Updates to the Alberta Drug Benefit List

Effective August 1, 2020

Alberta Government

Inquiries should be directed to:

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Website: https://www.alberta.ca/drug-benefit-list-and-drug-review-process.aspx

Administered by Alberta Blue Cross
on behalf of Alberta Health.

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 Drug Benefit List* 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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Special Authorization

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
ORENCIA 250 MG / VIAL INJECTION	ABATACEPT	00002282097	BMS

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACCEL-PILOCARPINE 5 MG TABLET	PILOCARPINE HCL	00002496119	ACP
ACH-OLMESARTAN 20 MG TABLET	OLMESARTAN MEDOXOMIL	00002456311	AHI
ACH-OLMESARTAN 40 MG TABLET	OLMESARTAN MEDOXOMIL	00002456338	AHI
APO-TRAZODONE D 150 MG TABLET	TRAZODONE HCL	00002147653	APX
JAMP-TIMOLOL 0.5% OPHTHALMIC SOLUTION	TIMOLOL MALEATE	00002447800	JPC
MINT-VALGANCICLOVIR 450 MG TABLET	VALGANCICLOVIR HCL	00002495457	MPI
NAT-PREGABALIN 25 MG CAPSULE	PREGABALIN	00002494841	NTP
NAT-PREGABALIN 50 MG CAPSULE	PREGABALIN	00002494868	NTP
NAT-PREGABALIN 75 MG CAPSULE	PREGABALIN	00002494876	NTP
NAT-PREGABALIN 150 MG CAPSULE	PREGABALIN	00002494884	NTP
NAT-PREGABALIN 300 MG CAPSULE	PREGABALIN	00002494906	NTP

New Established Interchangeable (IC) Grouping(s)

The following IC Grouping(s) have been established and LCA pricing will be applied effective September 1, 2020.

Generic Description	Strength / Form	New LCA Price
PILOCARPINE	5 MG TABLET	1.2445

Least Cost Alternative (LCA) Price Change(s)

The following established IC Grouping(s) are affected and a revised LCA price has been established. Groupings affected by a price decrease, will be effective September 1, 2020. Groupings affected by a price increase, will be effective August 1, 2020. Please review the online ***Interactive Drug Benefit List*** *for further information.*

Generic Description	Strength / Form	New LCA Price
VALGANCICLOVIR HCL	450 MG TABLET	5.8553

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until August 31, 2020. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
LAPELGA (0.6 ML / SYRINGE) 6 MG INJECTION	PEGFILGRASTIM	00002474565	APX
MYLAN-INDAPAMIDE 1.25 MG TABLET	INDAPAMIDE HEMIHYDRATE	00002240067	MYP
PMS-METHYLPHENIDATE 20 MG TABLET	METHYLPHENIDATE HCL	00000585009	PMS
TEVA-FLUVASTATIN 20 MG CAPSULE	FLUVASTATIN SODIUM	00002299224	TEV
TEVA-FLUVASTATIN 40 MG CAPSULE	FLUVASTATIN SODIUM	00002299232	TEV

Discontinued Listing(s)

Notification of discontinuation has been received from the manufacturer(s). The Alberta government-sponsored drug programs previously covered the following drug product(s). Effective August 1, 2020, the listed product(s) will no longer be a benefit and where applicable, will not be considered for coverage by Special Authorization. A transition period will be applied and as of September 1, 2020 claims will no longer pay for these product(s).

Trade Name / Strength / Form	Generic Description	DIN	MFR
ISDN 5 MG SUBLINGUAL TABLET	ISOSORBIDE DINITRATE	00000670944	AAP
JAMP-LISINOPRIL 20 MG TABLET	LISINOPRIL	00002361566	JPC
MODECATE CONCENTRATE 100 MG / ML INJECTION	FLUPHENAZINE DECANOATE	00000755575	BMS
PMS-RAMIPRIL 2.5 MG CAPSULE	RAMIPRIL	00002247917	PMS
PMS-RAMIPRIL 5 MG CAPSULE	RAMIPRIL	00002247918	PMS
PMS-RAMIPRIL 10 MG CAPSULE	RAMIPRIL	00002247919	PMS
SANDOZ DICLOFENAC 50 MG ENTERIC-COATED TABLET	DICLOFENAC SODIUM	00002261960	SDZ
SANDOZ FENOFIBRATE S 160 MG TABLET	FENOFIBRATE	00002288052	SDZ
SANDOZ RANITIDINE 150 MG TABLET	RANITIDINE HCL	00002243229	SDZ
SANDOZ RANITIDINE 300 MG TABLET	RANITIDINE HCL	00002243230	SDZ

Product(s) Removed from the ADBL as Price Policy Requirements not Satisfied

The Alberta government-sponsored drug programs previously covered the following drug product(s). Effective August 1, 2020, the listed product(s) will no longer be a benefit. A transition period will be applied and as of September 1, 2020 claims will no longer pay for this product.

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP-INDAPAMIDE 1.25 MG TABLET	INDAPAMIDE HEMIHYDRATE	00002373904	JPC

PART 2

Drug Additions

FLUVASTATIN SODIUM

20 MG (BASE) ORAL CAPSULE

00002299224	TEVA-FLUVASTATIN	TEV	***$ 0.1354***	$	0.6882

MAC pricing will be applied based on the LCA Price for Rosuvastatin Calcium 1 x 10 mg tablet or the LCA Price of Atorvastatin 1 x 20 mg tablet whichever is lower.

40 MG (BASE) ORAL CAPSULE

00002299232	TEVA-FLUVASTATIN	TEV	***$ 0.1354***	$	0.9671

MAC pricing will be applied based on the LCA Price for Rosuvastatin Calcium 1 x 10 mg tablet or the LCA Price of Atorvastatin 1 x 20 mg tablet whichever is lower.

INDAPAMIDE HEMIHYDRATE

1.25 MG (BASE) ORAL TABLET

00002245246	**APO-INDAPAMIDE**	**APX**	$	**0.0745**
00002240067	MYLAN-INDAPAMIDE	MYP	$	0.1490

METHYLPHENIDATE HCL

20 MG ORAL TABLET

00002249332	**APO-METHYLPHENIDATE**	**APX**	$	**0.2735**
00000585009	PMS-METHYLPHENIDATE	PMS	$	0.3387

OLMESARTAN MEDOXOMIL

20 MG ORAL TABLET

00002456311	**ACH-OLMESARTAN**	**AHI**	$	**0.3019**
00002442191	**ACT OLMESARTAN**	**APH**	$	**0.3019**
00002453452	**APO-OLMESARTAN**	**APX**	$	**0.3019**
00002443864	**AURO-OLMESARTAN**	**AUR**	$	**0.3019**
00002461641	**JAMP-OLMESARTAN**	**JPC**	$	**0.3019**
00002461307	**PMS-OLMESARTAN**	**PMS**	$	**0.3019**
00002443414	**SANDOZ OLMESARTAN**	**SDZ**	$	**0.3019**
00002318660	OLMETEC	MFC	$	1.1441

40 MG ORAL TABLET

00002456338	**ACH-OLMESARTAN**	**AHI**	$	**0.3019**
00002442205	**ACT OLMESARTAN**	**APH**	$	**0.3019**
00002453460	**APO-OLMESARTAN**	**APX**	$	**0.3019**
00002443872	**AURO-OLMESARTAN**	**AUR**	$	**0.3019**
00002461668	**JAMP-OLMESARTAN**	**JPC**	$	**0.3019**
00002461315	**PMS-OLMESARTAN**	**PMS**	$	**0.3019**
00002443422	**SANDOZ OLMESARTAN**	**SDZ**	$	**0.3019**
00002318679	OLMETEC	MFC	$	1.1441

PILOCARPINE HCL

5 MG ORAL TABLET

00002496119	**ACCEL-PILOCARPINE**	**ACP**	$	**1.2445**
00002216345	SALAGEN	PFI	$	1.4641

PREGABALIN

25 MG ORAL CAPSULE				
00002394235	APO-PREGABALIN	APX	$	0.1481
00002433869	AURO-PREGABALIN	AUR	$	0.1481
00002435977	JAMP-PREGABALIN	JPC	$	0.1481
00002423804	MINT-PREGABALIN	MPI	$	0.1481
00002494841	NAT-PREGABALIN	NTP	$	0.1481
00002359596	PMS-PREGABALIN	PMS	$	0.1481
00002403692	PREGABALIN	SIV	$	0.1481
00002405539	PREGABALIN	SNS	$	0.1481
00002392801	RAN-PREGABALIN	RAN	$	0.1481
00002390817	SANDOZ PREGABALIN	SDZ	$	0.1481
00002361159	TEVA-PREGABALIN	TEV	$	0.1481
50 MG ORAL CAPSULE				
00002394243	APO-PREGABALIN	APX	$	0.2324
00002433877	AURO-PREGABALIN	AUR	$	0.2324
00002435985	JAMP-PREGABALIN	JPC	$	0.2324
00002423812	MINT-PREGABALIN	MPI	$	0.2324
00002494868	NAT-PREGABALIN	NTP	$	0.2324
00002359618	PMS-PREGABALIN	PMS	$	0.2324
00002403706	PREGABALIN	SIV	$	0.2324
00002405547	PREGABALIN	SNS	$	0.2324
00002392828	RAN-PREGABALIN	RAN	$	0.2324
00002390825	SANDOZ PREGABALIN	SDZ	$	0.2324
00002361175	TEVA-PREGABALIN	TEV	$	0.2324
75 MG ORAL CAPSULE				
00002394251	APO-PREGABALIN	APX	$	0.3007
00002433885	AURO-PREGABALIN	AUR	$	0.3007
00002435993	JAMP-PREGABALIN	JPC	$	0.3007
00002424185	MINT-PREGABALIN	MPI	$	0.3007
00002494876	NAT-PREGABALIN	NTP	$	0.3007
00002359626	PMS-PREGABALIN	PMS	$	0.3007
00002403714	PREGABALIN	SIV	$	0.3007
00002405555	PREGABALIN	SNS	$	0.3007
00002392836	RAN-PREGABALIN	RAN	$	0.3007
00002390833	SANDOZ PREGABALIN	SDZ	$	0.3007
00002361183	TEVA-PREGABALIN	TEV	$	0.3007
150 MG ORAL CAPSULE				
00002394278	APO-PREGABALIN	APX	$	0.4145
00002433907	AURO-PREGABALIN	AUR	$	0.4145
00002436000	JAMP-PREGABALIN	JPC	$	0.4145
00002424207	MINT-PREGABALIN	MPI	$	0.4145
00002494884	NAT-PREGABALIN	NTP	$	0.4145
00002359634	PMS-PREGABALIN	PMS	$	0.4145
00002403722	PREGABALIN	SIV	$	0.4145
00002405563	PREGABALIN	SNS	$	0.4145
00002392844	RAN-PREGABALIN	RAN	$	0.4145
00002390841	SANDOZ PREGABALIN	SDZ	$	0.4145
00002361205	TEVA-PREGABALIN	TEV	$	0.4145
300 MG ORAL CAPSULE				
00002394294	APO-PREGABALIN	APX	$	0.4145
00002436019	JAMP-PREGABALIN	JPC	$	0.4145
00002494906	NAT-PREGABALIN	NTP	$	0.4145
00002359642	PMS-PREGABALIN	PMS	$	0.4145
00002403730	PREGABALIN	SIV	$	0.4145
00002405598	PREGABALIN	SNS	$	0.4145
00002392860	RAN-PREGABALIN	RAN	$	0.4145
00002390868	SANDOZ PREGABALIN	SDZ	$	0.4145
00002361248	TEVA-PREGABALIN	TEV	$	0.4145

TIMOLOL MALEATE

0.5 % (BASE) OPHTHALMIC SOLUTION

00000755834	**APO-TIMOP**	**APX**	$	**1.2140**
00002447800	**JAMP-TIMOLOL**	**JPC**	$	**1.2140**
00002166720	**SANDOZ TIMOLOL MALEATE**	**SDZ**	$	**1.2140**
00000451207	TIMOPTIC	PUR	$	4.0820

TRAZODONE HCL

150 MG ORAL TABLET

00002147653	**APO-TRAZODONE D**	**APX**	$	**0.1453**
00002144298	**TEVA-TRAZODONE**	**TEV**	$	**0.1453**
00002348799	**TRAZODONE**	**SNS**	$	**0.1453**

VALGANCICLOVIR HCL

450 MG (BASE) ORAL TABLET

00002435179	**AURO-VALGANCICLOVIR**	**AUR**	$	**5.8553**
00002495457	**MINT-VALGANCICLOVIR**	**MPI**	$	**5.8553**
00002413825	**TEVA-VALGANCICLOVIR**	**TEV**	$	**5.8553**
00002245777	VALCYTE	HLR	$	24.7087

PART 3

Special Authorization

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).

'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:
- Abatacept intravenous infusion: 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.
- Abatacept subcutaneous injection: a single IV loading dose of up to 1000 mg/dose followed by 125 mg subcutaneous injection within a day, then once-weekly 125 mg SC injections. Patients who are unable to receive an infusion may initiate weekly subcutaneous injections without an intravenous loading dose. Patients will be limited to receiving one-month supply of abatacept subcutaneous injection 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 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial 12 weeks 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 a period of 12 months. Coverage for abacept will be provided for one intravenous dose of up to 1000 mg every 4 weeks, or one weekly 125 mg subcutaneous injection. Ongoing coverage

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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 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/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Polyarticular 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 (pJIA) 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 and/or adalimumab and/or tocilizumab (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 one dose of 10 mg/kg (maximum dose 1000 mg) at 0, 2, 4, 8, 12 and 16 weeks (total of six doses).
- 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 abatacept) 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 abatacept 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 potential coverage for retreatment with abatacept following a subsequent 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.

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2) The Pediatric Rheumatology Specialist must confirm in writing that the patient is a responder that meets the following criteria (ACR Pedi 30):
- 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 ACR Pedi 30 and the CHAQ scores must be reported.
Following assessment and confirmation of initial treatment response, coverage for retreatment with abatacept may be approved for one dose of 10 mg/kg (maximum dose 1000 mg) at 0, 2*, 4, 8, 12 and 16 weeks (total of up to six doses; *the week 2 dose on retreatment is optional, to be administered at the discretion of the Pediatric Rheumatology Specialist). 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 ACR Pedi 30 variables for pJIA and 30% or greater 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)."

Please note: Coverage is provided for treatment of disease flares only. However, if a patient experiences a subsequent flare within 12 months of initiation of treatment with abatacept, they may be eligible for continuous coverage (i.e., one dose of 10 mg/kg (maximum dose 1000 mg) every 4 weeks) for a maximum period of two years, provided the patient has demonstrated a response to initial treatment."

All requests (including renewal requests) for abatacept for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60010).

250 MG / VIAL (BASE)	**INJECTION**			
00002282097	ORENCIA	BMS	$	500.3400

PEGFILGRASTIM

Effective March 1, 2020, all Special Authorization requests for pegfilgrastim will be assessed for coverage with Fulphila or Lapelga. Neulasta will not be approved for new pegfilgrastim starts or repeat treatments (e.g., new course of chemotherapy).

"In patients with non-myeloid malignancies, receiving myelosuppresive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia."

All requests for pegfilgrastim must be completed using the Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form (ABC 60013).

Please note: Coverage cannot be considered for palliative patients.

6 MG / SYR INJECTION SYRINGE

☒ 00002474565	LAPELGA (0.6 ML SYRINGE)	APX	$	1424.6300
☒ 00002484153	FULPHILA (0.6 ML SYRINGE)	BGP	$	1600.0000
☒ 00002249790	NEULASTA (0.6 ML SYRINGE)	AMG	$	2555.0600