 ANTIHYPOGLYCEMIC AGENTS (GLYCOGENOLYTIC AGENTS)

GLUCAGON, RDNA ORIGIN

1 MG / VIAL INJECTION				
00002243297	GLUCAGON	LIL	$	90.6675

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:24 PARATHYROID

SYNTHETIC CALCITONIN SALMON (SALCATONIN)

100 IU / ML INJECTION				
00002007134	CALTINE 100 (100 IU/ML)	FEI	$	8.4065
200 IU / ML INJECTION				
00001926691	CALCIMAR	SAV	$	28.5842

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:28 PITUITARY

COSYNTROPIN ZINC HYDROXIDE COMPLEX

1 MG / VIAL (BASE) INJECTION				
00000253952	SYNACTHEN DEPOT	NOV	$	33.1960

DESMOPRESSIN ACETATE

0.1 MG ORAL TABLET				
00002284030	**APO-DESMOPRESSIN**	**APX**	$	**0.7956**
00002287730	**NOVO-DESMOPRESSIN**	**TEV**	$	**0.7956**
00002304368	**PMS-DESMOPRESSIN**	**PMS**	$	**0.7956**
00000824305	DDAVP	FEI	$	1.4208
0.2 MG ORAL TABLET				
00002284049	**APO-DESMOPRESSIN**	**APX**	$	**1.5912**
00002287749	**NOVO-DESMOPRESSIN**	**TEV**	$	**1.5912**
00002304376	**PMS-DESMOPRESSIN**	**PMS**	$	**1.5912**
00000824143	DDAVP	FEI	$	2.8415
10 MCG / DOSE NASAL METERED DOSE SPRAY				
00002242465	**APO-DESMOPRESSIN**	**APX**	$	**1.4160**
00000836362	DDAVP	FEI	$	2.0296
150 MCG / DOSE NASAL METERED DOSE SPRAY				
00002237860	OCTOSTIM	FEI	$	16.5980
0.1 MG / ML NASAL SOLUTION				
00000402516	DDAVP	FEI	$	20.2960
4 MCG / ML INJECTION				
00000873993	DDAVP	FEI	$	10.8145

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:32 PROGESTINS

MEDROXYPROGESTERONE ACETATE

2.5 MG ORAL TABLET				
00002244726	**APO-MEDROXY**	**APX**	$	**0.0794**
00002221284	**NOVO-MEDRONE**	**TEV**	$	**0.0794**
00000708917	PROVERA	PFI	$	0.1724
5 MG ORAL TABLET				
00002244727	**APO-MEDROXY**	**APX**	$	**0.1569**
00002221292	**NOVO-MEDRONE**	**TEV**	$	**0.1569**
00000030937	PROVERA	PFI	$	0.3413
10 MG ORAL TABLET				
00002277298	**APO-MEDROXY**	**APX**	$	**0.3169**
00002221306	**NOVO-MEDRONE**	**TEV**	$	**0.3169**
00000729973	PROVERA	PFI	$	0.6926
100 MG ORAL TABLET				
00002267640	**APO-MEDROXY**	**APX**	$	**0.9153**
00000030945	PROVERA	PFI	$	1.3428
50 MG / ML INJECTION				
00000030848	DEPO-PROVERA	PFI	$	5.7392
150 MG / ML INJECTION				
00002322250	**MEDROXYPROGESTERONE ACETATE**	**SDZ**	$	**22.0000**
00000585092	DEPO-PROVERA	PFI	$	29.6086

PROGESTERONE

100 MG ORAL CAPSULE				
00002166704	PROMETRIUM	SCH	$	1.0416
50 MG / ML INJECTION				
00001977652	PROGESTERONE	CYT	$	6.3000

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.04 THYROID AND ANTITHYROID AGENTS (THYROID AGENTS)

DESSICATED THYROID

30 MG ORAL TABLET				
00000023949	THYROID	ERF	$	0.0560
60 MG ORAL TABLET				
00000023957	THYROID	ERF	$	0.0689
125 MG ORAL TABLET				
00000023965	THYROID	ERF	$	0.0992

LEVOTHYROXINE SODIUM

0.025 MG ORAL TABLET				
00002172062	SYNTHROID	ABB	$	0.0865
0.05 MG ORAL TABLET				
00002213192	**ELTROXIN**	**GSK**	$	**0.0301**
00002172070	SYNTHROID	ABB	$	0.0594
0.075 MG ORAL TABLET				
00002172089	SYNTHROID	ABB	$	0.0935
0.088 MG ORAL TABLET				
00002172097	SYNTHROID	ABB	$	0.0935

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.04 THYROID AND ANTITHYROID AGENTS (THYROID AGENTS)

LEVOTHYROXINE SODIUM

0.1 MG ORAL TABLET				
00002213206	**ELTROXIN**	**GSK**	$	**0.0370**
00002172100	SYNTHROID	ABB	$	0.0732
0.112 MG ORAL TABLET				
00002171228	SYNTHROID	ABB	$	0.0987
0.125 MG ORAL TABLET				
00002172119	SYNTHROID	ABB	$	0.0999
0.137 MG ORAL TABLET				
00002233852	SYNTHROID	ABB	$	0.1687
0.15 MG ORAL TABLET				
00002213214	**ELTROXIN**	**GSK**	$	**0.0410**
00002172127	SYNTHROID	ABB	$	0.0784
0.175 MG ORAL TABLET				
00002172135	SYNTHROID	ABB	$	0.1071
0.2 MG ORAL TABLET				
00002213222	**ELTROXIN**	**GSK**	$	**0.0434**
00002172143	SYNTHROID	ABB	$	0.0837
0.3 MG ORAL TABLET				
00002213230	**ELTROXIN**	**GSK**	$	**0.0663**
00002172151	SYNTHROID	ABB	$	0.1154

LIOTHYRONINE SODIUM

5 MCG (BASE) ORAL TABLET				
00001919458	CYTOMEL	KNG	$	1.0554
25 MCG (BASE) ORAL TABLET				
00001919466	CYTOMEL	KNG	$	1.1473

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.08 THYROID AND ANTITHYROID AGENTS (ANTITHYROID AGENTS)

METHIMAZOLE

5 MG ORAL TABLET				
00000015741	TAPAZOLE	PAL	$	0.2389

PROPYLTHIOURACIL

50 MG ORAL TABLET				
00000010200	PROPYL-THYRACIL	PAL	$	0.2062
100 MG ORAL TABLET				
00000010219	PROPYL-THYRACIL	PAL	$	0.3227

80:00

Serums, Toxoids and Vaccines

80:00 SERUMS, TOXOIDS, AND VACCINES

80:04 SERUMS

ALLERGY SERUM

INJECTION

00000999981	ALLERGY SERUM	XXX	$	0.0000

80:00 SERUMS, TOXOIDS, AND VACCINES

80:12 VACCINES

HEPATITIS B VACCINE (RECOMBINANT)

10 MCG / ML INJECTION

00000749486	RECOMBIVAX-HB	MFC	$	21.3500

20 MCG / ML INJECTION

00001919431	ENGERIX-B	GSK	$	22.3062

84:00

Skin and Mucous Membrane Agents

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:00

COMPOUND PRESCRIPTION

00000999106	**COMPD- HYDROQUINONE/RETINOIC ACID (TRETINOIN) TOP**	**XXX**	$	**0.0000**
00000999112	**MISCELLANEOUS TOPICAL COMPOUND**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999206	**COMPD- HYDROQUINONE/RETINOIC ACID (TRETINOIN) TOP**	**XXX**	$	**0.0000**
00000999213	**MISCELLANEOUS TOPICAL COMPOUND**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04 ANTI-INFECTIVES

COMPOUND PRESCRIPTION

00000999103	**COMPOUND-ANTI-INFECTIVE (TOPICAL)**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999203	**COMPOUND-ANTI-INFECTIVE (TOPICAL)**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.04 ANTI-INFECTIVES
(ANTIBACTERIALS)

FUSIDIC ACID

2 % TOPICAL CREAM				
00000586668	FUCIDIN	LEO	$	0.6282

GENTAMICIN SULFATE

0.1 % (BASE) TOPICAL CREAM				
00000805386	RATIO-GENTAMICIN SULFATE	RPH	$	0.4106
0.1 % (BASE) TOPICAL OINTMENT				
00000805025	RATIO-GENTAMICIN SULFATE	RPH	$	0.3560

METRONIDAZOLE

0.75 % TOPICAL CREAM				
00002226839	METROCREAM	GAL	$	0.4948
1 % TOPICAL CREAM				
00002156091	NORITATE	SAV	$	0.5568
0.75 % TOPICAL LOTION				
00002248206	METROLOTION	GAL	$	0.4948
0.75 % TOPICAL GEL				
00002092832	METROGEL	GAL	$	0.6600
1 % TOPICAL GEL				
00002297809	METROGEL	GAL	$	0.6000

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.04 ANTI-INFECTIVES (ANTIBACTERIALS)

METRONIDAZOLE

10 % VAGINAL CREAM

00001926861	FLAGYL	SAV	$	0.2391

METRONIDAZOLE/ NYSTATIN

100 MG / G * 20,000 UNIT / G VAGINAL CREAM

00001926845	FLAGYSTATIN	SAV	$	0.5847

500 MG * 100,000 UNIT VAGINAL OVULE

00001926829	FLAGYSTATIN	SAV	$	3.2155

MUPIROCIN

2 % TOPICAL CREAM

00002239757	BACTROBAN	GKC	$	0.5233

2 % TOPICAL OINTMENT

00002279983	**TARO-MUPIROCIN**	**TAR**	$	**0.3453**
00001916947	BACTROBAN	GKC	$	0.5233

NEOMYCIN SULFATE/ POLYMYXIN B SULFATE

40 MG / ML (BASE) * 200,000 UNIT / ML IRRIGATION SOLUTION

00000666157	NEOSPORIN	GSK	$	1.7754

SODIUM FUSIDATE

2 % TOPICAL OINTMENT

00000586676	FUCIDIN	LEO	$	0.6282

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.04 ANTI-INFECTIVES ANTIFUNGALS (ALLYLAMINES)

TERBINAFINE HCL

1 % TOPICAL CREAM

00002031094	LAMISIL	NOV	$	0.5472

1 % TOPICAL SOLUTION

00002238703	LAMISIL	NOV	$	0.5518

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.08 ANTI-INFECTIVES ANTIFUNGALS (AZOLES)

KETOCONAZOLE

2 % TOPICAL CREAM

00002245662	KETODERM	TPT	$	0.3335

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.20 ANTI-INFECTIVES
ANTIFUNGALS
(HYDROXYPYRIDONES)

CICLOPIROX OLAMINE

1 % TOPICAL CREAM				
00002221802	LOPROX	SAV	$	0.5086

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.92 ANTI-INFECTIVES
(MISCELLANEOUS LOCAL ANTI-INFECTIVES)

SILVER SULFADIAZINE

1 % TOPICAL CREAM				
00000323098	FLAMAZINE	SNE	$	0.3150

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

AMCINONIDE

0.1 % TOPICAL CREAM				
00002247098	**RATIO-AMCINONIDE**	**RPH**	$	**0.2737**
00002246714	**TARO-AMCINONIDE**	**TAR**	$	**0.2737**
0.1 % TOPICAL OINTMENT				
00002247096	RATIO-AMCINONIDE	RPH	$	0.3148
0.1 % TOPICAL LOTION				
00002247097	RATIO-AMCINONIDE	RPH	$	0.2613

BECLOMETHASONE DIPROPIONATE

250 MCG / G TOPICAL CREAM				
00002089602	PROPADERM	PAL	$	0.4371

BETAMETHASONE 17-VALERATE

0.05 % (BASE) TOPICAL CREAM				
00000716618	**BETADERM MILD**	**TAR**	$	**0.0606**
00000535427	RATIO-ECTOSONE MILD	RPH	$	0.0611
0.1 % (BASE) TOPICAL CREAM				
00000716626	**BETADERM REGULAR**	**TAR**	$	**0.0903**
00000535435	RATIO-ECTOSONE REGULAR	RPH	$	0.0911
0.05 % (BASE) TOPICAL OINTMENT				
00000716642	BETADERM MILD	TAR	$	0.0638
0.1 % (BASE) TOPICAL OINTMENT				
00000716650	BETADERM REGULAR	TAR	$	0.0951
0.05 % (BASE) TOPICAL LOTION				
00000653209	RATIO-ECTOSONE MILD	RPH	$	0.2192
0.1 % (BASE) TOPICAL LOTION				
00000750050	RATIO-ECTOSONE REGULAR	RPH	$	0.2884
0.1 % (BASE) SCALP LOTION				
00000653217	**RATIO-ECTOSONE SCALP**	**RPH**	$	**0.0853**
00000027944	VALISONE SCALP	VLP	$	0.0917

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

BETAMETHASONE DIPROPIONATE

0.05 % (BASE) TOPICAL CREAM				
00000323071	**DIPROSONE**	**SCH**	$	**0.2046**
00000804991	RATIO-TOPISONE	RPH	$	0.2047
0.05 % (BASE) TOPICAL GLYCOL CREAM				
00000688622	**DIPROLENE GLYCOL**	**SCH**	$	**0.5187**
00000849650	**RATIO-TOPILENE**	**RPH**	$	**0.5187**
0.05 % (BASE) TOPICAL OINTMENT				
00000344923	**DIPROSONE**	**SCH**	$	**0.2153**
00000805009	**RATIO-TOPISONE**	**RPH**	$	**0.2153**
0.05 % (BASE) TOPICAL GLYCOL OINTMENT				
00000629367	**DIPROLENE GLYCOL**	**SCH**	$	**0.5187**
00000849669	**RATIO-TOPILENE**	**RPH**	$	**0.5187**
0.05 % (BASE) TOPICAL LOTION				
00000417246	**DIPROSONE**	**SCH**	$	**0.1980**
00000809187	**RATIO-TOPISONE**	**RPH**	$	**0.1980**
0.05 % (BASE) TOPICAL GLYCOL LOTION				
00000862975	**DIPROLENE GLYCOL**	**SCH**	$	**0.4683**
00001927914	**RATIO-TOPILENE**	**RPH**	$	**0.4683**

BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID

0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT				
00000578436	DIPROSALIC	SCH	$	0.7993
0.5 MG / ML (BASE) * 20 MG / ML TOPICAL LOTION				
00002245688	**RATIO-TOPISALIC**	**RPH**	$	**0.3523**
00000578428	DIPROSALIC	SCH	$	0.3971

BETAMETHASONE SODIUM PHOSPHATE

5 MG / ENM (BASE) RECTAL ENEMA				
00002060884	BETNESOL (5MG/100ML)	PAL	$	9.0829

BUDESONIDE

2.3 MG / ENM RECTAL ENEMA				
00002052431	ENTOCORT (115 ML)	AZC	$	8.5232

CLOBETASOL 17-PROPIONATE

0.05 % TOPICAL CREAM				
00002024187	**MYLAN-CLOBETASOL**	**MYP**	$	**0.3647**
00002093162	**NOVO-CLOBETASOL**	**TEV**	$	**0.3647**
00002232191	**PMS-CLOBETASOL**	**PMS**	$	**0.3647**
00001910272	**RATIO-CLOBETASOL**	**RPH**	$	**0.3647**
00002245523	**TARO-CLOBETASOL**	**TAR**	$	**0.3647**
00002213265	DERMOVATE	TPT	$	0.6859
0.05 % TOPICAL OINTMENT				
00002026767	**MYLAN-CLOBETASOL**	**MYP**	$	**0.3647**
00002126192	**NOVO-CLOBETASOL**	**TEV**	$	**0.3647**
00002232193	**PMS-CLOBETASOL**	**PMS**	$	**0.3647**
00001910280	**RATIO-CLOBETASOL**	**RPH**	$	**0.3647**
00002245524	**TARO-CLOBETASOL**	**TAR**	$	**0.3647**
00002213273	DERMOVATE	TPT	$	0.6859

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

CLOBETASOL 17-PROPIONATE

0.05 % SCALP LOTION				
00002216213	**MYLAN-CLOBETASOL**	**MYP**	$	**0.3184**
00002232195	**PMS-CLOBETASOL**	**PMS**	$	**0.3184**
00001910299	**RATIO-CLOBETASOL**	**RPH**	$	**0.3184**
00002245522	**TARO-CLOBETASOL**	**TAR**	$	**0.3184**
00002213281	DERMOVATE	TPT	$	0.5987

COMPOUND PRESCRIPTION

00000999107	**COMPOUND-CORTICOSTEROIDS - TOPICAL**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999207	**COMPOUND-CORTICOSTEROIDS - TOPICAL**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

DESONIDE

0.05 % TOPICAL CREAM				
00002229315	PMS-DESONIDE	PMS	$	0.2670
0.05 % TOPICAL OINTMENT				
00002229323	**PMS-DESONIDE**	**PMS**	$	**0.2662**
00002115522	DESOCORT	GAL	$	0.3097
0.05 % TOPICAL LOTION				
00002115514	DESOCORT	GAL	$	0.1549

DESOXIMETASONE

0.05 % TOPICAL CREAM				
00002221918	TOPICORT MILD	SAV	$	0.4808
0.25 % TOPICAL CREAM				
00002221896	TOPICORT	SAV	$	0.6936

FLUOCINONIDE

0.05 % TOPICAL CREAM				
00000716863	LYDERM	TPT	$	0.2755
0.05 % TOPICAL EMOLLIENT CREAM				
00000598933	TIAMOL	TPT	$	0.2562
0.05 % TOPICAL OINTMENT				
00002236996	LYDERM	TPT	$	0.3549
0.05 % TOPICAL GEL				
00002236997	LYDERM	TPT	$	0.3599

HALOBETASOL PROPIONATE

0.05 % TOPICAL CREAM				
00001962701	ULTRAVATE	VCL	$	0.8590

HYDROCORTISONE

0.5 % TOPICAL OINTMENT				
00000716685	CORTODERM MILD	TAR	$	0.1474
1 % TOPICAL OINTMENT				
00000716693	CORTODERM REGULAR	TAR	$	0.0411
100 MG / ENM RECTAL ENEMA				
00000230316	**HYCORT (100MG/60ML)**	**VCL**	$	**5.5286**
00002112736	CORTENEMA (100MG/60ML)	AXC	$	6.6419

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

HYDROCORTISONE 17-VALERATE

0.2 % TOPICAL CREAM

00002242984	HYDROVAL	TPT	$	0.1276

0.2 % TOPICAL OINTMENT

00002242985	HYDROVAL	TPT	$	0.1276

HYDROCORTISONE ACETATE

0.5 % TOPICAL CREAM

00000716820	HYDERM	TAR	$	0.1756

1 % TOPICAL CREAM

00000716839	HYDERM	TAR	$	0.0383

10 % RECTAL FOAM

00000579335	CORTIFOAM	PAL	$	5.8582

HYDROCORTISONE ACETATE/ PRAMOXINE HCL

1 % * 1 % RECTAL FOAM

00000363014	PROCTOFOAM-HC	DUI	$	1.7139

HYDROCORTISONE ACETATE/ PRAMOXINE HCL/ ZINC SULFATE

10 MG * 20 MG * 10 MG RECTAL SUPPOSITORY

00002240851	**PROCTODAN-HC**	**ODN**	$	**0.7826**
00000476242	ANUGESIC-HC	JJM	$	1.3975

0.5 % * 1 % * 0.5 % RECTAL OINTMENT

00002234466	**PROCTODAN-HC**	**ODN**	$	**0.5218**
00000505781	ANUGESIC-HC	JJM	$	0.9317

HYDROCORTISONE ACETATE/ ZINC SULFATE

10 MG * 10 MG RECTAL SUPPOSITORY

00002236399	**ANODAN-HC**	**ODN**	$	**0.6075**
00000607797	**RATIO-HEMCORT H.C.**	**RPH**	$	**0.6075**
00002242798	**SANDOZ ANUZINC HC**	**SDZ**	$	**0.6075**
00000476285	ANUSOL-HC	JJM	$	1.1183

0.5 % * 0.5 % RECTAL OINTMENT

00002128446	**ANODAN-HC**	**ODN**	$	**0.4130**
00000607789	**RATIO-HEMCORT H.C.**	**RPH**	$	**0.4130**
00002247691	**SANDOZ ANUZINC HC**	**SDZ**	$	**0.4130**
00000505773	ANUSOL-HC	JJM	$	0.7827

MOMETASONE FUROATE

0.1 % TOPICAL CREAM

00000851744	ELOCOM	SCH	$	0.6677

0.1 % TOPICAL OINTMENT

00002270862	**PMS-MOMETASONE**	**PMS**	$	**0.3353**
00002248130	**RATIO-MOMETASONE**	**RPH**	$	**0.3353**
00002264749	**TARO-MOMETASONE**	**TAR**	$	**0.3353**
00000851736	ELOCOM	SCH	$	0.6005

0.1 % TOPICAL LOTION

00000871095	ELOCOM	SCH	$	0.4476

TRIAMCINOLONE ACETONIDE

0.1 % TOPICAL CREAM

00000716960	**TRIADERM REGULAR**	**TAR**	$	**0.0650**
00002194058	ARISTOCORT R	VLP	$	0.1397

0.5 % TOPICAL CREAM

00002194066	ARISTOCORT C	VLP	$	1.2387

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

TRIAMCINOLONE ACETONIDE

0.1 % TOPICAL OINTMENT

00002194031	ARISTOCORT R	VLP	$	0.1397

0.1 % DENTAL PASTE

00001964054	ORACORT	TAR	$	1.1374

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06.00 ANTI-INFLAMMATORY AGENTS

(COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS)

BETAMETHASONE DIPROPIONATE/ CLOTRIMAZOLE

0.05 % (BASE) * 1 % TOPICAL CREAM

00000611174	LOTRIDERM	SCH	$	0.6966

COMPOUND PRESCRIPTION

00000999110	**COMBINATION ANTI-INFECTIVE /CORTICOSTEROID**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999211	**COMBINATION ANTI-INFECTIVE /CORTICOSTEROID**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

HYDROCORTISONE/ CINCHOCAINE HCL/ FRAMYCETIN SULFATE/ ESCULIN

5 MG * 5 MG * 10 MG * 10 MG RECTAL SUPPOSITORY

00002247882	**PROCTOL**	**ODN**	$	**0.6487**
00002223260	PROCTOSEDYL	AXC	$	1.1619

5 MG / G * 5 MG / G * 10 MG / G * 10 MG / G RECTAL OINTMENT

00002247322	**PROCTOL**	**ODN**	$	**0.4577**
00002223252	PROCTOSEDYL	AXC	$	0.8198

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:08 ANTIPRURITICS AND LOCAL ANESTHETICS

LIDOCAINE

5 % TOPICAL OINTMENT

00002083795	**LIDODAN**	**ODN**	$	**0.1548**
00000001961	XYLOCAINE	AZC	$	0.2764

LIDOCAINE HCL

2 % TOPICAL JELLY

00000001694	XYLOCAINE JELLY	AZC	$	0.3900

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:28 KERATOLYTIC AGENTS

COMPOUND PRESCRIPTION

00000999104 COMPOUND- SALICYLIC ACID (TOPICAL) XXX $ 0.0000
To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999204 COMPOUND- SALICYLIC ACID (TOPICAL) XXX $ 0.0000
To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:50.04 DEPIGMENTING AND PIGMENTING AGENTS (DEPIGMENTING AGENTS)

HYDROQUINONE

4 % TOPICAL CREAM				
00000632783	ULTRAQUIN PLAIN	CDX	$	0.6833
4 % TOPICAL GEL				
00000626724	ULTRAQUIN	CDX	$	0.6833

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:50.06 DEPIGMENTING AND PIGMENTING AGENTS (PIGMENTING AGENTS)

METHOXSALEN

10 MG ORAL CAPSULE				
☒ 00000252654	OXSORALEN ULTRA	VCL	$	0.4623
☒ 00000646237	ULTRAMOP	CDX	$	0.4755
☒ 00001946374	OXSORALEN	VCL	$	0.6206
10 MG / ML TOPICAL LOTION				
00001907476	OXSORALEN	VCL	$	1.5792

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:92 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

5-FLUOROURACIL

50 MG / G TOPICAL CREAM				
00000330582	EFUDEX	VCL	$	0.8600

ACITRETIN

10 MG ORAL CAPSULE				
00002070847	SORIATANE	ACV	$	1.9030
25 MG ORAL CAPSULE				
00002070863	SORIATANE	ACV	$	3.3426

AMINOBENZOATE POTASSIUM

500 MG ORAL TABLET				
00000550175	POTABA	GLE	$	0.3752
500 MG ORAL CAPSULE				
00000611271	POTABA	GLE	$	0.2862

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:92 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

AMINOBENZOATE POTASSIUM

2 G ORAL POWDER PACKET

00000611298	POTABA	GLE	$	1.1524

CALCIPOTRIOL

50 MCG / G TOPICAL CREAM

00002150956	DOVONEX	LEO	$	0.7943

50 MCG / G TOPICAL OINTMENT

00001976133	DOVONEX	LEO	$	0.7709

50 MCG / ML SCALP SOLUTION

00002194341	DOVONEX	LEO	$	0.7979

CALCIPOTRIOL MONOHYDRATE/ BETAMETHASONE DIPROPIONATE

50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL GEL

00002319012	XAMIOL	LEO	$	1.4879

CALCIPOTRIOL/ BETAMETHASONE DIPROPIONATE

50 MCG / G * 0.5 MG / G TOPICAL OINTMENT

00002244126	DOVOBET	LEO	$	1.4879

ISOTRETINOIN

10 MG ORAL CAPSULE

00000582344	**ACCUTANE**	**HLR**	$	**1.0011**
00002257955	**CLARUS**	**MYP**	$	**1.0011**

40 MG ORAL CAPSULE

00000582352	**ACCUTANE**	**HLR**	$	**2.0428**
00002257963	**CLARUS**	**MYP**	$	**2.0428**

PODOFILOX

0.5 % TOPICAL SOLUTION

00002074788	WARTEC	PAL	$	13.6140

TAZAROTENE

0.05 % TOPICAL GEL

00002230784	TAZORAC	ALL	$	1.4203

0.1 % TOPICAL GEL

00002230785	TAZORAC	ALL	$	1.4203

86:00

Smooth Muscle Relaxants

86:00 SMOOTH MUSCLE RELAXANTS

86:12 GENITOURINARY SMOOTH MUSCLE RELAXANTS

FLAVOXATE HCL

200 MG ORAL TABLET

00002244842	APO-FLAVOXATE	APX	$	0.7270

OXYBUTYNIN CHLORIDE

2.5 MG ORAL TABLET

00002240549	PMS-OXYBUTYNIN	PMS	$	0.1335

5 MG ORAL TABLET

00002163543	**APO-OXYBUTYNIN**	**APX**	$	**0.2485**
00002230800	**MYLAN-OXYBUTYNIN**	**MYP**	$	**0.2485**
00002230394	**NOVO-OXYBUTYNIN**	**TEV**	$	**0.2485**
00002158590	**NU-OXYBUTYN**	**NXP**	$	**0.2485**
00002240550	**PMS-OXYBUTYNIN**	**PMS**	$	**0.2485**

1 MG / ML ORAL SYRUP

00002223376	PMS-OXYBUTYNIN	PMS	$	0.0752

86:00 SMOOTH MUSCLE RELAXANTS

86:16 RESPIRATORY SMOOTH MUSCLE RELAXANTS

AMINOPHYLLINE

225 MG ORAL SUSTAINED-RELEASE TABLET

00002014270	PHYLLOCONTIN	PUR	$	0.2331

350 MG ORAL SUSTAINED-RELEASE TABLET

00002014289	PHYLLOCONTIN-350	PUR	$	0.2969

25 MG / ML INJECTION

00000497193	AMINOPHYLLINE	HSP	$	0.3920

OXTRIPHYLLINE

20 MG / ML ORAL ELIXIR

00000792942	**PMS-OXTRIPHYLLINE**	**PMS**	$	**0.0234**
00000476366	CHOLEDYL	ERF	$	0.0388

OXTRIPHYLLINE/ GUAIFENESIN

20 MG / ML * 10 MG / ML ORAL ELIXIR

00000476374	CHOLEDYL EXPECTORANT	ERF	$	0.0776

THEOPHYLLINE

100 MG ORAL SUSTAINED-RELEASE TABLET

00000692689	APO-THEO LA	APX	$	0.1300

200 MG ORAL SUSTAINED-RELEASE TABLET

00000692697	APO-THEO LA	APX	$	0.1350

300 MG ORAL SUSTAINED-RELEASE TABLET

00000692700	APO-THEO LA	APX	$	0.1400

400 MG ORAL SUSTAINED-RELEASE TABLET

00002014165	UNIPHYL	PUR	$	0.5354

600 MG ORAL SUSTAINED-RELEASE TABLET

00002014181	UNIPHYL	PUR	$	0.6484

5.3 MG / ML ORAL LIQUID

00001966219	THEOLAIR	GRC	$	0.0271

88:00

Vitamins

88:00 VITAMINS

88:08 VITAMIN B COMPLEX

CYANOCOBALAMIN

1,000 MCG / ML INJECTION

00001987003	**CYANOCOBALAMIN**	**CYT**	$	**0.4500**
00000521515	**VITAMIN B12**	**SDZ**	$	**0.4500**

FOLIC ACID

5 MG ORAL TABLET

00000426849	APO-FOLIC	APX	$	0.0404

5 MG / ML INJECTION

00000816086	FOLIC ACID	SDZ	$	1.9484

THIAMINE HCL

100 MG / ML INJECTION

00002193221	**THIAMIJECT**	**OMG**	$	**1.1880**
00002243525	**THIAMINE HCL**	**CYT**	$	**1.1880**
00000816078	VITAMIN B1	SDZ	$	1.5652

88:00 VITAMINS

88:16 VITAMIN D

ALFACALCIDOL

0.25 MCG ORAL CAPSULE

00000474517	ONE-ALPHA	LEO	$	0.4499

1 MCG ORAL CAPSULE

00000474525	ONE-ALPHA	LEO	$	1.3464

2 MCG / ML ORAL DROPS

00002240329	ONE-ALPHA	LEO	$	5.1442

2 MCG / ML INJECTION

00002242502	ONE-ALPHA	LEO	$	16.4968

CALCITRIOL

0.25 MCG ORAL CAPSULE

00000481823	ROCALTROL	HLR	$	0.9976

0.5 MCG ORAL CAPSULE

00000481815	ROCALTROL	HLR	$	1.5865

1 MCG / ML INJECTION

00000891738	CALCIJEX	ABB	$	10.2000

2 MCG / ML INJECTION

00000891746	CALCIJEX	ABB	$	18.5000

VITAMIN D2

8,288 UNIT / ML ORAL LIQUID

00002017598	DRISDOL	SAV	$	0.4588

88:00 VITAMINS

88:24 VITAMIN K ACTIVITY

PHYTONADIONE

2 MG / ML INJECTION

00000781878	VITAMIN K1 PEDIATRIC	SDZ	$	4.5738

10 MG / ML INJECTION

00000804312	VITAMIN K1	SDZ	$	2.6312

88:00 VITAMINS

88:28 MULTIVITAMIN PREPARATIONS

PIPRADROL HCL/ THIAMINE HCL/ RIBOFLAVIN/ PYRIDOXINE HCL/ NIACINAMIDE/ CHOLINE/ INOSITOL

0.04 MG / ML * 0.22 MG / ML * 0.11 MG / ML * 0.04 MG / ML * 1.11 MG / ML * 2.22 MG / ML * 2.22 MG / ML ORAL LIQUID

00002103052	ALERTONIC	ODN	$	0.0643

88:00 VITAMINS

88:28.01 MULTIVITAMIN PREPARATIONS (VITAMINS & MINERALS)

VITAMIN A PALMITATE/ VITAMIN D3/ TOCOPHEROL D-ALPHA/ PHYTONADIONE/ ASCORBIC ACID/ FOLIC ACID/ THIAMINE/ RIBOFLAVIN (VITAMIN B2)/ NIACIN/ PYRIDOXINE/ CYANOCOBALAMIN/ BIOTIN/ CALCIUM D-PANTOTHENATE/ ZINC GLUCONATE/ BETA CAROTENE

4,000 UNIT * 400 UNIT * 150 UNIT * 0.15 MG * 60 MG * 0.2 MG * 1.2 MG * 1.3 MG * 10 MG * 1.5 MG * 12 MCG * 50 MCG * 10 MG (BASE) * 7.5 MG (BASE) * 3 MG ORAL TABLET

00002031388	ADEKS	AXC	$	0.3294

92:00

Miscellaneous Therapeutic Agents

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

ALLOPURINOL

100 MG ORAL TABLET				
00000402818	**APO-ALLOPURINOL**	**APX**	$	**0.0780**
00000364282	**NOVO-PUROL**	**TEV**	$	**0.0780**
200 MG ORAL TABLET				
00000479799	**APO-ALLOPURINOL**	**APX**	$	**0.1300**
00000565342	**NOVO-PUROL**	**TEV**	$	**0.1300**
300 MG ORAL TABLET				
00000402796	**APO-ALLOPURINOL**	**APX**	$	**0.2125**
00000363693	**NOVO-PUROL**	**TEV**	$	**0.2125**

AZATHIOPRINE

50 MG ORAL TABLET				
00002242907	**APO-AZATHIOPRINE**	**APX**	$	**0.5418**
00002231491	**MYLAN-AZATHIOPRINE**	**MYP**	$	**0.5418**
00002236819	**NOVO-AZATHIOPRINE**	**TEV**	$	**0.5418**
00000004596	IMURAN	GSK	$	1.0339

BETAHISTINE DIHYDROCHLORIDE

16 MG ORAL TABLET				
00002280191	**NOVO-BETAHISTINE**	**TEV**	$	**0.3557**
00002243878	SERC	SLO	$	0.4756

BOTULINUM TOXIN TYPE A

INJECTION				
00001981501	BOTOX (100 - 200 UNITS/VIAL)	ALL	$	3.5700

CLODRONATE DISODIUM

400 MG ORAL CAPSULE				
00002245828	CLASTEON	SPC	$	1.2989

CLODRONATE DISODIUM TETRAHYDRATE

400 MG ORAL CAPSULE				
00001984845	BONEFOS	BHP	$	1.9435
60 MG / ML INJECTION				
00001984837	BONEFOS	BHP	$	13.0656

CLONIDINE HCL

0.025 MG ORAL TABLET				
00002248732	**APO-CLONIDINE**	**APX**	$	**0.1523**
00002304163	**NOVO-CLONIDINE**	**TEV**	$	**0.1523**
00000519251	DIXARIT	BOE	$	0.2720

COLCHICINE

0.6 MG ORAL TABLET				
00000572349	COLCHICINE	ODN	$	0.2665
1 MG ORAL TABLET				
00000621374	COLCHICINE	ODN	$	0.5285

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

COMPOUND PRESCRIPTION

INJECTION

00000999215	MISCELLANEOUS INJECTABLE COMPOUND	XXX	$	0.0000

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

☒ 00000999999	COMPOUND	XXX	$	0.0000
00000999114	**MISCELLANEOUS INJECTABLE COMPOUND**	**XXX**	$	**0.0000**
00000999113	**MISCELLANEOUS ORAL COMPOUND**	**XXX**	$	**0.0000**

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999216	**MISCELLANEOUS COMPOUND**	**XXX**	$	**0.0000**
00000999214	**MISCELLANEOUS ORAL COMPOUND**	**XXX**	$	**0.0000**

To be used when the compound has been procured from a licensed compounding and repackaging pharmacy and dispensed by a licensed community pharmacy.

DIMETHYL SULFOXIDE

50 % BLADDER IRRIGATION SOLUTION

00002243231	**DIMETHYL SULFOXIDE IRRIGATION**	**SDZ**	$	**0.9990**
00000493392	RIMSO-50	ALV	$	1.1900

ETIDRONATE DISODIUM

200 MG ORAL TABLET

00002248686	**CO ETIDRONATE**	**COB**	$	**0.8257**
00002245330	**MYLAN-ETIDRONATE**	**MYP**	$	**0.8257**

ETIDRONATE DISODIUM/ CALCIUM CARBONATE

400 MG * 500 MG ORAL TABLET

00002263866	**CO ETIDROCAL**	**COB**	$	**0.2808**
00002247323	**MYLAN-ETI-CAL-CAREPAC**	**MYP**	$	**0.2808**
00002324199	**NOVO-ETIDRONATECAL**	**TEV**	$	**0.2808**
00002176017	DIDROCAL	WCC	$	0.5014

FLUNARIZINE HCL

5 MG (BASE) ORAL CAPSULE

00002246082	APO-FLUNARIZINE	APX	$	0.7204

LEUCOVORIN CALCIUM

5 MG (BASE) ORAL TABLET

00002170493	LEDERLE LEUCOVORIN CALCIUM	WAY	$	6.5428

10 MG / ML INJECTION

00002087316	LEUCOVORIN CALCIUM	TEV	$	10.4312

NAFARELIN ACETATE

2 MG / ML (BASE) NASAL SOLUTION

00002188783	SYNAREL	PFI	$	37.7379

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

PAMIDRONATE DISODIUM

For the products within the following three groupings, pricing has been established on a per vial basis.

30 MG / VIAL INJECTION				
00002244550	**PAMIDRONATE DISODIUM**	**HSP**	$	**82.1860**
00002249669	**PAMIDRONATE DISODIUM OMEGA**	**OMG**	$	**82.1860**
00002059762	AREDIA	NOV	$	174.3973
60 MG / VIAL INJECTION				
00002244551	PAMIDRONATE DISODIUM	HSP	$	123.2790
90 MG / VIAL INJECTION				
00002244552	**PAMIDRONATE DISODIUM**	**HSP**	$	**246.5581**
00002264986	**PAMIDRONATE DISODIUM**	**SDZ**	$	**246.5581**
00002249685	**PAMIDRONATE DISODIUM OMEGA**	**OMG**	$	**246.5581**
00002245999	**PMS-PAMIDRONATE**	**PMS**	$	**246.5581**
00002059789	AREDIA	NOV	$	523.1810

PENTOSAN POLYSULFATE SODIUM

100 MG ORAL CAPSULE				
00002029448	ELMIRON	JOI	$	1.6980

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:36 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

LEFLUNOMIDE

RESTRICTED BENEFIT - This product is a benefit for the treatment of rheumatoid arthritis when prescribed by a Specialist in Rheumatology or Internal Medicine.

10 MG ORAL TABLET				
00002256495	**APO-LEFLUNOMIDE**	**APX**	$	**6.0417**
00002261251	**NOVO-LEFLUNOMIDE**	**TEV**	$	**6.0417**
00002283964	**SANDOZ LEFLUNOMIDE**	**SDZ**	$	**6.0417**
00002241888	ARAVA	SAV	$	11.3660
20 MG ORAL TABLET				
00002256509	**APO-LEFLUNOMIDE**	**APX**	$	**6.0417**
00002261278	**NOVO-LEFLUNOMIDE**	**TEV**	$	**6.0417**
00002283972	**SANDOZ LEFLUNOMIDE**	**SDZ**	$	**6.0417**
00002241889	ARAVA	SAV	$	11.3660

94:00

Devices

94:00 DEVICES

94:00

AEROSOL HOLDING CHAMBER

RESTRICTED BENEFIT - Coverage is limited to one aerosol holding chamber per plan participant per year.

DEVICE				
00000990014	SPACE CHAMBER	KGH	$	12.9000
00000990080	VORTEX	KGH	$	20.9600
00000990089	AEROCHAMBER AC BOYZ CHAMBER	TMI	$	21.5400
00000990088	AEROCHAMBER AC GIRLZ CHAMBER	TMI	$	21.5400
00000990084	AEROCHAMBER MAX	TMI	$	23.5500

AEROSOL HOLDING CHAMBER/MASK

RESTRICTED BENEFIT - Coverage is limited to one of each size (infant, pediatric, adult) aerosol holding chamber mask or chamber w/ mask per plan participant per year.

INFANT DEVICE				
00000990081	VORTEX BABY WHIRL INFANT MASK	KGH	$	9.1400
00000990015	SPACE CHAMBER INFANT MASK	KGH	$	13.9800
00000990087	INFANT AEROCHAMBER MAX W/ MASK	TMI	$	37.6700
PEDIATRIC DEVICE				
00000990082	VORTEX SPINNER PEDIATRIC MASK	KGH	$	9.1400
00000990016	SPACE CHAMBER PEDIATRIC MASK	KGH	$	13.9800
00000990086	CHILD AEROCHAMBER MAX W/ MASK	TMI	$	37.6700
ADULT DEVICE				
00000990017	SPACE CHAMBER ADULT MASK	KGH	$	13.9800
00000990085	ADULT AEROCHAMBER MAX W/ MASK	TMI	$	39.8600

DEVICE

DEVICE				
00000999949	SEREVENT DISKHALER	GSK	$	5.8695

Appendices

Abbreviations

Pharmaceutical Manufacturers

Appendix 1
Abbreviations

ASA ..... acetylsalicylic acid
ENM ..... enema
FC ..... film coated
G ..... gram(s)
HCL ..... hydrochloride

HR ..... hour
IU ..... international unit(s)
MCG ..... microgram
MEQ ..... milliequivalent

MG ..... milligram
ML ..... millilitre
PTH ..... patch
SYR ..... syringe

W ..... with
% ..... percent

Appendix 2
Pharmaceutical Manufacturers

A

ABB Abbott Laboratories Limited
ACV Actavis
ALC Alcon Canada Inc.
ALL Allergan Inc.
ALV Alveda Pharmaceuticals Inc.
AMG Amgen Inc.
APX Apotex Inc.
ASP Astellas Pharma Canada, Inc.
ATL Atlas Laboratories Inc.
AXC Axcan Pharma Inc.
AZC AstraZeneca Canada Inc.

B

BAI Bayer Inc.
BAR Barr laboratories, Inc.
BAX Baxter Corporation
BHP Bayer Healthcare Pharmaceuticals
BIO Biogen Idec Canada Inc
BMS Bristol-Myers Squibb
BOE Boehringer Ingelheim (Canada) Ltd.
BOV Biovail Pharmaceuticals Canada
BVM Biovitrum AB

C

CDX Canderm Pharma Inc.
CHD Church & Dwight Canada
COB Cobalt Pharmaceuticals Inc.
CYT Cytex Pharmaceuticals Inc.

D

DUI Duchesnay Inc.
DUR Duramed Pharmaceuticals Inc.

E

ERF ERFA Canada Inc.
ETP Ethypharm Inc.

F

FEI Ferring Inc.

G

GAL Galderma Canada Inc.
GIL Gilead Sciences Inc.
GKC GlaxoSmithKline Consumer Healthcare
GLE Glenwood Laboratories Canada Ltd.
GMD Genmed, A Division Of Pfizer Canada Inc.
GRC Graceway Canada Company
GSK GlaxoSmithKline

H

HLR Hoffman-La Roche Limited
HSP Hospira Healthcare Corporation

I

IRO Iroko Pharmaceuticals, LLC

J

JHP JHP Pharmaceuticals, LLC
JJI Johnson & Johnson Inc.
JJM Johnson & Johnson - Merck
JOI Janssen-Ortho Inc.
JPC Jamp Pharma Corporation

K

KGH Kego Healthcare
KNG King Pharmaceuticals Canada Inc.

L

LBC Lundbeck Canada Inc.
LEO Leo Pharma Inc.
LIL Eli Lilly Canada Inc.

M

MCL McNeil Consumer Healthcare
MED Meda AB
MFC Merck Frosst Canada & Co.
MPI Mint Pharmaceuticals Inc.
MYP Mylan Pharmaceuticals ULC

N

NGP NEXT GENERATION PHARMA INC.
NNA Novo Nordisk Canada Inc.
NOV Novartis Pharmaceuticals Canada Inc.
NTI Nucro-Technics Incorporated
NXP Nu-Pharm Inc.
NYC Nycomed Canada Inc.

O

ODN Odan Laboratories Ltd.
OMG Omega Laboratories Ltd.
ORG Organon Canada Ltd.

Appendix 2
Pharmaceutical Manufacturers

P

PAL Paladin Labs Inc.
PFI Pfizer Canada Inc.
PHH Pharmel Inc.
PMS Pharmascience Inc.
PPC Pharmaceutical Partners of Canada, a division of Abraxis Bioscience Inc.
PPH Pendopharm Inc.
PUR Purdue Pharma

R

RAN Ranbaxy Pharmaceuticals Canada Inc
ROG Rougier Pharma Inc. (Div. of ratiopharm)
RPH ratiopharm
RVP Laboratoire Riva Inc./Pharmascience Inc.

S

SAV Sanofi-Aventis
SCH Schering Canada Inc.
SDZ Sandoz Canada Inc.
SEV Servier Canada Inc.
SHB Shire Canada Inc.
SLO Solvay Pharma Inc.
SNE Smith & Nephew Inc.
SPC Sepracor Pharmaceuticals, Inc.
SRO EMD Serono Canada Inc.
STM Sterimax Inc.

T

TAK Takeda Canada, Inc.
TAR Taro Pharmaceuticals Inc.
TCI Tercica, Inc.
TEV Teva Canada Limited
TMI Trudell Medical International
TMP Teva Neuroscience
TPT Taropharma, A Div. of Taro Pharmaceuticals Inc.

U

UCB UCB Pharma Canada Inc.

V

VCL Valeant Canada Limittee/Limited
VLP Valeo Pharma Inc.

W

WAY Wyeth Pharmaceuticals
WCC Warner Chilcott Canada Co.
WSD Westwood Squibb (Div. Bristol-Myers Squibb Canada)
WSP Wellspring Pharmaceutical Canada Corp.

X

XXX Miscellaneous Manufacturers

Z

ZMC Zymcan Pharmaceuticals Inc.

Indices

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00002277263	SEC 3.66	00002281260	13	00002283794	54	00002287447	SEC 3.22
00002277271	SEC 3.66	00002281279	13	00002283964	173	00002287498	27
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00002277344	85	00002281546	38	00002284006	SEC 3.14	00002287706	57
00002277352	85	00002281554	38	00002284030	151	00002287714	58
00002277360	85	00002281562	38	00002284049	151	00002287722	58
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00002278537	129	00002281791	89	00002284243	90	00002287773	79
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00002278553	81	00002281813	90	00002284278	91	00002288044	35
00002278561	81	00002281821	90	00002284286	91	00002288052	35
00002278588	6	00002281848	90	00002284383	50	00002288087	SEC 3.13
00002278618	129	00002282097	SEC 3.6	00002284391	50	00002288109	SEC 3.14
00002278626	129	00002282119	92	00002284677	SEC 3A.4	00002288184	129
00002278669	134	00002282127	92	00002284685	SEC 3A.4	00002288192	129
00002278677	22	00002282135	92	00002284707	SEC 3A.4	00002288559	9

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00002289091	35	00002293951	4	00002297744	56	00002300133	55
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00002289539	11	00002294346	149	00002297809	157	00002300230	55
00002290111	108	00002294400	150	00002297841	60	00002300486	133
00002290146	108	00002294419	11	00002297868	129	00002300680	54
00002290154	108	00002294427	11	00002297876	129	00002301083	133
00002290332	53	00002294524	55	00002297906	SEC 3.59	00002301148	57
00002290340	53	00002294532	55	00002297914	SEC 3.59	00002301156	57
00002291037	52	00002294702	67	00002297922	SEC 3.59	00002301164	58
00002291045	52	00002294710	67	00002298074	133	00002301172	58
00002291053	52	00002294826	12	00002298082	133	00002301288	41
00002291061	52	00002294834	12	00002298279	SEC 3.59	00002301407	SEC 3.18
00002291088	52	00002294885	43	00002298287	SEC 3.59	00002301423	SEC 3.59
00002291134	54	00002295121	43	00002298295	SEC 3.59	00002301431	SEC 3.59
00002291142	54	00002295148	50	00002298457	15	00002301458	SEC 3.59
00002291150	54	00002295369	57	00002298538	145	00002301482	SEC 3.23
00002291398	57	00002295482	57	00002298546	145	00002301490	SEC 3.23
00002291401	57	00002295490	57	00002298570	43	00002301768	56
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00002291967	129	00002295946	145	00002298651	SEC 3A.4	00002302187	4
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00002303167	90	00002308908	60	00002314177	133	00002319985	73
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00002303183	90	00002308932	3	00002314630	SEC 3.32	00002320312	98
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