Alberta
Drug Benefit List

Effective April 1, 2021

Alberta
Government

Inquiries should be directed to:

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Alberta Blue Cross
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Edmonton AB T5J 3C5

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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.

Table of Contents

Table of Contents, continued

Table of Contents, continued

SECTION 2—PRICE POLICY

SECTION 3—CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

SECTION 3A— CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

Table of Contents, continued

SECTION 4—RARE DISEASES DRUG COVERAGE PROGRAM

PART 2

PHARMACOLOGIC–THERAPEUTIC CLASSIFICATION OF DRUGS

APPENDICES

INDICES

PART 1

SECTION 1

Policies and Guidelines

INTRODUCTION

Acknowledgments

Alberta Health 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 sponsored drug programs.

Eligibility

The Alberta Drug Benefit List *(*the *"*List*"* or *"*ADBL*")* defines the Drug Products and Devices 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, or
2. the Alberta Blue Cross *Coverage for Seniors (Group 66)* provided to all Alberta senior citizens, or
3. the drug coverage provided to individuals approved by Alberta Health for *Palliative Coverage.* (For these individuals the *Palliative Coverage Drug Benefit Supplement* must also be considered), or
4. the drug coverage provided to Alberta Human Services clients. (For these clients the *Alberta Human Services 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 Classification (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 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 Notification Form (DNF)
   - Notice of Compliance (NOC)
   - Product Monograph

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6. Drug Identification Numbers (DINs) and Natural Product Numbers (NPNs) listed reflect current Manufacturer information available as the date this was published.
7. Alberta Health 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 on the date of the change (unless otherwise stated) and regardless of the date of publication of the pdf 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, or Natural Product Number (NPN) assigned by the Natural and Non-prescription Health Products Directorate (NNHPD). For other types of Drug Products or Devices, a Product Identification Number (PIN) will be assigned.
6. A box containing an X ☒ to the left of the DIN/NPN/PIN 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 Drug 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 0.5 mg/g hydrocortisone acetate and 30 mg/g salicylic acid.
9. Brand name of the Drug Product or Device.
10. Three letter identification code assigned to each manufacturer. The codes are listed in Appendix 2 at the end of the List.
11. For Drug 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 Drug Products and Devices 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 Drug 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 ADBL or List.
15. Drug 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 Emend is restricted to the drug being prescribed by the Directors of Alberta Health Services – Cancer Care “Cancer Centres” (or their designates). For more information about Drug Products or Devices designated as restricted benefits, refer to the restricted benefits section of the List.
16. A MAC Grouping means a grouping of Drug Products or Devices that have been listed on the ADBL 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. Groupings subject to MAC Price will have the maximum amount established by the Minister which will be paid by the Government of Alberta.

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Example of Drug Product Listings

08:00 ANTI-INFECTIVE AGENTS
08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM
250 MG (BASE) * 125 MG (BASE) ORAL TABLET

00002243350	APO-AMOXI CLAV	APX	$	0.9375	

28:00 CENTRAL NERVOUS SYSTEM AGENTS
28:08:08 ANALGESICS AND ANTIPYRETICS
(OPIATE AGONISTS)

OXYCODONE HCL
10 MG ORAL TABLET

00000443948	**SUPEUDOL**	**SDZ**	**$**	**0.2283**	
00002319985	**PMS-OXYCODONE**	**PMS**	**$**	**0.2517**	
00002240131	OXY-IR	PUR	$	0.4260	

28:00 CENTRAL NERVOUS SYSTEM AGENTS
28:08:04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM
100 MG ORAL SUSTAINED-RELEASE TABLET

00002091194	APO-DICLO SR	APX	***$***	***0.3124***	$	0.4048
00002231505	PMS-DICLOFENAC-SR	PMS	***$***	***0.3124***	$	0.4048
00002261944	SANDOZ DICLOFENAC SR	SDZ	***$***	***0.3124***	$	0.4048

MAC pricing has been applied based on the LCA price for 4 x 25 mg oral enteric-coated tablets.

08:00 ANTI-INFECTIVE AGENTS
08:12.28.20 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(LINCOMYCINS)

CLINDAMYCIN PHOSPHATE
150 MG / ML (BASE) INJECTION

00002230535	CLINDAMYCIN (60 & 120 ML)	SDZ	$	3.7799	
00002230540	CLINDAMYCIN	SDZ	$	3.7799	
00000260436	DALACIN C PHOSPHATE	PFI	$	4.4469	

84:00 SKIN AND MUCOUS MEMBRANE AGENTS
84:06 ANTI-INFLAMMATORY AGENTS

BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID
0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT

00000578436	DIPROSALIC	MFC	$	0.9084	

FLUOCINONIDE
0.05 % TOPICAL EMOLLIENT CREAM

☒ 00000598933	TIAMOL	VCL	$	0.2183	
☒ 00002163152	LIDEMOL	TPT	$	0.2162	

48:00 RESPIRATORY TRACT AGENTS
48:10.24 ANTI-INFLAMMATORY AGENTS
(LEUKOTRIENE MODIFIERS)

APREPITANT
RESTRICTED BENEFIT - This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates).
80 MG ORAL CAPSULE

00002298791	EMEND 80 MG	MFC	$	34.2387	

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

DRUG AND DEVICE REVIEWS

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

Manufacturers wishing to have their Drug Product(s) or Device(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 CDEC. Alberta Health and Alberta Blue Cross are not involved in the administration process for CDR submissions and so any questions regarding CDR submissions should be directed to the CDR. Submissions relating to New Drugs, Drugs with a New Indication(s), or New Combination Products that have received a Health Canada Notice of Compliance (NOC) or conditional NOC (NOC/c), or have a pending NOC or NOC/c for the indication(s) to be reviewed should be directed to the CDR for consideration. Submissions to the CDR must comply with the CDR Procedure and Submission Guideline requirements available on the CDR website at https://www.cadth.ca/about-cadth/what-we-do/products-services/cdr

Expert Committee on Drug Evaluation and Therapeutics Drug Reviews

The Minister of Health has established an Expert Committee on Drug Evaluation and Therapeutics to refine and maintain the List on an ongoing basis. All Drug Products and Devices not eligible for review under the CDR Procedure or the 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 and Devices. The Committee receives advice and assistance from external consultants and agencies when needed. The Expert Committee makes recommendations on the List to Alberta Health through the Executive Director, Pharmaceuticals & Supplementary Health Benefits.

Interchangeable Reviews

Drug Products may be considered for listing in interchangeable groupings 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. Interchangeable drug submissions requiring a Full Review will be reviewed by the Expert Committee under its usual Drug Product review procedure.

Biosimilar Reviews

Biosimilar Drug Product submissions may be considered through Expedited Review.

Device Reviews

Device submissions may be considered through Expedited Review.

Referrals

Alberta Health 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 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 ADBL 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 or Device,
   (d) the listing,
   (e) the price,
   (f) any other relevant criteria or factor.

Alberta Health
Expert Committee on Drug Evaluation and Therapeutics

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SUBMISSIONS FOR DRUG AND DEVICE REVIEWS

Only submissions satisfying all of the submission requirements of the applicable category of Drug Product or Device that are deemed complete by the applicable submission deadline date will be put forward for review.

1) In addition to the submission requirements, the Expert Committee and/or Alberta Health, at their sole discretion, reserve the right to request the Drug Product or Device file from Health Canada's Therapeutic Products Directorate (TPD) or Medical Devices Directorate (MDD), or any additional information from the Manufacturer, CDEC, or any other entity that the Expert Committee and/or Alberta Health considers necessary, which may result in a delay in the listing recommendation for the Drug Product or Device.
2) 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.
3) Pre-NOC submissions may be made; however, the submission will only be reviewed once it is complete.
4) 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.
5) Only one (1) copy of a submission for a Drug Product or Device 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.
6) 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 TPD, Health Canada). Comparative studies with other listed Drug Products or Devices are most relevant.
7) Drug Products or Devices that have been previously listed on the List and have had a lapse in coverage for two (2) years or more will require a new submission under the appropriate submission category.
8) Drug Products or Devices that have been previously listed on the List and have had a price policy submission denied over a period of two (2) years or more will require a new submission under the appropriate submission category.
9) Drug Product or Device submissions that remain incomplete or that have an incomplete price policy submission for twelve (12) months from the date of the original submission will be returned to the Manufacturer.
10) Information on submission deadlines are posted on the ADBL website which can be accessed at https://www.ab.bluecross.ca/dbl/manufacturers.php

Notice of Significant Changes - By making a submission (i.e., if a Drug Product or Device is either under review or listed on the List), Manufacturers acknowledge and agree that they are required to notify the Manager, Scientific and Research Services of any significant change to the Drug Product or Device. Significant changes are considered to be changes to the design or intended use of a Device, changes in NOC, Drug Product or Device name, Manufacturer or distributor, indication, product monograph, packaging and labelling, formulation, manufacturing specifications, issuance of safety advisories or warnings, business/marketing or cross-licensing agreements and any change that could potentially affect the bioavailability or bioequivalence of a Drug Product. Please note: Changes to product monographs must be itemized in covering or separate correspondence with the Date of Revision of the product monograph clearly stated.

Correspondence and Receipt of Submissions

Manufacturers may provide submissions for consideration for potential addition to the ADBL via email to the following address: submissions@ab.bluecross.ca

Submissions sent to other email addresses will not be considered for potential addition to the ADBL. It is recommended that manufacturers place the device name or the drug name(s) and strength(s) of the submitted product(s) in the subject header in order to ensure that multiple emails can be easily associated with one another.

Manufacturers are reminded that hard copies of submissions must follow by mail and should be sent to the attention of:

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

A copy of covering correspondence and summary documents **only** should be forwarded to:

Executive Director
Pharmaceuticals & Supplementary Health Benefits
Alberta Health
11th floor, 10025 Jasper Avenue
Edmonton, Alberta T5J 1S6

Questions or comments regarding submissions can be addressed 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
Email: submissions@ab.bluecross.ca

Manufacturers should note that only **complete submissions, satisfying all the submission requirements of the applicable category received by 4:30 p.m. Mountain Standard / Daylight Savings Time (as applicable) on the deadline**, will be put forward for consideration by the Expert Committee on Drug Evaluation and Therapeutics or Expedited Review, as applicable. There is no guarantee that every completed submission will be reviewed and/or a recommendation made at the next scheduled meeting of the Expert Committee.

Criteria for Listing Drug Products or Devices

- **The *Criteria for Listing*, as adjudicated by the Expert Committee on Drug Evaluation and Therapeutics (Expert Committee), apply to all Drug Product and Device submissions.**

- **If more than one criterion apply, at the sole discretion of the Expert Committee, Alberta Health 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 - Additional Criteria*".**

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

2. The Drug Product or Device must:

   a. possess therapeutic advantage (as defined in No. 3) for the disease entity for which the Drug Product or Device 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 or any other International Regulatory Agency issued 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/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 or Device to meet the demand in Alberta (as determined by Alberta Health 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 Product, Device, class or category and indications for use,
vi. other available alternative products, treatments or therapies,
vii. whether the Drug Product is interchangeable,
viii. cost of the Drug Product or Device and/or potential cost savings or impact on Drug Product or Device expenditures under the List,
ix. volume of use and amounts paid out for similar Drug Products or Devices, classes or categories,
x. utilization patterns
xi. expenditure management and resources,
xii. patent issues,
xiii. coverage provided by other programs,
xiv. for interchangeable Drug 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 or Device.

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 Drug Benefit List *(*ADBL) contains designations of interchangeability for approved Multisource Drug Products. The Expert Committee on Drug Evaluation and Therapeutics makes recommendations on interchangeability to Alberta Health through the Executive Director, Pharmaceuticals & Supplementary Health Benefits. The Minister of Health makes the final decisions on interchangeability after reviewing the recommendations of the Expert Committee and/or Alberta Health.

Definitions:

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

Canadian Innovator Reference Product (CIRP): A CIRP is a Drug Product that is marketed in Canada by the innovator manufacturer of the Drug Product and for which safety and efficacy have been demonstrated clinically.

Canadian Non-Innovator Reference Product (CNIRP): A CNIRP is a subsequent-entry generic Drug Product that is used as a Reference Product in a comparative study (e.g., bioequivalence, pharmacodynamic, therapeutic equivalence, or physical-chemical comparison) when the CIRP or a suitable Non-Canadian Innovator Reference Product (NCIRP) is no longer available on the market. *See also 4 c) of the Additional Criteria.*

Cross Licensed Product: A cross licensed or pseudo-generic Drug Product is a Drug Product that is manufactured according to the identical master formula 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 ADBL within the submission product's interchangeable grouping.

Interchangeable Drug Product: An Interchangeable Drug Product is a Drug Product that has been designated as interchangeable by the Minister of Health after reviewing the recommendations of the Expert Committee or Alberta Health. 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.

Non-Canadian Innovator Reference Product (NCIRP): A NCIRP is a Drug Product that is marketed elsewhere in the world by the same innovator, corporate entity, or through a licensing arrangement with the innovator or corporate entity, that currently markets or historically marketed, the same drug in the same dosage form in Canada.

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.

TPD Reports - refers collectively to the following TPD, Health Canada guidance publications as of April 1, 2015:

- *Guidance Document: Conduct and Analysis of Comparative Bioavailability Studies (2012)*; (which may be referred to in the List as "**TPD Report No.1**"); and
- *Guidance Document*: *Comparative Bioavailability Standards: Formulations Used for Systemic Effects (2012);* (which may be referred to in the List as "**TPD Report No.2**")

Review of Interchangeable Drug Product Submissions:

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

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>

Alberta Health and/or the Minister reserves the right to refer any Drug Product submission that would otherwise meet the Expedited Review requirements for Full Review by the Expert Committee.

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).

c. The Drug Product is a cross licensed Drug Product with the innovator brand of the drug or any Drug Product that is currently listed on the ADBL within the submission product's interchangeable grouping.

d. The Drug Product is **NOT** a biosimilar (biosimilars are not eligible for review as interchangeable products).

e. The Drug Product has been granted a Notice of Compliance (NOC) by Health Canada that includes a declaration of equivalence with a CIRP that is listed (or at the sole discretion of Alberta Health and/or the Minister, has been previously listed) on the Alberta Drug Benefit List.

f. The Drug Product must be a pharmaceutical equivalent to the CIRP.

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

h. Even if the drug submission review is expedited, the Minister may decide not 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 biosimilar (biosimilars 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 comparative 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 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.*

iii. 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*.

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

v. 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 comparative 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 No.2; or

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

and

ii) Sufficient rationale for why a comparative bioequivalence study cannot be conducted and an explanation of why the method submitted is a valid surrogate for bioequivalence assessment**.**

c. For Drug Product submissions using a Canadian Non-Innovator Reference Product (CNIRP) the following criteria apply:

i) The CIRP or a suitable NCIRP for the active therapeutic ingredient(s) contained in a CNIRP is no longer available on the market.

ii) The CNIRP must be currently listed on the ADBL at the time the Drug Product submission is under review.

iii) There must be evidence from historical product reviews for the ADBL that the CNIRP was directly compared with the CIRP in a suitable study/studies and shown to be bioequivalent.

iv) If a subsequent-entry generic Drug Product was approved on the basis of a comparison with a NCIRP, then the Drug Product is not eligible for consideration as a CNIRP.

v) Once a CNIRP for an interchangeable grouping has been established for the ADBL, the specific CNIRP must be used consistently thereafter in comparative studies for submitted Drug Products to be considered for a potential interchangeability designation. This is true as long as the established CNIRP is listed on the ADBL.

In situations where a manufacturer wishes to use a CNIRP in a comparative study to support an interchangeability designation on the ADBL, the manufacturer is advised to contact the Scientific and Research Services Department of Alberta Blue Cross to confirm the identity of the CNIRP for the interchangeable grouping in the ADBL, if one has been established.

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 TPD Report No. 2; 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: Comparative 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% inclusive; the relevant AUC or AUCs as described in TPD Report No. 2 are to be determined.
2. The 90% confidence interval of the relative mean 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.
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%.

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. Comparative 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) measurable 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:

1. Comparative bioequivalence studies must meet the requirements and standards in the TPD *Reports.*
2. The assay used for measurement of the drug must be validated for the alternate matrix of measurement.
3. The use of metabolite concentrations in an alternate matrix is not acceptable.
4. 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 moiety or moieties is/are 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. Comparative bioequivalence studies must meet the requirements and standards in the TPD *Reports.*
2. For old Drug Products for which comparative 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 No. 2; or

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

        and

    ii) Sufficient rationale for why a comparative 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. Comparative 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 may at any time review the benefit status of a Drug Product or Device, a group of Drug Products or Devices, a class or classes of Drug Products or Devices, or a category or categories of Drug Products or Devices listed or being considered for listing on the ADBL. The Expert Committee and/or Alberta Health 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 Drug Product(s) or Device(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 Drug Product(s) or Device(s), no longer possesses demonstrated therapeutic advantage compared to other presently accepted therapies or treatments of the disease entity for which the Drug Product(s) and Device(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 Drug Product(s) or Device(s) is/are no longer cost-effective compared to other presently accepted therapies or treatments of the disease entity for which the Drug Product(s) or Device(s) is/are indicated.
4. To enable broader coverage of higher priority Drug Product(s) or Device(s).
5. When a Drug Product or Device has been discontinued by the manufacturer.
6. When Drug Product(s) is/are changed from prescription to non-prescription status, the Expert Committee may recommend continuing, altering or discontinuing benefit status of the Drug Product(s) based upon scientific, therapeutic, clinical and socio-economic merits of the Drug Product(s).
7. For all ROBS reviews, the Expert Committee, Alberta Health 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 Devices, 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.

SUBMISSION REQUIREMENTS

The following Submission Requirements pertain to submissions for Drug Products 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 or 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.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. A hard copy and electronic (CD) copy only 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.
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 Drug 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. Health Canada-approved Product Monograph
   - A hard copy, and
   - an electronic (CD) copy compatible with Microsoft Word

9. Economic Information
   - a comprehensive pharmacoeconomic analysis in accordance with: the "*Guidelines for the economic evaluation of health technologies: Canada* [4th Edition]". Ottawa: Canadian Agency for Drugs and Technologies in Health; 2017; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful, and
   - a completed *Budget Impact Assessment for the* Alberta Drug Benefit List form. The form can be obtained at https://www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.
10. If requested, the Manufacturer must provide written confirmation from the CDR 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 on the List 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.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
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 only 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.
5. Copy of Notice of Compliance (NOC) for the new indication.
6. Current Patent Status
   - a signed statement from the Manufacturer stating that the submitted Drug 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. Health Canada-approved Product Monograph (revised to include the new indication)
   - A hard copy, and
   - an electronic (CD) copy compatible with Microsoft Word
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* [4th Edition]". Ottawa: Canadian Agency for Drugs and Technologies in Health; 2017; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful

- a completed Budget Impact Assessment for the Alberta Drug Benefit List form **prepared with respect to the new indication only**. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

10. If requested, the Manufacturer must provide written confirmation from the CDR 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 Drug Products are not eligible for review under the CDR Procedure.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Justification for the Line Extension
   - a separate concise, one page document indicating the reason for and evidence to justify the need for the new strength, formulation or reformulation of the Drug Product, AND
   - a separate signed statement clearly identifying:
     i. the DIN of the Drug Product(s) being submitted as a Line Extension, AND
     ii. the DIN of the Manufacturer's Drug Product(s) currently listed or under consideration for listing on the ADBL, to which the submitted Drug Product(s) is/are being directly linked via clinical, bioequivalence or formulation proportionality/dissolution profile data.
4. A hard copy and electronic (CD) copy only 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 Drug Product(s) and a currently listed or under consideration Drug 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 Drug 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. Health Canada-approved Product Monograph (revised to include the line extension)
    - A hard copy, and
    - an electronic (CD) copy compatible with Microsoft Word
11. Economic Information
    - a completed *Budget Impact Assessment for the* Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.
12. If requested, the Manufacturer must provide written confirmation from the CDR 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 List.

For Expedited and Full Reviews:

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
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 Drug Product does not infringe any patents
6. *For Cross Licensed 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 Drug 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 pricing in Alberta must be in compliance with the Price Policy. Exceptions to the Fixed Pricing Rules may be considered at the sole discretion of the Minister. Accordingly, a request for an exception (as per the Price Policy) must accompany a submission that does not meet the Price Policy in order for it to be deemed complete.
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. Health Canada-approved Product Monograph
   - A hard copy, and
   - an electronic (CD) copy compatible with Microsoft Word

   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 have been met. See *Criteria for Listing Drug Products or Devices* **and** *Interchangeable Drug Products* sections for specific applicable criteria.
11. If a submitted drug product has been compared with a Canadian Non-Innovator Reference Product (CNIRP) (as defined in Interchangeable Drug Products - Additional Criteria) in a comparative bioavailability study, the full TPD review of the submitted Drug Product must be provided. The Comprehensive Summary - Bioequivalence (CS-BE) that is prepared by the manufacturer prior to filing an Abbreviated New Drug Submission (ANDS) is not sufficient.

E) Natural Health Products

Natural Health Product: A Natural Health Product is a Drug Product where the active moiety or moieties are defined as a "natural health product" by Health Canada under the *Natural Health Products Regulations*.

The following submission requirements pertain to Natural Health Products submitted for listing on the Alberta Drug Benefit List.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Natural Health Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Natural Health Product submission and resubmission information and information about the Natural Health Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Natural Health Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Copy of Market Authorization for Sale (current Product License that is not suspended or cancelled at the time the submission is made)
4. Current Patent Status (if applicable)
   - a signed statement from the Manufacturer stating that the submitted Natural Health Product does not infringe any patents
5. Price Information
   - The proposed price for Alberta (which must be in compliance with the ADBL Price Policy)
6. Copy of completed and approved Certified Product Information Document (CPID)

   Note: In lieu of the CPID, a Master Formula, Final Product Specifications and Certificate of Analysis must be provided
7. Single Ingredient Monographs or Product Monographs
   - The Prescribing Information may be provided in lieu of Single Ingredient Monographs or Product Monographs.
8. The submission must include:
   I. Evidence that the active moiety or moieties or Natural Health Product was previously or is currently listed in the same formulation on the ADBL and;
   II. Evidence from the Manufacturer to demonstrate that there is an unmet need for the submitted Natural Health Product(s) (e.g. therapeutic need, therapeutic dose, stability of supply, formulation).

Note: Submissions for combination products where one or more of the active moieties was previously listed as a single entity will not be accepted. Similarly, submissions for single entity products where one or more of the active moieties was previously listed in a combination product will not be accepted.

9. Interchangeability may be evaluated based upon evidence submitted by the Manufacturer. The Expert Committee on Drug Evaluation and Therapeutics will provide recommendations on interchangeability to the Minister for a final decision. Acceptable evidence to support interchangeability includes:
    1. Bioequivalence studies which meet the requirements and standards in the TPD *Reports.*
    2. For Natural Health 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 No. 2 (as defined in *Interchangeable Drug Products - Additional Criteria*); or
            (C) surrogate comparisons using *in vivo* or *in vitro* test methods;
            and
        ii) Sufficient rationale for why a bioequivalence study cannot be conducted.
10. Economic Information
    - A completed *Budget Impact Assessment* for the Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca

F) Non-Interchangeable Old Drug Products

Non-Interchangeable Old Drug Products: Are Drug Products where the active moiety or moieties are designated as an "Old Drug" by Health Canada and evidence to support interchangeability CANNOT be provided. The Drug Product is approved on the basis of a DIN application (i.e. a NOC is not issued by Health Canada).

Previously Listed means the Drug Product was previously listed in the same formulation on the ADBL at any time in the past.

Not Previously Listed means the Drug Product was NOT previously listed in the same formulation on the ADBL at any time in the past.

The following submission requirements pertain to both **Previously Listed** and **Not Previously Listed** Non-Interchangeable Old Drug Products that are submitted for listing, but not as interchangeable, with another Drug Product that is currently listed in the ADBL.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Copy of completed Drug Identification Number (DIN) notification form
4. Current Patent Status
   - a signed statement from the Manufacturer stating that the submitted Drug Product does not infringe any patents
5. Price Information
   - The proposed price for Alberta (which must be in compliance with the ADBL Price Policy)
6. Copy of completed and approved Certified Product Information Document (CPID)
   Note: In lieu of the CPID, a Master Formula, Final Product Specifications and Certificate of Analysis must be provided
7. Product Monograph
   - The Prescribing Information may be provided in lieu of the Product Monograph.
8. Evidence from the Manufacturer to demonstrate that there is an unmet need for the submitted Drug Products (e.g., therapeutic need, therapeutic dose, stability of supply, formulation)

9. Economic Information
   - A completed *Budget Impact Assessment* for the Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca

For Non-Interchangeable Old Drug Products that were Previously Listed ONLY, the following ADDITIONAL information must be provided:

10. Evidence that the Drug Product was previously listed on the ADBL for the same indication and use in the past; and
   - Assurance that the formulation of the Drug Product has remained unchanged since the time of listing, or
   - If any Notifiable Changes have occurred since the time of listing, summary documentation describing the changes that have occurred since the time of listing must be provided.

For Non-Interchangeable Old Drug Products that were NOT Previously Listed ONLY, the following ADDITIONAL information must be provided:

11 Clinical evidence for the efficacy and safety of the active therapeutic ingredient(s) for the submitted indication that may be in the form of (in order of preference):
   - An electronic (CD) copy only 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).
   - If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu.
   - If a Comprehensive Summary was not prepared for Health Canada, a concise summary of the efficacy and safety evidence based on an up-to-date literature review of the current medical literature may be acceptable in lieu.

G) Resubmissions

Resubmission Requests – General

1. A resubmission request may be made for a Drug Product or Device that is not currently listed on the ADBL in a case where the Drug Product or Device:

    a. was previously listed on the ADBL;
    b. was the subject of a previous submission for listing on the ADBL; or
    c. is listed on the ADBL but is subject to restrictions.

2. A resubmission request:

    a. must comply with the requirements set out below; and
    b. may be made by a Manufacturer for a Drug Product or Device only once in a 12 month period, running from April 1st through to March 31st, unless the Minister of Health (Minister), in the Minister's sole discretion, invites a Manufacturer to make a resubmission request.

3. The Minister, the Expert Committee on Drug Evaluation and Therapeutics (Expert Committee), and Alberta Health:

    a. may request information in addition to the requirements set out below; and
    b. may from time to time set deadlines by which a resubmission request may be made, or a request for additional information must be provided.

4. In the case where:

    a. additional information has been requested by the Minister, the Expert Committee or Alberta Health, the resubmission request is not considered to be complete unless and until the requested additional information is provided to the Minister, the Expert Committee or Alberta Health; and
    b. a deadline has been set as referred to above, failure to provide a complete resubmission request within such deadline means that a resubmission request will not be reviewed by the Expert Committee or Alberta Health or considered by the Minister.

5. The Minister may, in the Minister's sole discretion, refer a Drug Product or Device, that was the subject of a resubmission request which meets the requirements set out in this policy, to an Alberta Price Confirmation (APC) or Interim APC process.

6. In the event that a Drug Product or Device is referred to an APC or Interim APC process, the Manufacturer must comply with the Price Policy and the Terms and Conditions of the APC or Interim APC. A referral to an APC or Interim APC or the submission of a Price Confirmation or Confirmed Price for the Drug Product or Device by the Manufacturer does not obligate the Minister to list a Drug Product or Device on the ADBL.

7. In the event that the Minister, in the Minister's sole discretion, requires additional advice or input on a resubmission request, the Minister may refer the resubmission request to the CDR Procedure, the Expert Committee or any other entity for further advice or a full review.

8. For additional clarity, the provisions outlined under the "Submissions for Drug Product and Device Reviews" are also deemed to apply to resubmission requests except as specifically modified by the provisions in this subsection "G) Resubmissions", in which case this subsection applies.

Resubmission Requests Requiring Expert Committee Review

9. In addition to the requirements in "Resubmission Requests – General" above, this section applies to a resubmission request for a Drug Product or Device that was reviewed by the Expert Committee and a decision was made by the Minister to:

    a. not add the Drug Product or Device to the ADBL for reasons other than those specified in section 12 below;
    b. add the Drug Product or Device to the ADBL with restrictions; or
    c. maintain current listing status of the Drug Product or Device on the ADBL despite the Manufacturer's request for change.

10. A general resubmission request may be made for a previously submitted Drug Product or Device on the *Resubmission for the* Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

11. A resubmission request must be complete and must include:

    a. a completed *Resubmission for the* Alberta Drug Benefit List form. A resubmission request requires review by the Expert Committee and a recommendation made by the Expert Committee for the Minister's consideration for listing or not listing the Drug Product or Device on the ADBL. The form must contain new information not previously submitted for a review of the Drug Product or Device by the Expert Committee, unless otherwise indicated;

    b. an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product or Device and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product or Device submission and resubmission information and information about the Drug Product or Device in the possession of

Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert

Committee, and the government of a province or territory;

c. a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product or Device in a quantity consistent with applicable APC or Interim APC requirements; and

d. a revised Budget Impact Assessment (BIA) form in the case where new economic information about the Drug Product or Device is available, that has not been previously submitted, to support the resubmission request. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

Resubmission Requests based on the ADBL Price Policy

12. In addition to the requirements in "Resubmission Requests – General" above, this section applies to resubmission requests for a Drug Product or Device that:

    a. has not been listed on the ADBL, or that has been removed from the ADBL, by the Minister where the requirements of an Alberta Price Confirmation (APC), Interim APC or the Price Policy were not satisfied; or

    b. has been removed from the ADBL at the request of the Manufacturer.

13. A price policy resubmission request may be made on the *Alberta Price Policy Resubmission Form for the* Alberta Drug Benefit List. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

14. A resubmission request must be complete and must include:

    a. a completed *Alberta Price Policy Resubmission Form for the* Alberta Drug Benefit List;

    b. an unconditional consent letter authorizing Alberta Health and its employees, contractors , consultants and agents to collect and use information respecting a Drug Product or Device and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product or Device submission and resubmission information and information about the Drug Product or Device in the possession of

Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory; and

c. a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product or Device in a quantity consistent with applicable APC or Interim APC requirements.

H) Biosimilar Drug Products

Biosimilar Drug Product: a biosimilar (previously referred to as subsequent-entry biologic) is a Drug Product demonstrated to be highly similar to a biologic drug that has previously been authorized for sale in Canada (Reference Biologic Drug). Biosimilars are approved by Health Canada based on a thorough comparison to a Reference Biologic Drug. A Biosimilar and a Reference Biologic Drug can be shown to be similar, but not identical.

Reference Biologic Drug: a biologic drug authorized by Health Canada on the basis of a complete quality, non-clinical, and clinical data package, to which a Biosimilar Drug Product is compared to demonstrate similarity.

Biosimilar Drug Product submissions may be considered through Expedited Review. However, Alberta Health and/or the Minister reserves the right to refer any Biosimilar Drug Product submission for Full Review by the Expert Committee.

Even if a Biosimilar Drug Product submission review is expedited, the Minister may decide not to list a Biosimilar Drug Product, or the listing of the 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.

The following submission requirements pertain to biosimilars of Reference Biologic Drugs that are currently, or were previously, listed on the ADBL.

1. Cover letter:
   - Specify drug name with active pharmaceutical ingredient, strength(s), dosage form(s), route of administration(s), and Drug Identification Number(s) (DINs).
   - Specify the reference biologic product with active pharmaceutical ingredient
   - Specify the Health Canada-approved indication(s) for each product including those not being sought by the Manufacturer in this submission
   - Health Canada-approved indication(s) submitted
   - Manufacturer's reimbursement request
2. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
3. Letter Confirming Ability to Supply

- a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.

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 Drug Product does not infringe any patents
7. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
8. Health Canada-approved Product Monograph
   - A hard copy, and
   - an electronic (CD) copy compatible with Microsoft Word
9. If requested, the Manufacturer must provide the following Economic Information
   - a completed *Budget Impact Assessment* for the Alberta Drug Benefit List form. The form can be obtained at https://www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.
10. If requested, additional clinical or economic information as requested by the Expert Committee, Alberta Health and/or the Minister.

I) Devices - Blood Glucose Test Strips

A Device refers to a Medical Device that is listed or under consideration for listing by the Minister on the ADBL. Medical Devices are approved by Health Canada and are monitored and evaluated through the Health Canada Medical Devices Directorate.

At this time, the only Device submissions being accepted are for blood glucose test strips, to be reviewed through the Expedited Review process.

Alberta Health and/or the Minister reserves the right to refer any Device submission that would otherwise meet the Expedited Review requirements for Full Review by the Expert Committee.

Even if a Device submission review is expedited, the Minister may decide not to list a Device, or the listing of the Device 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.

The following submission requirements pertain to blood glucose test strip products that are submitted for listing on the ADBL:

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Device and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Device submission and resubmission information and information about the Device in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Device in a quantity consistent with applicable APC or Interim APC requirements.
3. Evidence of Health Canada Issued Authorization
   - a copy of the Medical Device License
4. Price Information
   - must provide unit pricing
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
5. Evidence of the Product’s Effectiveness
   - a summary of specifications of the Device
6. All Promotional Materials
   - such as product labels, instructions, product descriptions and/or package Inserts
7. If requested, the Manufacturer must provide the following Economic Information

- a comprehensive pharmacoeconomic analysis in accordance with: the "*Guidelines for the economic evaluation of health technologies: Canada* [4th Edition]". Ottawa: Canadian Agency for Drugs and Technologies in Health; 2017; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful, and
- a completed *Budget Impact Assessment for the* Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.php or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca

Non-Innovator Policy

1. The Minister may request submissions or direct Alberta Health and/or the Expert Committee to request submissions for Drug Products from time to time. Specifically, the Minister may request submissions for Multisource Drug Products seeking a listing designation as interchangeable with a CIRP that is not currently listed on the *Alberta Drug Benefit List (*ADBL) when that CIRP has been identified by the Minister.

2. The Minister may identify a CIRP which has been considered but never listed on the ADBL and where the availability of a Multisource Drug Product(s) may now alter the cost effectiveness of the molecule:

    a. During the Minister's evaluation of a CIRP to be identified under this Policy, the Minister will provide written notice of the evaluation to the CIRP manufacturer who may, at their discretion, provide materials to the Minister to be considered as part of the evaluation.

3. If such a CIRP is identified by the Minister, it will be included in the list included in this Non-Innovator Policy and any manufacturers with a valid NOC may make a submission (including the CIRP manufacturer).

4. Submissions must fulfill the applicable submission guidelines outlined below:

    a. For Interchangeable products, the applicable Expedited or Full Submission Guidelines outlined in the ADBL as if the CIRP was currently listed on the ADBL including compliance with the prevailing Price Policy.

    b. CIRP manufacturers must fulfill the following Submission Requirements outlined in Section A) New Chemical Entities/Single Source Drug Products in the ADBL (Section 1.25 – 1.26): Consent Letter, Letter Confirming Ability to Supply, Hard Copy and CD copy of the following Common Technical Document sections (Module 2.5 and 2.7.1, 2.7.3, 2.7.4 and 2.7.6), Copy DIN Notification Form, Copy of NOC, Current Patent Status, Price Information, Health Canada-approved Product Monograph:

    c. Only pricing information submitted according to the prevailing Price Policy will be evaluated for CIRPs under this Non-Innovator Policy. The Product Listing Agreement Policy will not be considered.

5. For clarity, Special Authorization requests for coverage of a specific brand under the Special Authorization Guidelines outlined in the ADBL will not be considered unless the specific brand requested is a benefit on the ADBL.

6. Where the Minister has requested submissions for a specific Drug Product through this Requested Submissions Policy by including it in Section 7 below, but no submissions are received and the drug product continues to be funded through an Alberta Government Sponsored program (for example, Health Benefits Exception Committee), Alberta Health may publish the price established for the molecule through that pan-Canadian Generic Initiative (please refer to the Price Policy for further details) and will pay no more than that price for beneficiaries under any Government of Alberta Sponsored Drug program.

7. Submissions are currently being accepted for Multisource Drug Products for the following non-listed CIRPs. For clarity, the CIRP itself continues to be eligible to submit for listing on the ADBL.

    - Lyrica (pregabalin) 25 mg, 50 mg, 75 mg, 150 mg & 300 mg capsules
    - Revia (naltrexone hydrochloride) 50 mg tablet
    - Truvada (emtricitabine/ tenofovir disoproxil fumarate) 200 mg/300 mg tablet

Supply Shortages

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

1. If the unavailable Drug Product is a Single Source Drug Product on the List, Drug Products not otherwise allowed as benefits may be added temporarily or temporarily reimbursed for the Alberta government-sponsored drug programs.
2. Drug Products or Devices added or reimbursed under this policy may remain as temporary benefits until the supply shortage is rectified.
3. In order to remain as benefits after the shortage is rectified, Manufacturers of these Drug Products or Devices must follow the usual submission and review process for listing.
4. Alberta Health may recover any cost difference from the manufacturer unable to supply a Drug Product or Device.
5. Alberta Health 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.
6. Alberta Health may:

    - refuse to list any Drug Product or Device of the manufacturer,
    - refuse to consider any Drug Product or Device submission of the manufacturer for expedited or priority review; or
    - cancel or modify the listing of the Drug Product or Device 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 *ADBL*
Ampoules	Millilitre
Bladder Irrigation Solutions	Millilitre
Dental Pastes	Gram
Devices	Device
Inhalation Capsules	Capsule
Inhalation Cartridges	Cartridge, Dose
Inhalation Disks	Disk
Inhalation Solutions or Suspensions	Millilitre – all preparations including nebules
Inhalation Unit Dose Solution	Millilitre, Dose, Actuation
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

Units of Issue for Pricing, continued

Dosage Form	Unit of Issue Priced in ADBL
Oral Liquids – all formulations	Millilitre
Oral Powders	Gram (or Dose where indicated)
Oral Powder Packets	Individual Packet
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 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 is not prepared to have any Challenge Information considered by the Expert Committee unless the Manufacturer whose Drug 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 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 its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
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:

Manager
Scientific and Research Services
Alberta Blue Cross
10009 - 108 Street NW
Edmonton AB T5J 3C5
Phone: (780) 498-8098
Fax: (780) 498-3534

Your Comments Disclosure for Potential Conflicts of Interest

Anyone who wants to give comments about Drug Products to the Alberta Health Expert Committee on Drug Evaluation and Therapeutics (ECDET) must complete a Declaration of Conflict of Interest Form. A conflict of interest is when opinions may be affected by family, friendships, or relationships with support groups, or by receiving money or gifts from companies related to the Drug Product.

If the Conflict of Interest form is not completed, or if you do not report conflicts on the form you send in but we find there are conflicts when your form is looked over; your comments will not be sent to the Expert Committee.

Your Contact Information:

Mailing Address:_____

Fax: _____ Phone: _____ E-mail:_____

Check off your position. I am a…

☐ Patient ☐ Health Care Professional ☐ Other, Please explain: _____

Did you receive help to complete this request? ☐ Yes ☐ No If yes, please explain and list who helped you.

_____

Please complete the table below. Report relationships from the last 2 years before the date you send this form.

☐ I do not have a relationship (financial or anything else) with any for-profit or not-for-profit organizations.
☐ I have a relationship (financial or anything else) with a for-profit or not-for-profit organization.

Were you ever paid (gifts, money or support) or put money into any drug companies, medical devices companies, or other companies (for profit or non-profit e.g. disease-specific support groups) that support the Drug Product? ☐ Yes ☐ No If yes, please explain: _____
Are you a member on an advisory board, support group or committee for this Drug Product or for a medical condition related to this Drug Product? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been or are a part of a clinical trial for this Drug Product? ☐ Yes ☐ No If yes, please explain: _____
Were you ever paid or received gifts to speak for a drug company or medical communication company related to this Drug Product or medical condition related to this Drug Product? ☐ Yes ☐ No If yes, please explain: _____
If you have any other conflicts or are not sure, please include here. Attach extra sheets if you need more space: _____ _____ _____

I have mentioned all of my conflicts of interest.

Date: _____ Name: _____

Company or Organization you are a part of (state position): _____

E-Signature: _____

If e-signature is not possible for you, you can email this form without a signature but please use your own email to send it, so that we can be sure who is providing this information. Or, you can print and sign the form.

Your Comments are Important to Us Form

To improve the high standards established for this publication, the Alberta Health 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.

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

Please write your comments in the space provided below. Attach extra sheets if you need more space, or if printing this form. Please send the Comments form and the completed conflict of interest form by mail/fax/email to:

Alberta Health Expert Committee on Drug Evaluation and Therapeutics c/o
Manager, Scientific and Research Services Alberta Blue Cross, 10009 108 Street NW
Edmonton, Alberta T5J 3C5
submissions@ab.bluecross.ca
Fax: (780) 498-3534

RESTRICTED BENEFITS

Selected Devices or Drug Products are eligible benefits with restrictions in the Alberta 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 00:00:02

- **Diabetes Supplies** Blood Glucose Test Strips, Blood Letting Lancet, Insulin Pen Needles, Insulin Syringes, Urine Test Strips

PTC 08:12.06.04

- **Cefadroxil** 500 mg oral capsule

PTC 08:12.07.08

- **Ertapenem** 1 g/vial injection
- **Imipenem/ Cilastatin Sodium** 500 mg/vial / 500 mg/vial injection
- **Meropenem** 500 mg/vial and 1 g/vial injection

PTC 08:12.07.12

- **Cefoxitin Sodium** 1 g/vial and 2 g/vial injection

PTC 08:12.12.92

- **Azithromycin** 600 mg oral tablet

PTC 08:12.16.08

- **Ampicillin** 250 mg and 500 mg oral capsule

PTC 08:12.16.16

- **Piperacillin Sodium/ Tazobactam Sodium** 2 g/vial / 250 mg/vial, 3 g/vial / 375 mg/vial, and 4 g/vial / 500 mg/vial injection

PTC 08:12.28.24

- **Linezolid** 600 mg oral tablet

PTC 08:14.08

- **Fluconazole** 10 mg/ml oral suspension
- **Itraconazole** 10 mg/ml oral suspension
- **Voriconazole** 50 mg and 200 mg oral tablet, 200 mg/vial injection and 40 mg/ml oral suspension

PTC 08:14.16
- **Caspofungin** 50 mg/vial and 70 mg/vial injection

PTC 08:16.92
- **Rifabutin** 150 mg oral capsule

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

PTC 08:18.32
- **Adefovir Dipivoxil** 10 mg oral tablet
- **Entecavir** 0.5 mg oral tablet

PTC 12:20.04
- **Cyclobenzaprine HCL** 10 mg oral tablet

PTC 12:92:00
- **Varenicline Tartrate** 0.5 mg and 1 mg oral tablet, 0.5 mg/1 mg oral tablet

PTC 20:12.04.92
- **Rivaroxaban** 10 mg oral tablet

PTC 20:12.18
- **Ticagrelor** 90 mg oral tablet

PTC 28:08.08
- **Codeine Phosphate/ Acetaminophen** 1.6 mg/ml / 32 mg/ml oral elixir

PTC 28:16.08.04
- **Aripiprazole** 2 mg and 5 mg oral tablet
- **Risperidone Tartrate** 1 mg/ml oral solution

PTC 28:20.04
- **Lisdexamfetamine Dimesylate** 20 mg, 30 mg, 40 mg, 50 mg, 60 mg oral capsule

PTC 28:20.92
- **Methylphenidate HCL** 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg oral controlled-release capsule

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 disintegrating tablet and 10 mg oral disintegrating tablet
- **Sumatriptan Hemisulfate** 5 mg/dose and 20 mg/dose nasal unit dose spray
- **Sumatriptan Succinate** 50 mg oral tablet, 100 mg oral tablet and 6 mg/syringe injection
- **Zolmitriptan** 2.5 mg oral tablet, 2.5 mg oral dispersible tablet and 5 mg/dose nasal unit dose spray

PTC 48:10.24

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

PTC 52:92:00

- **Aflibercept** 2 mg/vial injection
- **Ocriplasmin** 0.5 mg/vial injection
- **Ranibizumab** 2.3 mg/vial injection

PTC 56:22.92

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

PTC 68:04:00

- **Mometasone Furoate** 100 mcg/dose metered inhalation powder

PTC 86:12:00

- **Propiverine Hydrochloride** 5 mg oral tablet

PTC 92:00:00

- **Ulipristal Acetate** 5 mg oral tablet

PTC 92:36:00

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

PTC 94:00:00

- **Aerosol Holding Chamber** device
- **Aerosol Holding Chamber/Mask** infant, pediatric and adult chamber/mask device

Limited Restricted Benefits

Selected Drug Products and Devices are eligible benefits with limits and restrictions in the Alberta 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.

SPECIAL AUTHORIZATION GUIDELINES

Special Authorization Policy

Drug Products and Devices Eligible for Consideration by Special Authorization

Drug Products and Devices 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 or Device **not** eligible for consideration by special authorization. Please see the end of this section for information regarding Drug Products and Devices not eligible for consideration by special authorization.

1. The Drug Product or Device is covered by Alberta Health under specified criteria (listed in the following sections). Devices and Drug Products and indications other than those specified are not eligible for consideration by special authorization.
2. The Drug Product or Device 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 Product or Device is required because other Drug Products or Devices listed in the Alberta Drug Benefit List are contraindicated or inappropriate because of the clinical condition of the patient.
4. The particular brand of Drug Product 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 Product.
5. A particular Device, Drug Product or dosage form of a Drug Product is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the Drug Product or Device level. Coverage may be considered only where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with the Drug Product or Device 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 or Device 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 and Devices are eligible for the following auto-renewal process (for eligibility, see the Special Authorization criteria for each Drug Product and Device).

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 or Device's Special Authorization criteria.

2. As long as the patient has submitted a claim for the Drug Product or Device 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 or Device during the Approval Period, the approval will lapse and a new special authorization request must be submitted.

Step Therapy Approval Process

Select Drug Products and Devices 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) or Device(s) within the preceding 12 months, the claim for the step therapy Drug Product or Device 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) or Device(s) have been claimed within the preceding 12 months.
3. Subsequent claims for Drug Product(s) or Device(s) permitted by step therapy will continue to be approved as long as the Drug Product or Device 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* claims cannot be adjudicated through the automated real-time claims adjudication system.

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

Drug Products and Devices *Not Eligible* for Consideration by Special Authorization

The following categories of Drug Products and Devices are **not** eligible for special authorization:

1. Drug Products and Devices **deleted** from the List.
2. Drug Products and Devices **not yet reviewed** by the Alberta Health 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
   * Drug Products where the Manufacturer has not made a submission for review.

   Drug Products not yet reviewed may encompass new pharmaceutical Drug Products, new strengths of Drug Products already listed, reformulated products and new interchangeable (generic) products.
3. Drug Products and Devices that have **completed the review** process and are **not included** on the List.
4. Most Drug Products 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
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. A separate request is required for each patient.

2. 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 Human Services 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.

3. For most drug products, written requests from a prescriber may be submitted on the general *Drug Special Authorization Request* (ABC 60015).

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

Special Authorization Forms

Special Authorization forms can be found on the following pages:

- *Drug Special Authorization Request Form* (ABC 60015)
- *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* (ABC 60034) - All requests for donepezil HCl, galantamine hydrobromide or rivastigmine hydrogen tartrate and must be submitted using this form only.
- *Darbepoetin/Epoetin Special Authorization Request Form* (ABC 60006) - All requests for darbepoetin or epoetin alfa must be submitted using this form only.
- *Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/ Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60027) - All requests for abatacept, adalimumab, anakinra, certolizumab, etanercept, golimumab, infliximab, sarilumab, tocilizumab or tofacitinib for Rheumatoid Arthritis must be submitted using this form only.
- *Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form* (ABC 60045) - All requests for peginterferon alfa-2a for Chronic Hepatitis C must be submitted using this form only.
- *Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60011) - All requests for adalimumab, etanercept or tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be submitted using this form only.
- *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form* (ABC 60029) - All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab, ixekizumab, or secukinumab for Psoriatic Arthritis must be submitted using this form only.
- *Select Quinolones Special Authorization Request Form* (ABC 60042) - All requests for ciprofloxacin, levofloxacin or moxifloxacin must be submitted using this form only.
- *Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form* (ABC 60043) - All requests for alendronate, raloxifene, or risedronate for Osteoporosis must be submitted using this form only.
- *Celecoxib Special Authorization Request Form* (ABC 60032) – All requests for celecoxib must be submitted using this form only.
- *Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form* (ABC 60013) – All requests for filgrastim, pegfilgrastim or plerixafor must be submitted using this form only.
- *Fentanyl Special Authorization Request Form* (ABC 60005) - All requests for fentanyl or fentanyl citrate must be submitted using this form only.
- *Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form* (ABC 60030) - All requests for adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab for Plaque Psoriasis must be submitted using this form only.
- *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form* (ABC 60028) - All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab or secukinumab for Ankylosing Spondylitis must be submitted using this form only.
- *Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* (ABC 60031) - All requests for adalimumab or vedolizumab 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.

- *Rituximab for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60046) - All requests for rituximab for Rheumatoid Arthritis must be submitted using this form only.
- *Imiquimod Special Authorization Request Form* (ABC 60038) – All requests for imiquimod must be submitted using this form only.
- *Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form* (ABC 60024) – All requests for aripiprazole/paliperidone/risperidone prolonged release injection must be submitted using this form only.
- *Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60010) - All requests for abatacept for Polyarticular Juvenile Idiopathic Arthritis must be submitted using this form only.
- *Montelukast/Zafirlukast Special Authorization Request Form* (ABC 60039) – All requests for montelukast or zafirlukast must be submitted using this form only.
- *Febuxostat Special Authorization Request Form* (ABC 60037) – All requests for febuxostat must be submitted using this form only.
- *Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form* (ABC 60007) – All requests for denosumab 60 mg/syr injection syringe or for zoledronic acid 0.05 mg/ml injection for osteoporosis must be submitted using this form only.
- *Omalizumab for Asthma Special Authorization Request Form* (ABC 60020) - All requests for omalizumab for Asthma must be submitted using this form only.
- *Eculizumab Special Authorization Request Form* (ABC 60009) – All requests for eculizumab must be submitted using this form only.
- *Eculizumab Consent Form* (ABC 60035) –– All requests for eculizumab must be accompanied by this form.
- *Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form* (ABC 60018) –– All requests for rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis must be submitted using this form only.
- *Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60048) – All requests for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be submitted using this form only.
- *DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonists Special Authorization Request Form* (ABC 60012) - All requests for saxagliptin, saxagliptin+metformin, sitagliptin, sitagliptin+metformin, linagliptin, linagliptin+metformin, lixisenatide,canagliflozin, dapagliflozin, dapagliflozin+metformin, empagliflozin, empagliflozin+metformin, or semaglutide must be submitted using this form only.
- *Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form* (ABC 60019) – All requests for apixaban 2.5 mg & 5 mg, dabigatran 110 mg & 150 mg, edoxaban 15 mg, 30 mg & 60 mg, or rivaroxaban 15 mg & 20 mg must be submitted using this form only.
- *Tacrolimus Topical Ointment Special Authorization Request Form* (ABC 60047) - All requests for tacrolimus topical ointment must be submitted using this form only.
- *Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form* (ABC 60001) - All requests for dimethyl fumarate, glatiramer acetate, interferon beta-1a, ocrelizumab, peginterferon beta-1a or teriflunomide for RRMS or interferon beta-1b for SPMS or RRMS must be submitted using this form only.

- *Cladribine/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form* (ABC 60000) - All requests for cladribine, fingolimod or natalizumab must be submitted using this form only.
- *Ivacaftor Special Authorization Request Form* (ABC 60004) – All requests for ivacaftor must be submitted using this form only.
- *Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form* (ABC 60008) – All requests for adalimumab, golimumab, infliximab, tofacitinib or vedolizumab for ulcerative colitis must be submitted using this form only.
- *Antivirals for Chronic Hepatitis C Special Authorization Request Form* (ABC 60022) – All requests for elbasvir/grazoprevir, glecaprevir/pibrentasvir, sofosbuvir, sofosbuvir/ledipasvir, sofosbuvir/velpatasvir, or sofosbuvir/velpatasvir/voxilaprevir must be submitted using this form only.
- *Proton-Pump Inhibitors Pricing Authorization Request Form (*ABC 60049) – All requests for MAC override for Proton-Pump Inhibitor products that are subject to MAC pricing on the iDBL must be submitted using this form only. Please refer to the iDBL for full listing of Proton-Pump Inhibitor products.
- *Nintedanib/Pirfenidone Special Authorization Request Form* (ABC 60051) – All requests for nintedanib or pirfenidone must be submitted using this form only.
- *Deferiprone Special Authorization Request Form* (ABC 60054) – All requests for deferiprone must be completed using this form only.
- *Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form* (ABC 60025) - All requests for aclidinium bromide + formoterol fumarate dihydrate, budesonide + formoterol fumarate dihydrate, fluticasone propionate + salmeterol xinafoate, fluticasone furoate + umeclidinium bromide + vilanterol trifenatate, fluticasone furoate + vilanterol trifenatate, glycopyrronium bromide + indacaterol maleate, tiotropium bromide + olodaterol hydrochloride or umeclidinium bromide + vilanterol trifenatate must be submitted using this form only.
- *Eplerenone/Ivabradine/Sacubitril + Valsartan Special Authorization Request Form* (ABC 60050) – All requests for eplerenone, ivabradine or sacubitril + valsartan must be submitted using this form only.
- *Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form* (ABC 60058) – All requests for adalimumab for Hidradenitis Suppurativa must be completed using this form only.
- *Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form* (ABC 60056) – All requests for omalizumab for Chronic Idiopathic Urticaria must be completed using this form only.
- *Benralizumab/Mepolizumab Special Authorization Request Form* (ABC 60061) – All requests for benralizumab or mepolizumab must be completed using this form only.
- *Alirocumab/Evolocumab for HeFH Special Authorization Request Form* (ABC 60060) – All requests for alirocumab or evolocumab for Heterozygous Familial Hypercholesterolemia must be completed using this form only.
- *Fidaxomicin Special Authorization Request Form* (ABC 60014) – All requests for fidaxomicin must be submitted using this form only.
- *Asfotase Alfa Special Authorization Request Form* (ABC 60063) – All requests for asfotase alfa must be submitted using this form only.
- *Asfotase Alfa Consent Form* (ABC 60057) -– All initial requests for asfotase alfa must be accompanied by this form.
- *Nusinersen Special Authorization Request Form* (ABC 60064) – All requests for nusinersen must be submitted using this form only.

- *Obeticholic Acid Special Authorization Request Form* (ABC 60065) – All requests for obeticholic acid must be submitted using this form only.
- *Tocilizumab for Giant Cell Arteritis Special Authorization Request Form* (ABC 60066) – All requests for tocilizumab for Giant Cell Arteritis must be submitted using this form only.
- *Ocrelizumab for PPMS Special Authorization Request Form* (ABC 60067) – All requests for ocrelizumab for PPMS must be submitted using this form only.
- *Levodopa/Carbidopa Intestinal Gel Special Authorization Request Form* (ABC 60068) – All requests for levodopa/carbidopa intestinal gel must be completed using this form only
- *Velaglucerase Alfa/Taliglucerase Alfa for Gaucher Disease Special Authorization Request Form* (ABC 60070) – All requests for Velaglucerase Alfa or Taliglucerase Alfa for Gaucher Disease must be completed using this form only.
- *Migalastat Special Authorization Request Form* (ABC60071) – All requests for Migalstat must be completed using this form only.
- *Single Entity Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form* (ABC 60072) – All requests for MAC override for single entity angiotensin-converting enzyme inhibitors that are subject to MAC pricing on the iDBL must be submitted using this form only. Please refer to the iDBL for full listing of Single Entity Angiotensin-Converting Enzyme Inhibitor products.
- *Calcium Channel Blocking Agents (CCBs) Pricing Authorization Request Form* (ABC 60073) – All requests for MAC override for calcium channel blocking agents that are subject to MAC pricing on the iDBL must be submitted using this form only. Please refer to the iDBL for full listing of calcium channel blocking agent products.
- *HMG-COA Reductase Inhibitors (Statins) Pricing Authorization Request Form* (ABC 60074) – All requests for MAC override for HMG-COA reductase inhibitors (statins) that are subject to MAC pricing on the iDBL must be submitted using this form only. Please refer to the iDBL for full listing of for HMG-COA Reductase Inhibitor (Statin) products.
- *Combination Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form* (ABC 60075) – All requests for MAC override for combination angiotensin-converting enzyme inhibitors that are subject to MAC pricing on the iDBL must be submitted using this form only. Please refer to the iDBL for full listing of Combination Angiotensin-Converting Enzyme Inhibitor products.
- *Biosimilar Initiative Exception Special Authorization Request Form* (ABC 60076) – All requests for an exception to the Biosimilar Initiative must be submitted using this form only.
- *Alemtuzumab For Multiple Sclerosis Special Authorization Request Form (ABC 60079)* - All requests for alemtuzumab for multiple sclerosis must be submitted using this form only.
- *Edaravone Special Authorization Request Form (ABC 60080)* - All requests for edaravone must be submitted using this form only.
- *Rivaroxaban 2.5 mg Special Authorization Request Form (ABC 60081)* - All requests for rivaroxaban 2.5 mg must be submitted using this form only.
- *Icatibant / Lanadelumab For HAE Type I Or II Special Authorization Request Form (*ABC 60083) – All requests for icatibant acetate and lanadelumab must be submitted using this form only.
- *Inotersen/Patisiran for HATTR-PN Special Authorization Request Form (ABC 60084)* – All requests for inotersen or patisiran for hATTR polyneuropathy must be submitted using this form only.

Forms for Physicians

Forms for physicians can be found on the following pages:

- *Registration for MS Neurologist Status Form* (ABC 60002) - Special authorization requests for eligible MS Disease Modifying Therapies must be submitted by a "Registered MS Neurologist". Neurologists may apply to be a "Registered MS Neurologist" by completing the Registration for MS Neurologist Status Form (ABC 60002).
- *Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form* (ABC 60021) - Ophthalmologists with training in the administration of intravitreal injections may apply to be a Registered Prescriber by completing this form. Registration allows for practitioner's patients to receive coverage of Jetrea. Ophthalmologists who choose not to apply to be a Registered Prescriber may also prescribe Jetrea, but patients will not be eligible for payment under the program for such prescriptions. The patient may choose to receive the product at their own expense.
- *Registration for Designated Prescriber Status for Alberta Drug Benefit List Claim Coverage – Select Quinolone Antibiotics* (ABC 60041) - Refer to Section 3A of the *Alberta Drug Benefit List* for criteria for Optional Special Authorization of select quinolone drug products and the form for *Registration for Designated Prescriber Status for Alberta Drug Benefit List Claim Coverage – Select Quinolone Antibiotics.*
- *Opioid Agonist Therapy Program Coverage Extension Request form (ABC 60082)* – Requests for extension of coverage of the opioid agonist therapy program 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 60015).

- **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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

☐ **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

Previous medications and patient response to therapy

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Donepezil/Galantamine/Rivastigmine Special Authorization Request Form

On the reverse is the official *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* (ABC 60034).

- All requests for donepezil hydrochloride, 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY , PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

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 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

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.

Special Authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug.

Note: an MMSE score below 10 or an InterRAI-Cognitive Performance Scale score greater than 4 at any time will result in discontinuation of coverage.

PLEASE COMPLETE ALL SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

Indicate which drug is requested

- ☐ **Donepezil (e.g. Aricept)**
- ☐ **Galantamine (e.g. Reminyl ER)**
- ☐ **Rivastigmine (e.g. Exelon)**

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 current MMSE or InterRAI-Cognitive Performance Scale score* <u>and</u> the date the exam was administered

MMSE score _____ Date of exam _____

InterRAI-Cognitive Performance Scale score _____ Date of exam _____

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Darbepoetin/Epoetin Special Authorization Request Form

On the reverse is the official *Darbepoetin/Epoetin Special Authorization Request Form* (ABC 60006).

- 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

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/syringe 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

NEW patients
a) Provide pre-treatment hemoglobin level (g/L) _____

b) Is the hemoglobin level falling? ☐ Yes ☐ No

Patients currently on darbepoetin or epoetin
Provide current hemoglobin level (g/L)

Please provide the current iron status: Transferrin saturation is >20% ☐ Yes ☐ No

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

☐ 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 **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 (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for 12 months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 300 mcg per month."

"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 should be reduced by about 25 per cent. Special authorization will be granted for 12 months."

In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.

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

The following product(s) are eligible for auto-renewal for the indication of the treatment of anemia of chronic renal failure.

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

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for 12 months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 60,000 units per month."

"For the treatment of anemia in AZT-treated/HIV infected patients. Special authorization will be granted for twelve months."

"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 should be reduced by about 25%. Special authorization will be granted for 12 months."

In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.

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

The following product(s) are eligible for auto-renewal for the indication of treatment of anemia of chronic renal failure.

EPOETIN 30,000 and 40,000 IU/syringe 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 should be reduced by about 25 per cent. Patients may be granted a maximum allowable dose of 40,000 IU per week. Special authorization will be granted for 12 months."

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 therapy.

ABC 60006 (2017/08)

Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/ Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/ Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60027).

- All requests for abatacept, adalimumab, anakinra, certolizumab, etanercept, golimumab, infliximab, sarilumab, tocilizumab or tofacitinib for Rheumatoid Arthritis must be submitted using the *Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/ Tocilizumab/Tofacitinib 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/ ADALIMUMAB/ ANAKINRA/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ SARILUMAB/ TOCILIZUMAB/ TOFACITINIB 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

PATIENT LAST NAME	FIRST NAME	INITIAL

BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

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

REGISTRATION NUMBER

PHONE

FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

- ☐ Rheumatoid Arthritis
- ☐ Other (specify)

Indicate requested drug

- ☐ Actemra
- ☐ Avsola
- ☐ Brenzys
- ☐ Cimzia
- ☐ Erelzi
- ☐ Humira
- ☐ Inflectra
- ☐ Kevzara
- ☐ Kineret
- ☐ Orencia
- ☐ Renflexis
- ☐ Simponi
- ☐ Xeljanz
- ☐ Xeljanz XR

Current weight (kg)

Dosage and frequency

Date of last dose

For patients new to coverage but currently maintained on the requested drug, provide the treatment start date (YYYY-MM-DD) _____

*Pre-treatment scores	Current scores
DAS28 Score ___.____ Date _____	DAS28 Score ___.____ **OR** ☐ ACR20 (renewals only) Date _____
HAQ Score ___.___ ___ Date _____	HAQ Score ___.___ ___ Date _____

*Requests for patients new to the requested drug and requests for patients new to coverage but currently maintained on the requested drug require pre-treatment scores. All 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.

Please provide reason if a switch to a different drug is requested

Note: patients will not be permitted to switch back to a previously trialed drug if they were deemed unresponsive to therapy.

For all drugs EXCEPT Abatacept

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

☐ YES ☐ NO

For Abatacept ONLY

Will the patient be maintained on methotrexate or another DMARD in combination with Abatacept? ☐ YES ☐ NO

If NO to any of the above, please specify reason

Please provide the following information for all NEW requests

Previous medications utilized: Dose, duration and response are required for ALL FOUR of the following or contraindications, if applicable

- ☐ Methotrexate PO _____
- ☐ Methotrexate SC or IM _____
- ☐ Methotrexate with another DMARD other than leflunomide (specify agent) _____
- ☐ Leflunomide _____

For Kineret requests, please indicate if the following drugs were tried and the response to therapy, or contraindications, if applicable

☐ Abatacept _____	☐ Etanercept _____	☐ Rituximab _____
☐ Adalimumab _____	☐ Golimumab _____	☐ Sarilumab _____
☐ Certolizumab _____	☐ Infliximab _____	☐ Tocilizumab _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **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 60045).

- 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 LAST NAME	FIRST NAME	INITIAL

BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

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, if requested, to Alberta Human Services; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health.

PATIENT CONSENT

I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health, and (if they request it) to Alberta Human Services (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health 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 LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

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

REGISTRATION NUMBER

PHONE

FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Diagnosis of chronic hepatitis C

	YES	NO	Not tested
Is the patient serum HCV RNA positive (by PCR), pre-treatment….....	☐	☐	☐

Evidence of active liver disease:

At least one of the following

	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)……	☐	☐	☐
OR			
c) does the patient have elevated liver stiffness as demonstrated by transient elastography (fibrosis)……	☐	☐	☐

If the patient is currently on peginterferon alfa-2a, indicate start date (YYY-MM-DD):

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 an 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 an 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**
  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/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form

On the reverse is the official *Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60011).

- All requests for adalimumab, etanercept or tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be submitted using the *Adalimumab/Etanercept/Tocilizumab for Polyarticular 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®

ADALIMUMAB/ ETANERCEPT/ TOCILIZUMAB for Polyarticular 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			**FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED**

Please provide the following information for ALL requests

Diagnosis	**Indicate requested drug**	**For Actemra, Brenzys, Erelzi, or Enbrel requests, indicate current weight (kg)**	**Dosage** **Frequency**
☐ Polyarticular Juvenile Idiopathic Arthritis ☐ Other (please specify)	☐ Actemra ☐ *Enbrel ☐ Humira ☐ *Brenzys ☐ *Erelzi ***Note: all new requests for Enbrel for etanercept naïve patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for patients weighing less than 63 kg. Coverage for Enbrel will continue for patients who are currently well maintained and are considered a 'responder' as defined in criteria.**		

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

Pre-treatment ACR Pedi 30 score (provide for NEW requests for treatment naïve and treatment experienced patients)	**Current ACR Pedi 30 score (provide for ALL RENEWAL requests and for INITIAL requests for treatment experienced patients)**
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 DMARDs utilized (specify agents): Dose, duration and response is required

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

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Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/ Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form

On the reverse is the official *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/ Secukinumab for Psoriatic Arthritis Special Authorization Request Form* (ABC 60029).

- All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab, ixekizumab, or secukinumab for Psoriatic Arthritis must be submitted using the *Adalimumab/Certolizumab/ Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab 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/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ IXEKIZUMAB/ SECUKINUMAB for Psoriatic Arthritis

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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Polyarticular Psoriatic Arthritis

☐ Pauciarticular Psoriatic Arthritis
Joints affected ☐ Knee joints ☐ Hip joints
☐ Other (specify) _____

☐ Other (specify) _____

Indicate requested drug

☐ Avsola ☐ Cosentyx ☐ Inflectra ☐ Simponi
☐ Brenzys ☐ Erelzi ☐ Renflexis ☐ Taltz
☐ Cimzia ☐ Humira

Current weight (kg)

Dosage and frequency

Date of last dose

For patients new to coverage but currently maintained on the requested drug, provide the treatment start date (YYYY-MM-DD) _____

*Pre-treatment scores		Current scores		
DAS28 score ___.____	Date _____	DAS28 score ___.____	**OR** ☐ ACR20 (renewals only)	Date _____
HAQ score ___.___ ___	Date _____	HAQ score ___.___ ___		Date _____

*Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores. All 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.

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 are required for ALL THREE of the following or contraindications, if applicable

☐ Methotrexate PO _____

☐ Methotrexate SC or IM _____

☐ DMARD other than methotrexate (specify agent) _____

For Cosentyx requests only: has the patient had an inadequate response to previous therapy with an anti-TNF alpha agent? ☐ YES ☐ NO

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **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

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Select Quinolones Special Authorization Request Form

On the reverse is the official *Select Quinolones Special Authorization Request Form* (ABC 60042).

- All requests for ciprofloxacin, levofloxacin or moxifloxacin 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

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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

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 and soft tissue / bone and joint infection

- ☐ Malignant / invasive otitis externa
- ☐ Bone / joint infection due to gram-negative organisms
- ☐ 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 (e.g. AMA CPGs or Bugs and 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 three months, HIV/AIDS, or 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

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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®

BACKGROUND INFORMATION REGARDING SELECT QUINOLONE SPECIAL AUTHORIZATION PROCESS

Optional Special Authorization for Quinolones

Select quinolones covered through optional special authorization for Alberta Government sponsored drug programs include **ciprofloxacin, levofloxacin** and **moxifloxacin**. 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 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 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) Physicians 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 Drug Benefit List*, and referenced on this form. *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 six 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 complete the *Select Quinolone Antibiotics Registration for Designated Prescriber Status* Form found at www.health.alberta.ca/services/drug-benefit-list.html and return your completed registration by FAX to 1-877-305-9911.

For more information, please contact Clinical Drug Services, Alberta Blue Cross, at 780-498-8480 in Edmonton, and 1-866-998-8480 toll-free all other areas.

Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form

On the reverse is the official *Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form* (ABC 60043).

- All requests for alendronate, raloxifene, or risedronate for Osteoporosis must be submitted using the *Alendronate/Raloxifene/Risedronate 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 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX or the most recent (2010) version of the Canadian Association of Radiologist and Osteoporosis Canada (CAROC) table.

*** Alendronate 70 mg and risedronate 35 mg are regular benefits not requiring Special Authorization.**

** Alendronate and risedronate also have Special Authorization criteria for Paget's disease. Please refer to the Alberta Drug Benefit List for alendronate and risedronate's other criteria for the indication of Paget's disease: http://www.health.alberta.ca/services/drug-benefit-list.html

Please provide the following information for ALL requests

Indicate which drug is requested (check ONE box) ☐ Alendronate ☐ Raloxifene ☐ Risedronate

Please provide the following information for all NEW requests

Diagnosis ☐ For the treatment of Osteoporosis ☐ Osteopenia ☐ Other (please specify) _____

Fracture risk

a) Has the patient experienced FRACTURES related to the diagnosis? ☐ No ☐ Yes

b) Does the patient have a 20% or greater 10-year fracture risk? ☐ No ☐ Yes

Information regarding previous alendronate 70mg or risedronate 35mg use

☐ alendronate 70mg or risedronate 35mg HAS been utilized.

Nature of response ☐ Intolerance

☐ Other (please specify) _____

☐ alendronate 70mg or risedronate 35mg has NOT been utilized (please specify) _____

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		• **Alberta Blue Cross, Clinical Drug Services** **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

Celecoxib Special Authorization Request Form

On the reverse is the official *Celecoxib Special Authorization Request Form* (ABC 60032).

- 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE: / FAX:
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

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 six 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

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services** **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.

The information on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form

On the reverse is the official *Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form* (ABC 60013)

- All requests for filgrastim, pegfilgrastim or plerixafor must be submitted using the *Filgrastim/ Pegfilgrastim/Plerixafor 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 / PLERIXAFOR 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested (check ONE box)

- ☐ **Fulphila (pegfilgrastim) → complete Section I only**
- ☐ **Grastofil (filgrastim) → complete Section I or II**
- ☐ **Lapelga (pegfilgrastim) → complete Section I only**
- ☐ **Nivestym (filgrastim) → complete Section I or II**
- ☐ **Plerixafor (e.g. Mozobil) → complete Section III only**
- ☐ **Ziextenzo (pegfilgrastim) → complete Section I only**

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

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

b) 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)

a) 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** _____

Section III (Plerixafor requests, check ALL that apply)

a) Please provide the patient's current weight (kg) _____

b) Please **SPECIFY** the type of cancer being treated

- ☐ multiple myeloma (MM) ☐ Non-Hodgkin's lymphoma (NHL) ☐ other, please **SPECIFY** _____

c) Please provide the indication for which the drug is requested

- ☐ patient is undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy
- ☐ other (please **SPECIFY)** _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

FILGRASTIM / PEGFILGRASTIM / PLERIXAFOR SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

FILGRASTIM (e.g. Grastofil, Nivestym) special authorization criteria
“In patients with non-myeloid malignancies, receiving myelosuppressive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia.” “Following induction and consolidation treatment for acute myeloid leukemia, for the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization." "In patients with a diagnosis of congenital, cyclic or idiopathic neutropenia, to increase neutrophil counts and to reduce the incidence and duration of infection." Please note for the first criterion: coverage cannot be considered for palliative patients.
PEGFILGRASTIM (e.g. Fulphila, Lapelga, Ziextenzo) special authorization criteria
"In patients with non-myeloid malignancies, receiving myelosuppressive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia." Please note: coverage cannot be considered for palliative patients.
PLERIXAFOR (e.g. Mozobil) special authorization criteria
"For the treatment of patients with Non-Hodgkin’s lymphoma (NHL) or multiple myeloma (MM) undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy, in combination with filgrastim, when prescribed by a designated prescriber." Coverage may be approved for a maximum of four doses (0.24mg/kg given daily) for a single mobilization attempt. Special authorization may be granted for 12 months.

Fentanyl Special Authorization Request Form

On the reverse is the official *Fentanyl Special Authorization Request Form* (ABC 60005).

- 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 LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION		
PRESCRIBER LAST NAME FIRST NAME INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	
STREET ADDRESS		
CITY, PROVINCE	PHONE	FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

CRITERIA FOR COVERAGE OF FENTANYL

Fentanyl injection	Fentanyl patch
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 six months. This product is eligible for auto-renewal.	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 six 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 six months. This product is eligible for auto-renewal.

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

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

For FENTANYL PATCH requests

Patients must have tried at least two discrete courses* of therapy with two 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.

Treatment course 1 MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug)

☐ morphine _____

☐ hydromorphone _____

☐ oxycodone _____

☐ other (specify) _____

Treatment course 2 MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug)

☐ morphine _____

☐ hydromorphone _____

☐ oxycodone _____

☐ other (specify) _____

For FENTANYL INJECTION requests

Previous MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug)

☐ morphine _____

☐ hydromorphone _____

If patient is unable to swallow, please provide information regarding specific reasons patient is unable take oral medications

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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

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

On the reverse is the official *Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form* (ABC 60030).

- All requests for adalimumab, etanercept, infliximab, ixekizumab, risankizumab, secukinumab or ustekinumab for Plaque Psoriasis must be submitted using the *Adalimumab/Etanercept/ Infliximab/Ixekizumab/Risankizumab/Secukinumab/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/ IXEKIZUMAB/ SECUKINUMAB/ RISANKIZUMAB/ 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Indicate requested drug**		**Current weight (kg)**	**Dosage and frequency**
☐ Plaque Psoriasis ☐ Other (specify)	**Tier 1 Drugs**[1] ☐ Cosentyx ☐ [2]Erelzi ☐ Inflectra ☐ Skyrizi ☐ [2]Enbrel ☐ Humira ☐ Renflexis ☐ Taltz	**Tier 2 Drugs**[1] ☐ Stelara		**Date of last dose**
	1. See p. 2 for SA Criteria Change; 2. See p. 2 for Biosimilar Switch Policy			

For patients new to coverage but currently maintained on the requested drug, provide the treatment start date (YYYY-MM-DD) _____

Location: Prior to treatment with the requested biologic, did the patient have significant involvement of the face, palms of the hands, soles of the feet or genital region?
☐ YES ☐ NO

***Pre-treatment scores**		**Current scores**	
PASI _____	Date _____	PASI _____	Date _____
DLQI _____	Date _____	DLQI _____	Date _____

*Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores.
Note: PASI and DLQI scores are required for all requests including those requests for patients that have significant involvement of the face, palms, soles of the feet or genital region.

Please provide reason if a switch to a different drug is requested

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 - Check all that apply and indicate dose, duration and response or contraindication, if applicable

☐ Methotrexate PO _____
☐ Methotrexate SC or IM _____
☐ Cyclosporine _____
☐ Phototherapy _____

For TIER 2 drug requests
Please indicate which TIER 1 drugs were tried and the response to therapy, reasons for discontinuation or contraindications, if applicable

☐ Adalimumab _____ ☐ Ixekizumab _____
☐ Etanercept _____ ☐ Risankizumab _____
☐ Infliximab _____ ☐ Secukinumab _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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®

ADALIMUMAB/ ETANERCEPT/ INFLIXIMAB/ IXEKIZUMAB/ SECUKINUMAB/ RISANKIZUMAB/ 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

1. Special Authorization Criteria Change

As of December 12, 2019, tiering will be implemented for biologic drugs for plaque psoriasis. Patients must trial the number of drugs in tier 1 that is equal to the number of different mechanisms of action of the tier 1 drug products prior to accessing a tier 2 drug. Should therapy with a tier 1 therapeutic option(s) fail or be inappropriate due to intolerance or contraindication, access to a more expensive tier 2 agent *may* be considered.

Health Area/Indication	Drugs in Tier 1	Drugs in Tier 2
Dermatology (Plaque Psoriasis)	• Cosentyx (secukinumab) • Erelzi (etanercept) • Humira (adalimumab) • Inflectra (infliximab) • Renflexis (infliximab) • Skyrizi (risankizumab) • Taltz (ixekizumab) *Number of tier 1 drugs that must be trialed: 3*	• Stelara (ustekinumab)

For Tiering Exception Requests

For exception requests for tier 2 drugs for patients already on the requested tier 2 drug

Please provide the date that the tier 2 drug was initiated (YYYY-MM-DD) _____

Please indicate whether the patient is stabilized on the tier 2 drug ☐ YES ☐ NO

Please provide Information on the previous method of reimbursement for the tier 2 drug (such as private coverage, compassionate supply)

_____

For exception requests for tier 2 drugs for patients new to the requested tier 2 drug

Please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form.

2. Biosimilar Switch Policy

As of December 12, 2019, adult (18 years of age and older) patients currently on an originator drug for which there is a biosimilar version for their medical condition must switch to the biosimilar prior to the originator drug delisting date in order to maintain coverage for the molecule through their Alberta government sponsored drug plan. During the switching period, both the originator drug and biosimilar(s) will be covered. As of the delisting date for the particular originator drug, the authorization will only cover the biosimilar(s) listed below, for the affected indication(s).

Drug	Originator (Switch from)	Biosimilar (Switch to)	Indication	Originator delisting date
Etanercept	Enbrel	Erelzi	Plaque Psoriasis	May 1, 2021

For Biosimilar Initiative Exception Requests

Please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form.

Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/ Secukinumab for Ankylosing Spondylitis Special Authorization Request Form

On the reverse is the official *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form* (ABC 60028).

- All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab or secukinumab for Ankylosing Spondylitis must be submitted using the *Adalimumab/ Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab 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/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ SECUKINUMAB 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 LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Ankylosing Spondylitis (meeting modified NY criteria)

☐ Other (specify)

Indicate requested drug

☐ Avsola ☐ Cosentyx ☐ Inflectra

☐ Brenzys ☐ Erelzi ☐ Renflexis

☐ Cimzia ☐ Humira ☐ Simponi

Current weight (kg)

Dosage and frequency

Date of last dose

Please provide the following information for all NEW requests

Previous medications utilized

Have two or more NSAIDs been tried for a minimum of four 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** _____

For patients new to coverage but currently maintained on the requested drug, provide the treatment start date (YYYY-MM-DD) _____

NEW requests: Please provide *pre-treatment scores

BASDAI #1	Date (YYYY-MM-DD)
BASDAI #2	Date (YYYY-MM-DD)
Spinal Pain VAS #1 (cm)	Date (YYYY-MM-DD)
Spinal Pain VAS #2 (cm)	Date (YYYY-MM-DD)

* Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores. Scores 1 and 2 for each parameter must be at least eight weeks apart.

RENEWAL requests: Please provide current scores

BASDAI	Date (YYYY-MM-DD)
Spinal pain VAS (cm)	Date (YYYY-MM-DD)

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 (YYYY-MM-DD)	Please forward this request to ▪ **Alberta Blue Cross, Clinical Drug Services** **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/Vedolizumab for Crohn's/Infliximab for Crohn's/ Fistulizing Crohn's Disease Special Authorization Request Form

On the reverse is the official *Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* (ABC 60031).

- All requests for adalimumab or vedolizumab 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/Vedolizumab 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 / VEDOLIZUMAB 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

PATIENT LAST NAME	FIRST NAME	INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		
STREET ADDRESS	CITY / PROV / POSTAL CODE		ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME / FIRST NAME / INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
STREET ADDRESS	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
CITY, PROVINCE	PHONE / FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

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

Indicate requested drug
- ☐ Avsola ☐ Humira ☐ Renflexis
- ☐ Entyvio ☐ Inflectra

Current weight (kg)

Dosage and frequency

Date of last dose

For INITIAL requests, please indicate if the drug is requested for a
- ☐ NEW patient who has never been treated with the requested drug by any health care provider.
- ☐ EXISTING patient who is being treated or has previously been treated with the requested drug.
  Please provide the treatment start date _____

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 requests

Dose, duration and response are required for all medications previously utilized.

Azathioprine

6-mercaptopurine

Antibiotic(s) (specify 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 (please specify) _____
- ☐ Loss of response to 5mg/kg dosing: increase to 10mg/kg required

Adalimumab, Infliximab or Vedolizumab for MSAC

INITIAL requests

Dose, duration and response are required for all medications previously utilized, or contraindications, if applicable

Azathioprine

6-mercaptopurine

Methotrexate

Mesalamine

Glucocorticoid(s) (specify drug name)

ALL requests

Modified Harvey-Bradshaw Index score _____ Date of score _____

For Infliximab requests for an increase to 10mg/kg dosing

1) Is the patient already maintained on Infliximab 10 mg/kg?

☐ Yes ☐ No

2) Confirm the patient had an incomplete response to Infliximab 5mg/kg dosing

☐ Yes ☐ No (explain) _____

3) Most recent Modified Harvey-Bradshaw Index score from when the patient was *responding* to 5mg/kg dosing _____ Date _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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

Rituximab for Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Rituximab for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60046).

- All requests for rituximab for Rheumatoid Arthritis must be submitted using the *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®

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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE	PHONE		FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

Diagnosis
☐ Rheumatoid Arthritis
☐ Other (specify)

Indicate drug requested
☐ Riximyo ☐ Ruxience ☐ Truxima

Dosage and frequency

Pre-treatment scores*
DAS28 Score _____
Date _____

AND
HAQ Score _____
Date _____

Requests for re-treatment after two-dose course
Date of initial dose of the previous course of therapy
_____

Response scores 16 to 24 weeks after initial dose of previous course of therapy
DAS28 Score _____ Date _____
HAQ Score _____ Date _____

Current scores
DAS28 Score _____ Date _____
HAQ Score _____ Date _____

Please provide reason if a switch from a different drug to rituximab is requested

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?
☐ 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, or contraindications, if applicable

☐ Methotrexate PO _____
☐ Methotrexate SC or IM _____
☐ Methotrexate with another DMARD other than leflunomide (specify agent) _____
☐ Leflunomide _____
☐ Anti-TNF therapy _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

Imiquimod Special Authorization Request Form

On the reverse is the official *Imiquimod Special Authorization Request Form* (ABC 60038).

- 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®

IMIQUIMOD
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

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 six months.

This product is eligible for auto-renewal.

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

Diagnosis

☐ Actinic Keratosis → Area affected

☐ Head or neck ☐ Other (please specify) _____

☐ Other (please 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 (please specify) _____

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

AND

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

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

☐ No (specify reason, if applicable) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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

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Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form

On the reverse is the official *Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form* (ABC 60024).

- All requests for aripiprazole, paliperidone or risperidone prolonged release injection must be submitted using the *Aripiprazole/Paliperidone/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®

ARIPIPRAZOLE/PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION 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**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested

☐ **Aripiprazole Prolonged Release Injection (e.g. Abilify Maintena)**

☐ **Risperidone Prolonged Release Injection (e.g. Risperdal Consta)**

☐ **Paliperidone 1-Month Prolonged Release Injection (e.g. Invega Sustenna)**

☐ **Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Trinza)**

Diagnosis

☐ Schizophrenia or related psychotic disorder ☐ Other (please specify) _____

Compliance issues

Has this patient demonstrated a pattern of significant non-compliance with other dosage forms that is compromising or has compromised this patient's therapeutic success?

☐ Yes ☐ No, specify reason _____

Previous drug therapy (CHECK ALL THAT APPLY) In order to comply with criteria, check at least one 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; or

☐ is refractory to trials of at least two other antipsychotic therapies.

Risperidone or paliperidone requests only	**Aripiprazole requests only**
Previous risperidone or paliperidone therapy: does the patient possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy? ☐ Yes ☐ No, specify reason _____	**Previous aripiprazole therapy:** does the patient possess clinical evidence of previous successful treatment with aripiprazole therapy? ☐ Yes ☐ No, specify reason _____

Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Trinza) requests only

Has this patient been maintained on Paliperidone 1-Month Prolonged Release Injection (e.g. Invega Sustenna) for at least four months?

☐ Yes ☐ No, specify reason _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

ARIPIPRAZOLE/PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION
SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

ARIPIPRAZOLE PROLONGED RELEASE INJECTION (e.g. Abilify Maintena)

"For the maintenance treatment of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with aripiprazole therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

PALIPERIDONE 1-MONTH PROLONGED RELEASE INJECTION (e.g. Invega Sustenna)

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

PALIPERIDONE 3-MONTH PROLONGED RELEASE INJECTION (e.g. Invega Trinza)

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

RISPERIDONE PROLONGED RELEASE INJECTION (e.g. Risperdal Consta)

"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 possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form

On the reverse is the official *Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60010).

- All requests for abatacept for Polyarticular Juvenile Idiopathic Arthritis must be submitted using the *Abatacept for Polyarticular 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 Polyarticular 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

PATIENT LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH: YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

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

REGISTRATION NUMBER

PHONE	FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

- ☐ Polyarticular Juvenile Idiopathic Arthritis
- ☐ Other (please specify) _____

Current weight (kg)

Dosage

Dosing frequency

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

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

Current ACR Pedi 30 FLARE score (provide for ALL requests)

Date of assessment_____

1. Rheumatologist global assessment (0-10) _____
2. Patient global assessment (0-10) _____
3. No. 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

ACR Pedi 30 RESPONSE score at 16 to 20 weeks after first dose of previous abatacept treatment (provide for RETREATMENT requests)

Date of assessment_____

1. Rheumatologist global assessment (0-10) _____
2. Patient global assessment (0-10) _____
3. No. 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 medications utilized: Dose, duration and response is required

- ☐ DMARD(s) (please specify agents)
- ☐ Adalimumab
- ☐ Etanercept
- ☐ Tocilizumab
- ☐ Other (please 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 **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

ABC 60010 (2016/10)

Montelukast/Zafirlukast Special Authorization Request Form

On the reverse is the official *Montelukast/Zafirlukast Special Authorization Request Form* (ABC 60039).

- 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®

MONTELUKAST/ZAFIRLUKAST
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate drug requested (check one box): ☐ **Montelukast 5mg + 10mg (e.g. Singulair)** ☐ **Zafirlukast 20mg (e.g. Accolate)**

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 six months. This product is eligible for auto-renewal.

Note: Refer to the Alberta Drug Benefit List for Restricted Benefit coverage of patients two to 18 years of age inclusive for Montelukast and 12 to 18 years of age inclusive for Zafirlukast.

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 (please specify) _____

Section 2: Prophylaxis and chronic treatment of asthma

A. Previous Medication Use

a) Please indicate if an inhaled glucocorticosteroid was used
☐ Yes ☐ No (If no, please specify reason) _____

b) Please indicate if a long-acting beta 2 agonist (e.g. salmeterol or formoterol) was tried
☐ Yes → Response: ☐ Persistent symptoms
☐ Other (please specify) _____
☐ No (If no please specify) _____

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 (please specify) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Febuxostat Special Authorization Request Form

On the reverse is the official *Febuxostat Special Authorization Request Form* (ABC 60037).

- All requests for febuxostat must be submitted using the *Febuxostat 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®

FEBUXOSTAT
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of FEBUXOSTAT

"For the treatment of symptomatic gout in patients with a documented hypersensitivity to allopurinol.

Special authorization may be granted for 6 months."

Please note: Hypersensitivity to allopurinol is a rare condition that is characterized by a major skin manifestation, fever, multi-organ involvement, lymphadenopathy and hematological abnormalities (eosinophilia, atypical lymphocytes). Intolerance or lack of response to allopurinol will not be covered by this criteria.

The following product(s) are eligible for auto-renewal.

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

Diagnosis

☐ Symptomatic gout ☐ Other (please specify) _____

Previous medications utilized: Information is required for the following

☐ Allopurinol has been utilized → please indicate response to therapy

☐ Documented *hypersensitivity

☐ Other (please specify) _____

Please note: Hypersensitivity to allopurinol is a rare condition that is characterized by a major skin manifestation, fever, multi-organ involvement, lymphadenopathy and hematological abnormalities (eosinophilia, atypical lymphocytes).* ***Intolerance or lack of response to allopurinol will not be covered by this criteria.*

☐ Allopurinol has NOT been utilized. Please specify reason, if applicable

_____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form

On the reverse is the official *Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form* (ABC 60007).

- All requests for denosumab 60 mg/syringe injection or for zoledronic acid 0.05 mg/ml injection for osteoporosis must be submitted using the *Denosumab/Zoledronic Acid 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®

DENOSUMAB / ZOLEDRONIC ACID 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

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested (check ONE box) ☐ **Denosumab 60 mg/syr** ☐ **Zoledronic Acid 0.05 mg/ml**

Indicate diagnosis ☐ **Osteoporosis** ☐ **Other (specify)** _____

Indicate fracture risk and history (check ALL that apply)

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

☐ high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture

☐ moderate 10-year fracture risk (i.e.,10-20%)

☐ prior fragility fracture

Indicate which of the following pertain to this patient (check ALL that apply)

☐ oral bisphosphonates are contraindicated due to an abnormality of the esophagus which delays esophageal emptying

☐ persistent severe gastrointestinal intolerance to a course of therapy with either alendronate or risedronate

☐ unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for 1 year and evidence of a decline in BMD below pre-treatment baseline level)

Denosumab requests only

☐ bisphosphonates are contraindicated due to drug-induced hypersensitivity (i.e., immunologically mediated)

☐ bisphosphonates are contraindicated due to severe renal impairment (i.e., creatinine clearance < 35 mL/min)

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **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.

Omalizumab for Asthma Special Authorization Request Form

On the reverse is the official *Omalizumab for Asthma Special Authorization Request Form* (ABC 60020).

- All requests for omalizumab for Asthma must be submitted using the *Omalizumab for Asthma 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®

OMALIZUMAB for Asthma
SPECIAL AUTHORIZATION REQUEST FORM

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

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE ☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH(YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

SPECIALIST IN RESPIROLOGY OR CLINICAL IMMUNOLOGIST INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	Current weight (kg)	Smoking status	**Please indicate if this patient is**
☐ Severe persistent asthma ☐ Other (please specify) _____		☐ Smoker ☐ Non-smoker	☐ starting drug upon approval …… . **complete section I** ☐ new to coverage but currently maintained on drug …**complete section I and II** ☐ submitting renewal request ……..**complete section II**

Section I: Please provide <u>pre-treatment</u> information for NEW requests for treatment-naive and treatment-experienced patients

Total serum human immunoglobulin (IgE) (IU/ml)	Date	AQLQ – Juniper score		Date
☐ Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing	Date	ACQ-5 scores	Score #1	Date
FEV1 (pre-bronchodilator per cent predicted)	Date		Score #2	Date

***Number of exacerbations of asthma within the 12-month period <u>prior to starting omalizumab</u> that resulted in**

a) an emergency room visit/hospitalization _____

b) physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids _____

***Please provide <u>exact</u> numbers. If the patient has had no exacerbations, it should be reported as 'zero (0)'.**

Previous medications utilized: Check all that apply and include name of medication, dose, duration and response.

☐ High-dose inhaled corticosteroids

☐ Long-acting beta-2 agonists

☐ Oral corticosteroids

Please check if the following applies

Chronic use (greater than 50 per cent of the year) of oral corticosteroids prior to initiation of omalizumab? Yes ☐ No ☐

Section II: Complete the following for all RENEWAL requests and for INITIAL requests for treatment-experienced patients

Current FEV1 (pre-bronchodilator % predicted)	Date	Current AQLQ – Juniper score	Date	Current ACQ-5 score	Date

***Number of exacerbations of asthma within the previous 12-month period <u>while on omalizumab</u> that resulted in**

a) an emergency room visit/hospitalization _____

b) physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids _____

***Please provide <u>exact</u> numbers. If the patient has had no exacerbations, it should be reported as 'zero (0)'**

Please check if the following applies:

☐ Patient demonstrated at least a 25per cent reduction in the number of exacerbations, which required oral corticosteroids from the 12 months prior to initiation of omalizumab that required systemic corticosteroids; or

☐ For patients that were on chronic (greater than 50per cent of the year) courses of oral corticosteroids in the 12 months prior to initiation of omalizumab, tapering of oral corticosteroid use by at least 25 per cent from baseline.

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Eculizumab Special Authorization Request Form and Consent Form

On the reverse is the official *Eculizumab Special Authorization Request Form* (ABC 60009) and the official *Eculizumab Consent Form* (ABC 60035)

- All requests for eculizumab must be submitted using the *Eculizumab Special Authorization Request Form* and *Eculizumab Consent Form*.
- **Photocopy these forms 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®

ECULIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

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

PATIENT INFORMATION

Patient last name	First name	Middle initial	Gender M / F	Date of birth YYYY	MM	DD	Alberta Personal Health Number

Street address	City	Province	Postal code

ID/client/coverage number	Coverage type	
	☐Alberta Blue Cross ☐Alberta Human Services	☐Other

SPECIALIST IN HEMATOLOGY INFORMATION

Last name	First name	Middle initial

Street address	City	Province	Postal code

Telephone number	Fax number	College of Physicians and Surgeons registration number

Date form completed	Last consult date	Specialist in hematology signature

PHARMACY INFORMATION

Pharmacy name	Telephone number	Fax number

INFORMATION REQUIRED

For **INITIAL COVERAGE (new to drug),** please complete the first two pages, and submit laboratory data and consent form as attachments

For **CONTINUED COVERAGE (on drug now or prior use of drug),** please complete applicable sections of all pages and submit laboratory data as an attachment

Note: Additional pages may be attached as required; please submit all required pages and attachments together

TREATMENT REQUESTED

Dosage and frequency requested

CONFIRMATION OF DIAGNOSIS

	Yes	No	Date (YYYY/MM/DD)	Lab result
Does the patient have a PNH granulocyte or monocyte clone size (by flow cytometry and/or FLAER test) equal to or greater than 10 per cent?	☐granulocyte ☐monocyte	☐		
Does the patient have a Lactate/Dehydrogenase (LDH) level at least 1.5 times the upper limit of normal?	☐	☐		

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

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ALBERTA BLUE CROSS®

ECULIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only) _____

ADDITIONAL CLINICAL CRITERIA

Does the patient have any of the following?	Yes	No	Comment
a) Thrombosis: Evidence that the patient has had a thrombotic or embolic event which required the institution of therapeutic anticoagulant therapy.	☐	☐	
b) Transfusions: Evidence that the patient has been transfused with at least four units of red blood cells in the last 12 months.	☐	☐	
c) Anemia: Evidence that the patient has chronic or recurrent anemia where causes other than hemolysis have been excluded and demonstrated by more than one measure of less than or equal to 70g/L or by more than one measure of less than or equal to 100 g/L with concurrent symptoms of anemia.	☐	☐	
d) Pulmonary insufficiency: Evidence that the patient has debilitating shortness of breath and/or chest pain resulting in limitation of normal activity (New York Heart Association Class III) and/or established diagnosis of pulmonary arterial hypertension where causes other than PNH have been excluded.	☐	☐	
e) Renal insufficiency: Evidence that the patient has a history of renal insufficiency, demonstrated by an eGFR less than or equal to 60mL/min/1.73m^2, where causes other than PNH have been excluded.	☐	☐	
f) Smooth muscle spasm: Evidence that the patient has recurrent episodes of severe pain requiring hospitalisation and/or narcotic analgesia where causes other than PNH have been excluded	☐	☐	

CONTRAINDICATIONS TO COVERAGE

Does the patient have any of the following?	Yes	No
Small clone size - granulocyte and monocyte clone sizes below 10 percent.	☐	☐
Aplastic anaemia with two or more of the following: neutrophil count below 0.5 x 10^9/L, platelet count below 20 x 10^9/L, reticulocytes below 25 x 10^9/L or severe bone marrow hypocellularity.	☐	☐
Presence of another life threatening or severe disease where the long term prognosis is unlikely to be influenced by therapy (for example acute myeloid leukaemia or high-risk myelodysplastic syndrome).	☐	☐
Presence of another medical condition that might reasonably be expected to compromise a response to therapy	☐	☐

IMMUNIZATION

		Yes	No	Date (YY/MM/DD)
All patients must receive meningococcal immunization with a quadravalent vaccine (A, C, Y and W135) at least two weeks prior to receiving the first dose of eculizumab. Treating physicians will be required to submit confirmation of meningococcal immunizations in order for their patients to continue to be eligible for treatment with eculizumab. Pneumococcal immunization with a 23-valent polysaccharide vaccine and a 13-valent conjugate vaccine, and a Haemophilus influenza type b (Hib) vaccine, must be given according to current clinical guidelines. All patients must be monitored and reimmunized according to current clinical guidelines for vaccine use.	Meningococcal (A,C,Y and W135)	☐	☐	
	Pneumococcal 23-valent	☐	☐	
	Pneumococcal 13-valent	☐	☐	
	Hib	☐	☐	

TRANSFUSION HISTORY

Transfusion date (YYYY/MM/DD)	RBC units	Comments

Case Number _____

MONITORING REQUIREMENTS (please attach the following laboratory results with each request)

- Lactate dehydrogenase (LDH)
- Full blood count and reticulocytes
- Iron studies
- Urea, electrolytes and eGFR
- PNH Granulocyte or Monocyte clone size (initial coverage and every 12 months)

Recent clinical history (update for each request, attach additional pages as required)

Case Number

ALBERTA BLUE CROSS®

ECULIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only)

Progress report on the clinical symptoms that formed the basis of initial eligibility (update annually, attach additional pages as required)

❑Thrombosis ❑Transfusions ❑Anemia ❑Pulmonary insufficiency ❑Renal insufficiency ❑Smooth muscle spasm

Quality of life, through clinical narrative (update annually, attach additional pages as required)

Case Number

ALBERTA BLUE CROSS®

ECULIZUMAB CONSENT FORM

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

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER M/F	DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

ID/CLIENT/COVERAGE NUMBER	COVERAGE TYPE	
		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other

SPECIALIST IN HEMATOLOGY INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

TELEPHONE NUMBER	FAX NUMBER	COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER

PATIENT CONSENT FOR SERVICE

I have received a copy of the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (the Policy) and have read and understand the requirements of a patient receiving Alberta government sponsored funded treatment.

I agree to comply with the requirements for coverage as set out in the Policy, including (without limitation) the requirements for monitoring, review and data collection.

I understand and agree that I must continue to qualify for, and continue to be a member of, an Alberta government sponsored drug program to continue to be eligible for eculizumab coverage in accordance with the Policy.

I understand and agree that approval for initial and continued coverage is conditional upon meeting and continuing to meet the requirements of the Policy.

I understand that my consent must be and is ongoing and my failure to comply with the requirements as set out in the Policy may preclude me from continuing to be eligible for eculizumab coverage.

I understand that prior to potential discontinuance of eculizumab coverage, as outlined in the Policy, my Specialist in Hematology will receive notice of this in writing. I understand that my Specialist in Hematology has a responsibility to notify me, and to work with me to address the reason for potential withdrawal of eculizumab coverage.

I understand that therapy may be withdrawn at the request of the patient or the patient's parent/guardian at any time. Notification of withdrawal from therapy must be made by the Specialist in Hematology or patient in writing. I understand there may be side effects from medication and I have discussed the risks and benefits of this treatment with my Specialist in Hematology.

I, either as the patient or as the patient's parent/guardian (as appropriate), and on behalf of the patient's heirs and my estate and any other person claiming through the patient, hereby release the Minister, the Minister's delegate, the Minister's agents and employees from any and all liability and all claims for any and all damages, injuries, loss and costs which may arise directly or indirectly in relation to or in connection with the Application and coverage, funding and use of eculizumab for the patient pursuant to the Policy, including (without limitation) all claims relating to coverage, any changes in coverage, any restrictions or conditions of coverage, discontinuance of coverage, and the patient's use of eculizumab. I agree and acknowledge that this release is binding on the patient, the patient's heirs and estate, and any other person claiming through the patient against the Minister, the Minister's agents and employees.

Name of patient _____

Signature of patient (for patients > or equal to 18 years old) _____ Date _____

Name of parent/guardian (for patients <18 years old) _____

Signature of parent/guardian (for patients <18 years old) _____ Date _____

The information on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

ECULIZUMAB CONSENT FORM

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

PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

I give consent for my Specialist in Hematology to disclose relevant health registration, assessment, diagnostic, and treatment information to, the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy) for the purpose of determining my initial and continued eligibility for, or discontinuance of, eculizumab coverage. I understand that the Expert Advisors are specialists engaged by the Alberta government to provide advice to the Minister or the Minister's delegate in accordance with the Policy.

I also give consent to the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the Policy to disclose relevant health registration, assessment, diagnostic, and treatment information to each other and to my Specialist in Hematology, for the purpose of determining my initial and continued eligibility for, or discontinuance of, eculizumab coverage.

I understand that I have been asked to disclose my health information in order to determine eligibility for funding for eculizumab and payment for this drug. I understand the risks and benefits of consenting or refusing to consent. I understand that I may revoke this consent at any time by giving notice in writing to Alberta Blue Cross at the address below. I understand and agree that if I revoke this consent, this revocation is deemed a request for withdrawal of coverage.

This consent is effective on execution and will remain in effect unless revoked with notice in writing.

Name of patient _____

Signature of patient (for patients > or equal to 18 years old) _____ Date _____

Name of parent/guardian (for patients <18 years old) _____

Signature of parent/guardian (for patients <18 years old) _____ Date _____

SPECIALIST IN HEMATOLOGY CONSENT

I agree to comply with the requirements for monitoring, review and data collection as set out in the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy).

I understand that information about the patient's ongoing eligibility, and possible discontinuation (if appropriate), will be supplied to me, and that I will be responsible for passing this information on to my patient or my patient's parent/guardian.

I understand that reviews of my patient will be ongoing and my failure to provide monitoring data on behalf of my patient, as set out in the Policy, may preclude my patient from continuing to receive Alberta government funded treatment.

I understand that prior to the potential withdrawal of eculizumab coverage as outlined in the Policy, I will receive notice of this in writing. I understand that it is my responsibility to notify my patient and work with my patient to address the reason for potential withdrawal of eculizumab coverage.

I have provided my patient or my patient's parent/guardian with the Policy so that they are aware of the requirements of a patient receiving Alberta government sponsored funded treatment. I have also read the Policy and understand what is required of me, as the treating physician.

Name of specialist in hematology _____

Signature of specialist in hematology _____ Date _____

Completed Eculizumab Consent Forms or written withdrawal of consent should be directed by mail or FAX to:

Alberta Blue Cross, Clinical Drug Services
10009 108 Street NW, Edmonton, Alberta T5J 3C5
FAX: **780-401-1150** in Edmonton • **1-888-401-1150** toll free all other areas

Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form

On the reverse is the official *Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form* (ABC 60018).

- All requests for rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis must be submitted using the *Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis 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®

RITUXIMAB for Granulomatosis with Polyangiitis / Microscopic Polyangiitis 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE	PHONE	FAX	
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

Indication for use

☐ Induction of remission of granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis)

☐ Induction of remission of microscopic polyangiitis (MPA)

☐ Other (please specify) _____

Indicate requested drug

☐ Ruxience

☐ Truxima

Patient's body surface area (per square metre)

Requested dose

Dosing frequency

Please provide the following information for all NEW requests

Severity and organ(s) affected

a) Is the patient's disease life- or organ-threatening? ☐ Yes ☐ No

b) **If yes,** specify the organ(s) affected

_____

c) **If yes,** specify how the organ(s) is/are threatened

_____

Laboratory evidence of disease

Does the patient have a positive serum as say for either a) or b) below? (Note: copy of the lab report must be provided)

		YES	NO	Not tested
a)	proteinase 3-ANCA….....	☐	☐	☐
b)	myeloperoxidase-ANCA……..	☐	☐	☐

Previous cyclophosphamide usage: ONE of the following reasons must be specified

☐ The patient has failed a minimum of six intravenous pulses of cyclophosphamide

☐ The patient has failed three months of oral cyclophosphamide therapy

☐ The patient has a severe intolerance or an allergy to cyclophosphamide. Specify the nature of intolerance _____

☐ Cyclophosphamide is contraindicated. Specify the nature of contraindication _____

☐ The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide

Requests for treatment of RELAPSE following a rituximab-induced remission

Severity and organ(s) affected

a) Is the patient's disease life- or organ-threatening? ☐ Yes ☐ No

b) Is the patient experiencing worsening symptoms in two or more organs? ☐ Yes ☐ No

c) **If yes to a) or b),** specify the organ(s) affected _____

d) **If yes to a) or b),** specify how the organ(s) is/are threatened _____

Note: Additional coverage may be approved no sooner than six months after previous rituximab treatment.

Please provide the date of the last dose of the previous course of treatment with rituximab _____

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

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form

On the reverse is the official *Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60048).

- All requests for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be submitted using the *Tocilizumab for Systemic 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®

TOCILIZUMAB for Systemic 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 LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Patient's current weight (kg)**	**Requested dose (mg/kg)**
☐ Systemic Juvenile Idiopathic Arthritis ☐ Other (please specify)_____		**Dosing frequency**

Please provide the following information for NEW requests

Please check all of the following that apply

☐ Fever (>38°C) for at least two weeks
☐ Rash of systemic JIA
☐ Serositis
☐ Lymphadenopathy
☐ Hepatomegaly
☐ Splenomegaly

Previous medications utilized (specify agents): Dose, duration and response is required

☐ NSAIDs

☐ Systemic corticosteroids

Please provide the following information for RENEWAL requests

The patient is a responder as demonstrated by (check all that apply)

☐ JIA ACR30
☐ Absence of fever
☐ Reduction in inflammatory markers (e.g. CRP concentration of less than 15 mg/L or reduction in ESR)
☐ Other (specify):

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to ▪ **Alberta Blue Cross, Clinical Drug Services** **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

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DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonists Special Authorization Request Form

On the reverse is the official *DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonists Special Authorization Request Form* (ABC 60012).

- All requests for saxagliptin, saxagliptin + metformin, sitagliptin, sitagliptin + metformin, linagliptin, linagliptin + metformin, canagliflozin, dapagliflozin, dapagliflozin + metformin, empagliflozin, empagliflozin + metformin, or semaglutide must be submitted using the *DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonists 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®

DPP-4/SGLT2 INHIBITORS / GLP-1 RECEPTOR AGONISTS 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested

For the treatment of Type 2 diabetes	**Criteria for coverage***	**Complete section(s)**
☐ CANAgliflozin (e.g. Invokana) ☐ LINAgliptin (e.g. Trajenta) ☐ LINAgliptin + metformin (e.g. Jentadueto) ☐ SAXAgliptin (e.g. Onglyza) ☐ SAXAgliptin + metformin (e.g. Komboglyze) ☐ SEMAglutide (e.g. Ozempic) ☐ SITAgliptin (e.g. Januvia) ☐ SITAgliptin + metformin (e.g. Janumet, Janumet XR)	First-line drug product(s): metformin Second-line drug product(s): sulfonylureas And where insulin is not an option	Sections I & II
☐ DAPAgliflozin (e.g. Forxiga) ☐ DAPAgliflozin + metformin (e.g. Xigduo)	First-line drug product(s): metformin or sulfonylureas Second-line drug product(s): sulfonylureas or metformin And where insulin is not an option	Sections I & II
☐ LIXIsenatide (e.g. Adlyxine)	First-line drug product(s): metformin Second-line drug product(s): sulfonylureas And insulin	Sections I & II
For the treatment of Type 2 diabetes OR Type 2 diabetes and established CV diseases as defined in the criteria for coverage	**Criteria for coverage***	**Complete section(s)**
☐ EMPAgliflozin (e.g. Jardiance) ☐ EMPAgliflozin + metformin (e.g. Synjardy)	*See page 2 for complete criteria	Sections I &/or II (as applicable)

Section I. Please indicate if **metformin** was tried for **at least 6 months**

☐ Yes ☐ No, specify reason _____

Section II. Please indicate if a **sulfonylurea** was tried

☐ Yes ☐ No, specify reason _____

Please indicate if **insulin** was tried

☐ Yes ☐ No, indicate why insulin is not an option for this patient

☐ Cognitive impairment ☐ Manual dexterity concerns

☐ Needle phobia ☐ Visual impairment

☐ Other, specify _____

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to ▪ **Alberta Blue Cross, Clinical Drug Services** **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.

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ALBERTA BLUE CROSS®

DPP-4/SGLT2 INHIBITORS / GLP-1 RECEPTOR AGONISTS SPECIAL AUTHORIZATION CRITERIA

Criteria for coverage

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

CANAgliflozin (e.g. Invokana), LINAgliptin (e.g. Trajenta), LINAgliptin + metformin (e.g. Jentadueto), LIXIsenatide (e.g. Adlyxine), SAXAgliptin (e.g. Onglyza), SAXAgliptin + metformin (e.g. Komboglyze), SEMAglutide (e.g. Ozempic), SITAgliptin (e.g. Januvia) and SITAgliptin + metformin (e.g. Janumet, Janumet XR) special authorization criteria

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.
Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

DAPAgliflozin (e.g. Forxiga) and DAPAgliflozin + metformin (e.g. Xigduo) special authorization criteria

FIRST-LINE DRUG PRODUCT(S): METFORMIN OR SULFONYLUREAS
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS OR METFORMIN
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy to metformin or a sulfonylurea for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin who have a contraindication or intolerance to a sulfonylurea, OR a sulfonylurea who have a contraindication or intolerance to metformin,
- AND for whom insulin is not an option.

Special authorization may be granted for 24 months.

EMPAgliflozin (e.g. Jardiance) and EMPAgliflozin + metformin (e.g. Synjardy) special authorization criteria

FIRST-LINE DRUG PRODUCT(S): METFORMIN

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.
Or, for whom these products are contraindicated.

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes and established cardiovascular diseases who have an inadequate glycemic control, if the following criteria are met:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- established cardiovascular disease* as defined in the EMPA-REG OUTCOME trial.

* Established cardiovascular disease is defined on the basis of one of the following:
1) History of myocardial infarction (MI)
2) Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
3) Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress or discharged from hospital with a documented diagnosis of unstable angina within the last 12 months
4) Last episode of unstable angina greater than 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease
5) History of ischemic or hemorrhagic stroke
6) Occlusive peripheral artery disease

Special authorization may be granted for 24 months.

LIXIsenatide (e.g. Adlyxine) special authorization criteria

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND INSULIN

“As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- insulin.
Or, for whom these products are contraindicated

Special authorization may be granted for 24 months.

ABC 60012 (2020/05)

Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form

On the reverse is the official *Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form* (ABC 60019).

- All requests for apixaban 2.5 mg & 5 mg or dabigatran 110 mg & 150 mg, edoxaban 15 mg, 30 mg, or 60 mg or rivaroxaban 15 mg & 20 mg must be submitted using the *Apixaban/ Dabigatran/Edoxaban/Rivaroxaban 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®

APIXABAN/ DABIGATRAN/ EDOXABAN/ RIVAROXABAN 15 MG & 20 MG 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Notes: Rivaroxaban 10 mg is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total knee replacement surgery. Coverage is restricted to two 14-day courses of therapy per patient per year. Rivaroxaban 10 mg is also a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total hip replacement surgery. Coverage is restricted to two 35-day courses of therapy per patient per year. Rivaroxaban 10 mg is not eligible for special authorization for coverage beyond these restrictions.

Rivaroxaban 2.5 mg is eligible via special authorization for use in patients with concomitant coronary artery disease and peripheral artery disease. Please see the Rivaroxaban 2.5 mg Special Authorization Request Form (ABC 60081).

Drug requested (check ONE box)

- ☐ **Apixaban (e.g. Eliquis) → complete Section I, II, and/or III**
- ☐ **Dabigatran (e.g. Pradaxa) → complete Section I only**
- ☐ **Edoxaban (e.g. Lixiana) → complete Section I and/or II**
- ☐ **Rivaroxaban 15 mg/20 mg (e.g. Xarelto) → complete Section I and/or II**

Section I Prevention of stroke and systemic embolism in atrial fibrillation (AF) patients

a) Does the patient have non-valvular atrial fibrillation (AF)?

☐ Yes ☐ No

b) Please indicate if **warfarin** was used

☐ Yes → If yes, please indicate if a **two month trial of warfarin** was used

☐ Yes ☐ No, please specify reason _____

☐ No → If no, please elaborate

a) If the patient has a contraindication to warfarin, provide information regarding the nature of the contraindication

_____

b) If this patient is unable to monitor via INR testing services, please specify the reason

_____

Section II APIXABAN 2.5mg/5mg (e.g. Eliquis), EDOXABAN (e.g. Lixiana) or RIVAROXABAN 15mg/20mg (e.g. Xarelto) for treatment of venous thromboembolic events

****Special authorization may be granted for up to six months****

a) Is the request for **treatment** of deep vein thrombosis (DVT)?

☐ No ☐ Yes → date of most recent event _____

b) Is the request for **treatment** of a pulmonary embolism (PE)?

☐ No ☐ Yes → date of most recent event _____

Section III APIXABAN 2.5mg (e.g. Eliquis) for prophylaxis of venous thromboembolism (VTE) following elective total hip or total knee replacement surgery

a) Has the patient had elective total **hip** replacement surgery?

☐ Yes ☐ No

b) Has the patient had elective total **knee** replacement surgery?

☐ Yes ☐ No

PRESCRIBER 'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

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Tacrolimus Topical Ointment Special Authorization Request Form

On the reverse is the official *Tacrolimus Topical Ointment Special Authorization Request Form* (ABC 60047).

- All requests for tacrolimus topical ointment must be submitted using the *Tacrolimus Topical Ointment 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®

TACROLIMUS TOPICAL OINTMENT 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 LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY , PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

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

PHONE	FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Indicate which drug is requested (check one box)

☐ Tacrolimus 0.03% Topical Ointment (e.g. Protopic 0.03%) ☐ Tacrolimus 0.1% Topical Ointment (e.g. Protopic 0.1%)

Please provide the following information for all NEW requests

Diagnosis

☐ For the treatment of atopic dermatitis ☐ Other (please specify) _____

Areas affected (check all that apply)

☐ Face ☐ Flexures
☐ > 30% of body surface area ☐ Other (please specify) _____

Information regarding previous topical steroid therapy

☐ Topical steroid therapy HAS been utilized → **please complete both a) and b)**

a) Name of topical steroid(s) tried including strength and dosage form

_____

b) Response to topical steroid therapy

☐ Failure ☐ Requires ongoing use
☐ Intolerance ☐ Other (please specify) _____

☐ Topical steroid therapy has NOT been utilized

☐ Contraindication. Please elaborate_____

☐ Other reasons topical steroid therapy was NOT tried (please specify)_____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		• **Alberta Blue Cross, Clinical Drug Services** **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

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ALBERTA BLUE CROSS®

TACROLIMUS TOPICAL OINTMENT SPECIAL AUTHORIZATION CRITERIA

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

Criteria for Coverage

TACROLIMUS 0.03 % TOPICAL OINTMENT
"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 criterion, information is also required regarding the area(s) affected. In order to comply with the fourth criterion, information is also required regarding the percentage body surface area affected. These products are eligible for auto-renewal.

TACROLIMUS 0.1 % TOPICAL OINTMENT
"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 criterion, information is also required regarding the area(s) affected. In order to comply with the second criterion, information is also required regarding the percentage body surface area affected. These products are eligible for auto-renewal.

Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/ Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/ Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form

On the reverse is the official *Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/ Peginterferon Beta-1a/Teriflunomide for RRMS/ Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form* (ABC 60001).

- All requests for dimethyl fumarate, glatiramer acetate, interferon beta-1a, ocrelizumab, peginterferon beta 1a, or teriflunomide for RRMS or interferon beta-1b for SPMS or RRMS must be submitted using the *Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/ Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/ Interferon Beta-1b for SPMS or RRMS 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®

DIMETHYL FUMARATE / GLATIRAMER ACETATE / INTERFERON BETA-1A / OCRELIZUMAB / PEGINTERFERON BETA-1A / TERIFLUNOMIDE for RRMS / INTERFERON BETA-1B for SPMS or RRMS

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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	
STREET ADDRESS			PHONE	FAX
CITY, PROVINCE				
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

Indicate which MS disease modifying therapy (DMT) is requested (check one box)

☐ **Aubagio** (teriflunomide)
☐ **Avonex PS/Pen** (interferon beta-1a)
☐ **Betaseron / Extavia** (interferon beta-1b)
☐ **Glatect** (glatiramer acetate)
☐ **Ocrevus** (ocrelizumab)
☐ **Plegridy** (peginterferon beta-1a)
☐ **Rebif** (interferon beta-1a)
☐ **Tecfidera** (dimethyl fumarate)

☐ **NEW request** (i.e. to MS DMT and/or coverage) ☐ **RENEWAL request** ☐ **RESTART request** ☐ **MS DMT SWITCH**

For patients already on the requested MS DMT, specify start date (YYYY-MM-DD) _____

Diagnosis
☐ Relapsing-remitting multiple sclerosis (RRMS)
☐ Secondary-progressive multiple sclerosis (SPMS) with relapses
☐ Other (please specify) _____

Current *EDSS _____ . _____ **Date** _____

***If the current EDSS is 7.0 or above,** has the EDSS score been sustained at 7.0 or above for one year or more?
☐ Yes ☐ No

Please provide the following information for all NEW requests and for RESTART after treatment interruption

Qualifying relapses: provide dates of two relapses within the last two years, OR the two years prior to starting MS DMT

Date of relapse (YYYY/MM/DD)	**Type of relapse** (one MRI relapse may substitute for one clinical relapse)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

a) Has the patient been on MS DMT of any kind since the relapse(s)? ☐ No ☐ Yes → If yes, answer b) and c)

b) Specify the MS DMT start date (YYYY-MM-DD) _____

c) Indicate if there have been any interruptions in therapy since starting MS DMT ☐ No ☐ Yes → **If yes, indicate**

i) Reason for the interruption in therapy _____

ii) Specify time period of interruption **from** (YYYY-MM-DD) _____ **to** (YYYY-MM-DD) _____

iii) How many relapses did the patient experience while off therapy? _____

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Cladribine/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form

On the reverse is the official *Claridbine/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form (ABC 60000)*.

- All requests for cladribine, fingolimod or natalizumab must be submitted using the *Alemtuzumab/Fingolimod/Natalizumab for Multiple Sclerosis 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.

CLADRIBINE / FINGOLIMOD / NATALIZUMAB For Multiple Sclerosis SPECIAL AUTHORIZATION REQUEST FORM

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

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		
STREET ADDRESS	CITY / PROV / POSTAL CODE		ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME / FIRST NAME / INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
	☐ CPSA ☐ CARNA ☐ ACP	☐ ACO ☐ ADA+C ☐ Other	REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE	PHONE		FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

Indicate which MS disease modifying therapy (DMT) is requested (check one box)

☐ **Gilenya** (fingolimod) ☐ **Mavenclad** (cladribine) → provide patient weight (kg) _____ ☐ **Tysabri** (natalizumab)

☐ **NEW request** (i.e. new to MS DMT and/or coverage) ☐ **RENEWAL request** ☐ **RESTART request** ☐ **MS DMT SWITCH**

For patients already on the requested MS DMT, specify start date (YYYY-MM-DD) _____

For patients already on cladribine, also specify the number of treatment courses and doses/course administered _____

Diagnosis

☐ Relapsing-remitting multiple sclerosis

☐ Other (please specify) _____

Current *EDSS _____. _____ Date_____

***If the current EDSS is 7.0 or above,** has the EDSS score been sustained at 7.0 or above for one year or more? ☐ Yes ☐ No

Please provide the following information for all NEW requests and for RESTART after treatment interruption

Qualifying relapses: Provide the dates of two relapses within the last two years OR the two years prior to starting MS DMT

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

a) Has the patient been on MS DMT of any kind since the relapse(s)? ☐ No ☐ Yes → **If yes, answer b) and c)**

b) Specify the MS DMT start date (YYYY-MM-DD) _____

c) Indicate if there have been any interruptions in therapy since starting MS DMT ☐ No ☐ Yes → **If yes, indicate**

i) Reason for the interruption in therapy _____

ii) Specify time period of interruption: **from** (YYYY-MM-DD) _____ **to** (YYYY-MM-DD) _____

iii) How many relapses did the patient experience while off therapy? _____

NEW and SWITCH requests: Provide response to ONE of the following MS DMT
DIMETHYL FUMARATE; GLATIRAMER ACETATE; INTERFERON BETA; OCRELIZUMAB; PEGINTERFERON BETA; TERIFLUNOMIDE

Name of MS DMT utilized _____ and date of treatment initiation (YYYY-MM-DD) _____

☐ **INTOLERANCE** despite the use of symptom management techniques; **OR** ☐ **REFRACTORY** → answer a) and b)

a) Does the patient have clinically significant titres of neutralizing antibodies to interferon beta? ☐ Yes ☐ No ☐ N/A

b) Within a consecutive 12-month period while on the MS DMT, did the patient experience at least two relapses of MS?

☐ No ☐ Yes → **Provide the dates of either 2 clinical relapses OR 1 clinical relapse and 1 MRI relapse**

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

Fingolimod or Natalizumab RENEWAL requests and NEW requests for patients already on drug, please provide the following information

a) Has the patient experienced **more than one** relapse event per year since starting treatment? ☐ Yes ☐ No

b) If yes and the patient experienced four or more relapses in the year prior to starting treatment, has the patient demonstrated a 50 per cent reduction in relapse events since starting treatment? ☐ Yes ☐ No

Please provide the following information for the first natalizumab RENEWAL request only

Natalizumab neutralizing antibody test result

☐ Negative for natalizumab antibodies ☐ Positive for natalizumab antibodies Date of the test _____

PRESCRIBER 'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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.

Ivacaftor Special Authorization Request Form

On the reverse is the official *Ivacaftor Special Authorization Request Form* (ABC 60004).

- All requests for ivacaftor must be submitted using the *Ivacaftor 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®

IVACAFTOR
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER.

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

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

Diagnosis

☐ Cystic Fibrosis

☐ Other (please specify) _____

Mutation affecting the *Cystic Fibrosis Transmembrane conductance Regulator (CFTR)* gene

☐ G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R

☐ R117H

☐ Other (please specify) _____

Please provide the following pre-treatment information for NEW requests

Sweat Chloride test (mmol/L)	Date
FEV_1 (pre-bronchodilator % predicted)	Date

☐ **RENEWAL Please provide the following current information for RENEWAL requests**

Initial renewal		**Subsequent renewals**	
Sweat Chloride test (mmol/L)	Date	Sweat Chloride test (mmol/L)	Date
FEV_1 (pre-bronchodilator % predicted) one month after starting treatment	Date	FEV_1 (pre-bronchodilator % predicted)	Date
FEV_1 (pre-bronchodilator % predicted) three months after starting treatment	Date		

Note: If the expected reduction in sweat chloride does not occur, the patient's CF clinician will first explore any problems in following the recommended dosing schedule for ivacaftor. The patient's sweat chloride will then be re-tested around one week later and funding discontinued if the patient does not meet criteria.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form

On the reverse is the official *Adalimumab*/*Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form* (ABC 60008).

- All requests for adalimumab, golimumab, infliximab, tofacitinib or vedolizumab must be submitted using the *Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis 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 / GOLIMUMAB / INFLIXIMAB / TOFACITINIB / VEDOLIZUMAB for Ulcerative Colitis 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

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		
STREET ADDRESS	CITY / PROV / POSTAL CODE		ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME / FIRST NAME / INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS	
CITY, PROVINCE	PHONE / FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	Indicate requested drug	Current weight (kg)	Dosage and frequency Date of last dose
☐ Ulcerative Colitis ☐ Other (please specify)	☐ Avsola ☐ Entyvio ☐ Humira ☐ Inflectra ☐ Renflexis ☐ Simponi ☐ Xeljanz		

For patients new to coverage but currently maintained on the requested drug, please provide the treatment start date (YYYY-MM-DD) _____

Please provide reason if a switch to a different drug or change in dose is requested

Note patients will not be permitted to switch back to a previously trialed drug if they were deemed unresponsive to therapy.

***Pre-treatment score**
Partial Mayo score _____ Date _____

Current score
Partial Mayo score _____ Date _____

*Requests for patients new to the requested drug and requests for patients new to coverage but currently maintained on the requested drug require pre-treatment scores. The Partial Mayo Score is a 9 point score consisting of 3 domains (same as full Mayo except endoscopic findings are eliminated). Please provide exact score(s).

For INITIAL requests - dose, duration and response are required for all medications previously utilized. If the following medications were not tried, please provide reason.

☐ Mesalamine

☐ Corticosteroids (please specify drug name)

☐ Other (please specify)

For requests to increase maintenance dosing to Infliximab 10 mg/kg, Golimumab 100 mg or Tofacitinib 10 mg

1) Is the patient already maintained on a dose of infliximab 10 mg/kg, golimumab 100 mg or tofacitinib 10 mg? ☐ Yes ☐ No

2) Has the patient had a *secondary loss of response* while on maintenance dosing with infliximab 5 mg/kg, golimumab 50 mg or tofacitinib 5 mg? ☐ Yes ☐ No (explain) _____

3) Provide the most recent partial Mayo score from when the patient was *responding* to maintenance dosing with infliximab 5 mg/kg, golimumab 50 mg or tofacitinib 5 mg _____ Date of Score _____

Additional information relating to request

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

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

Antivirals for Chronic Hepatitis C Special Authorization Request Form

On the reverse is the official *Antivirals for Chronic Hepatitis C Special Authorization Request Form* (ABC 60022).

- All requests for elbasvir/grazoprevir, glecaprevir/pibrentasvir, sofosbuvir, sofosbuvir/ledipasvir**,** sofosbuvir/velpatasvir, or sofosbuvir/velpatasvir**/**voxilaprevir must be submitted using the *Antivirals 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®

ANTIVIRALS 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				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

1) Indicate the requested drug regimen and the patient's Hepatitis C Virus (HCV) Genotype

***Drug regimen requested**	**Corresponding HCV genotype**
☐ Elbasvir/grazoprevir (e.g. Zepatier) +/- ribavirin (e.g. Ibavyr)	☐ Genotype 1 → Specify subtype _____ ☐ Genotype 4
☐ Glecaprevir/pibrentasvir (e.g. Maviret)	Genotype _____ (optional if treatment naïve)
☐ Sofosbuvir (e.g. Sovaldi) + ribavirin (e.g. Ibavyr)	☐ Genotype 2 ☐ Genotype 3
☐ Sofosbuvir/ledipasvir (e.g. Harvoni) +/- ribavirin (e.g. Ibavyr)	☐ Genotype 1
☐ Sofosbuvir/velpatasvir (e.g. Epclusa) +/- ribavirin (e.g. Ibavyr)	Genotype _____ (optional)
☐ Sofosbuvir/velpatasvir/voxilaprevir (e.g. Vosevi)	Genotype _____ (optional if prior NS5A inhibitor)

*Duration of therapy and coverage of ribavirin in combination with the selected drug regimen will be approved according to criteria specified in the *Alberta Drug Benefit List.*

2 a) Does the patient have a quantitative HCV RNA value within six months of this request?

☐ **Yes** → Provide test date (YYYY-MM-DD) _____ ☐ **No** ☐ **Not tested**

2 b) For sofosbuvir/ledipasvir requests, is the patient's most recent viral load greater than 6 M IU/mL? ☐ **Yes** ☐ **No**

3) What is the patient's fibrosis stage (optional)? ☐ **F0** ☐ **F1** ☐ **F2** ☐ **F3** ☐ **F4** ☐ **Not tested**

4) Does the patient have cirrhosis?

☐ **Yes, compensated cirrhosis with Child-Turcotte-Pugh A** (i.e. score five to six)

☐ **Yes, decompensated cirrhosis with Child-Turcotte-Pugh B or C** (i.e. score seven or above)

☐ **No**

5) Is treatment requested post liver transplant? ☐ **Yes** ☐ **No**

6) Has the patient previously been treated with an HCV antiviral drug regimen?

☐ **Yes** → Specify drug regimen previously used _____

→ Specify the patient's response

☐ failure (i.e. null or partial response or virologic breakthrough/rebound) ☐ intolerance ☐ relapse

☐ other; specify _____

☐ **No,** the patient is treatment-naïve

7) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) _____

8) Indicate the name of the specialist consulted, where applicable _____

Additional information relating to request

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

Proton-Pump Inhibitors Pricing Authorization Request Form

On the reverse is the official *Proton-Pump Inhibitors Pricing Authorization Request Form (*ABC 60049).

- All requests for MAC override for Proton-Pump Inhibitor products that are subject to MAC pricing on the iDBL must be submitted using the *Proton-Pump Inhibitors Pricing Authorization Request Form* only. Please refer to the iDBL for full listing of Proton-Pump Inhibitor products.
- **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®

PROTON-PUMP INHIBITORS PRICING 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROVINCE	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
CITY	PROVINCE		PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

PPI products* that are subject to MAC and LCA pricing on the iDBL. MAC pricing will be applied as follows effective April 1, 2018.

Active ingredient	LCA/MAC price	
LANSOPRAZOLE 15 MG OMEPRAZOLE 10 MG RABEPRAZOLE SODIUM 10 MG	$0.0669	*MAC pricing has been applied based on the LCA price for rabeprazole sodium 1 X 10 mg enteric-coated tablet.*
LANSOPRAZOLE 30 MG OMEPRAZOLE 20 MG PANTOPRAZOLE MAGNESIUM 40 MG PANTOPRAZOLE SODIUM 40 MG	$0.1875	*MAC pricing has been applied based on the LCA price for pantoprazole magnesium 1 X 40 mg enteric-coated tablet.*
RABEPRAZOLE SODIUM 20 MG	*These products are not affected by MAC pricing. Least cost alternative pricing will continue to apply.*	

***Please refer to the iDBL for a full listing of PPI products.**

Pricing authorization request where the patient is unable to use the MAC reference product

1) Select PPI and indicate if the corresponding MAC reference product has been used.

Requested PPI (please check one).	**Has the patient used the MAC reference product for the requested PPI?**
☐ lansoprazole 15 mg ☐ omeprazole 10 mg	☐ Yes, rabeprazole sodium was used. ☐ No, rabeprazole sodium was not used. Please specify reasons. _____
☐ lansoprazole 30 mg ☐ omeprazole 20 mg ☐ pantoprazole sodium 40 mg	☐ Yes, pantoprazole magnesium was used. ☐ No, pantoprazole magnesium was not used. Please specify reasons. _____

2) If the patient has used the MAC reference product for the requested PPI, what was the response?

☐ Therapeutic failure of the MAC reference product. Please specify diagnosis. _____

☐ Adverse effects. Please elaborate on the nature and severity of the adverse effects experienced by your patient on the MAC reference product. _____

→ Has the patient used the MAC reference product for a sufficient duration to determine that the adverse effects will not resolve over time? ☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

PROTON-PUMP INHIBITORS PRICING AUTHORIZATION REQUEST FORM

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

Frequently asked questions

1. What is the difference between LCA and MAC pricing?

The **Least Cost Alternative (LCA) price** means the maximum amount that will be paid by the Government of Alberta for a drug product in an established or new interchangeable grouping for members of a plan. For example, Prevacid 30 mg is in a grouping with several generic brands of lansoprazole 30 mg that are interchangeable with brand name Prevacid 30 mg. The maximum unit price paid for Prevacid 30 mg is thus based on the lowest-priced generic interchangeable product within the grouping.

A **MAC grouping** means a grouping of drug products that have been listed on the *Alberta Drug Benefit List (ADBL)* as being subject to a maximum price. Note that a MAC grouping may include one or more groupings of interchangeable drugs. For example, PPIs have been grouped together such that the maximum unit price paid for select higher strength PPIs (lansoprazole 30 mg, omeprazole 20 mg, pantoprazole magnesium 40 mg or pantoprazole sodium 40 mg) will be based on the cost of pantoprazole magnesium 40 mg, which is $0.1875 per unit (tablet).

2. What happens if a product is subject to both LCA and MAC pricing?

If a product is subject to both MAC and LCA pricing, the maximum unit price paid for the Drug Product will be based on the unit cost of the product that establishes the MAC grouping. For example, Prevacid 30 mg is subject to both LCA and MAC pricing and as such, the maximum unit price paid will be based on the product that establishes the MAC grouping; in this case, pantoprazole magnesium 40 mg, which is $0.1875 per unit (tablet).

Nintedanib/Pirfenidone Special Authorization Request Form

On the reverse is the official *Nintedanib/Pirfenidone Special Authorization Request Form* (ABC 60051).

- All requests for nintedanib or pirfenidone must be submitted using the *Nintedanib/Pirfenidone 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.

NINTEDANIB/PIRFENIDONE 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY , PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested (choose *ONE only): ☐ **Nintedanib (e.g. Ofev)** ☐ **Pirfenidone (e.g. Esbriet)**

*Note: Combination use of pirfenidone and nintedanib will not be funded.

Please provide the following information for NEW requests: Initial approval period for patients meeting criteria: seven months (allow four weeks for repeat pulmonary function tests)

a) Diagnosis

☐ Mild to moderate idiopathic pulmonary fibrosis (IPF)

☐ Other (please specify) _____

b) Has the diagnosis been confirmed by a respirologist and a high-resolution CT scan within the previous 24 months? ☐ Yes ☐ No (explain) _____

c) Have all other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) been excluded? ☐ Yes ☐ No (explain) _____

d) Please provide the following pre-treatment information for NEW requests

Forced Vital Capacity (FVC) (% predicted)	Date

Initial Renewal (at six months): Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% from initiation of therapy until renewal (initial six-month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted four weeks later. Approval period for patients meeting criteria is six months

Forced Vital Capacity (FVC) (% predicted)	Date
In the case of disease progression as defined above, please provide a confirmatory Forced Vital Capacity (FVC) conducted four weeks later (% predicted)	Date

Second and subsequent renewals (at 12 months and thereafter): Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% within any 12-month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted four weeks later. Approval period for patients meeting criteria is 12 months

Forced Vital Capacity (FVC) (% predicted)	Date
In the case of disease progression as defined above, please provide a confirmatory Forced Vital Capacity (FVC) conducted four weeks later (% predicted)	Date

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **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®

NINTEDANIB/PIRFENIDONE SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

NINTEDANIB (e.g. Ofev) and PIRFENIDONE (e.g. Esbriet)

Initial approval criteria:

Adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF):
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded.
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.
- Patient is under the care of a physician with experience in IPF.

Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests)

Initial renewal criteria (at 6 months):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 6 months

Second and subsequent renewals (at 12 months and thereafter):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

Patients who have experienced intolerance or failure to pirfenidone or nintedanib will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria.

Deferiprone Special Authorization Request Form

On the reverse is the official *Deferiprone Special Authorization Request Form* (ABC 60054).

- All requests for deferiprone must be submitted using the *Deferiprone 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®

DEFERIPRONE
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS				
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for NEW requests

Criteria for Coverage

"For the treatment of transfusional iron overload due to thalassemia syndromes in patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications to deferoxamine 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, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

Diagnosis

☐ Transfusional iron overload due to thalassemia syndromes
☐ Other (please specify) _____

Please indicate if **deferoxamine (e.g. Desferal)** was tried for **at least six months**

☐ Yes
☐ No; please indicate why deferoxamine was not tried for at least six months.
- ☐ 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 (please elaborate) _____
- ☐ Severe needle phobia
- ☐ Concomitant bleeding disorders (please specify) _____
- ☐ Immunocompromised with a risk of infection with parenteral administration
- ☐ Risk of bleeding due to anticoagulation
- ☐ Other (please specify) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **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

Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form

On the reverse is the official *Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form* (ABC 60025).

- All requests for aclidinium bromide + formoterol fumarate dihydrate, budesonide + formoterol fumarate dihydrate, fluticasone propionate + salmeterol xinafoate, fluticasone furoate + umeclidinium bromide + vilanterol trifenatate, fluticasone furoate + vilanterol trifenatate, glycopyrronium bromide + indacaterol maleate, tiotropium bromide + olodaterol hydrochloride or umeclidinium bromide + vilanterol trifenatate must be submitted using the *Long-Acting Fixed-Dose Combination Products for Asthma/COPD 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®

Long-Acting Fixed-Dose Combination Products for Asthma/COPD
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTHDATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY , PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please select requested drug (and specific strength or product, where applicable)	**Complete the following section(s)**
☐ Budesonide + formoterol fumarate dihydrate (such as Symbicort) ☐ Fluticasone furoate + vilanterol trifenatate (such as Breo Ellipta) → **Applicable strength** ☐ 100 mcg/25 mcg ☐ Fluticasone propionate + salmeterol xinafoate (such as Advair) → **Applicable products** ☐ 250 mcg/50 mcg inhalation powder ☐ 500 mcg/50 mcg inhalation powder	Section I and/or II
☐ Fluticasone furoate + vilanterol trifenatate (such as Breo Ellipta) → **Applicable strength** ☐ 200 mcg/25 mcg ☐ Fluticasone propionate + salmeterol xinafoate (such as Advair) → **Applicable products** ☐ 100 mcg/50 mcg inhalation powder ☐ Advair 125 MDI ☐ Advair 250 MDI	Section I only
☐ Aclidinium bromide + formoterol fumarate dihydrate (such as Duaklir Genuair) ☐ Fluticasone furoate + umeclidinium bromide + vilanterol trifenatate (such as Trelegy Ellipta) ☐ Glycopyrronium bromide + indacaterol maleate (such as Ultibro Breezhaler) ☐ Tiotropium bromide + olodaterol hydrochloride (such as Inspiolto Respimat) ☐ Umeclidinium bromide + vilanterol trifenatate (such as Anoro Ellipta)	Section II only

Section I. Inhaled combination drug products for the treatment of asthma

Has the patient tried a single-entity Inhaled Corticosteroid (ICS) (such as beclomethasone, budesonide, ciclesonide, fluticasone or mometasone)?

☐ Yes ☐ No → Please specify reason _____

Section II. Inhaled combination drug products for the treatment of COPD

- **DUAL therapy requests:** check the boxes that apply to your patient for each of **a) AND b)** below.
- **TRIPLE therapy requests:** check the boxes that apply to your patient for each of **b) AND c)** below.

a) Requests for DUAL therapy combination products ONLY

☐ patient has severe (such as FEV1 < 50 per cent predicted) Chronic Obstructive Pulmonary Disease (COPD)

b) Requests for DUAL and TRIPLE therapy combination products

☐ patient has tried a single-entity Long-Acting Beta-2 Agonist (LABA) (such as formoterol, indacaterol or salmeterol)

☐ patient has tried a single-entity Long-Acting Muscarinic Antagonist (LAMA) (such as aclidinium, glycopyrronium, tiotropium or umeclidinium)

c) Requests for TRIPLE therapy combination products ONLY

☐ patient has tried optimal dual therapy with either a LABA/LAMA or ICS/LABA combination product

OR if none of the above apply, please specify reason why the patient has not tried a single-entity LABA or LAMA product and/or dual therapy combination LABA/LAMA or ICS/LABA product

_____

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

Long-Acting Fixed-Dose Combination Products for Asthma/COPD
SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs

Criteria for Coverage

BUDESONIDE + FORMOTEROL FUMARATE DIHYDRATE (such as Symbicort) **FLUTICASONE FUROATE + VILANTEROL TRIFENATATE (such as Breo Ellipta 100 mcg/25 mcg)** **FLUTICASONE PROPIONATE + SALMETEROL XINAFOATE (such as Advair 250 Diskus, Advair 500 Diskus)**
ASTHMA FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS) "For the treatment of asthma in patients uncontrolled on inhaled steroid therapy." CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (THAT IS, LABA OR LAMA) "For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (such as FEV1 < 80 per cent predicted) COPD, who have an inadequate response to a long-acting bronchodilator LABA or LAMA." "For the long-term maintenance treatment of airflow obstruction in patients with severe (such as FEV1 < 50 per cent predicted) COPD." "Special authorization may be granted for 24 months."
FLUTICASONE FUROATE + VILANTEROL TRIFENATATE (such as Breo Ellipta 200 mcg/25 mcg) **FLUTICASONE PROPIONATE + SALMETEROL XINAFOATE (such as Advair 100 Diskus, Advair 125 MDI, Advair 250 MDI)**
ASTHMA FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS) "For the treatment of asthma in patients uncontrolled on inhaled steroid therapy." "Special authorization may be granted for 24 months."
ACLIDINIUM BROMIDE + FORMOTEROL FUMARATE DIHYDRATE (such as Duaklir Genuair) **GLYCOPYRRONIUM BROMIDE + INDACATEROL MALEATE (such as Ultibro Breezhaler)** **TIOTROPIUM BROMIDE + OLODATEROL HYDROCHLORIDE (such as Inspiolto Respimat)** **UMECLIDINIUM BROMIDE + VILANTEROL TRIFENATATE (such as Anoro Ellipta)**
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (THAT IS, LABA OR LAMA) "For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (such as FEV1 < 80 per cent predicted) COPD, who have an inadequate response to a long-acting bronchodilator (that is, LABA or LAMA)." "For the long-term maintenance treatment of airflow obstruction in patients with severe (such as FEV1 < 50 per cent predicted) COPD." "Special authorization may be granted for 24 months."
FLUTICASONE FUROATE + UMECLIDINIUM BROMIDE + VILANTEROL TRIFENATATE (e.g. Trelegy Ellipta)
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (THAT IS, LABA OR LAMA) SECOND-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR DUAL THERAPY (THAT IS, LABA OR LAMA) OR DUAL THERAPY OF ICS AND LABA “For the long-term maintenance treatment of COPD, including chronic bronchitis and/or emphysema, in patients who are not controlled on optimal dual inhaled therapy (that is, LABA or LAMA OR ICS or LABA).” “Special authorization may be granted for 24 months.”

Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form

On the reverse is the official *Eplerenone/Ivabradine/Sacubitri + Valsartan Special Authorization Request Form* (ABC 60050).

- All requests for eplerenone, ivabradine or sacubitril + valsartan must be submitted using the *Eplerenone/Ivabradine/Sacubitril + Valsartan 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®

EPLERENONE / IVABRADINE / SACUBITRIL+VALSARTAN 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**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services
				☐ Other _____
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested

☐ **Eplerenone (e.g. Inspra) → complete section I only**

☐ **Ivabradine (e.g. Lancora) → complete sections I, II and III**

☐ **Sacubitril+Valsartan (e.g. Entresto) → complete sections I, II and IV**

Note: - For coverage of Ivabradine or Sacubitril+Valsartan, the drug must be initiated by a specialist in cardiology or internal medicine.

- If the patient is already on the requested drug, information provided should reflect the patient's status prior to starting the drug.

Section I. For ALL requests, please specify the following:

a) Diagnosis

☐ Heart failure (HF) → chronic? ☐ Yes ☐ No

☐ Other (specify) _____

b) Left ventricular ejection fraction (LVEF) (%) _____

c) New York Heart Association (NYHA) class _____

Section II. For Ivabradine or Sacubitril+Valsartan requests, please provide the following information

d) Drugs utilized ***prior to the requested drug***: Please check ALL that apply and indicate the name of the drugs utilized and response to each. If there is a contraindication to a particular therapy, elaborate as to its nature.

☐ Angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor antagonist (ARB) _____

☐ Beta-blocker _____

☐ Aldosterone antagonist _____

☐ Other recommended therapies _____

e) Are the HF symptoms present/active despite at least FOUR weeks of treatment with a stable dose of an ACEI or an ARB in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)?

☐ Yes ☐ No, explain _____

f) If the patient is already on the requested drug, please indicate treatment start date _____

Section III. For Ivabradine requests, please provide the following information:

g) Resting Heart Rate _____ bpm (on average using either an ECG on at least three separate visits or by continuous monitoring)

h) In sinus rhythm? ☐ Yes ☐ No

i) Number of hospitalizations due to HF in the last 12 months _____

Section IV. For Sacubitril+Valsartan requests, please provide the following information:

j) Plasma B-type natriuretic peptide (BNP) level (pg/mL) _____ and date _____; **OR**

N-terminal prohormone B-type natriuretic peptide (NT-proBNP) level (pg/mL) _____ and date _____

k) Has been hospitalized for HF within the past 12 months prior to the BNP or NT-proBNP testing date? ☐ Yes ☐ No

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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®

EPLERENONE/SACUBITRIL+VALSARTAN SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

EPLERENONE (e.g. Inspra) special authorization criteria

"For persons suffering from New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction with ejection fraction less than or equal to 35 per cent as a complement to standard therapy."

Special authorization will be granted for 12 months.

This product is eligible for auto-renewal.

IVABRADINE (e.g. Lancora) special authorization criteria

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (less than or equal to 35%)

And

2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of optimal treatment with

- a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)

- in combination with a beta-blocker and, if tolerated, a mineralcorticoid receptor antagonist (MRA)

And

3) Who are in sinus rhythm with a resting heart rate greater than or equal to 77 beats per minute (bpm) on average using either an ECG on at least three separate visits or by continuous monitoring

And

4) Who had at least one hospitalization due to HF in the last year

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

SACUBITRIL + VALSARTAN (e.g. Entresto) special authorization criteria

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (< 40%)

And

2) New York Heart Association (NYHA) class II or Ill HF symptoms despite at least FOUR weeks of treatment with

- a stable dose of an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)

- in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)

And

3) Who have Plasma B-type natriuretic peptide (BNP) >= 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) >= 600 pg/mL; or

- if the patient has been hospitalized for HF within the past 12 months and has plasma BNP >= 100 pg/mL or NT-proBNP >= 400 pg/mL levels

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months.

This product is eligible for auto-renewal.

ABC 60050 (2018/11)

Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form

On the reverse is the official *Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form* (ABC 60058).

- All requests for adalimumab for Hidradenitis Suppurativa must be submitted using the *Adalimumab for Hidradenitis Suppurativa 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 Hidradenitis Suppurativa
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**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTHDATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis ☐ Active moderate to severe Hidradenitis Suppurativa

☐ Other (specify) _____

Please provide the following information for INITIAL requests

1) Total abscess and nodule (AN) count at pre-treatment baseline _____ and date of count _____

2) Does the patient have lesions in at least two distinct anatomical areas? ☐ Yes ☐ No

3) Does the patient have Hurley Stage II or III lesions in at least one anatomical area? ☐ Yes ☐ No

4) Previous therapy

a) Have systemic antibiotics been tried for at least 90 days?

☐ Yes → Specify antibiotics and response _____

☐ No → Specify reason _____

b) Is there documented non-response to conventional therapy other than systemic antibiotics?

☐ Yes → Specify which therapies have been tried, including dose and duration

_____

_____

☐ No → Specify reason _____

Please provide the following information for RENEWAL requests

1) Current AN count _____ and date of count _____

2) Indicate the patient's response to treatment (check ALL that apply)

☐ Fifty per cent or greater reduction in AN count from pre-treatment baseline.

☐ No increase in abscess count or draining fistula count relative to pre-treatment baseline.

Note: Treatment with adalimumab should be discontinued if there is insufficient improvement after 12 weeks of treatment.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY/MM/DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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.

Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form

On the reverse is the official *Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form* (ABC 60056).

- All requests for omalizumab for Chronic Idiopathic Urticaria must be submitted using the *Omalizumab for Chronic Idiopathic Urticaria 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®

OMALIZUMAB for Chronic Idiopathic Urticaria 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 LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Moderate to severe Chronic Idiopathic Urticaria (CIU)

☐ Other (specify) _____

Please indicate if this patient is

☐ Starting drug upon approval …….. **complete section I**

☐ New to coverage but currently maintained on drug … **complete section I and II**

☐ Renewal request …….. **complete section II**

Section I: Please provide <u>pre-treatment</u> information for all INITIAL requests

i) Has the patient had a therapeutic trial with H1 antihistamines?

☐ Yes → a) Specify H1 antihistamines used _____

b) Specify response to therapy ☐ Failure ☐ Intolerance ☐ Other (specify) _____

☐ No → Provide reason _____

ii) Were oral therapies other than H1 antihistamines tried?

☐ Yes → Specify drugs utilized, including dose, duration and patient's response _____

_____

☐ No → Provide reason _____

iii) Baseline (pre-treatment) measure of disease severity

Urticaria Activity Score over seven days (UAS7) _____ Date _____

iv) Is the patient currently on therapy with omalizumab? ☐ Yes → Indicate start date of therapy _____ ☐ No

Section II: Complete for ADDITIONAL 24-WEEK TREATMENT COURSE requests and TREATMENT RE-INITIATION requests

i) Measure of disease severity at the end of the previous 24-week treatment course of omalizumab

UAS7 score _____ Date _____

ii) If the patient's UAS7 score recorded above for i) is zero (0), was this complete symptom control maintained for at least 12 consecutive weeks? ☐ Yes ☐ No ☐ Not applicable (patient's UAS7 at the end of treatment was not zero)

iii) Has omalizumab been discontinued due to temporary symptom control? ☐ Yes → Answer a) and b) below ☐ No

a) Provide the date of discontinuation of previous course of omalizumab _____

b) Provide the current measure of disease severity: UAS7 score _____ Date _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

OMALIZUMAB
for Chronic Idiopathic Urticaria
SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

For the treatment of adults and adolescents (12 years of age and above) with moderate to severe chronic idiopathic urticaria (CIU), defined as having a baseline Urticaria Activity Score over seven days (UAS7) of greater than or equal to 16, who remain symptomatic (presence of hives and/or associated itching) despite optimum management with available oral therapies. Oral therapies should include a therapeutic trial with H_1 antihistamines, unless contraindicated or not tolerated.

For coverage, the drug must be initiated and monitored by a Specialist in Dermatology, Clinical Immunology or Allergy.

Coverage may be approved for a period of 24 weeks at a maximum dose of 300 mg every four weeks.
Patients will be limited to receiving a one-month supply of omalizumab per prescription at their pharmacy.
Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Continued coverage of a further 24-week treatment period may be considered if the patient has experienced:
- complete symptom control (i.e. UAS7 of 0) for less than 12 consecutive weeks; OR
- partial symptom control, with a reduction in baseline UAS7 of greater than or equal to 9.5 points.

Treatment cessation should be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24-week treatment period.

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation should be considered should CIU symptoms reappear.

Benralizumab/Mepolizumab Special Authorization Request Form

On the reverse is the official *Benralizumab/Mepolizumab Special Authorization Request Form* (ABC 60061).

- All requests for benralizumab or mepolizumab must be submitted using the *Benralizumab/Mepolizumab 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®

BENRALIZUMAB / MEPOLIZUMAB 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 LAST NAME	FIRST NAME	INITIAL
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER	

STREET ADDRESS	CITY	PROV.	POSTAL CODE

COVERAGE TYPE

☐ Alberta Blue Cross
☐ Alberta Human Services
☐ Other _____

ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

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

REGISTRATION NUMBER

PHONE | FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Requested drug ☐ Fasenra ☐ Nucala

Dosage and frequency

Diagnosis
☐ Severe Eosinophilic Asthma
☐ Other (please specify) _____

Please indicate if this patient is
☐ Starting drug upon approval …….. **complete section I**
☐ New to coverage but currently maintained on drug …..**complete section I and II**
☐ Renewing coverage ……..**complete section II**

Section I: Please provide pre-treatment information for NEW requests for treatment-naive and treatment-experienced patients

1) Blood eosinophil count _____ (cells/mcL) **Date** _____

2) Number* of clinically significant exacerbations of asthma within the 12-month period prior to starting the requested drug
(defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized) _____

***Please provide an exact number. If the patient has had no exacerbations it should be reported as 'zero (0)'.**

3) Asthma Control Questionnaire (ACQ-5) score _____ **Date** _____

4) Current medications: Check all that apply and include name of medication, dose, duration and response

☐ High-dose inhaled corticosteroids _____

☐ Oral corticosteroids (OCS) _____
→ Patient requires daily maintenance OCS prior to initiation of requested drug? ☐ Yes ☐ No

☐ Other asthma controllers (e.g. long-acting beta-2 agonist, please specify) _____

Section II: Complete the following for all RENEWAL requests and for INITIAL requests for treatment-experienced patients

1) Number* of clinically significant asthma exacerbations within the previous 12-month period while on the requested drug
(defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department visit or was hospitalized) _____

***Please provide an exact number. If the patient has had no exacerbations it should be reported as 'zero (0)'.**

2) Current Asthma Control Questionnaire (ACQ-5) score _____ **Date** _____

3) Check if the following applies to the patient in the previous 12-month period while on the requested drug

☐ A decrease in the daily maintenance OCS dose from pre-treatment baseline
☐ The reduction in the daily maintenance OCS dose achieved after the first 12 months of therapy has at least been maintained

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Alirocumab/Evolocumab for HeFH Special Authorization Request Form

On the reverse is the official *Alirocumab/Evolocumab for HeFH Special Authorization Request Form* (ABC 60060).

- All requests for alirocumab or evolocumab for Heterozygous Familial Hypercholesterolemia must be submitted using the *Alirocumab/Evolocumab for HeFH 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®

ALIROCUMAB / EVOLOCUMAB for HeFH
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

1) Drug requested ☐ Praluent ☐ Repatha

2) Dosage and frequency

3) Diagnosis

☐ **Definite or Probable** diagnosis of heterozygous familial hypercholesterolemia (HeFH)

→Was the diagnosis confirmed using the Simon Broome or Dutch Lipid Network criteria, or genetic testing? ☐Yes ☐No

☐ Other (specify) _____

Please provide the following information for INITIAL requests for treatment-naive and treatment-experienced patients

1) Pre-treatment Low Density Lipoprotein-Cholesterol (LDL-C) _____ (mmol/L) Date _____

Note *Pre-treatment refers to the LDL-C level taken prior to initiation of the requested drug, rather than the untreated baseline LDL-C level.*

2) Previous therapy *(check the applicable box)*

☐ Adherence to **high dose statin** (e.g. atorvastatin 80 mg or rosuvastatin 40 mg) in combination with **ezetimibe** for at least three months

→Specify statin utilized _____ **Dose** _____

OR

☐ Adherence to **ezetimibe** for at least three months *[please confirm if patient meets a) or b) below by checking the applicable box]*

→ **a)** ☐ **Statins are contraindicated** (specify) _____

→ **b)** ☐ **Patient was unable to tolerate high dose statin** *[please complete i) to v) below]*

i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose *[specify 2 statins utilized including dose and check ALL that apply for ii) to v) for each statin below]*

☐ **Statin #1** _____ **Dose** _____ ☐ **Statin #2** _____ **Dose** _____

ii)	Dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality [creatine kinase (CK) > five times the upper limit of normal (ULN)] resolution rather than discontinuation of statin altogether	☐ Statin #1	☐ Statin #2
iii)	Intolerable symptoms (myopathy) or abnormal biomarkers (CK > five times the ULN) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate	☐ Statin #1	☐ Statin #2
iv)	Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out	☐ Statin #1	☐ Statin #2
v)	Patient developed confirmed and documented rhabdomyolysis	☐ Statin #1	☐ Statin #2

3) Despite the above previous therapy, is the patient unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention)? ☐Yes ☐No

4) If the patient is currently on the requested drug, please indicate start date (YYYY-MM-DD) _____

Please provide the following information for RENEWAL requests and for INITIAL requests for treatment-experienced patients

1) Is the patient adherent to therapy? ☐Yes ☐No

2) Current LDL-C _____ (mmol/L) Date _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

Fidaxomicin Special Authorization Request Form

On the reverse is the official *Fidaxomicin Special Authorization Request Form* (ABC 60014).

- All requests for fidaxomicin must be submitted using the *Fidaxomicin 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®

FIDAXOMICIN
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Special authorization criteria

For the treatment of:
1) C. difficile infection (CDI) where the patient has failed, or is intolerant of oral vancomycin; or
2) Patients with third or greater recurrence of CDI (ie. fourth or greater episode of CDI)

Note:
- Fidaxomicin should not be used as an add-on to existing therapy (metronidazole or vancomycin).
- Not studied in multiple recurrences or those with life-threatening or fulminant CDI, toxic megacolon or inflammatory bowel disease.

Special authorization coverage for fidaxomicin will be provided for one treatment course (10 days) plus one additional treatment course for an early relapse occurring within eight weeks of the start of the most recent fidaxomicin course.

New episode of CDI after eight weeks will require treatment with first line therapy before fidaxomicin coverage may be considered.

Please provide the following information for ALL requests

1) Indicate diagnosis ☐ Clostridium difficile infection (CDI) ☐ Other (specify) _____

2) Is this the third or greater recurrence of CDI (i.e. fourth or greater episode of CDI)? ☐ Yes ☐ No

3) **Re-treatment requests ONLY:** Please indicate if treatment is requested for ☐ an early relapse OR ☐ a new CDI episode

Note: a CDI episode occurring ≥ 8 weeks after a previous episode with no intermittent recurrence of symptoms would be considered a new CDI episode.

4) **Previous medications utilized**

☐ Oral vancomycin has been used

a) Provide start date of most recent course (YYYY-MM-DD) _____

b) Specify response ☐ Failure ☐ Intolerance ☐ Other (specify) _____

☐ Oral vancomycin has NOT been used. Please provide reason _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **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

Asfotase Alfa Special Authorization Request Form and Consent Form

On the reverse is the official *Asfotase Alfa Special Authorization Request Form* (ABC 60063) followed by the official *Asfotase Alfa Consent Form* (ABC 60057).

- All requests for asfotase alfa must be submitted using the *Asfotase Alfa Special Authorization Request Form* and all initial requests must be accompanied by the *Asfotase Alfa Consent Form*.
- **Photocopy these forms 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®

ASFOTASE ALFA
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 last name	First name	Initial	Gender M / F	Birth date YYYY	MM	DD	Alberta Personal Health Number

Street address	City	Province	Postal code

ID/client/coverage number	Coverage type	
		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____

METABOLIC SPECIALIST INFORMATION

Last name	First name	Initial

Street address	City	Province	Postal code

Telephone number	Fax number	College of Physicians and Surgeons registration number

Date form completed (YYYY-MM-DD)	Last consult date (YYYY-MM-DD)	Metabolic Specialist signature

PHARMACY INFORMATION

Pharmacy name	Telephone number	Fax number

INFORMATION REQUIRED

For **INITIAL COVERAGE (new to drug)**, please complete applicable sections of all pages, and submit together with the consent form.

For **CONTINUED COVERAGE (on drug now or prior use of drug)**, please complete page 1 and the response to therapy section on page 4. For first requests for patients currently/previously on the drug, please complete all pages and submit together with the consent form.

Note: Additional pages may be attached as required; please submit the request form and attachments together.

TREATMENT REQUESTED

Dosage and frequency requested

DIAGNOSIS

☐ **Hypophosphatasia (HPP)**

→ Specify type ☐ Antenatal ☐ Newborn ☐ Infantile ☐ Juvenile (Childhood) ☐ Adult

→ Specify age at onset and nature of first symptom _____

☐ Other, specify _____

CONFIRMATION OF DIAGNOSIS

Does the patient have **perinatal/infantile or juvenile-onset HPP** confirmed by	**Yes**	**No**	**Details (attach laboratory reports)**
a) Genetic testing (documented tissue-nonspecific alkaline phosphatase [TNSALP] gene mutation(s))?	☐	☐	
b) Serum alkaline phosphatase (ALP) level below the age-adjusted normal range?	☐	☐	
c) Plasma pyridoxal-5-phosphate (PLP) above the upper limit of normal established and validated in testing laboratory?	☐	☐	
d) Documented history of HPP-related skeletal abnormalities confirmed radiologically?	☐	☐	

FOR TREATMENT EXPERIENCED PATIENTS

1) Patient is currently on therapy? ☐ Yes ☐ No → specify stop date and reason	
2) Indicate initial therapy start date	3) Patient started therapy prior to 18 years of age? ☐ Yes ☐ No

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only) _____

ADDITIONAL CLINICAL CRITERIA

System	Details (Check ALL that apply and attach relevant reports)
1) Growth	Current height _____ cm (_____ %) Current head circumference _____ cm (_____ %) Current weight _____ kg (_____ %) ☐ Poor growth ☐ Poor weight gain ☐ Failure to thrive ☐ Growth chart attached Comments
2) Dental	☐ OdontoHPP ☐ Early loss of primary teeth → age at first tooth loss _____ ☐ Poor dentition Comments
3) Skeletal	☐ Severe hypomineralization/osteopenia ☐ Fractures, specify number, location and if non-healing/healed _____ ☐ Orthopedic surgical procedures, specify type of surgery, age at procedure _____ ☐ Rickets/Osteomalacia ☐ Scoliosis ☐ Skeletal deformities (e.g. knock-knees, bowed legs), specify _____ ☐ Craniosynostosis → With systemic signs and symptoms, including muscle weakness, fractures, rickets, pain or nephrocalcinosis, and/or bony disease? ☐ Yes ☐ No ☐ Joint swelling, specify _____ ☐ Weakness, specify _____ ☐ Abnormal gait/running, specify _____ Motor development ☐ Appropriate for age ☐ Delayed → Gross motor delay with substantial skeletal disease? ☐ Yes ☐ No → Delayed walking (>15 months)? ☐ Yes ☐ No ☐ 6 Minute Walk Test result attached ☐ Use of assistive devices, specify _____ ☐ Participates in sports ☐ Misses school Patient's/parent's assessment of pain and QOL _____ Comments (provide RGIC and Thacher scores)

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only) _____

ADDITIONAL CLINICAL CRITERIA (continued)

System	Details (Check ALL that apply and attach relevant reports)
4) Pain	☐ Muscle pain ☐ Bone pain ☐ Joint pain Type of pain, location, pain at rest or with activity, daytime or at night _____ Interventions ☐ Analgesics, specify drug(s) and dose _____ ☐ Heating pad ☐ Massage ☐ Other, specify _____ Response to previous interventions _____ ☐ Visual analog for pain report attached Comments
5) X-ray findings	☐ Skeletal survey, specify age at X-rays, X-ray findings, and most recent X-ray results _____ ☐ X-ray report attached
6) Renal	☐ Nephrocalcinosis ☐ Renal failure/reduced renal function ☐ Lab report attached Comments
7) Respiratory	☐ Lung hypoplasia ☐ Decreased thoracic volume ☐ Respiratory failure ☐ Supplemental O2 required ☐ Assisted ventilation Comments
8) Biochemical	☐ Lab reports attached for calcium, phosphate, magnesium, alkaline phosphatise (ALP), PTH, 25 OH vitamin D, pyridoxal-5-phosphate (PLP), urine phosphoethanolamine (PEA)
9) Other	☐ Hearing Loss, specify _____ ☐ Seizures → B6 responsive? ☐ Yes ☐ No ☐ Delayed cognitive development, specify _____ Comments
Additional information relating to request	

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only)

MONITORING AND GOALS OF THERAPY

1) Signs and symptoms to be monitored depend on age at diagnosis and may include, in addition to the parameters listed in the "Additional Clinical Criteria" table on page 2 of this form:

For perinatal/infantile HPP: Discontinuation or reduction of ventilatory support, increased mobility (improvement in gait vs. baseline), attainment of age-appropriate gross motor milestones.

For juvenile HPP: Healing of rickets, improvement of bone mineralization and/bony deformities, fewer fractures, less pain, need for less pain medication, improved growth, increased mobility.

Please indicate which clinical, radiological and biochemical parameters and goals of therapy will be monitored for this patient:

2) Documented compliance by patient and family with respect to follow up visits and re-evaluation of laboratory and radiological parameters.

RESPONSE TO THERAPY (update for each request for continuation of therapy, attach additional pages as required)

1) Were the pre-specified goals of therapy met? (include documented signs/symptoms noted above)

2) Were the patient and family compliant with respect to follow up visits and re-evaluation of laboratory and radiological parameters?

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA CONSENT FORM

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

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

METABOLIC SPECIALIST INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER	
STREET ADDRESS			PHONE	FAX
CITY, PROVINCE				
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

PATIENT CONSENT FOR SERVICE

I have received a copy of the policy relating to asfotase alfa in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (the Policy) and have read and understand the requirements of a patient receiving Alberta government sponsored funded treatment.

I agree to comply with the requirements for coverage as set out in the Policy, including (without limitation) the requirements for monitoring, review and data collection.

I understand and agree that I must continue to qualify for, and continue to be a member of, an Alberta government sponsored drug program to continue to be eligible for asfotase alfa coverage in accordance with the Policy.

I understand and agree that approval for initial and continued coverage is conditional upon meeting and continuing to meet the requirements of the Policy.

I understand that my consent must be and is ongoing and my failure to comply with the requirements as set out in the Policy may preclude me from continuing to be eligible for asfotase alfa coverage.

I understand that prior to potential discontinuance of asfotase alfa coverage, as outlined in the Policy, my Metabolic Specialist will receive notice of this in writing. I understand that my Metabolic Specialist has a responsibility to notify me, and to work with me to address the reason for potential withdrawal of asfotase alfa coverage.

I understand that therapy may be withdrawn at the request of the patient or the patient's parent/guardian at any time. Notification of withdrawal from therapy must be made by the Metabolic Specialist or patient in writing. I understand there may be side effects from medication and I have discussed the risks and benefits of this treatment with my Metabolic Specialist.

I, either as the patient or as the patient's parent or guardian (as appropriate), and on behalf of the patient's heirs and my estate and any other person claiming through the patient, hereby release the Minister, the Minister's delegate, the Minister's agents and employees from any and all liability and all claims for any and all damages, injuries, loss and costs which may arise directly or indirectly in relation to or in connection with the Application and coverage, funding and use of asfotase alfa for the patient pursuant to the Policy, including (without limitation) all claims relating to coverage, any changes in coverage, any restrictions or conditions of coverage, discontinuance of coverage, and the patient's use of asfotase alfa. I agree and acknowledge that this release is binding on the patient, the patient's heirs and estate, and any other person claiming through the patient against the Minister, the Minister's agents and employees.

Name of patient _____

Signature of patient (for patients 18 years of age or older) _____ Date _____

Name of parent or guardian (for patients under the age of 18) _____

Signature of parent or guardian (for patients under the age of 18) _____ Date _____

ALBERTA BLUE CROSS®

ASFOTASE ALFA CONSENT FORM

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

PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

I give consent for my Metabolic Specialist to disclose relevant health registration, assessment, diagnostic, and treatment information to, the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the policy relating to asfotase alfa in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy) for the purpose of determining my initial and continued eligibility for, or discontinuance of, asfotase alfa coverage. I understand that the Expert Advisors are specialists engaged by the Alberta government to provide advice to the Minister or the Minister's delegate in accordance with the Policy.

I also give consent to the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the Policy to disclose relevant health registration, assessment, diagnostic, and treatment information to each other and to my Metabolic Specialist, for the purpose of determining my initial and continued eligibility for, or discontinuance of, asfotase alfa coverage.

I understand that I have been asked to disclose my health information in order to determine eligibility for funding for asfotase alfa and payment for this drug. I understand the risks and benefits of consenting or refusing to consent. I understand that I may revoke this consent at any time by giving notice in writing to Alberta Blue Cross at the address below. I understand and agree that if I revoke this consent, this revocation is deemed a request for withdrawal of coverage.

This consent is effective on execution and will remain in effect unless revoked with notice in writing.

Name of patient _____

Signature of patient (for patients 18 years of age or older) _____ Date _____

Name of parent or guardian (for patients under the age of 18) _____

Signature of parent or guardian (for patients under the age of 18) _____ Date _____

METABOLIC SPECIALIST CONSENT

I agree to comply with the requirements for monitoring, review and data collection as set out in the policy relating to asfotase alfa in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy).

I understand that information about the patient's ongoing eligibility, and possible discontinuation (if appropriate), will be supplied to me, and that I will be responsible for passing this information on to my patient or my patient's parent or guardian.

I understand that reviews of my patient will be ongoing and my failure to provide monitoring data on behalf of my patient, as set out in the Policy, may preclude my patient from continuing to receive Alberta government funded treatment.

I understand that prior to the potential withdrawal of asfotase alfa coverage as outlined in the Policy, I will receive notice of this in writing. I understand that it is my responsibility to notify my patient and work with my patient to address the reason for potential withdrawal of asfotase alfa coverage.

I have provided my patient or my patient's parent or guardian with the Policy so that they are aware of the requirements of a patient receiving Alberta government sponsored funded treatment. I have also read the Policy and understand what is required of me, as the treating physician.

Name of Metabolic Specialist _____

Signature of Metabolic Specialist _____ Date _____

Completed consent form or written withdrawal of consent should be directed by mail or FAX to:

Alberta Blue Cross, Clinical Drug Services
10009 108 Street NW, Edmonton, Alberta T5J 3C5
FAX: **780-401-1150** in Edmonton • **1-888-401-1150** toll free all other areas

Tocilizumab for Giant Cell Arteritis Special Authorization Request Form

On the reverse is the official *Tocilizumab for Giant Cell Arteritis Special Authorization Request Form* (ABC 60066). All requests for must be submitted using this form only.

- All requests for tocilizumab for Giant Cell Arteritis must be submitted using the *Tocilizumab for Giant Cell Arteritis 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®

TOCILIZUMAB for Giant Cell Arteritis
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Dosage & frequency**	**Please indicate if this patient is**
☐ Giant cell arteritis (GCA) ☐ Other (specify)		☐ Starting first treatment course upon approval ……..**complete section I** ☐ Renewal request at 12 to 16 weeks of therapy.....**complete section II** ☐ New to coverage but currently maintained on drug…..**complete sections I and II** ☐ Re-treatment requests .....**complete sections I and III**

Section I: Please complete for all NEW requests for first or subsequent treatment courses (Initial approval for 16 weeks)

1) The current tocilizumab treatment course will be (or was) initiated in combination with a glucocorticoid?
- ☐ Yes → specify glucocorticoid _____
- ☐ No → indicate reason(s) _____

2) If the patient is currently on tocilizumab, indicate start date of treatment course (YYYY-MM-DD) _____

3) For coverage, tocilizumab must be initiated in consultation with a specialist in internal medicine, rheumatology or neurology.
Please indicate the specialist consulted for the current treatment course, where applicable _____

Section II: Please complete for RENEWAL requests at 12 to 16 weeks of therapy (Renewal approval for 36 weeks)

4) Has the patient's disease flared* while on tocilizumab? ☐ Yes ☐ No

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

5) Has the patient's C-reactive protein (CRP) normalized to <1 mg/dL (<10 mg/L)?
- ☐ Yes → indicate CRP level _____ mg/dL (or _____ mg/L) and date (YYYY-MM-DD) _____
- ☐ No → explain _____

Section III: Please complete for RE-TREATMENT requests

6) Provide the date of discontinuation of the previous tocilizumab treatment course (YYYY-MM-DD) _____

7) Has the patient's disease flared* **after discontinuation** of treatment with tocilizumab?
- ☐ Yes
- ☐ No → explain _____

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Nusinersen Special Authorization Request Form

On the reverse is the official *Nusinersen Special Authorization Request Form* (ABC 60064).

- All requests for nusinersen must be submitted using the *Nusinersen 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®

NUSINERSEN
SPECIAL AUTHORIZATION REQUEST FORM

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

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE ☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		
STREET ADDRESS	CITY / PROV / POSTAL CODE		ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME / FIRST NAME / INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS	
CITY, PROVINCE	PHONE / FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Please indicate if this patient is**
☐ 5q Spinal Muscular Atrophy (SMA) ☐ Other (specify) _____	☐ starting drug upon approval ……..... **complete section I** ☐ new to coverage but currently maintained on drug …...**complete section I and II** ☐ submitting renewal request ……..…..**complete section II**

Dosage and frequency requested	Treatment start date	Date of last dose

Section I: Please provide pre-treatment information for all INITIAL requests for treatment naive and treatment experienced patients

Confirmation of diagnosis

☐ Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote Date
Note: copy of the test report must be provided

Disease Onset and Duration

Please check which of the following applies (check ONE only)

☐ Pre-symptomatic with two or three copies of the Survival Motor Neuron 2 (SMN2) gene **Note: copy of the test report must be provided**

☐ Disease duration of less than six months, two copies of SMN2, and symptom onset after the first week after birth and on or before seven months of age **Note: copy of the test report must be provided**

☐ Under the age of 18 with symptom onset after six months of age, regardless of the ability to walk independently

Please respond to the following

1) Disease duration at treatment initiation _____

2) Age of onset of clinical signs and symptoms consistent with SMA _____

3) Were symptoms present at birth? ☐ Yes ☐ No

Ventilation status

Patient requires permanent invasive ventilation* at treatment initiation? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Age-Appropriate Motor function score – Provide at least one of the following PRE-TREATMENT scores

a) Hammersmith Infant Neurological Examination [HINE] Section 2 pre-treatment score _____ Date _____

b) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND] pre-treatment score _____ Date _____

c) Hammersmith Functional Motor Scale-Expanded [HFMSE] pre-treatment score _____ Date _____

Section II: Please complete the following for all RENEWAL requests and for INITIAL requests for treatment experienced patients

Age-Appropriate Motor function score – Provide at least one of the following CURRENT RESPONSE scores

a) Hammersmith Infant Neurological Examination [HINE] Section 2 response score _____ Date _____

b) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND] response score _____ Date _____

c) Hammersmith Functional Motor Scale-Expanded [HFMSE] response score _____ Date _____

Ventilation status

Patient currently requires permanent invasive ventilation*? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Obeticholic Acid Special Authorization Request Form

On the reverse is the official *Obeticholic Acid Special Authorization Request Form* (ABC 60065).

- All requests for obeticholic acid must be submitted using the *Obeticholic Acid 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®

OBETICHOLIC ACID
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

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

Diagnosis ☐ Primary biliary cholangitis (PBC) → confirmed by ☐ Positive antimitochondrial antibodies (AMA)
☐ Liver biopsy results consistent with PBC
☐ Other (specify) _____

Previous therapy

Ursodeoxycholic acid (UDCA) has been used? ☐ Yes ☐ No (explain) _____

a) UDCA has been used for a minimum of 12 months? ☐ Yes ☐ No

b) Indicate response ☐ Inadequate response
☐ Documented and unmanageable intolerance
☐ Other (specify) _____

Concomitant use of UDCA

For patients who had an inadequate response to UDCA alone, will obeticholic acid be used in combination with UDCA?

☐ Yes ☐ No (explain) _____

Baseline measures

a) Alkaline phosphatase (ALP) _____ Units/L
Date _____
Reference range _____

b) Bilirubin _____ mmol/L
Date _____
Reference range _____

Please provide the following information for RENEWAL requests

Current measures

Alkaline phosphatase (ALP) _____ Units/L Date _____ Reference range _____

Concomitant use of UDCA? ☐ Yes ☐ No (explain) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

OBETICHOLIC ACID
SPECIAL AUTHORIZATION CRITERIA

Criteria for coverage

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

OBETICHOLIC ACID (e.g. Ocaliva) special authorization criteria

For the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA, where the following criteria are met:

I. A confirmed diagnosis of PBC, defined as:

- Positive antimitochondrial antibodies (AMA); or

- Liver biopsy results consistent with PBC.

AND

II.a. The patient has received ursodeoxycholic acid (UDCA) for a minimum of 12 months and has experienced an inadequate response to UDCA and can benefit from the addition of obeticholic acid. An inadequate response is defined as:

- alkaline phosphatase (ALP) >= 1.67 x upper limit of normal (ULN) and/or

- bilirubin > ULN and < 2 x ULN.

OR

II.b. The patient has experienced documented and unmanageable intolerance to UDCA and can benefit from switching therapy to obeticholic acid.

AND

III. Initiated by a gastroenterologist or hepatologist (or an internal medicine specialist with an interest in gastroenterology / hepatology on a case-by-case basis, in geographic areas where access to these specialities is not available).

Initial coverage may be approved for a period of 12 months.

Ongoing coverage may be considered only if the patient continues to benefit from treatment with obeticholic acid as evidenced by:

- A reduction in the ALP level to less than 1.67 x ULN; or

- A 15 per cent reduction in the ALP level compared with values before beginning treatment with obeticholic acid.

Continued coverage may be approved for up to 12 months.

ABC 60065 (2019/01)

Ocrelizumab for PPMS Special Authorization Request Form

On the reverse is the official *Ocrelizumab for PPMS Special Authorization Request Form* (ABC 60067).

- All requests for ocrelizumab for PPMS must be submitted using the *Ocrelizumab for PPMS 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®

TOCILIZUMAB for Giant Cell Arteritis
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Dosage & frequency**	**Please indicate if this patient is**
☐ Giant cell arteritis (GCA) ☐ Other (specify)		☐ Starting first treatment course upon approval ……..**complete section I** ☐ Renewal request at 12 to 16 weeks of therapy.....**complete section II** ☐ New to coverage but currently maintained on drug…..**complete sections I and II** ☐ Re-treatment requests .....**complete sections I and III**

Section I: Please complete for all NEW requests for first or subsequent treatment courses (Initial approval for 16 weeks)

1) The current tocilizumab treatment course will be (or was) initiated in combination with a glucocorticoid?
- ☐ Yes → specify glucocorticoid _____
- ☐ No → indicate reason(s) _____

2) If the patient is currently on tocilizumab, indicate start date of treatment course (YYYY-MM-DD) _____

3) For coverage, tocilizumab must be initiated in consultation with a specialist in internal medicine, rheumatology or neurology.
Please indicate the specialist consulted for the current treatment course, where applicable _____

Section II: Please complete for RENEWAL requests at 12 to 16 weeks of therapy (Renewal approval for 36 weeks)

4) Has the patient's disease flared* while on tocilizumab? ☐ Yes ☐ No

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

5) Has the patient's C-reactive protein (CRP) normalized to <1 mg/dL (<10 mg/L)?
- ☐ Yes → indicate CRP level _____ mg/dL (or _____ mg/L) and date (YYYY-MM-DD) _____
- ☐ No → explain _____

Section III: Please complete for RE-TREATMENT requests

6) Provide the date of discontinuation of the previous tocilizumab treatment course (YYYY-MM-DD) _____

7) Has the patient's disease flared* **after discontinuation** of treatment with tocilizumab?
- ☐ Yes
- ☐ No → explain _____

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Levodopa/Carbidopa Intestinal Gel Special Authorization Request Form

On the reverse is the official *Levodopa/Carbidopa Intestinal Gel Special Authorization Request Form (ABC 60068).* All requests for must be submitted using this form only.

- All requests for levodopa/carbidopa intestinal gel must be submitted using the *Levodopa/Carbidopa Intestinal Gel 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®

LEVODOPA/CARBIDOPA INTESTINAL GEL 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**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services ☐ Other _____
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
ADDRESS				
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for NEW requests

Note: For coverage of levodopa/carbidopa intestinal gel, the drug must be initiated by a movement disorder specialist who has appropriate training in its use and is practising in a movement disorder clinic that provides ongoing management and support.

Diagnosis ☐ Parkinson's Disease → advanced? ☐ Yes ☐ No

☐ Other (specify) _____

Previous therapy

1) The patient received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response?

☐ Yes ☐ No (explain) _____

2) The patient trialed frequent dosing of levodopa (at least five doses per day)?

☐ Yes → response ☐ severe disability associated with at least 25 percent of the waking day in the off state

☐ ongoing, bothersome levodopa-induced dyskinesias

☐ other (specify) _____

☐ No (explain) _____

3) The patient had an adequate trial of the following adjunctive medications? (Please check all that apply and indicate the name of the drugs utilized, where applicable and the patient's response to each. If there is a contraindication to a particular therapy, elaborate as to its nature.)

☐ Catechol-O-methyl transferase (COMT) inhibitor _____

☐ Dopamine agonist _____

☐ Monoamine oxidase (MAO-B) inhibitor _____

☐ Amantadine _____

Does the patient have severe psychosis or dementia? ☐ Yes ☐ No

Please provide the following information for RENEWAL requests

The patient has demonstrated a significant reduction in the time spent in the off state and/or in ongoing, bothersome levodopa-induced dyskinesias, along with an improvement in the related disability?

☐ Yes ☐ No (explain) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

LEVODOPA/CARBIDOPA INTESTINAL GEL SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

LEVODOPA/CARBIDOPA INTESTINAL GEL (e.g. Duodopa) special authorization criteria

Special authorization coverage may be provided for the treatment of patients with advanced levodopa-responsive Parkinson's disease, who meet the following criteria:

1) The patient experiences severe disability associated with at least 25 percent of the waking day in the off state and/or ongoing, bothersome levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day). Time in the off state, frequency of motor fluctuations and severity of associated disability should be assessed by a movement disorder subspecialist and be based on an adequate and reliable account from longitudinal specialist care, clinical interview of a patient and/or care partner, or motor symptom diary.

2) The patient has received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response.

3) The patient has failed or is intolerant to adequate trials of each of the following adjunctive medications, if not contraindicated: a catechol-O-methyl transferase (COMT) inhibitor, a dopamine agonist, a monoamine oxidase (MAO-B) inhibitor and amantadine.

4) The patient is able to administer the medication and care for the administration port and infusion pump. Alternatively, trained personnel or a care partner must be available to perform these tasks reliably.

5) The patient does not have a contraindication to the insertion of a percutaneous endoscopic gastrostomy-jejunostomy (PEG-J) tube.

6) The patient does not have severe psychosis or dementia.

7) Levodopa/carbidopa intestinal gel is initiated by a movement disorder subspecialist who has appropriate training in its use and is practising in a movement disorder clinic that provides ongoing management and support for patients receiving treatment.

Initial coverage may be approved 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:

- The patient demonstrates a significant reduction in the time spent in the off state and/or in ongoing, bothersome levodopa-induced dyskinesias, along with an improvement in the related disability.

ABC 60068 (2019/05)

Velaglucerase Alfa/Taliglucerase Alfa for Gaucher Disease Special Authorization Request Form

On the reverse is the official *Velaglucerase Alfa/Taliglucerase Alfa for Gaucher Disease Special Authorization Request Form (ABC 60070).* All requests for must be submitted using this form only.

- All requests for Velaglucerase Alfa or Taliglucerase Alfa for Gaucher Disease must be submitted using the *Velaglucerase Alfa/Taliglucerase Alfa for Gaucher 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®

VELAGLUCERASE ALFA/ TALIGLUCERASE ALFA for Gaucher Disease
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for INITIAL requests

1) Drug requested

☐ VPRIV

☐ Elelyso: if requesting Elelyso, please indicate the reasons that the patient is unable to receive therapy with velaglucerase alfa, including

- ☐ Rare cases of severe allergic reactions or hypersensitivity to velaglucerase alfa, please elaborate on the nature of reaction*_____
- ☐ Patients who are sub-optimally responsive despite maximum doses of velaglucerase alfa for at least 12 months, please elaborate*_____
- ☐ Patients unable to receive velaglucerase alfa for medical reasons, please elaborate*_____

Supporting documentation may be required

Please indicate if this patient is

☐ starting drug upon approval

☐ new to coverage but currently maintained on drug

☐ submitting renewal request

2a) Weight (kg) **2b) Dosage and frequency**

3) Diagnosis

☐ **Type 1 Gaucher Disease** ☐ Other (specify) _____

4) Confirmation of Diagnosis	
☐ Specific deficiency of glucocerebrosidase in tissue or cultured skin fibroblasts.	Date
☐ Presence, in tissue or peripheral blood leukocytes, of mutations in the glucocerebrosidase gene known to result in severe enzyme deficiency.	Date
☐ Other potentially confounding diagnoses, such as Hodgkin's disease or other storage disorders must have been ruled out	Date:

Please provide the following information for ALL requests

5) Exclusion criteria (does patient meet any of the following?)	
The presence of any Gaucher disease-related condition that might reasonably be expected to compromise a response to therapy	☐Yes ☐No
The presence of another medical condition that might reasonably be expected to compromise a response to therapy	☐Yes ☐No
Asymptomatic Gaucher disease	☐Yes ☐No
The presence of primary neurological disease due to Gaucher disease	☐Yes ☐No

ALBERTA BLUE CROSS®

VELAGLUCERASE ALFA/ TALIGLUCERASE ALFA for Gaucher Disease
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.

Please provide the following information for ALL requests

6) Clinical Measures monitored for the patient:

Baseline parameters	Baseline Measures	Response measures for renewals and for patients already on drug but new to coverage
Hemoglobin	<85% of lower limit of age- and sex-appropriate normal ☐Yes ☐No	Hb level (g/L): _____ Date:
Platelet count	<50 x 10^9/L on two separate occasions at least one month apart ☐Yes ☐No	☐ Increase platelet count to level sufficient to prevent spontaneous bleeding ☐ Normalization of platelet count in splenectomized patients ☐ In patients with intact spleen, an increase of at least 1.5X in baseline platelet count
Splenic infarction	☐Yes ☐No	☐ Spleen volume reduction: _____(%) ☐ Prevention of further splenic infarcts ☐ Evidence of splenic infarcts
Bone crises	☐Yes ☐No	☐ Prevention of bone crises ☐ Evidence of bone crises
Radiographic or MRI evidence of incipient destruction of any major joint at baseline	☐Yes ☐No	☐ Improvement in imaging parameters (either MRI, QCSI2, or BMD) ☐ Evidence of further joint destruction
Spontaneous fractures	☐Yes ☐No	☐ Prevention of spontaneous fractures ☐ Evidence of further fractures
Chronic bone pain	☐Yes ☐No	☐ Reduced bone pain ☐ Increased bone pain
Major Joint Replacement	☐Yes ☐No	☐ Optimize surgical outcome for major joint replacement surgery where required at baseline. ☐ Need for new major joint replacement surgery where it was not required at baseline.
Liver synthetic dysfunction	☐Yes ☐No	☐ Improvement in liver function ☐ Decline in liver function
Symptomatic hepatosplenomegaly	☐Yes ☐No	☐ Spleen volume reduction: _____(%) ☐ Liver volume reduction: _____ (%
Progressive pulmonary disease due to Gaucher disease	Pulmonary hypertension (PH) ☐Yes ☐No Need for oxygenation ☐Yes ☐No Hepatopulmonary syndrome ☐Yes ☐No	☐ pulmonary hypertension (PH) ☐improvement ☐ evidence of worsening PH ☐ oxygenation ☐improvement ☐ decrease ☐ hepatopulmonary syndrome ☐reversal ☐ continuation
Growth failure in children	☐Yes ☐No	☐ Return to normal range on height percentiles ☐ less than normal range on height percentiles

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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

Migalastat Special Authorization Request Form

On the reverse is the official *Migalastat Special Authorization Request Form (ABC 60071).* All requests for must be submitted using this form only.

- All requests for Migalastat must be submitted using the *Migalastat 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®

MIGALASTAT
SPECIAL AUTHORIZATION REQUEST FORM

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

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD) / GENDER (M/F)	ALBERTA PERSONAL HEALTH NUMBER		
STREET ADDRESS	CITY / PROV / POSTAL CODE		ID, CLIENT/COVERAGE NUMBER

NOTIFICATION

You may be eligible to receive migalastat drug benefits. Information from your prescriber is collected for the sole purpose of determining eligibility for drug coverage. Your consent is required: (A) for your prescriber to release necessary and relevant information to Alberta Blue Cross, to Alberta Health, to Alberta Human Services (if requested) and to the Canadian Fabry Disease Initiative; and (B) for Alberta Blue Cross to release that to Alberta Health and the Canadian Fabry Disease Initiative. The information will be shared with Canadian Fabry Disease Initiative which reviews the request for coverage. In addition, related usage information may be released to Alberta Health.

PATIENT CONSENT

I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health, Alberta Human Services (if they request it) and to the Canadian Fabry Disease Initiative (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and the Canadian Fabry Disease Initiative, 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 (YYYY-MM-DD) Patient's signature

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME / FIRST NAME / INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS	
CITY, PROVINCE	PHONE / FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

☐ Migalastat (e.g. Galafold) ☐ **Other** _____	Dosage and frequency requested

☐ **New request (please see Section 1a – page 1 and Section 1b – page 2)** ☐ **Renewal request (please see Section 2 – page 2)**

Section 1a – New requests

α-galactosidase levels (copy of test report must be provided) _____ **Reference range** _____

DNA mutation (copy of test report must be provided) _____

Please check all that apply

System	Criteria
☐ **Renal (1 major OR 2 minor)**	**Major** ☐ GFR <60 ml/min/1.73m^2 (2 consistent estimates or measures over 2 months) ☐ GFR 60-90 ml/min/1.73m^2 (3 consistent estimates or measures over 4 months with GFR slope greater than age-related normal) ☐ GFR >135 ml/min/1.73m^2 (15% decrease in GFR or GFR slope greater than age-related normal. Must be measured in GFR) ☐ Persisting Proteinuria of 500 mg/day/1.73m^2 without any other causes ☐ Renal pathology (males only)
	Minor ☐ Hyperfiltration (GFR ≥135 ml.min/1.73m^2, 2 consistent measured GFR at least 1 month apart) ☐ Isolated proteinuria of 300 mg/day/1.73m^2 or greater without cause ☐ Renal tubular dysfunction (Nephrogenic diabetes insipidus and/or Fanconi syndrome) ☐ Hypertension ☐ Renal pathology (females)

For new requests, please continue to section 1b for new requests on page 2.

For renewal requests, please continue to section 2 for renewal requests on page 2.

The information on this form is being collected and 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 purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. The information will be shared with Canadian Fabry Disease Initiative which reviews the request for coverage. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

MIGALASTAT
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs

Section 1b for new requests

System	Criteria
☐ **Cardiac (2)**	☐ LV wall thickness >12 mm in males and >11 mm in females ☐ LVH by ECG; Estes ECG score must be > 5. ☐ LVMI by 2D echocardiogram 20% above normal for age ☐ Diastolic filling abnormalities by 2D echo. Grade 2 or 3 diastolic dysfunction and or presence of speckle tracking abnormalities ☐ Increase of LV mass of at least 5 g/m^2/year (3 measurements over a minimum 12 months) ☐ Abnormal base to apex circumferential strain gradient ☐ Increase of LA size on 2D echo.In parasternal long axis view (PLAX) >40 mm; Left atrial volume index > 34 ml/m^2 ☐ Cardiac conduction and rhythm abnormalities: AV block, short PR interval, LBBB, ventricular or atrial tachyarrhythmias, sinus bradycardia (in the absence of drugs with negative chronotropic activity or other causes) ☐ Moderate to severe mitral or aortic insufficiency ☐ Late enhancement of LV wall on MRI ☐ T1 values using a 1.5 Tesla magnet in males below 901 ms and females below 916 ms ☐ Increase of N-terminal pro-natriuretic brain peptide (NT-proBNP) OR increase in high sensitivity troponin more than two times the upper limit of normal range
☐ **Neuro (1)**	☐ Stroke or TIA documented by a neurologist ☐ Acute onset unilateral hearing loss without other cause. ☐ Acute monocular visual loss without other cause
☐ **Gastrointestinal**	☐ Chronic, intractable diarrhea and/or abdominal pain/cramps, refractory to standard management for at least 6 months
☐ **Pain**	☐ Chronic, intractable neuropathic pain, refractory to analgesics and standard pain management for at least 6 months

Section 2 – Renewal requests

According to the Canadian Fabry Disease Treatment Guidelines, does the patient meet any of the following criteria for consideration of discontinuation of disease specific therapy?

☐ Yes – please check all that apply

- ☐ Patient request
- ☐ Life expectancy < 1 year
- ☐ Permanent severe neurocognitive decline
- ☐ Severe reduction of quality of life and functional status despite disease specific therapy
- ☐ Lack of response to disease specific therapy for one year in which the sole indication for disease specific therapy was neuropathic pain or severe gastrointestinal symptoms
- ☐ Lack of response to disease specific therapy that initially mandated treatment start
- ☐ Lack of compliance
- ☐ Persistent life threatening reactions that do not respond to prophylaxis e.g. anaphylaxis

☐ No

Additional information relating to request:

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to ▪ **Alberta Blue Cross, Clinical Drug Services** **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

Single Entity Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form

On the reverse is the official Single Entity Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form (ABC 60072).

- All requests for MAC override for single entity angiotensin-converting enzyme inhibitors that are subject to MAC pricing on the iDBL must be submitted using the *Single Entity Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form* only. Please refer to the iDBL for full listing of Single Entity Angiotensin-Converting Enzyme Inhibitor products.
- 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®

SINGLE ENTITY ANGIOTENSIN-CONVERTING ENZYME INHIBITORS PRICING 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROVINCE	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
CITY	PROVINCE		PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

ACEI products* that are subject to MAC and LCA pricing on the iDBL. MAC pricing will be applied as follows effective December 1, 2019.

Active ingredient	Strength/Form	LCA/MAC price	
BENAZEPRIL HCL	5 MG, 10MG & 20 MG ORAL TABLET	$0.1945	*MAC pricing has been applied based on the LCA price for Lisinopril 1 X 20 mg tablet.*
CAPTOPRIL	12.5 MG, 25 MG, 50 MG & 100 MG ORAL TABLET		
CILAZAPRIL	1 MG, 2.5 MG & 5 MG ORAL TABLET		
ENALAPRIL MALEATE	2.5 MG, 5 MG, 10 MG & 20 MG ORAL TABLET		
FOSINOPRIL SODIUM	10 MG & 20 MG ORAL TABLET		
PERINDOPRIL ERBUMINE	2 MG, 4 MG & 8 MG ORAL TABLET		
QUINAPRIL	5 MG, 10 MG, 20 MG & 40 MG ORAL TABLET		
TRANDOLAPRIL	0.5 MG, 1 MG, 2 MG & 4 MG ORAL CAPSULE		
LISINOPRIL	5 MG, 10 MG & 20 MG ORAL TABLET	*These products are not affected by MAC pricing. Least cost alternative pricing will continue to apply.*	
RAMIPRIL	1.25 MG, 2.5 MG, 5 MG & 10 MG ORAL TABLET/CAPSULE		

***Please refer to the iDBL for a full listing of ACEI products.**

Pricing Authorization request where the patient is unable to use the MAC reference product

1) Select ACEI and indicate if the corresponding MAC reference product has been used.

Requested ACEI (please check one).	**Has the patient used the MAC reference product for the requested ACEI?**
☐ benazepril HCL 5 mg, 10 mg, or 20 mg ☐ captopril 12.5 mg, 25 mg, 50 mg, or 100 mg ☐ cilazapril 1 mg, 2.5 mg, or 5 mg ☐ enalapril maleate 2.5 mg, 5 mg, 10 mg, or 20 mg ☐ fosinopril sodium 10 mg or 20 mg ☐ perindopril erbumine 2 mg, 4 mg, or 8 mg ☐ quinapril 5 mg, 10 mg, 20 mg, or 40 mg ☐ trandolapril 0.5 mg, 1 mg, 2 mg, or 4 mg	☐ Yes, lisinopril or ramipril was used. ☐ No, lisinopril or ramipril was not used. Please specify reasons. _____ _____ _____ _____ _____

2) Is the requested ACEI required for any of the following? If so, skip question three.

☐ pediatric patient ☐ heart failure condition with twice daily dosing ☐ breast feeding patient

3) If the patient has used the MAC reference product for the requested ACEI, what was the response?

☐ Therapeutic failure of the MAC reference product. Please specify diagnosis. _____

☐ Adverse effects. Please elaborate on the nature and severity of the adverse effects experienced by your patient on the MAC reference product. _____

→ Has the patient used the MAC reference product for a sufficient duration to determine that the adverse effects will not resolve over time?

☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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®

SINGLE ENTITY ANGIOTENSIN-CONVERTING ENZYME INHIBITORS PRICING AUTHORIZATION REQUEST FORM

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

Frequently asked questions

1. What is the difference between LCA and MAC pricing?

The **Least Cost Alternative (LCA) price** means the maximum amount that will be paid by the Government of Alberta for a drug product in an established or new interchangeable grouping for members of a plan. For example, Altace 10 mg is in a grouping with several generic brands of ramipril 10 mg that are interchangeable with brand name Altace 10 mg. The maximum unit price paid for Altace 10 mg is thus based on the lowest-priced generic interchangeable product within the grouping.

A **MAC grouping** means a grouping of drug products that have been listed on the *Alberta Drug Benefit List (ADBL)* as being subject to a maximum price. Note that a MAC grouping may include one or more groupings of interchangeable drugs. For example, ACEIs have been grouped together such that the maximum unit price paid for select ACEIs (benazepril HCL 5 mg, 10mg & 20 mg, captopril 12.5 mg, 25 mg, 50 mg & 100 mg, cilazapril 1 mg, 2.5 mg & 5 mg, enalapril maleate 2.5 mg, 5 mg, 10 mg & 20 mg, fosinopril sodium 10 mg & 20 mg, perindopril erbumine 2 mg, 4 mg & 8 mg, quinapril 5 mg, 10 mg, 20 mg & 40 mg, and trandolapril 0.5 mg, 1 mg, 2 mg & 4 mg) will be based on the cost of lisinopril 20 mg, which is $0.1945 per unit (tablet).

2. What happens if a product is subject to both LCA and MAC pricing?

If a product is subject to both MAC and LCA pricing, the maximum unit price paid for the Drug Product will be based on the unit cost of the product that establishes the MAC grouping. For example, Mavik 4 mg is subject to both LCA and MAC pricing and as such, the maximum unit price paid will be based on the product that establishes the MAC grouping; in this case, lisinopril 20 mg, which is $0.1945 per unit (tablet).

Calcium Channel Blocking Agents (CCBs) Pricing Authorization Request Form

On the reverse is the official *Calcium Channel Blocking Agents (CCBs) Pricing Authorization Request Form (*ABC 60073).

- All requests for MAC override for Calcium Channel Blocking Agent products that are subject to MAC pricing on the iDBL must be submitted using the *Calcium Channel Blocking Agents (CCBs) Pricing Authorization Request Form* only. Please refer to the iDBL for full listing of Calcium Channel Blocking Agent products.
- **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.

CALCIUM CHANNEL BLOCKING AGENTS (CCBs) PRICING AUTHORIZATION REQUEST FORM

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

PATIENT INFORMATION				COVERAGE TYPE
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROVINCE	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
CITY	PROVINCE		PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

CCB products* that are subject to MAC and LCA pricing on the iDBL. MAC pricing will be applied as follows effective December 1, 2019.

Active ingredient	Strength/Form	LCA/MAC price	
FELODIPINE	2.5 MG, 5 MG & 10 MG ORAL EXTENDED-RELEASE TABLET	$0.1993	*MAC pricing has been applied based on the LCA price for Amlodipine Besylate 1 X 10 mg tablet.*
NIFEDIPINE	20 MG, 30 MG & 60 MG ORAL EXTENDED-RELEASE TABLET		
AMLODIPINE BESYLATE	2.5 MG, 5 MG & 10 MG ORAL TABLET	*These products are not affected by MAC pricing. Least cost alternative pricing will continue to apply.*	

***Please refer to the iDBL for a full listing of CCB products.**

Pricing authorization request where the patient is unable to use the MAC reference product

1) Select CCB and indicate if the corresponding MAC reference product has been used.

Requested CCB (please check one).	Has the patient used the MAC reference product for the requested CCB?
☐ felodipine 2.5 mg, 5 mg & 10 mg ☐ nifedipine extended release 20 mg, 30 mg & 60 mg	☐ Yes, amlodipine besylate was used. ☐ No, amlodipine besylate was not used. Please specify reasons. _____

2) If the patient has used the MAC reference product for the requested CCB, what was the response?

☐ Therapeutic failure of the MAC reference product. Please specify diagnosis. _____

☐ Adverse effects. Please elaborate on the nature and severity of the adverse effects experienced by your patient on the MAC reference product. _____

→ Has the patient used the MAC reference product for a sufficient duration to determine that the adverse effects will not resolve over time?

☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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.

Frequently asked questions

1. What is the difference between LCA and MAC pricing?

The **Least Cost Alternative (LCA) price** means the maximum amount that will be paid by the Government of Alberta for a drug product in an established or new interchangeable grouping for members of a plan. For example, Plendil 10 mg is in a grouping with generic brands of felodipine 10 mg that are interchangeable with brand name Plendil 10 mg. The maximum unit price paid for Plendil 10 mg is thus based on the lowest-priced generic interchangeable product within the grouping.

A **MAC grouping** means a grouping of drug products that have been listed on the *Alberta Drug Benefit List (ADBL)* as being subject to a maximum price. Note that a MAC grouping may include one or more groupings of interchangeable drugs. For example, CCB products have been grouped together such that the maximum unit price paid for select CCB products (felodipine 2.5 mg, 5 mg & 10 mg, nifedipine extended release 20 mg, 30 mg & 60 mg) will be based on the cost of amlodipine besylate 10 mg, which is $0.1993 per unit (tablet).

2. What happens if a product is subject to both LCA and MAC pricing?

If a product is subject to both MAC and LCA pricing, the maximum unit price paid for the Drug Product will be based on the unit cost of the product that establishes the MAC grouping. For example, Adalat XL 30 mg is subject to both LCA and MAC pricing and as such, the maximum unit price paid will be based on the product that establishes the MAC grouping; in this case, amlodipine besylate 10 mg, which is $0.1993 per unit (tablet).

HMG-COA Reductase Inhibitors (Statins) Pricing Authorization Request Form

On the reverse is the official *HMG-COA Reductase Inhibitors (Statins) Pricing Authorization Request Form (*ABC 60074).

- All requests for MAC override for HMG-COA Reductase Inhibitor (Statin) products that are subject to MAC pricing on the iDBL must be submitted using the *HMG-COA Reductase Inhibitors (Statins) Pricing Authorization Request Form* only. Please refer to the iDBL for full listing of HMG-COA Reductase Inhibitor (Statin) products.
- **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®

HMG-COA REDUCTASE INHIBITORS (STATINS) PRICING 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROVINCE	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
CITY	PROVINCE		PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Statin products* that are subject to MAC and LCA pricing on the iDBL. MAC pricing will be applied as follows effective December 1, 2019.

Active ingredient	Strength/Form	LCA/MAC price	
FLUVASTATIN SODIUM	20 MG & 40 MG ORAL CAPSULE	$0.1354	*MAC pricing has been applied based on the LCA price for Rosuvastatin Calcium 1 x 10 mg tablet*
FLUVASTATIN SODIUM	80 MG ORAL EXTENDED-RELEASE TABLET		
LOVASTATIN	20 MG & 40 MG ORAL TABLET		
PRAVASTATIN SODIUM	10 MG, 20 MG & 40 MG ORAL TABLET		
SIMVASTATIN	5 MG, 10 MG, 20 MG, 40 MG & 80 MG ORAL TABLET		
ATORVASTATIN CALCIUM	10 MG, 20 MG, 40 MG & 80 MG ORAL TABLET	*These products are not affected by MAC pricing. Least cost alternative pricing will continue to apply.*	
ROSUVASTATIN CALCIUM	5 MG, 10 MG, 20 MG & 40 MG ORAL TABLET		

***Please refer to the iDBL for a full listing of Statin products.**

Pricing authorization request where the patient is unable to use the MAC reference product

1) Select Statin and indicate if the corresponding MAC reference product has been used.

Requested Statin (please check one).	**Has the patient used the MAC reference product for the requested Statin?**
☐ fluvastatin sodium 20 mg & 40 mg ☐ fluvastatin sodium 80 mg extended-release ☐ lovastatin 20 mg & 40 mg ☐ pravastatin sodium 10 mg, 20 mg & 40 mg ☐ simvastatin 5mg, 10mg, 20mg, 40mg & 80mg	☐ Yes, rosuvastatin or atorvastatin was used. ☐ No, rosuvastatin or atorvastatin was not used. Please specify reasons. _____ _____

2) If the patient has used the MAC reference product for the requested Statin, what was the response?

☐ Therapeutic failure of the MAC reference product. Please specify diagnosis. _____

☐ Adverse effects. Please elaborate on the nature and severity of the adverse effects experienced by your patient on the MAC reference product. _____

→ Has the patient used the MAC reference product for a sufficient duration to determine that the adverse effects will not resolve over time?

☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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.

Frequently asked questions

1. What is the difference between LCA and MAC pricing?

The **Least Cost Alternative (LCA) price** means the maximum amount that will be paid by the Government of Alberta for a drug product in an established or new interchangeable grouping for members of a plan. For example, Crestor 10mg is in a grouping with several generic brands of rosuvastatin 10mg mg that are interchangeable with brand name Crestor 10 mg. The maximum unit price paid for Crestor 10mg is thus based on the lowest-priced generic interchangeable product within the grouping.

A **MAC grouping** means a grouping of drug products that have been listed on the *Alberta Drug Benefit List (ADBL)* as being subject to a maximum price. Note that a MAC grouping may include one or more groupings of interchangeable drugs. For example, Statin products have been grouped together such that the maximum unit price paid for select Statin products (fluvastatin sodium 20 mg & 40 mg, fluvastatin sodium 80 mg extended-release, lovastatin 20 mg & 40 mg, pravastatin sodium 10 mg, 20 mg & 40 mg, and simvastatin 5 mg, 10 mg, 20 mg, 40 mg & 80 mg) will be based on the cost of rosuvastatin calcium 10 mg, which is $0.1354 per unit (tablet).

2. What happens if a product is subject to both LCA and MAC pricing?

If a product is subject to both MAC and LCA pricing, the maximum unit price paid for the Drug Product will be based on the unit cost of the product that establishes the MAC grouping. For example, Pravachol 20 mg is subject to both LCA and MAC pricing and as such, the maximum unit price paid will be based on the product that establishes the MAC grouping; in this case, rosuvastatin calcium 10 mg, which is $0.1354 per unit (tablet).

Combination Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form

On the reverse is the official *Combination Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form (*ABC 60075).

- All requests for MAC override for Combination Angiotensin-Converting Enzyme Inhibitor products that are subject to MAC pricing on the iDBL must be submitted using the *Combination Angiotensin-Converting Enzyme Inhibitors Pricing Authorization Request Form* only. Please refer to the iDBL for full listing of Combination Angiotensin-Converting Enzyme Inhibitor products.
- **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®

COMBINATION ANGIOTENSIN-CONVERTING ENZYME INHIBITORS PRICING 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
ADDRESS			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
CITY	PROVINCE		PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

ACEI combination products* that are subject to MAC and LCA pricing on the iDBL. MAC pricing will be applied as follows effective December 1, 2019.

Active ingredient	Strength/Form	LCA/MAC price	
CILAZAPRIL/ HYDROCHLOROTHIAZIDE	5 MG / 12.5 MG ORAL TABLET	$0.2503	*MAC pricing has been applied based on the LCA price for Lisinopril /HCTZ 1 x 20 mg/25 mg tablet.*
ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE	5 MG / 12.5 MG & 10 MG / 25 MG ORAL TABLET		
PERINDOPRIL ERBUMINE/ INDAPAMIDE HEMIHYDRATE	4 MG / 1.25 MG & 8 MG / 2.5 MG ORAL TABLET		
QUINAPRIL/ HYDROCHLOROTHIAZIDE	10 MG / 12.5 MG, 20 MG / 12.5 MG & 20 MG / 25 MG ORAL TABLET		
RAMIPRIL/ HYDROCHLOROTHIAZIDE	2.5 MG / 12.5 MG, 5 MG / 12.5 MG, 5 MG / 25 MG, 10 MG / 12.5 MG & 10 MG / 25 MG ORAL TABLET		
LISINOPRIL/ HYDROCHLOROTHIAZIDE	10 MG / 12.5 MG, 20 MG / 12.5 MG & 20 MG / 25 MG ORAL TABLET	*These products are not affected by MAC pricing. Least cost alternative pricing will continue to apply.*	

***Please refer to the iDBL for a full listing of ACEI combination products.**

Pricing authorization request where the patient is unable to use the MAC reference product

1) Select ACEI combination product and indicate if the corresponding MAC reference product has been used.

Requested ACEI combination product (please check one).	Has the patient used the MAC reference product for the requested ACEI combination product?
☐ cilazapril/hydrochlorothiazide 5 mg/12.5 mg ☐ enalapril maleate/hydrochlorothiazide 5 mg/12.5 mg & 10 mg/25 mg ☐ perindopril erbumine/indapamide hemihydrate 4 mg/1.25 mg & 8 mg/2.5 mg ☐ quinapril/hydrochlorothiazide 10 mg/12.5 mg, 20 mg/12.5 mg & 20 mg/25 mg ☐ ramipril/hydrochlorothiazide 2.5 mg/12.5 mg, 5 mg/12.5 mg, 5 mg/25 mg, 10 mg/12.5 mg & 10 mg/25 mg	☐ Yes, lisinopril/HCTZ was used. ☐ No, lisinopril/HCTZ was not used. Please specify reasons. _____ _____ _____

2) Is the requested ACEI combination product required for any of the following? If so, skip question 3.

☐ pediatric patient ☐ heart failure condition with twice daily dosing ☐ breast feeding patient

3) If the patient has used the MAC reference product for the requested ACEI combination product, what was the response?

4) ☐ Therapeutic failure of the MAC reference product. Please specify diagnosis. _____

☐ Adverse effects. Please elaborate on the nature and severity of the adverse effects experienced by your patient on the MAC reference product.

_____

→ Has the patient used the MAC reference product for a sufficient duration to determine that the adverse effects will not resolve over time?

☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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®

COMBINATION ANGIOTENSIN-CONVERTING ENZYME INHIBITORS PRICING AUTHORIZATION REQUEST FORM

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

Frequently asked questions

1. What is the difference between LCA and MAC pricing?

The **Least Cost Alternative (LCA) price** means the maximum amount that will be paid by the Government of Alberta for a drug product in an established or new interchangeable grouping for members of a plan. For example, Zestoretic 10 mg/12.5 mg is in a grouping with several generic brands of lisinopril/ hydrochlorothiazide 10 mg/12.5 mg that are interchangeable with brand name Zestoretic 10 mg/12.5 mg. The maximum unit price paid for Zestoretic 10 mg/12.5 mg is thus based on the lowest-priced generic interchangeable product within the grouping.

A **MAC grouping** means a grouping of drug products that have been listed on the *Alberta Drug Benefit List (ADBL)* as being subject to a maximum price. Note that a MAC grouping may include one or more groupings of interchangeable drugs. For example, ACEI combination products have been grouped together such that the maximum unit price paid for select ACEI combination products (cilazapril/ hydrochlorothiazide 5 mg / 12.5 mg, enalapril maleate/hydrochlorothiazide 5 mg/12.5 mg & 10 mg/25 mg, perindopril erbumine/indapamide hemihydrate 4 mg/1.25 mg & 8 mg/2.5 mg, quinapril/hydrochlorothiazide 10 mg/12.5 mg, 20 mg/12.5 mg & 20 mg/25 mg, and ramipril/hydrochlorothiazide 2.5 mg/12.5 mg, 5 mg/12.5 mg, 5 mg/25 mg, 10 mg/12.5 mg & 10 mg/25 mg) will be based on the cost of lisinopril/hydrochlorothiazide 20 mg/25 mg, which is $0.2503 per unit (tablet).

2. What happens if a product is subject to both LCA and MAC pricing?

If a product is subject to both MAC and LCA pricing, the maximum unit price paid for the Drug Product will be based on the unit cost of the product that establishes the MAC grouping. For example, Accuretic 20 mg/12.5 mg is subject to both LCA and MAC pricing and as such, the maximum unit price paid will be based on the product that establishes the MAC grouping; in this case, lisinopril/hydrochlorothiazide 20 mg/25 mg, which is $0.2503 per unit (tablet).

Biosimilar Initiative Exception Special Authorization Request Form

On the reverse is the official Biosimilar Initiative Exception Special Authorization Request Form (ABC 60076).

- All requests for an exception to the Biosimilar Initiative must be submitted using the *Biosimilar Initiative Exception 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®

BIOSIMILAR INITIATIVE / TIERING EXCEPTION 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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

NOTIFICATION

You may be eligible to receive the requested drug benefits. Information from your prescriber is collected for the sole purpose of determining eligibility for drug coverage. Your consent is required: (A) for your prescriber to release necessary and relevant information to Alberta Blue Cross, to Alberta Health, to Alberta Human Services (if requested) for the Biosimilar Initiative/Tiering exception; and (B) for Alberta Blue Cross to release that to Alberta Health and the reviewing specialists. The information will be shared with the specialists who review the request for coverage. In addition, related usage information may be released to Alberta Health.

PATIENT CONSENT

I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health, Alberta Human Services (if they request it); and (B) Alberta Blue Cross to release to Alberta Health and the specialists who review the request, 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 (YYYY-MM-DD) Patient's signature

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION REGISTRATION NUMBER ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate requested drug for a) OR b)		Diagnosis (please specify)	Dosage
a) Request for originator as biosimilar cannot be used Please specify requested originator _____	**b) Exception is required for tier 2 drug** Please specify requested tier 2 drug _____	**For Remicade and Stelara requests only: Current weight (kg)** **For Rituxan requests for GPA/MPA only: Body surface area (m^2)**	**Frequency**

Please provide additional documentation for the following in order for the exception request to be considered:

1. Please provide summary of clinical status and disease course: *Please include ALL applicable clinical assessment scores*
2. Please provide previous / current medications used: *Please indicate when the medications were used, dose, duration of use and response to each treatment*
3. Please provide rationale for Exception Request: *Clearly indicate the reason(s) why patient is unable to switch to the biosimilar or is unable to use the tier 1 drugs*
4. Please provide information as to whether the patient has tried the biosimilar or prerequisite number of tier 1 drugs:
   a) If so, please provide the duration of the trial and nature of response (provide scores to indicate biosimilar was not effective if applicable, laboratory values (e.g. A1c changes for insulin glargine while on biosimilar), detailed documentation to include frequency and severity of adverse effects (e.g. for insulin glargine: provide hypoglycemic or hyperglycemic events per week, A1c change while on biosimilar versus while on originator))
   b) If not, please provide additional clinical information relating to patient's condition (e.g. for Crohn's, the number and date of any intestinal resections, include any underlying, diagnosed co-morbidities that preclude use of the biosimilar, and indicate if such co-morbidities are well controlled or being managed)

If the reason for exception request is pregnancy, indicate if patient is currently pregnant ☐ Yes, anticipated due date ☐ No

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Alemtuzumab for Multiple Sclerosis Special Authorization Request Form

On the reverse is the official *Alemtuzumab for Multiple Sclerosis Special Authorization Request Form (ABC 60079)*.

- All requests for alemtuzumab must be submitted using the Alemtuzumab for Multiple Sclerosis 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®

ALEMTUZUMAB
For Multiple Sclerosis
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

☐ **NEW request** (i.e. new to MS DMT and/or coverage) ☐ **MS disease modifying therapy (DMT) SWITCH**

For patients new to coverage and already on alemtuzumab, specify start date (YYYY-MM-DD) _____ and number of treatment courses and doses/course administered _____

Diagnosis ☐ Relapsing-remitting multiple sclerosis
☐ Other (specify) _____

Current EDSS _____. _____ Date (YYYY-MM-DD) _____

NEW requests: Qualifying relapses
Provide the dates of two relapses within the last two years OR the two years prior to starting MS DMT

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

a) Has the patient been on MS DMT of any kind since the relapse(s)? ☐ No ☐ Yes → If yes, answer b) and c)

b) Specify the MS DMT start date (YYYY-MM-DD) _____

c) Indicate if there have been any interruptions in therapy since starting MS DMT ☐ No ☐ Yes → **If yes, indicate**

i) Reason for the interruption in therapy _____

ii) Specify time period of interruption: **from** (YYYY-MM-DD) _____ **to** (YYYY-MM-DD) _____.

iii) How many relapses did the patient experience while off therapy? _____

ALL requests: Provide response to <u>TWO</u> of the following MS DMT
DIMETHYL FUMARATE; GLATIRAMER ACETATE; INTERFERON BETA; OCRELIZUMAB; PEGINTERFERON BETA; TERIFLUNOMIDE

Name of <u>1st</u> MS DMT utilized _____ and date of treatment initiation (YYYY-MM-DD) _____

☐ **INTOLERANCE** despite the use of symptom management techniques; **OR** ☐ **REFRACTORY** → answer a) and b)

a) Does the patient have clinically significant titres of neutralizing antibodies to interferon beta? ☐ Yes ☐ No ☐ N/A

b) Within a consecutive 12-month period while on the MS DMT, did the patient experience at least two relapses of MS?
☐ No ☐ Yes → **Provide the dates of either two clinical relapses OR one clinical relapse and one MRI relapse**

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

Name of <u>2nd</u> MS DMT utilized _____ and date of treatment initiation (YYYY-MM-DD) _____

☐ **INTOLERANCE** despite the use of symptom management techniques; **OR** ☐ **REFRACTORY** → answer a) and b)

a) Does the patient have clinically significant titres of neutralizing antibodies to interferon beta? ☐ Yes ☐ No ☐ N/A

b) Within a consecutive 12-month period while on the MS DMT, did the patient experience at least two relapses of MS?
☐ No ☐ Yes → **Provide the dates of either two clinical relapses OR one clinical relapse and one MRI relapse**

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

PRESCRIBER 'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

Edaravone Special Authorization Request Form

On the reverse is the official *Edaravone Special Authorization Request Form (ABC 60080)*.

- All requests for edaravone must be submitted using the Edaravone 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®

EDARAVONE
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION		
PRESCRIBER LAST NAME FIRST NAME INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS		
CITY, PROVINCE	PHONE	FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

Diagnosis	**Please indicate if this patient is**	
☐ Probable or definite diagnosis of amyotrophic lateral sclerosis (ALS), as defined by World Federation of Neurology (WFN) criteria. ☐ Other (specify) _____.	☐ starting drug upon approval ……....**complete section I.** ☐ new to coverage but currently maintained on drug …..**complete section I and II.** ☐ submitting renewal request ……**complete section II.**	
Dosage and frequency requested	Treatment start date	Date of last dose

Section I: Provide <u>pre-treatment</u> information for all INITIAL requests for treatment naive and treatment experienced patients

Disease onset and duration		
Has the patient had ALS symptoms for two years or less *prior* to initiation of the requested drug?	☐ Yes	☐ No
Ventilation status		
Does the patient require permanent non-invasive or invasive ventilation at treatment initiation?	☐ Yes	☐ No
PRE-TREATMENT scores		
a) Pre-treatment Forced Vital Capacity (FVC) _____.	Date _____	
b) Pre-treatment ALS Functional Rating Scale – Revised (ALSFRS-R) _____.	Date _____	
c) Does the patient have **scores of at least two (2) points on each item** of the ALSFRS-R provided in b)?	☐ Yes	☐ No

Section II: Please complete the following for all RENEWAL requests and for INITIAL requests for treatment experienced patients

CURRENT RESPONSE scores		
a) Current ALS Functional Rating Scale – Revised (ALSFRS-R) _____	Date _____	
b) Is the patient **non-ambulatory** (ALSFRS-R score of less than or equal to 1 for item 8)?	☐ Yes	☐ No
c) Is the patient **unable** to cut food and feed themselves without assistance, irrespective of whether a gastrostomy is in place (ALSFRS-R score less than 1 for item 5a or 5b)?	☐ Yes	☐ No
Ventilation status		
Does the patient currently require permanent non-invasive or invasive ventilation?	☐ Yes	☐ No
Additional information relating to request		

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to ▪ **Alberta Blue Cross, Clinical Drug Services** **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

Rivaroxaban 2.5 mg Special Authorization Request Form

On the reverse is the official Rivaroxaban 2.5 mg Special Authorization Request Form (ABC 60081).

- All requests for an exception to the Biosimilar Initiative must be submitted using the *Rivaroxaban 2.5 mg 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®

RIVAROXABAN 2.5 MG
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 LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for INITIAL requests

1) Intended use (check all that apply)
☐ Prevention of stroke, myocardial infarction, and cardiovascular death, and for the prevention of acute limb ischemia and mortality.
☐ Other (specify) _____

2) Will rivaroxaban 2.5 mg be used in combination with acetylsalicylic acid (ASA) 75 mg to 100 mg?
☐ Yes.
☐ No, explain _____

3) Does the patient have coronary artery disease (CAD)?
☐ Yes → complete a) and b) below.
☐ No.

a) Please indicate if the patient has one or more of the following by checking the applicable boxes.
☐ Myocardial infarction within the last 20 years
☐ Multi-vessel coronary disease (i.e., stenosis of greater than or equal to 50 per cent in two or more coronary arteries, or in one coronary territory if at least one other territory has been revascularized) with symptoms or history of stable or unstable angina.
☐ Multi-vessel percutaneous coronary intervention.
☐ Multi-vessel coronary artery bypass graft surgery.

b) ***For patients less than 65 years old,*** does the patient have documented atherosclerosis or revascularization involving at least two vascular beds (coronary and other vascular) or at least two additional risk factors (current smoker, diabetes mellitus, estimated glomerular filtration rate less than 60 mL/min, heart failure, non-lacunar ischemic stroke 1 month or more ago)?
☐ Yes
☐ No

4) Does the patient have peripheral artery disease (PAD)?
☐ Yes → complete a) below
☐ No

a) Please indicate if the patient has one or more of the following by checking the applicable boxes
☐ Previous aorto-femoral bypass surgery, limb bypass surgery, or percutaneous transluminal angioplasty revascularization of the iliac or infrainguinal arteries.
☐ Previous limb or foot amputation for arterial vascular disease.
☐ History of intermittent claudication and one or more of the following:
- An anklebrachial index less than 0.90.
- Significant peripheral stenosis (greater than or equal to 50%) documented by angiography or by duplex ultrasound.

☐ Previous carotid revascularization or asymptomatic carotid artery stenosis greater than or equal to 50%, as diagnosed by duplex ultrasound or angiography.

5) Exclusion criteria: do any of the following apply to the patient?

a) High risk of bleeding	☐ Yes	☐ No
b) A history of stroke within one month of treatment initiation or any history of hemorrhagic or lacunar stroke.	☐ Yes	☐ No
c) Severe heart failure with a known ejection fraction less than 30% or New York Heart Association (NYHA) class III or IV symptoms.	☐ Yes	☐ No
d) An estimated glomerular filtration rate less than 15 mL/min.	☐ Yes	☐ No
e) Require dual antiplatelet therapy, other non-ASA antiplatelet therapy, or oral anticoagulant therapy.	☐ Yes	☐ No

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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 on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

Icatibant / Lanadelumab for HAE Type I or II Special Authorization Request Form

On the reverse is the official *Icatibant / Lanadelumab for HAE Type I or II Special Authorization Request Form* (ABC 60083).

- All requests for icatibant acetate/lanadelumab must be submitted using the *Icatibant / Lanadelumab 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®

ICATIBANT / LANADELUMAB FOR HAE TYPE I OR II 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
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services
				☐ Other _____
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER
ADDRESS			☐ CARNA ☐ ADA+C
			☐ ACP ☐ Other
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested

☐ **Icatibant (e.g. Firazyr) → complete section I only**

☐ **Lanadelumab (e.g. Takhzyro) → complete section II only**

If the requested drug was prescribed in consultation with another physician who is experienced in the treatment of HAE, please provide the physician's name _____

Section I. For ICATIBANT (e.g. Firazyr) Requests

1) Intended use

☐ Treatment of acute attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients with C1-esterase inhibitor deficiency

☐ Other (specify) _____

2) Specify the type and severity of acute attacks to be treated

☐ Acute non-laryngeal attack(s) of at least moderate severity

☐ Acute laryngeal attack(s) of any severity

☐ Other (specify) _____

Section II. For LANADELUMAB (e.g. Takhzyro) Requests

1) Intended use – Initial Requests

☐ Routine prevention of attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE)

☐ Other (specify) _____

2) HAE attacks PRIOR to initiating long-term prophylactic therapy – Initial Requests (complete a) or b) as applicable)

a) For patients starting (or who originally began) long-term prophylactic therapy with lanadelumab

i. Indicate the *highest number* of HAE attacks that required the use of an acute injectable treatment *within any four-week period in the three months before starting* lanadelumab _____

AND

ii. Indicate the *total number* of HAE attacks requiring the use of an acute injectable treatment *in the three months before starting* lanadelumab _____

b) For patients transitioning (or have already transitioned) from another long-term prophylactic treatment (e.g. C1-INH) to lanadelumab

i. Indicate the *highest number* of HAE attacks that required the use of an acute injectable treatment *within any four-week period in the three months before starting* long-term prophylactic therapy _____

AND

ii. Indicate the *total number* of HAE attacks requiring the use of an acute injectable treatment *in the three months before starting* long-term prophylactic therapy _____

3) Response to therapy – Renewals and Initial Requests for patients already receiving long-term prophylactic treatment

Please indicate the number of HAE attacks requiring use of an acute injectable treatment *within the last three months* _____

4) Combination therapy – ALL Requests

Will lanadelumab be used in combination with other medications used for the long-term prophylactic treatment of angioedema? ☐ Yes ☐ No

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **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.

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ICATIBANT / LANADELUMAB FOR HAE TYPE I OR II SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

ICATIBANT (e.g. Firazyr) special authorization criteria

"For the treatment of acute attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients with C1-esterase inhibitor deficiency. Icatibant is to be used for:
- acute non-laryngeal attack(s) of at least moderate severity, or
- acute laryngeal attack(s) of any severity

This medication must be prescribed by, or in consultation with, a physician experienced in the treatment of HAE.

Special authorization may be granted for 12 months.

Patients will be limited to a maximum of two doses of icatibant per prescription at their pharmacy."

This product is eligible for auto-renewal.

LANADELUMAB (e.g. Takhzyro) special authorization criteria

"For the routine prevention of attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients 12 years of age or older who have had at least three HAE attacks that required the use of an acute injectable treatment within any four-week period in the three months before initiating lanadelumab therapy.

This medication must be prescribed by, or in consultation with, a physician experienced in the treatment of HAE. A record of the baseline total of HAE attacks requiring use of an acute injectable treatment in the three months prior to initiating lanadelumab is required.

Initial coverage may be approved for 3 months. The patient must be assessed after the initial three months to determine response. Patients who have a response to initial treatment* may receive continued coverage with lanadelumab for six months, and should be assessed for continued response** every six months.

*Response to initial lanadelumab treatment is defined as:
- at least a 50% reduction in the number of HAE attacks requiring use of an acute injectable treatment compared to the three month baseline number of attacks prior to initiation of lanadelumab.

**Continued response is defined as:
- maintenance of a minimum improvement of a 50% reduction in the number of HAE attacks requiring use of an acute injectable treatment compared to the baseline number of attacks observed before initiating treatment with lanadelumab.

Coverage cannot be provided for lanadelumab when used in combination with other medications used for long-term prophylactic treatment of angioedema (e.g., C1-INH).

Coverage may be approved for a dosage of up to 300 mg every two weeks. Patients will be limited to receiving a one-month supply per prescription at their pharmacy."

ABC 60083 (2020/12)

Inotersen/Patisiran for HATTR-PN Special Authorization Request Form

On the reverse is the official *Inotersen/Patisiran for HATTR-PN Special Authorization Request Form* (ABC 60084).

- All requests for inotersen or patisiran for hATTR polyneuropathy must be submitted using the *Inotersen/Patisiran for HATTR-PN 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®

INOTERSEN / PATISIRAN FOR HATTR-PN
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**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services ☐ Other _____
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested ☐ **Inotersen (e.g. Tegsedi)** ☐ **Patisiran (e.g. Onpattro)**

Please provide the following information for ALL requests

Diagnosis

☐ Hereditary transthyretin amyloidosis polyneuropathy (hATTR-PN)

☐ Other (specify)

_____

Please indicate if this patient is

☐ starting drug upon approval ……....complete section I

☐ new to coverage but currently maintained on drug …..complete section I & II

☐ submitting renewal request …….. complete section II

Combination use

Please indicate if the patient will be using the requested drug in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR ☐ Yes ☐ No

Section I: INITIAL requests for treatment naïve and treatment experienced patients

Does the patient have a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR)?

☐ Yes → please provide a copy of the genetic test report ☐ No

Please indicate if the following apply to this patient at treatment initiation (check all that apply):

☐ is symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II

☐ does NOT exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)

☐ has NOT previously undergone a liver transplant

Section II: RENEWAL requests and INITIAL requests for treatment experienced patients

Please indicate if the following currently apply to this patient (check Yes or No for a-c below):	**Yes**	**No**
a) shows continued benefit from treatment with the requested drug	☐	☐
b) is permanently bedridden and dependent on assistance for basic activities of daily living	☐	☐
c) is receiving end-of-life care	☐	☐

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **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.

INOTERSEN / PATISIRAN FOR HATTR-PN
SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

INOTERSEN (e.g. Tegsedi) special authorization criteria

"For the treatment of polyneuropathy in adult patients with a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) in patients who meet the following criteria:
- Are symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II
And
- do not exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)
And
-have not previously undergone a liver transplant.

For coverage, this drug must be prescribed by a specialist with experience in the diagnosis and management of hATTR.

Initial coverage may be approved for 284 mg administered subcutaneously once weekly for a period of nine months. Patients will be limited to receiving a four-week supply of inotersen per prescription at their pharmacy.

For renewal of coverage, patients must show continued benefit from treatment with inotersen and must NOT be:
- permanently bedridden and dependent on assistance for basic activities of daily living, NOR
- receiving end-of-life care.
Continued coverage may be approved for 284 mg weekly for a period of six months.

Coverage cannot be provided for use in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR."

PATISIRAN (e.g. Onpattro) special authorization criteria

"For the treatment of polyneuropathy in adult patients with a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) in patients who meet the following criteria:
-Patients are symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II
And
- do not exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)
And
-have not previously undergone a liver transplant.

For coverage, this drug must be prescribed by a specialist with experience in the diagnosis and management of hATTR.

Initial coverage may be approved 30 mg administered intravenously once every three weeks for a period of nine months. Patients will be limited to receiving one dose of patisiran per prescription at their pharmacy.

For renewal of coverage, patients must show continued benefit from treatment with patisiran and must NOT be:
- permanently bedridden and dependent on assistance for basic activities of daily living, NOR
- receiving end-of-life care.
Continued coverage may be approved for 30 mg every three weeks for a period of six months.

Coverage cannot be provided for use in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR."

ABC 60084 (2021/02)

Registration for MS Neurologist Status Form

On the reverse is the official *Registration for MS Neurologist Status Form* (ABC 60002).

- All requests to become a "Registered MS Neurologist" must be submitted using the *Registration for MS Neurologist Status 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®

ALBERTA GOVERNMENT SPONSORED DRUG BENEFIT PROGRAMS

REGISTRATION FOR MS NEUROLOGIST STATUS
for *Alberta Drug Benefit List* Special Authorization Coverage

Eligible MS Disease Modifying Therapies
(e.g., alemtuzumab, dimethyl fumarate, fingolimod hydrochloride, glatiramer acetate, interferon beta-1a, interferon beta-1b, natalizumab, teriflunomide)

Requests for special authorization coverage of eligible MS Disease Modifying Therapies is restricted to those neurologists who have registered with Alberta Blue Cross as an "MS Neurologist". Approval of patient coverage may or may not be granted based on the information provided on the Special Authorization Request Form.

Responsibilities of a registered "MS Neurologist" & including the following:

- Maintain adequate knowledge regarding multiple sclerosis (MS) and its treatment.
- Maintain expertise in treating/managing patients with MS.
- Provide adequate follow-up for their patients. This includes assessment of adverse events including discussion of concerns brought by the patient to the MS Special Therapies Nurse. It also includes assessment of tolerance, effectiveness, indications for continuation (on at least a yearly basis) and completion of the renewal request for continued coverage.

Neurologists who choose not to apply to be a registered "MS Neurologist" may also prescribe MS Disease Modifying Therapies, but patients will not be eligible for coverage under the program for such prescriptions. The patient may choose to receive the product at their own expense.

Please complete all sections of this form and return it by fax to Alberta Blue Cross

Registrations will be accepted on an ongoing basis

NEUROLOGIST LAST NAME	FIRST NAME	INITIAL	OFFICE PHONE	FAX

OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER
OR PROFESSIONAL REGISTRATION NUMBER

I agree to abide by the responsibilities of a registered "MS Neurologist" and submit special authorization requests for eligible MS Disease Modifying Therapies in accordance with policies and criteria as updated from time to time in the Special Authorization section of the *Alberta Drug Benefit List*.

SIGNATURE OF PRESCRIBER (required) ☐ _____ **DATE** _____

The information on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-828-4106

Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form

On the reverse is the official *Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form* (ABC 60021).

- All requests to become a "Registered Prescriber" must be submitted using the *Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  1-877-330-5211 toll-free

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

ALBERTA BLUE CROSS®

APPLICATION FOR REGISTERED PRESCRIBER STATUS for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs

Jetrea

Coverage of Jetrea is restricted to those patients for whom the drug is prescribed by a Registered Prescriber.

- Ophthalmologists with training in the administration of intravitreal injections may apply to be a Registered Prescriber by completing this form. Registration allows for practitioner's patients to receive coverage of Jetrea.
- Ophthalmologists who choose not to apply to be a Registered Prescriber may also prescribe Jetrea but patients will not be eligible for payment under the program for such prescriptions. The patient may choose to receive the product at their own expense.

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	PHONE	FAX

ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER
OR PROFESSIONAL REGISTRATION NUMBER

I have reviewed the criteria for coverage of Jetrea as attached and I agree to abide with these criteria as updated from time to time in the *Alberta Drug Benefit List* for coverage under the program.

SIGNATURE OF PRESCRIBER (required) ✗ _____ **DATE** _____

The information on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-330-5211

ALBERTA BLUE CROSS®

Jetrea
COVERAGE CRITERIA

Coverage may only be considered if the following criteria are met.

Criteria for Coverage

JETREA

For the treatment of symptomatic vitreomacular adhesion (VMA) if the following clinical criteria and conditions are met:

Clinical Criteria
- Diagnosis of VMA should be confirmed through optical coherence tomography.
- Patient does not have any of the following: large diameter macular holes (> 400 micrometre), high myopia (> 8 dioptre spherical correction or axial length > 28 millimetre), aphakia, history of retinal detachment, lens zonule instability, recent ocular surgery or intraocular injection (including laser therapy), proliferative diabetic retinopathy, ischemic retinopathies, retinal vein occlusions, exudative age-related macular degeneration or vitreous hemorrhage.

Conditions
- For coverage, this drug must be prescribed by an ophthalmologist who is registered with Alberta Blue Cross as a Registered Prescriber. To register to become a Registered Prescriber, please complete the Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea form.
- Treatment with ocriplasmin should be limited to a single injection per eye (e.g. retreatments are not covered).

Opioid Agonist Therapy Program Coverage Extension Request form

On the reverse is the official *Opioid Agonist Therapy Program Coverage Extension Request form (ABC 60082).*

- Requests for extension of coverage of the opioid agonist therapy program must be submitted using this form only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  1-877-330-5211 toll-free

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

ALBERTA BLUE CROSS®

OPIOID AGONIST THERAPY PROGRAM
COVERAGE EXTENSION REQUEST

If the patient has applied for a Government-sponsored supplementary health benefit program, they DO NOT need to complete this form.

If the patient has applied for Employer Group coverage or Individual coverage, please complete this form.

Coverage for extension will only be considered if the patient has applied for supplementary health benefits coverage.

Please complete all sections of this form and return it by fax to Alberta Blue Cross.

Patient last name	**First name**	**Initial**	**Birth date (YYYY-MM-DD)**

Street address	**City**	**Province**	**Postal code**

Alberta personal health number

Drug requested: ☐ Suboxone
☐ Methadone liquid

Does the patient currently have drug coverage through another health benefits plan?

☐ Yes
☐ No

If not, has the patient applied for health benefits coverage through any of the following?

☐ Employer Group Coverage
☐ Individual Coverage
☐ Patient has not yet applied for additional coverage
☐ Other: _____

Note: if the patient has not yet applied for any additional coverage, this form is not applicable.

Date of application (YYYY-MM-DD):_____ Coverage start date (YYYY-MM-DD): _____

Extension of OAT is requested by: Last name _____ First name _____

☐ Patient ☐ Care taker ☐ Prescriber
☐ Pharmacist ☐ Social worker ☐ Other _____

Phone number: _____ Fax number: _____

Signature (required): **X** _____ **Date (YYYY-MM-DD):** _____

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PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-330-5211

ABC 60082 (2020/09)

SECTION 2

Price Policy

ADBL - Updated Price Policy
Effective February 11, 2021

PRICE POLICY

DEFINITIONS

In this Price Policy,

Alberta Blue Cross or ABC or Blue Cross means the ABC Benefits Corporation,

Alberta Drug Benefit List, List or ADBL means, unless otherwise indicated, the most recent drug benefit list (including drug benefit listing policies and processes and benefit supplements) published by the Minister from time to time,

Alberta Price Confirmation, APC or Interim APC means an electronic Alberta Price Confirmation process that may be issued by the Minister from time to time and administered by ABC on behalf of the Minister,

APC Terms and Conditions means the terms and conditions outlined in a Non-Fixed Price APC, Fixed Price APC, Pan-Canadian Select Molecule Price Initiative APC, Interim Non-Fixed Price APC or an Interim Fixed Price APC,

Brand Drug means an originator/brand Drug Product listed or under consideration for listing on the ADBL,

Brand Price means the price of the Brand Drug published in the February ADBL in an Established IC Grouping or, if there is more than one originator/brand product in the Established IC Grouping, the Brand Price is the lowest published price of a Brand Drug in the Established IC Grouping,

Claim means a submission for reimbursement to the Plan for a Drug Product,

Confirmed Price means a Confirmed Price in compliance with clauses 3, 4 and 5, and as submitted by the Manufacturer via the Price Confirmation **or as adjusted by the Minister pursuant to clauses 18(d), 23 or 25(b)**,

Device means a product approved by Health Canada as a device and listed or under consideration for listing by the Minister on the ADBL,

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

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

Effective Period means the Effective Period stated in the applicable APC Terms and Conditions,

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

Established IC Grouping means an IC Grouping that was established on or before February 1, 2021 and listed in the February ADBL,

February ADBL means the ADBL published by the Minister on or about February 1, 2021,

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

Fixed Price APC Terms and Conditions means the Terms and Conditions outlined in a Fixed Price APC and includes the Signature Page as defined in such Terms and Conditions,

IC Drug means a Drug Product that is listed, or is under consideration for listing, as interchangeable with one or more Drug Products as determined by the Minister in accordance with the requirements relating to interchangeability in Section 1 of the ADBL,

IC Grouping means a category on the ADBL where there are two or more IC Drugs listed or under consideration for listing as part of one grouping on the ADBL as determined by the Minister,

Interim APC means an Interim Fixed Price APC or an Interim Non-Fixed Price APC,

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

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

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

Interim Non-Fixed Price APC Terms and Conditions means the terms and conditions outlined in an Interim Non-Fixed Price APC,

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 IC Grouping or New IC Grouping for members of a Plan,

MAC Grouping means a grouping of Drug Products that have been listed on the ADBL and are 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,

Manufacturer means an entity that manufactures, sells or distributes a Drug Product,

Market Exit Assessment Form: An assessment form provided through the Pan-Canadian Generic Initiative that identifies a newly established price of a Fixed Price Drug Product that may be adjusted pursuant to the conditions identified in clause 18,

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

Maximum Term means the Maximum Term stated in the applicable APC Terms and Conditions,

Minister means Her Majesty the Queen in right of Alberta, as represented by the Minister of Health,

New IC Grouping means an IC Grouping that was established or may be established after February 1, 2021,

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

Non-Fixed Price APC Terms and Conditions means the Terms and Conditions outlined in a Non-Fixed Price APC and includes the Signature Page as defined in such Terms and Conditions,

Nutritional Product means a product categorized as a caloric agent once listed or under consideration for listing on the ADBL,

Patented Drug Product: Drug Products subject to the Non-Fixed Pricing Rules as well as subject to assessments under the PMPRB Guidelines.

Pan-Canadian Competitive Value Price Initiative for Generic Drugs or Pan-Canadian Generic Initiative is a collaboration of participating Canadian jurisdictions to establish the prices of generic Drug Products in accordance with the Pan-Canadian Generic Value Price Initiative which is established through the Pan-Canadian Generic Initiative Point of Entry process as further described in clause 18,

Pan-Canadian Select Molecule Price Initiative means the price-setting approach established by the Health Care Innovation Working Group of the Council of the Federation to set the price for select generic drug molecules in the Participating Jurisdictions as outlined in Appendix A of the Pan-Canadian Select Molecule Price Initiative Terms and Conditions,

Pan-Canadian Select Molecule Price Initiative Terms and Conditions means the Terms and Conditions outlined in Pan-Canadian Select Molecule Price Initiative APC and includes the Signature Page as defined in such Terms and Conditions,

Participating Jurisdiction has the same meaning as defined in the Pan-Canadian Select Molecule Price Initiative Terms and Conditions,

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

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 applicable APC Terms and Conditions,

Product Listing Agreement or PLA means a product listing agreement that is entered into or may be entered into by the Minister in respect of any Drug Product in accordance with the Minister's Product Listing Agreement Policy, including any Drug Product that is listed or under consideration for listing on the ADBL,

Product Listing Agreement Policy means any product listing agreement policy (including any processes related thereto) that may be published by the Minister from time to time.

ALBERTA PRICE CONFIRMATION (APC) FOR NON-FIXED PRICE, FIXED PRICE AND PAN-CANADIAN SELECT MOLECULE PRICE INITIATIVE DRUG PRODUCTS

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

2. The Manufacturer must ensure that a Price Confirmation and a Confirmed Price submitted by a Manufacturer comply with:

    a. the Price Policy published at the time of an APC or Interim APC;

    b. the applicable APC Terms and Conditions issued for the Price Confirmation;

    c. the Pan-Canadian Generic Initiative, where applicable; and

    d. the Pan-Canadian Select Molecule Price Initiative, where applicable.

3. The Confirmed Price is the price that, if accepted by the Minister, shall be published in the ADBL.

4. 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**, a price as set out in clause 18 of the Price Policy.

    b. **For a Drug Product subject to the Non-Fixed Pricing Rules,** a price that is less than or equal to the Non-Fixed price (per unit of issue) as set out in clause 19 of the Price Policy.

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

    a. is applicable to a Drug Product regardless of the package size for each Drug Product;

    b. must not include the Goods and Services Tax (GST) or any other tax; and must not include any additional fees and/or charges; and

    c. For clarity, notwithstanding clause 5(b), Drug Products that are nutritional products that are subject to provincially mandated container recycling fees in Alberta may include recycling fees within their Confirmed Price.

6. The Minister may extend the duration of the Effective Period for a period, or periods, of time up to and including the last day of the Maximum Term.

7.

    a. The Manufacturer is responsible for ensuring that sufficient supply of a Drug Product is available to the Alberta market prior to the acceptance of an APC, for which a Confirmed Price has been submitted, and is available for the Alberta market at the Confirmed Price for the duration of the Maximum Term.

b. If the Manufacturer anticipates that it may be unable to comply with the provisions of clause 7(a), the Manufacturer must advise Alberta Blue Cross immediately in writing via email to APCINQ@ab.bluecross.ca.

c. Where a Manufacturer is unable to supply a Drug Product after the Drug Product has been listed, the Manufacturer may be required to reimburse Alberta Health the difference in cost of covering a higher priced LCA Drug Product, the Brand Price or providing a temporary benefit, as described in the Supply Shortages policy in Section 1 of the ADBL, when one or more of the following criterion are met:

   i. Manufacturers of Entry IC Drug Product(s) or Non-Fixed Price Drug Product(s) under consideration for listing that have confirmed ability to supply the Alberta market through the following mechanisms:

      1. Letter confirming ability to supply the Alberta market as per the ADBL Submission Requirements located in Section 1 of the ADBL,

      2. Signing and returning the applicable Alberta Price Confirmation Signature Page, and

      3 The Minister has received confirmation that the Manufacturer's Pan-Canadian Generic Initiative price confirmation form has been accepted and the applicable tier has been established by the Pan-Canadian Generic Initiative.

   ii. Manufacturers of Drug Product(s) listed in a New IC or Established IC Grouping or currently listed Non-Fixed Drug Product(s) that have been confirmed as unable to supply by Alberta Blue Cross for at least six months.

d. Manufacturers of Drug Product(s) listed on the ADBL that fall under either clause 7(c)(i) or 7(c)(ii) will be granted the opportunity to provide rationale and documentation that the supply shortage of their Drug Product(s) was due to extraordinary events beyond the Manufacturers control. Based on the information provided, the Minister will consider whether reimbursement by the Manufacturer in accordance with clause 7(c) is required.

8. The Minister may consider a Confirmed Price and may accept none, one or more Confirmed Prices (with or without any request for an exception to the Fixed Pricing and Non-Fixed Pricing Rules (as applicable)) submitted in one or more Price Confirmations.

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

   a. an LCA Price,

   b. a MAC Price, or

   c. a special or exceptional price.

10. When considering a Confirmed Price for acceptance, and in determining whether to establish an LCA Price, a MAC Price, or a special or exceptional price, the Minister may consider any factor or criteria outlined in the ADBL, any matter permitted by the *Drug Program Act*, any matter arising from the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative, or any matter that the Minister determines is in the public interest.

INTERIM APC

11. Notwithstanding the acceptance of a Confirmed Price by the Minister, in the event that:

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

    b. a Drug Product is being considered by the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative;

    c. a Manufacturer submits a price reduction in accordance with clause 26 of this Price Policy;

    d. a Manufacturer transfers the authority to market a Drug Product to another Manufacturer;

    e. a Manufacturer is required to adjust their Confirmed Price to comply with the Patented Medicine Prices Review Board (PMPRB) Guidelines[1]

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

    the Minister may issue an Interim APC for one or more Drug Products, or one or more groupings of Drug Products.

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

    a. is equal to or less than the price as outlined in the Drug Product submission, and

    b. does not exceed the prices permitted under this Price Policy,

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

13. When a Pan-Canadian Select Molecule Price Initiative APC or Interim Fixed Price APC are issued, all Manufacturers who have a Fixed Price Drug Product listed in the affected Established IC Grouping, New IC Grouping or MAC Grouping will be required to submit a new Price Confirmation and Confirmed Price for the affected Fixed Price Drug Product in accordance with the Pan-Canadian Generic Initiative and the Pan-Canadian Select Molecule Price Initiative and the Fixed Pricing Rules as per clause 18 of this Price Policy. In the event that a new Confirmed Price for an affected Fixed Price Drug Product is not submitted or if the Confirmed Price for the affected Fixed Price Drug Product is greater than the price prescribed through the Pan-Canadian Generic Initiative, Pan-Canadian Select Molecule Price Initiative or the Fixed Pricing Rules then the affected Fixed Price Drug Product will be delisted.

[1] PMPRB Guidelines can be found at: https://www.canada.ca/en/patented-medicine-prices-review/services/legislation/about-guidelines/guidelines.html

Canadian Select Molecule Price Initiative or the Fixed Pricing Rules then the affected Fixed Price Drug Product will be delisted.

14. In the event the Minister issues an Interim APC, and one or more Confirmed Prices are accepted as a result of the Interim APC, the applicable APC Terms and Conditions supersede 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.

16. Unless permitted in this Price Policy or by the Minister, a Confirmed Price may not exceed a Confirmed Price for a Drug Product that has been submitted and approved by the Minister through a prior APC relating to such Drug Product.

17. The provisions in this Price Policy that apply to an APC also apply to an Interim APC, and where the term APC is used in such clauses, it shall be deemed to read Interim APC in the case of an Interim APC.

FIXED PRICING RULES

18. The Fixed Pricing Rules apply to any Drug Product, other than a Brand Drug, that is listed or under consideration for listing on the ADBL.

    a. During an APC or Interim Fixed Price APC, for a Fixed Price Drug Product listed or under consideration for listing that is not subject to the Pan-Canadian Select Molecule Price Initiative, it is the Manufacturer's responsibility to submit a Confirmed Price that is less than or equal to the LCA price of the most recently published ADBL, the price established through the Pan-Canadian Generic Initiative, or the price published in the February ADBL, whichever is lower.

    b. Where the Pan-Canadian Generic Initiative issues a Market Exit Assessment Form Manufacturers who have Drug Products that are in the same IC Grouping as the Drug Product identified in a Market Exit Assessment Form will receive a single opportunity to adjust the affected Drug Product's Confirmed Price to be equal to or less than the maximum price established through the Pan-Canadian Generic Initiative during an APC or Interim Fixed Price APC. Manufacturers are not required to adjust their current prices if current prices are equal or lower than the price identified on the Market Exit Assessment Form.

    c. During an APC or Interim Fixed Price APC, Manufacturers submitting a Confirmed Price for an IC Drug product subject to the Pan-Canadian Select Molecule Price Initiative must submit a price equal to the price established by the Pan-Canadian Select Molecule Price Initiative.

    d. **The Minister may decrease the price of a Fixed Price Drug Product(s) when a lower price than what is currently listed on the ADBL has been established through the Pan-Canadian Generic Initiative with or without issuing an APC or Interim APC and regardless of whether an Entry IC Drug is being added to the IC Grouping. Such price shall become the Confirmed Price.** If a Manufacturer does not agree with this rule they should not submit a Confirmed Price to an APC or initial Interim APC. Manufacturers who decline to submit a Confirmed Price through the APC or an initial Interim APC of the Effective Period for the affected Drug Products may not be listed on the ADBL.

For the purpose of this clause, the "initial Interim APC" refers to the first interim APC in which an Entry IC Drug submits pricing in accordance with the Alberta Price Policy.

e. The Minister may defer the listing of an Entry IC Drug Product if a price has not been received by the Pan-Canadian Generic Initiative.[2]

f. The Minister may request written evidence from the Pan-Canadian Generic Initiative that the price has been submitted and accepted in accordance with the Pan-Canadian Generic Value Price Initiative Point of Entry process.

Additional information regarding the Pan-Canadian Generic Initiative and the Pan-Canadian Select Molecule Price Initiative may be found at:

https://www.pcpacanada.ca/generic-drug-framework Questions regarding the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative can be directed to:

PCPAGenericsOffice@ontario.ca

NON-FIXED PRICING RULES

19. The Non-Fixed Pricing Rules apply to Brand Drugs.

a. The Confirmed Price must be:

i. less than or equal to the previous price of that Drug Product listed on the February ADBL, or

ii. the submitted price where that Drug Product was not previously listed on the ADBL, or

iii. the previous price of the Drug Product listed on the February ADBL, plus an increase that is less than or equal to the current PMPRB CPI-Based Price-Adjustment Factors[3]. Notwithstanding CPI price adjustment, the maximum allowable price increase for a Non-Fixed Price Drug product shall not exceed 5 per cent above the price in the February ADBL.

1. The Confirmed Price must be less than or equal to 3 per cent higher than it was February 2021 AND must be less than or equal to 5 per cent higher than it was on the December 31, 2018 ADBL.

[2] In order to issue a Fixed Price APC Alberta Blue Cross and Alberta Health must receive a completed and approved manufacturers' Tiered Pricing Confirmation Form which establishes the appropriate price and tier from the Pan-Canadian Generic Initiative **at least two business days** prior to Alberta Blue Cross issuing a Fixed Price APC.

[3] https://www.canada.ca/en/patented-medicine-prices-review/services/are-you-patentee/cpi-adjustment-factors/2021-cpi-adjustment-factors.html

2. Manufacturers requesting a price increase must review the published price their Drug Product was listed at on the December 2018 ADBL, the published price their Drug Product was listed at on the 2021 February ADBL; and the PMPRB Guidelines for allowable CPI increases for 2021. If the Non-Fixed Priced Drug Product was not listed on the December 2018 ADBL, the Manufacturer will be required to determine the applicable PMPRB Guidelines CPI and the appropriate publication of the ADBL to determine allowable price increases for April 1, 2021.

b. For Patented Drug Products, notwithstanding clause 19 (a), a Manufacturer of a Patented Drug Product shall notify Alberta Blue Cross immediately in writing via email to APCINQ@ab.bluecross.ca once a list price has been assessed and in effect for their Patented Drug Product through the PMPRB Guidelines process. Upon providing notification of this new price, the Confirmed Price must be less than or equal to the price established through the PMPRB Guidelines process for that Patented Drug Product.

c. The Confirmed Price in respect of a Drug Product may only increase from the price most recently published in an ADBL once per 12-month period for the APC, which shall be effective on or about April 1, 2021. Price increases will only be considered if a Manufacturer has entered into the Non-Fixed Price APC Terms and Conditions.

d. The Minister may provide the PMPRB with Confirmed Prices submitted through the APC to determine compliance with the PMPRB Guidelines.

EXCEPTIONS

20. Notwithstanding the Fixed Pricing Rules and the Non-Fixed Pricing Rules, a Manufacturer may request the Minister consider an exception to the Fixed Pricing Rules or the Non-Fixed Pricing Rules.

21. Notwithstanding anything else in this Price Policy, exception requests for Drug Products that are subject to either the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative, both of which fall under the Fixed Pricing Rules, will not be considered.

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

a. for Drug Products with less than 250 Claims or an annual net cost of less than $50,000 for Plans, as calculated by the Minister and based on Claims experience information provided by Alberta Blue Cross relating to Plans, for the period of time that the Drug Product was listed on the ADBL in the previous 12 months;

b. where the manufacturing and distribution costs for a Drug Product exceed the maximum price for such Drug Product permitted by the Fixed Pricing Rules or the Non-Fixed Pricing Rules, as applicable:

i. The Manufacturer must provide detailed written evidence of the following:

1. The costs for each raw material separately, including that of the active pharmaceutical ingredient,

2. The cost of manufacturing (excluding costs of raw materials),

3. Cost of distribution (including direct distribution fees paid to distributors but excluding all rebates and/or professional allowances), and

4. Other costs, as applicable.

ii. All costs must be stated per unit of issue;

or,

c. where exceptional circumstances exist.

i. 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 Product was not available on the ADBL. The Manufacturer must provide detailed written evidence outlining the exceptional circumstance;

ii. Exceptional circumstances do not include aligning with formulary pricing in other jurisdictions or to align with any PMPRB Guidelines other than the application described within the Alberta Price Policy.

23. Where an exception is requested, the maximum price increase which will be granted by the Minister is 5 per cent above the February ADBL price for that Drug Product. **Manufacturers who are granted an exception, but have requested a price increase above 5 per cent will be listed at 5 per cent above the price listed on the February ADBL. Such price shall become the Confirmed Price.** For clarity, for Non-Fixed Price Drug Products the maximum 5 per cent price increase is inclusive of any PMPRB increase as per clause 19.

24. The Minister reserves the right to defer consideration of the exception and request such additional evidence and information in support of such request as the Minister deems appropriate.

25. a. If an exception is requested for a Drug Product in an APC, but is not approved by the Minister, the Manufacturer will not be given another opportunity to submit a new Confirmed Price in respect of such Drug Product, unless:

i. the Minister determines it is advisable to do so; or

ii. the Manufacturer follows the applicable Resubmission process referred to in Section 1 of the ADBL.

b. Notwithstanding clause 25(a), if an exception request for a Drug Product is not approved by the Minister, the Minister may continue to list a Drug Product that was listed on the ADBL at the time the exception request was made in accordance with the following rules:

i. Drug Products subject to the Fixed Pricing Rules will continue to be listed at the previous price of the Drug Product listed on the February ADBL. Such price shall become the Confirmed Price; and

ii. Drug Products subject to the Non-Fixed Pricing Rules will continue to be listed at the previous price of the Drug Product listed on the February ADBL, plus an increase that is equal to the current allowable PMPRB CPI-Based Price-Adjustment Factors, up to a maximum of 5 per cent. Such price shall become the Confirmed Price.

PRICE REDUCTIONS

26. During an Effective Period, further price reduction requests for Drug Products listed on the ADBL will be considered as follows:

    i. For Drug Products listed in an Established IC Grouping or MAC Grouping the proposed price reduction must be at least 5 per cent less than the LCA price or MAC Price published at the time Alberta Blue Cross receives the proposed price reduction.

    ii. For all other Non-Fixed Price Drug Products, by notifying the Minister by sending a written notice to Alberta Blue Cross.

    iii. Price reductions will not be considered for IC Drug Products subject to the Pan-Canadian Select Molecule Price Initiative.

    If accepted by the Minister, the Minister will issue an Interim APC for the Manufacturer to provide the reduced Confirmed Price. Establishment of a new LCA Price or MAC Price and publication of a reduced price is the Minister's sole discretion.

MINISTER'S AUTHORITY

27. Notwithstanding any other provision in this Price Policy, where one or more of the following occurs:

    a. no Price Confirmation or Confirmed Price is submitted in respect of a Drug Product;

    b. there is a failure to issue an APC, or submit a Price Confirmation or Confirmed Price(s) in respect of a Drug Product in accordance with the applicable APC Terms and Conditions;

    c. there is a rejection or non-acceptance of all or part of an APC, Price Confirmation or Confirmed Price(s), or of a request for an exception to either the Fixed Pricing Rules or Non-Fixed Pricing Rules;

    d. a Price Confirmation or a Confirmed Price of an IC Drug in an APC or an Interim APC is lower than the Confirmed price or the Price Confirmation of any other IC Drug Products in an IC Grouping;

    e. there is a failure by the Manufacturer to comply with the ADBL Price Policy, the applicable APC Terms and Conditions and/or the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative in respect of a Drug Product listed or under consideration for listing on the ADBL;

    f. the Minister considers that a PLA that is satisfactory to the Minister must be entered into prior to and/or as a condition of the listing, or continued listing, of a Drug Product on the ADBL;

    the Minister may do any one or more of the following:

    i. cancel the listing of,

    ii. modify the listing of,

    iii. refuse to add to the ADBL,

iv. refuse to expedite the submission of,

v. cancel or modify the benefit payable for,

vi. modify or impose rules, terms, restrictions or conditions (including the execution of a PLA satisfactory to the Minister) relating to, or

vii. request reimbursement from a Manufacturer where the Minister has paid or reimbursed a claim for a Drug Product that exceeds the Confirmed Price of the Drug Product as a result of the Manufacturer's failure to comply with an APC and the ADBL Price Policy and on such repayment terms as may be determined by the Minister.

viii. take any other action the Minister considers appropriate

in relation to the affected Drug Product for any period of time as deemed appropriate by the Minister.

28. Notwithstanding any other provision in this Price Policy, the Minister has and retains the sole right to determine all matters relating to the listing or continued listing of a Drug Product on the ADBL, including (without limitation) the sole right to:

a. determine whether or not the Fixed Pricing Rules, the Non-Fixed Pricing Rules, the Pan-Canadian Generic Initiative, the Pan-Canadian Select Molecule Price Initiative, or any other rules apply to a Drug Product,

b. determine whether or not a Drug Product is to be considered a Brand Drug for purposes of this Price Policy and an APC,

c. determine whether or not to extend the Effective Period of an APC pursuant to clause 6,

d. determine whether or not a PLA must be executed as a condition of the listing or continued listing of a Drug Product on the ADBL,

e. make any decisions or take any steps to amend a published price, an LCA Price, a MAC Price, a special or exceptional price, the Price Policy, the Product Listing Agreement or Product Listing Agreement Policy, the ADBL or make any other adjustments the Minister considers advisable,

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

g. pursue, negotiate and enter into agreements with one or more Manufacturers, distributors or vendors, including (without limitation) a PLA or other contractual agreement,

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

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

j. terminate an APC, a Price Confirmation, or all or part of a Price Confirmation, or one or more Confirmed Prices, or the listing of any or all Drug Products on the ADBL, upon 10 days written notice to any 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 ADBL website operated by Alberta Blue Cross, or (b) by sending the notice via fax to the last known fax number of the Manufacturer, and the method of notice is at the Minister's discretion,

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

29.

a. For further clarity, in all cases where the execution of a PLA in respect of a Drug Product is required as a condition of the listing or continued listing of a Drug Product on the ADBL, the provisions of the Product Listing Agreement or Product Listing Agreement Policy must be satisfied. Nothing in this Price Policy is intended to limit or override the application or any provisions of the Product Listing Agreement Policy. The requirements for listing or continued listing of a Drug Product outlined in the ADBL, including (without limitation) this Price Policy, as well as the Product Listing Agreement or Product Listing Agreement Policy must be satisfied.

b. For clarity, where a PLA is terminated, the listing of any Drug Product subject to that PLA on the ADBL may be terminated in the manner set out in clause 28(j) at the Minister's discretion.

30. Subject to clause 28(e), where the Minister amends the Price Policy during an Effective Period, the Minister shall provide Manufacturers of Drug Products listed on the ADBL as at that date with 30 days' notice of such amendment, and the Minister may also issue an Interim APC in relation to any Drug Product affected by such amendment.

31. The Minister reserves the right to pursue any remedies available to the Minister in the event of any non-compliance with, or any breach of, the Price Policy, or any applicable APC Terms and Conditions.

32.

a. The Minister, Alberta Blue Cross, and their respective officers, employees, and agents, 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, an Interim APC, any Price Confirmation, a Confirmed Price, the Pan-Canadian Generic Initiative, the Pan-Canadian Select Molecule Price Initiative, or the ADBL, 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, Alberta Blue Cross, and their respective officers, employees, and agents, for damages related to an APC, an Interim APC, a Price Confirmation, a Confirmed Price, the Pan-Canadian Generic Initiative, the Pan-Canadian Select Molecule Price Initiative, or the ADBL be greater than $25,000, or the Manufacturer's actual costs of preparing and submitting a Price Confirmation in response to an APC, whichever is less.

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 a LCA Price in Established and New IC Groupings the LCA Price:

   a. is the lowest unit per issue 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 ADBL.

   c. applies to all Drug Products in the applicable IC Grouping, unless the Minister determines that an exception should be made.

3. Notwithstanding clause 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.

4. Subject to a Special Authorization being granted pursuant to clause 5 below, 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).

5. 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 clause of the ADBL.

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 on the ADBL 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, the MAC Price appears in ***bold italic*** type and is displayed in the ADBL 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.

4. The MAC Price Policy applies to the following MAC Groupings:

   - PTC 24:06.08

     Antilipemic Agents (HMG-COA Reductase Inhibitors)

   - PTC 24:28.08

     Calcium-Channel Blocking Agents (Dihydropyridines)

   - PTC 24:32.04
     Renin-Angiotensin-Aldosterone System Inhibitors
     (Angiotensin-Converting Enzyme Inhibitors)

   - 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
     Potassium Chloride (K+) 20 mEq Oral Tablet / Sustained-Release Tablets Potassium Chloride (K+)(CL-) 1.33 mEq / ml Oral Liquid

   - PTC 56:28:36

     Antiulcer Agents and Acid Suppressants (proton-pump inhibitors)

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 clause of the ADBL.

Transitional Period Price Policy

1. With the exception of IC Drug Products affected by the Pan-Canadian Select Molecule Price Initiative, the Minister may establish a transitional period of up to 30 days to provide a temporary benefit or payment for a Drug Product in accordance with the following:

    a. If a new IC Drug is added to the List which results in the establishment of a New IC Grouping, the Minister may temporarily pay the cost of the Brand Drug in that New IC Grouping for up to 30 days from the date the new IC Drug is listed;

    b. If a new IC Drug is added to the List in an Established IC Grouping at a lower price than the LCA Price , the Minister may temporarily pay the cost of the Drug Product that was the LCA Price prior to the addition of the new IC Drug for up to 30 days from the date the new IC Drug is listed;

    c. If a Drug Product is discontinued or removed from the ADBL, the Minister may continue the affected Drug Product as a temporary benefit for up to 30 days from the date of the notice that the Drug Product is discontinued, or the date the listing was cancelled;

    d. Where the Transitional Period Price Policy is implemented because of a supply shortage, and an alternate Drug Product is added to temporarily replace the Drug Product in short supply:

        i. If the supply shortage is rectified in 30 days or less, no transitional period applies to the alternate Drug Product;

        ii. If the supply shortage is rectified in more than 30 days, the alternate Drug Product added and reimbursed under the Supply Shortages policy may continue to be reimbursed for up to 30 days after the supply shortage is rectified.

2. The Minister may make adjustments to the application of the Transitional Period Price Policy as required.

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-sponsored drug programs. (For Alberta Human Services clients, the special authorization criteria for coverage can be found in the Criteria for Special Authorization of Select Drug Products section of the *Alberta Human Services 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 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 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 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.

Criteria for Coverage

Wording that appears within quotation marks (" ") in this section is the official special authorization criteria, as recommended by the Alberta Health Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health. 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
75 MG	**ORAL TABLET**
DIN N/A*	CYLERT

**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).

'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

ABATACEPT

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).

125 MG / SYR INJECTION

00002402475	ORENCIA	BMS	$	373.7875

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

ABATACEPT

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.

ABATACEPT

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

ACAMPROSATE CALCIUM

"For the treatment of alcohol use disorder in patients who have been abstinent for at least four days and as a component of an alcohol counseling program.

Initial approval period: 6 months

Renewal may be considered for an additional 6 months.

Continued coverage requests beyond 12 months may be considered on a case by case basis."

333 MG (BASE)	ORAL	DELAYED-RELEASE TABLET		
00002293269	CAMPRAL	MYP	$	0.8250

ACLIDINIUM BROMIDE/ FORMOTEROL FUMARATE DIHYDRATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for aclidinium bromide + formoterol fumarate dihydrate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

400 MCG / DOSE * 12 MCG / DOSE		**INHALATION**	**METERED INHALATION POWDER**		
00002439530	DUAKLIR GENUAIR		AZC	$	1.0000

ADALIMUMAB

20 MG / SYR INJECTION SYRINGE

00002474263	HUMIRA (20 MG/0.2 ML INJ SYR)	ABV	$	392.7250

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- Coverage may be approved for 24 mg per square meter body surface area (maximum dose 40 mg) every other week for 12 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 (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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 in each request.

Following this assessment, continued coverage may be approved for 24 mg per square meter body surface area (maximum dose 40 mg) every other week, 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for adalimumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

ADALIMUMAB

40 MG / SYR INJECTION SYRINGE

00002258595	HUMIRA (40 MG/0.8 ML INJ SYR)	ABV	$	785.4500

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:
1) The patient must be assessed at 12 weeks 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 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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Hidradenitis Suppurativa

"Special authorization may be provided for the treatment of adult patients with active moderate to severe Hidradenitis Suppurativa who meet all of the following criteria:

- A total abscess and nodule (AN) count of 3 or greater.
- Lesions in at least two distinct anatomical areas, one of which must be Hurley Stage II or III.
- An inadequate response to a 90-day trial of systemic antibiotics AND documented non response to conventional therapy.
For coverage, this drug must be initiated by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved for 12 weeks as follows: an initial dose of 160 mg, followed by one 80 mg dose two weeks later, then 40 mg every week beginning four weeks after the initial

ADALIMUMAB

dose, for a total of eleven doses.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- 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 the initial approval period the patient must meet the following criteria:

1) The patient must be assessed by a Dermatology Specialist after 12 weeks of treatment 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 50% reduction in AN count from pre-treatment baseline AND
- no increase in abscess count or draining fistula count relative to pre-treatment baseline.

Note: Treatment with adalimumab should be discontinued if there is insufficient improvement after 12 weeks of treatment.

Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every week for an additional 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 Hidradenitis Suppurativa must be completed using the Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form (ABC 60058).

Moderately to Severe 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 40mg/day,

ADALIMUMAB

tapering by 5 mg each week to 20 mg then tapering by 2.5mg 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]

AND
b) Immunosuppressive therapy as follows:
-Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
-6-mercaptopurine: minimum of 1mg/kg/day for a minimum of 3 months; OR
-Methotrexate: minimum of 15mg/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, 40mg 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 Disease.

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
-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:

ADALIMUMAB

-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 Disease; 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/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Special Authorization Request Form (ABC 60031).

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 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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

ADALIMUMAB

All requests (including renewal requests) for adalimumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- Coverage may be approved for 24 mg per square meter body surface area (maximum dose 40 mg) every other week for 12 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 (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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 in each request.

Following this assessment, continued coverage may be approved for 24 mg per square meter body surface area (maximum dose 40 mg) every other week, 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for adalimumab for Polyarticular Juvenile Idiopathic

ADALIMUMAB

Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 Humira 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, treatment with this biologic agent 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 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; and
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/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("RA Specialist").

-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 5 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:
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

ADALIMUMAB

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

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug 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 ('Specialist').

Initial coverage may be approved for an initial dose of 160 mg, followed by an 80 mg dose at week 2, then one 40 mg dose at weeks 4, 6 and 8. As an interim measure, an additional 40 mg dose of adalimumab will be provided at week 10 to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below, for a total of six 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 which it is being prescribed.

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 8 and 12 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 40 mg every 2 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 a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of adalimumab therapy."

All requests (including renewal requests) for adalimumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

ALEMTUZUMAB

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the treatment of highly active relapsing remitting multiple sclerosis (RRMS) to reduce the frequency of clinical relapses, 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 are refractory or intolerant to at least TWO of the following disease modifying therapies (DMTs):

- dimethyl fumarate
- fingolimod
- glatiramer acetate
- interferon beta
- natalizumab
- ocrelizumab
- peginterferon beta
- teriflunomide

Definition of 'intolerant'
Demonstrating serious adverse effects or contraindications to treatments as defined in the product monograph, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of MS disease modifying therapy (DMT).

Definition of 'refractory'
-Development of neutralizing antibodies to interferon beta.
-When the above MS DMTs are taken at the recommended doses for a full and adequate course of treatment, within a consecutive 12-month period while the patient was on the MS DMT, the patient has:

1) Been adherent to the MS DMT (greater than 80% of approved doses have been administered);
2) Experienced at least two relapses* of MS confirmed by the presence of neurologic deficits on examination.
i. The first qualifying clinical relapse must have begun at least one month after treatment initiation.
ii. Both qualifying relapses must be classified with a relapse severity of moderate, severe or very severe**.

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

**Relapse severity: with moderate relapses modification or more time is required to carry out activities of daily living; with severe relapses there is inability to carry out some activities of daily living; with very severe relapses activities of daily living must be completed by others.

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist.
To register to become an MS Neurologist, please complete the Registration for MS Neurologist Status Form (ABC 60002).

Coverage may be considered only if the following criteria are met:
1) The registered MS Neurologist must confirm a diagnosis of RRMS;
2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS DMT. In most cases this will be satisfied by the 'refractory' to treatment criterion but if a patient failed an MS DMT more than one

ALEMTUZUMAB

year earlier, ongoing active disease must be confirmed.
3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 5).
Coverage will not be approved when any MS DMT or other immunosuppressive therapy is to be used in combination with alemtuzumab.

Coverage of alemtuzumab will not be approved if the patient was deemed to be refractory to alemtuzumab in the past.

Following assessment of the request, alemtuzumab may be approved for coverage at a dose of 12 mg/day administered by intravenous (IV) infusion for 2 treatment courses:
- Initial Treatment Course: 12 mg/day for 5 consecutive days (60 mg total dose)
- Second Treatment Course: 12 mg/day for 3 consecutive days (36 mg total dose) administered 12 months after the initial treatment course.

Patients will be limited to receiving one treatment course (60 mg or 36 mg) of alemtuzumab per prescription at their pharmacy.

Coverage is limited to two treatment courses (i.e., eight doses)."

All requests for alemtuzumab must be completed using the Alemtuzumab For Multiple Sclerosis Special Authorization Request Form (ABC 60079).

12 MG / VIAL INJECTION			
00002418320	LEMTRADA	GZM	$ 13031.1100

ALENDRONATE SODIUM

Osteoporosis:

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

All requests for alendronate sodium for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form (ABC 60043).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

Paget's Disease:

"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."

10 MG ORAL TABLET

00002381486	**ALENDRONATE SODIUM**	**AHI**	$	**0.4986**
00002388545	**AURO-ALENDRONATE**	**AUR**	$	**0.4986**

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"

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

10 MG ORAL SUSTAINED-RELEASE TABLET

00002447576	**ALFUZOSIN**	**SIV**	$	**0.2601**
00002315866	**APO-ALFUZOSIN**	**APX**	$	**0.2601**
00002443201	**AURO-ALFUZOSIN**	**AUR**	$	**0.2601**
00002304678	**SANDOZ ALFUZOSIN**	**SDZ**	$	**0.2601**
00002245565	XATRAL	SAV	$	1.0404

ALIROCUMAB

"Special authorization coverage may be provided for the reduction of Low Density Lipoprotein Cholesterol (LDL-C) if the following clinical criteria and conditions are met:

I) Patient has a definite or probable diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) using the Simon Broome or Dutch Lipid Network criteria or genetic testing

AND

II) Patient is unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention) despite:

a) Confirmed adherence to high dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for at least 3 months.

OR

b) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is unable to tolerate high dose statin, defined as meeting all of the following:
i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose,
AND
ii) For each statin (two statins in total), dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality (creatine kinase (CK) > 5 times the upper limit of normal) resolution rather than discontinuation of statin altogether,
AND
iii) For each statin (two statins in total), intolerable symptoms (myopathy) or abnormal biomarkers (CK > 5 times the upper limit of normal) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate,
AND
iv) One of either:
- Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out,
OR
- Patient developed confirmed and documented rhabdomyolysis.

OR

c) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is statin contraindicated, i.e., active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal.

Initial coverage may be approved for either 75 mg once every two weeks or 300 mg once every 4 weeks for a period of 12 weeks.

- Patients prescribed alirocumab 300 mg once every 4 weeks must use the 150 mg/dose formulation.
- Patients will be limited to receiving a 4 week supply of alirocumab per prescription at their pharmacy.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
- Patient is adherent to therapy.
- Patient has achieved a reduction in LDL-C of at least 40% from baseline (4-8 weeks after initiation of alirocumab).

Continued coverage may be approved for either 75 mg once every 2 weeks or 300 mg once every 4 weeks for a period 12 months. The dosage may be adjusted to the maximum dosage of 150 mg administered every 2 weeks, depending on patient response.
- Patients are limited to 26 syringes/pens per year.

ALIROCUMAB

Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
- Patient is adherent to therapy.
- Patient continues to have a significant reduction in LDL-C (with continuation of alirocumab) of at least 40% from baseline since initiation of PCSK9 inhibitor. LDL-C should be checked periodically with continued treatment with PCSK9 inhibitors (e.g., every 6 months)."

All requests (including renewal requests) for alirocumab for Heterozygous Familial Hypercholesterolemia must be completed using the Alirocumab/Evolocumab for HeFH Special Authorization Request Form (ABC 60060).

75 MG / ML INJECTION				
00002453819	PRALUENT	SAV	$	256.2100
150 MG / ML INJECTION				
00002453835	PRALUENT	SAV	$	256.2100

ALMOTRIPTAN MALATE

(Refer to 28:32.28 of the Alberta 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				
00002398435	MYLAN-ALMOTRIPTAN	MYP	$	7.0433
12.5 MG (BASE) ORAL TABLET				
00002466821	**ALMOTRIPTAN**	**SNS**	$	**2.3478**
00002398443	**MYLAN-ALMOTRIPTAN**	**MYP**	$	**2.3478**
00002405334	**SANDOZ ALMOTRIPTAN**	**SDZ**	$	**2.3478**
00002434849	**TEVA-ALMOTRIPTAN**	**TEV**	$	**2.3478**

AMPICILLIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of infections caused by susceptible Shigella and Salmonella."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

250 MG ORAL CAPSULE				
00000020877	NOVO-AMPICILLIN	TEV	$	0.4434
500 MG ORAL CAPSULE				
00000020885	NOVO-AMPICILLIN	TEV	$	0.8406

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 ("RA Specialist").

- 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;
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.

ANAKINRA

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

100 MG / SYR	**INJECTION**	**SYRINGE**			
00002245913	KINERET		BVM	$	52.1849

APIXABAN
AT RISK PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage Criteria

"Subject to the Exclusions From Coverage noted below, Members of Alberta Government Sponsored Drug Plans who are At-Risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following at least a two month trial of warfarin; OR
- Anticoagulation using warfarin is contraindicated or not possible due to inability to regularly monitor the patient via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, or at home).

Exclusions from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <25 mL/min),
- Patients who are greater than or equal to 75 years of age and who do not have Documented Stable Renal Function,
- Patients who have hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis, or,
- Patients who have a prosthetic heart valve.

Definitions:
- "At-Risk" means patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Prescribers may consider an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.
- "Inadequate Anticoagulation" is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- "Documented Stable Renal Function" is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months

Notes:
- The usual recommended dose for the Drug Products is 5mg twice daily. A reduced dose of 2.5mg twice daily is recommended for patients with at least two (2) of the following three (3) characteristics:
- an age that is equal to or greater than 80 years
- a body weight that is equal to or lower than 60kg, and
- serum creatinine that is equal to or greater than 133 micromole/litre.
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Products monograph).
- Patients starting on the Drug Products should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Products provide adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so the Drug Products are not recommended in these populations.

Special Authorization may be granted for up to 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

APIXABAN

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

PROPHYLAXIS OF VENOUS THROMBOEMBOLISM

SPECIAL AUTHORIZATION

Coverage Criteria:

"For the prophylaxis of venous thromboembolism ("VTE") following elective total hip replacement surgery or elective total knee replacement surgery, where the initial post-operative doses are administered in an acute care (hospital) setting.

OTHER CRITERIA:

The dosage shall be 2.5mg twice daily.

DURATION OF COVERAGE:

Up to a total of 35 days of coverage following elective total hip replacement; or,
Up to a total of 14 days of coverage following elective total knee replacement.

Notes:

- The total duration of therapy includes the period during which doses are administered post-operatively in an acute care (hospital) setting, and the approval period is for the balance of the total duration after discharge.
- The first dose is typically administered 12 to 24 hours after surgery, assuming adequate hemostasis has been achieved.
- Due to the lack of evidence for the efficacy or safety of sequential use of a low molecular weight heparin followed by the Drug Products for the prophylaxis of VTE, coverage is not intended for this practice.
- Clinical judgment is warranted to assess the increased risk for VTE and/or adverse effects in patients with a history of previous VTE, myocardial infarction, transient ischemic attack or ischemic stroke; a history of intraocular or intracerebral bleeding; a history of gastrointestinal disease with gastrointestinal bleeding; moderate or severe renal insufficiency (estimated creatinine clearance < 30mL/min); severe liver disease; concurrent use of other anticoagulants; or age greater than 75 years.
- The Drug Products have not been studied in clinical trials in patients undergoing hip fracture surgery, and is not recommended in these patients."

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

The recommended dose of apixaban for patients initiating DVT or PE treatment is 10 mg twice daily for 7 days, followed by 5 mg taken orally twice daily.

Drug plan coverage for apixaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, apixaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for apixaban must be completed using the

APIXABAN

Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

2.5 MG ORAL TABLET

00002377233	ELIQUIS	BMS	$	1.6336

APIXABAN
AT RISK PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage Criteria

"Subject to the Exclusions From Coverage noted below, Members of Alberta Government Sponsored Drug Plans who are At-Risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following at least a two month trial of warfarin; OR
- Anticoagulation using warfarin is contraindicated or not possible due to inability to regularly monitor the patient via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, or at home).

Exclusions from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <25 mL/min),
- Patients who are greater than or equal to 75 years of age and who do not have Documented Stable Renal Function,
- Patients who have hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis, or,
- Patients who have a prosthetic heart valve.

Definitions:
- "At-Risk" means patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Prescribers may consider an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.
- "Inadequate Anticoagulation" is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- "Documented Stable Renal Function" is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months

Notes:
- The usual recommended dose for the Drug Products is 5mg twice daily. A reduced dose of 2.5mg twice daily is recommended for patients with at least two (2) of the following three (3) characteristics:
- an age that is equal to or greater than 80 years
- a body weight that is equal to or lower than 60kg, and
- serum creatinine that is equal to or greater than 133 micromole/litre.
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Products monograph).
- Patients starting on the Drug Products should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Products provide adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so the Drug Products are not recommended in these populations.

Special Authorization may be granted for up to 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

APIXABAN

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

The recommended dose of apixaban for patients initiating DVT or PE treatment is 10 mg twice daily for 7 days, followed by 5 mg taken orally twice daily.

Drug plan coverage for apixaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, apixaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for apixaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

5 MG ORAL TABLET

00002397714	ELIQUIS	BMS	$	1.6336

APOMORPHINE HCL

"For adjunctive therapy in patients with advanced Parkinson's Disease (PD) who are receiving optimized PD therapy (including levodopa and derivatives AND dopaminergic agonists) for the acute, intermittent treatment of hypomobility "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes)."

For coverage, this drug must be initiated in consultation with a Neurologist.

Special authorization may be granted for 6 months.

For renewals, patients must continue to demonstrate clinically significant improvement in motor function.

10 MG / ML INJECTION

00002459132	MOVAPO	PAL	$	14.8435

ARIPIPRAZOLE

"For the maintenance treatment of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with aripiprazole therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

All requests (including renewal requests) for aripiprazole prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

300 MG / VIAL INJECTION				
00002420864	ABILIFY MAINTENA	OTS	$	456.1800
400 MG / VIAL INJECTION				
00002420872	ABILIFY MAINTENA	OTS	$	456.1800

ASENAPINE MALEATE

"For the acute treatment of manic or mixed episodes associated with bipolar I disorder as co-therapy with lithium or divalproex sodium."

"For the acute treatment of manic or mixed episodes associated with bipolar I disorder as monotherapy, after a trial of lithium or divalproex sodium has failed due to intolerance or lack of response, or the presence of a contraindication to lithium or divalproex sodium as defined by the product monographs."

"Special authorization coverage may be granted for 24 months."

These products are eligible for auto-renewal.

5 MG (BASE) ORAL SUBLINGUAL TABLET				
00002374803	SAPHRIS	MFC	$	1.5225
10 MG (BASE) ORAL SUBLINGUAL TABLET				
00002374811	SAPHRIS	MFC	$	1.5225

ASFOTASE ALFA

1. ELIGIBILITY CRITERIA FOR ASFOTASE ALFA COVERAGE

In order to maintain the integrity of the ADBL, and having regard to the financial and social implications of covering asfotase alfa for the treatment of perinatal/infantile or juvenile-onset hypophosphatasia (HPP), the following special authorization criteria must be satisfied.

In order to be eligible for asfotase alfa coverage for the treatment of HPP, a patient must have submitted a completed Application and have satisfied all of the following requirements:

The patient must:
1) Be diagnosed with HPP in accordance with the requirements specified in the Clinical Criteria for asfotase alfa;
2) Have Alberta government-sponsored drug coverage;
3) Meet the Registration Requirements;
4) Satisfy the Clinical Criteria for asfotase alfa (initial or continued coverage, as appropriate); AND
5) Meet the criteria specified in Discontinuance of Coverage.

There is no guarantee that any application, whether for initial or continued coverage, will be approved. Depending on the circumstances of each case, the Minister or the Minister's delegate may:
- approve an Application;
- approve an Application with conditions;
- deny an Application;
- discontinue an approved Application; OR
- defer an Application pending the provision of further supporting information.

The process for review and approval is explained in further detail below.

2. REGISTRATION REQUIREMENTS

If the patient is a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of one (1) year prior to an application for coverage unless:
- the patient is less than one (1) year of age at the date of the application, then the patient's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of one (1) year; OR
- the patient 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 asfotase alfa in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for asfotase alfa as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

If the patient is not a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five (5) years prior to an application for coverage unless:
- the patient is less than five years of age at the date of the application, then the patients parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years; OR
- the patient 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 asfotase alfa in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for asfotase alfa as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

The Minister reserves the right to modify or waive the Registration Requirements applicable to a given patient if the patient or the patient's parent/guardian/legal representative can establish to the satisfaction of the Minister that the patient has not moved to Alberta for the sole/primary

ASFOTASE ALFA

purpose of obtaining coverage of asfotase alfa.

3. CLINICAL CRITERIA

"For enzyme replacement therapy (ERT) in patients with a confirmed diagnosis of perinatal/infantile or juvenile -onset hypophosphatasia (HPP). These patients must have been diagnosed prior to 12 years of age and have documented onset of signs/symptoms of HPP prior to 12 years of age.

Initiation Criteria:

1. Confirmed diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia (HPP) as defined below:
- Confirmed diagnosis via genetic testing (documented tissue-nonspecific alkaline phosphatase (TNSALP) gene mutations(s) AND
- Serum alkaline phosphatase (ALP) level below the age-adjusted normal range (these are age and gender adjusted norms developed through CALIPER which are used as reference https://apps.sbgh.mb.ca/labmanual/test/view?seedId=3662) AND
NOTE: Below upper limit of normal refers to 2 or lower standard deviations above the mean
- Plasma pyridoxal-5-phosphate (PLP) above the upper limit of normal established and validated in testing laboratory AND
- Documented history of HPP-related skeletal abnormalities confirmed radiologically:
For Infantile HPP: Full skeletal survey done at baseline - examine chest, wrist, knees, and skull. Changes to monitor include: abnormalities of skeletal mineralization including severely undermineralized and even "absence" of some or all bones; undermineralized skull; functional craniosynostosis; gracile bones; thin ribs; chest deformities; evidence of recent/ healed fractures; non-traumatic fractures, recurrent or poorly healing fractures; at the ends of long bones evaluate widening of the growth plate (physis) with irregularity of the provisional zone of calcification; metaphyseal radiolucencies, flaring and fraying at ends of metaphyses and metadiaphyseal patchy focal sclerosis

For Juvenile HPP: Similar to above however generally milder

AND

2. Assessed by a metabolic specialist who determines that the criteria noted above has been met as well as documented signs/symptoms that includes:

a. For Infantile HPP: Failure to thrive AND poor growth AND gross motor delay with substantial skeletal disease. May also have hypercalcemia, B6-responsive seizures and/or respiratory failure, respiratory compromise, including decreased thoracic volume and/or pulmonary hypoplasia; need for respiratory support;

b. For Juvenile HPP: Poor weight gain; unusual gait or running; delayed walking (>15 months); impaired mobility, need for ambulatory assistance; knock-knees; or rickets/bowed legs; muscle weakness/hypotonia; joint pain; muscle pain; bone pain sufficient to limit activity and require medication

c. Childhood HPP (after 6 months of age): gait disturbance, fractures, rickets and RGIC score(NOTE: RGIC score is a 7-point score of Radiographic Global Impressive of Change ie RGIC score assesses changes from baseline and is obtained on paired sequential radiographs with a score of +2 indicating substantial healing/improvement in HPP-related skeletal abnormalities), Thacher score (NOTE: Thacher score is a 10-point Rickets Severity Scale validated for Vitamin D deficiency rickets (and also valid for HPP); score of 10 = severe rickets and 0 = no rickets based on quantified growth plate abnormalities at wrists and knees), bowing of legs, short stature unexplained by other reasons and/or pain score. RGIC and Thacher scores are ideal as they are validated in HPP but a comparable radiologic assessment by an expert bone pediatric radiologist could also be considered

3. Patient is not an adult (ie > 18 years of age) at the time treatment is initiated AND

ASFOTASE ALFA

4. Patient does not have odontoHPP, IE premature loss of deciduous teeth alone or pseudoHPP and vitamin D deficiency to be ruled out. Patients with craniosynostosis alone who do not have other criteria noted above for the diagnosis of HPP need to be followed closely as initiation of treatment with ERT may be indicated if other systemic signs and symptoms develop including muscle weakness, fractures, rickets, pain or nephrocalcinosis and/or if bony disease develops clinically and radiologically AND

5. Patients should be initiated on treatment and followed in a specialized clinic with expertise in the diagnosis and management of HPP. Goals of therapy should be developed on a case-by-case basis prior to the initiation of therapy depending on age and signs and symptoms at presentation.

Signs and symptoms to be monitored depend on age at diagnosis and may include:

a) For perinatal/infantile would expect in addition to above parameters to be followed goals of therapy should include discontinuation or reduction of ventilatory support, increased mobility (improvement in gait vs. baseline), attainment of age-appropriate gross motor milestones. Clinical, radiological and biochemical criteria should be surveilled and these pre-specified goals met at Coverage should be reassessed following a trial of 24 weeks of therapy or more frequently depending on clinical status of patient at initiation of therapy.

b) For juvenile Healing of rickets, improvement of bone mineralization and/bony deformities, fewer fractures, less pain, need for less pain medication, improved growth, increased mobility.

If Initiation Criteria met, 24 week trial to be followed by reassessment by a metabolic specialist

Of Note: Treatment with ERT may not be recommended for newborns who are unable to be successfully ventilated and who have respiratory failure, irreversible pulmonary hypoplasia (underdeveloped lungs with reduced number of alveoli for air exchange) as assessed postnatally by established clinical and radiologic criteria (narrow chest circumference and apparent low lung volumes, evidence for increased pulmonary resistance, MRI changes consistent with lung hypoplasia), very small chest walls, very thin or absent ribs radiologically as assessed by pediatric respirologist, radiologist and treating metabolic specialist. A 6 month trial of ERT may however be recommended for such infants by the treating metabolic specialist and consultants with the consent of the parents. Discontinuation of ERT should be considered at this point and baby moved to palliative care.

Continuation Criteria:
- Assessed by a metabolic specialist who determines that the pre-specified goals have been met and includes documented signs/symptoms noted above.
- Documented compliance by patient and family with respect to follow up visits and reevaluation of laboratory and radiological parameters.
- Additional 24 week trials to be followed by reassessment by a metabolic specialist.

If Continuation Criteria are not met, the treatment should not be continued. In addition, ERT should be discontinued for lack of compliance or if patient does not come for follow up appointments, in spite of all efforts to assist patient and family in this regard, development of craniosynostosis or premature loss of deciduous teeth alone would not signify failure of treatment and ERT should be continued provided other continuation criteria are met.

Stopping Criteria:
- Consider discontinuation after growth is completed based on objective measurement of height and closure of growth plates (closure to be confirmed by Xray criteria and report from a Radiologist).
- Criteria for tapering and discontinuing treatment should be developed by expert committee and evaluated on a case-by-case basis at all age groups.
- Babies with perinatal/infantile HPP who fail treatment trials of 6 months as described above may be discontinued from ERT and moved to palliative care.

*Reference will be made re: dosing and approved vial use to minimize wastage"

ASFOTASE ALFA

4. PROCESS FOR ASFOTASE ALFA COVERAGE

For both initial and continued coverage the following documents (the Application) must be completed and submitted:

- An Asfotase alfa Special Authorization Request Form completed by the patient's Metabolic Specialist;
- An Asfotase alfa Consent Form completed by the patient, or a patient's parent/guardian/legal representative, and the patients Metabolic Specialist (for any initial coverage application); AND
- Any other documentation that may be required by the Minister or the Minister's delegate.

a. Expert Review

Once the Minister or the Minister's delegate has confirmed that the patient meets the Registration Requirement or granted a waiver of the Registration Requirement, the Application will be given to one or more Expert Advisors for review.

The Application, together with the recommendation or recommendations of the Expert Advisor(s), is then forwarded to the Minister or the Minister's delegate for a decision regarding coverage.

After the Minister or Minister's delegate has rendered a decision, the patient's Metabolic Specialist and the patient or patient's parent/guardian/legal representative will be notified by letter of the Minister's decision.

5. APPROVAL OF COVERAGE

The Minister or the Minister's delegate's decision in respect of an Application will specify the effective date of asfotase alfa coverage, if coverage is approved.

Initial coverage may be approved for a period of up to 26 weeks as follows: One dose of 2 mg/kg of asfotase alfa administered three times a week or one dose of 1 mg/kg of asfotase alfa administered six times a week (total of 78 doses for the 2mg/kg dosage regimen and a total of 156 doses for the 1 mg/kg dosage regimen).

Continued coverage may be approved for up to one dose of 2 mg/kg of asfotase alfa administered three times a week or one dose of 1 mg/kg of asfotase alfa administered six times a week for a period of six (6) months (total of 78 doses for the 2mg/kg dose and a total of 156 doses for the 1 mg/kg dose).

If a patient is approved for coverage, prescriptions for asfotase alfa must be written by a Metabolic Specialist. To avoid wastage, prescription quantities are limited to a two week supply. Extended quantity and vacation supplies are not permitted. The Government is not responsible and will not pay for costs associated with wastage or improper storage of asfotase alfa.

Approval of coverage is granted for a specific period, to a maximum of 26 weeks. If continued treatment is necessary, it is the responsibility of the patient or patient's parent/guardian/legal representative and the Metabolic Specialist to submit a new Application to re-apply for asfotase alfa coverage, and receive a decision thereon, prior to the expiry date of the authorization period.

6. WITHDRAWAL

Therapy may be withdrawn at the request of the patient or the patient's parent/guardian/legal representative at any time. Notification of withdrawal from therapy must be made by the Metabolic Specialist or patient in writing.

Applications, withdrawal requests, and any other information to be provided must be sent to Clinical Drug Services, Alberta Blue Cross.

ASFOTASE ALFA

18 MG / VIAL INJECTION				
00002444615	STRENSIQ	APG	$	1358.6400
28 MG / VIAL INJECTION				
00002444623	STRENSIQ	APG	$	2113.4400
40 MG / VIAL INJECTION				
00002444631	STRENSIQ	APG	$	3019.2000
80 MG / VIAL INJECTION				
00002444658	STRENSIQ	APG	$	6038.4000

AZITHROMYCIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"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."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

The following product(s) are eligible for auto-renewal.

600 MG ORAL TABLET				
00002261642	PMS-AZITHROMYCIN	PMS	$	10.6652

AZTREONAM

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): TOBRAMYCIN INHALATION SOLUTION

"For the treatment of chronic pulmonary Pseudomonas aeruginosa infections when used as cyclic treatment (28-day cycles) in patients 6 years of age and older with moderate to severe cystic fibrosis (CF) and deteriorating clinical condition despite treatment with inhaled tobramycin.

Coverage will not be considered when inhaled aztreonam and other inhaled antibiotic(s) (e.g. levofloxacin, tobramycin) are intended for use in combination.

Special authorization may be granted for 6 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

75 MG / VIAL INHALATION POWDER FOR SOLUTION				
00002329840	CAYSTON	GIL	$	44.0631

BENRALIZUMAB

"Special authorization coverage may be provided for add-on maintenance treatment of adult patients with severe eosinophilic asthma if the following clinical criteria and conditions are met:
Patient is inadequately controlled with high-dose inhaled corticosteroids (ICS) and one or more additional asthma controller(s) (e.g., a long-acting beta-agonist [LABA]).
AND
Patient has a blood eosinophil count of greater than or equal to 300 cells/mcL AND has experienced two or more clinically significant asthma exacerbations* in the 12 months prior to treatment initiation with benralizumab;
OR
Patient has a blood eosinophil count of greater than or equal to 150 cells/mcL AND is receiving daily maintenance treatment with oral corticosteroids (OCS).

For coverage, the drug must be initiated and monitored by a respirologist or clinical immunologist or allergist.

Initial coverage may be approved for a period of 12 months at a dosage of 30 mg administered every 4 weeks for the first 3 doses and 30 mg administered every 8 weeks thereafter.

-Patients will be limited to receiving one dose of benralizumab 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.
-Coverage cannot be provided for benralizumab when this medication is intended for use in combination with other biologics for the treatment of asthma.

If ALL of the following criteria are met, special authorization may be approved for 30 mg administered every 8 weeks for a further 12-month period:
1) An improvement in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 when compared to pre-treatment baseline or an ACQ-5 score of less than or equal to 1; AND
2) Maintenance or reduction in the number of clinically significant exacerbations* compared to the 12 months prior to initiation of treatment with benralizumab; AND
3) For patients on daily maintenance therapy with OCS prior to initiating benralizumab, a decrease in the OCS dose.

Continued coverage may be considered for 30 mg administered every 8 weeks if ALL of the following criteria are met at the end of each additional 12-month period:
1) The ACQ-5 score achieved during the first 12 months of therapy is at least maintained throughout treatment or the ACQ-5 score is less than or equal to 1; AND
2) Maintenance or reduction in the number of clinically significant exacerbations* compared to the previous 12-month period; AND
3) For patients on daily maintenance therapy with OCS prior to initiating benralizumab, the reduction in the OCS dose achieved after the first 12 months of therapy is at least maintained throughout treatment.

* Clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized."

All requests (including renewal requests) for benralizumab must be completed using the Benralizumab/Mepolizumab Special Authorization Request Form (ABC 60061).

30 MG / SYR	INJECTION	SYRINGE		
00002473232	FASENRA		AZC	$ 3876.9200

BRIVARACETAM

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Patients are not receiving concurrent therapy with levetiracetam, AND,
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for brivaracetam, eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

10 MG ORAL TABLET				
00002452936	BRIVLERA	UCB	$	4.3200
25 MG ORAL TABLET				
00002452944	BRIVLERA	UCB	$	4.3200
50 MG ORAL TABLET				
00002452952	BRIVLERA	UCB	$	4.3200
75 MG ORAL TABLET				
00002452960	BRIVLERA	UCB	$	4.3200
100 MG ORAL TABLET				
00002452979	BRIVLERA	UCB	$	4.3200

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	TPG	$	1.8093

BUDESONIDE/ FORMOTEROL FUMARATE DIHYDRATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for budesonide + formoterol fumarate dihydrate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

100 MCG / DOSE * 6 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002245385	SYMBICORT 100 TURBUHALER	AZC	$	0.5700
200 MCG / DOSE * 6 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002245386	SYMBICORT 200 TURBUHALER	AZC	$	0.7410

BUPRENORPHINE

"For the management of moderate to severe opioid use disorder in patients clinically stabilized on 8 mg to 24 mg per day of sublingual (SL) buprenorphine for a minimum of 7 days and to be used in combination with counseling and psychosocial support.

The patient should be under the care of a health care provider with experience in the diagnosis and management of opioid use disorder and who has been certified to administer subcutaneous buprenorphine extended release injection.

Buprenorphine extended release injection must be administered subcutaneously in the abdominal region by a healthcare provider.

Patients will be limited to receiving one syringe per prescription at their pharmacy.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

100 MG / SYR INJECTION SYRINGE				
00002483084	SUBLOCADE	IUK	$	550.0000
300 MG / SYR INJECTION SYRINGE				
00002483092	SUBLOCADE	IUK	$	550.0000

BUPRENORPHINE HCL

"For the management of opioid dependence in patients clinically stabilized on no more than 8 mg of sublingual (SL) buprenorphine for the preceding 90 days in combination with counseling and psychosocial support.

The patient should be under the care of a health care provider with experience in the diagnosis and management of opioid use disorder and has been trained to implant the buprenorphine subdermal implant.

Patients will be limited to receiving one kit per prescription at their pharmacy.
Special authorization may be granted for 24 months."

80 MG (BASE) SUBDERMAL IMPLANT				
00002474921	PROBUPHINE	KTI	$	1495.0000

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	CAG	$	8.5530
1 MG / ML (BASE) INJECTION				
00002225166	SUPREFACT	CAG	$	12.1873
6.3 MG (BASE) INJECTION IMPLANT				
00002228955	SUPREFACT DEPOT	CAG	$	827.8500

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."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

0.5 MG ORAL TABLET

00002455897	**APO-CABERGOLINE**	**APX**	$	**12.3941**
00002242471	DOSTINEX	PAL	$	15.6314

CANAGLIFLOZIN

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for canagliflozin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

100 MG ORAL TABLET

00002425483	INVOKANA	JAI	$	2.8560

300 MG ORAL TABLET

00002425491	INVOKANA	JAI	$	2.8560

CASPOFUNGIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For treatment of esophageal candidiasis in patients who are resistant or intolerant to fluconazole or itraconazole.

For treatment of invasive candidiasis resistant or intolerant to fluconazole.

For treatment of Invasive Aspergillosis in patients who are refractory to or intolerant of other therapies."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

50 MG / VIAL INJECTION				
00002460947	**CASPOFUNGIN**	**JUN**	$	**188.7000**
00002244265	CANCIDAS	MFC	$	222.0000
70 MG / VIAL INJECTION				
00002460955	**CASPOFUNGIN**	**JUN**	$	**188.7000**
00002244266	CANCIDAS	MFC	$	222.0000

CEFADROXIL

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of skin and skin structure infections."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

500 MG ORAL CAPSULE				
00002240774	**APO-CEFADROXIL**	**APX**	$	**0.8421**
00002235134	**TEVA-CEFADROXIL**	**TEV**	$	**0.8421**

CEFOXITIN SODIUM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of Mycobacterium abscessus infection."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

1 G / VIAL (BASE) INJECTION				
00002291711	**CEFOXITIN**	**APX**	$	**10.6000**
00002128187	**CEFOXITIN SODIUM**	**TEV**	$	**10.6000**
2 G / VIAL (BASE) INJECTION				
00002291738	**CEFOXITIN**	**APX**	$	**21.2500**
00002128195	**CEFOXITIN SODIUM**	**TEV**	$	**21.2500**

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 60032).

The following product(s) are eligible for auto-renewal.

100 MG ORAL CAPSULE

00002420155	**ACT CELECOXIB**	**APH**	$	**0.1279**
00002437570	**AG-CELECOXIB**	**AGP**	$	**0.1279**
00002418932	**APO-CELECOXIB**	**APX**	$	**0.1279**
00002445670	**AURO-CELECOXIB**	**AUR**	$	**0.1279**
00002426382	**BIO-CELECOXIB**	**BMD**	$	**0.1279**
00002429675	**CELECOXIB**	**SIV**	$	**0.1279**
00002424533	**JAMP-CELECOXIB**	**JPC**	$	**0.1279**
00002420058	**MAR-CELECOXIB**	**MAR**	$	**0.1279**
00002412497	**MINT-CELECOXIB**	**MPI**	$	**0.1279**
00002479737	**NRA-CELECOXIB**	**NRA**	$	**0.1279**
00002355442	**PMS-CELECOXIB**	**PMS**	$	**0.1279**
00002412373	**RAN-CELECOXIB**	**RAN**	$	**0.1279**
00002442639	**SDZ CELECOXIB**	**SDZ**	$	**0.1279**
00002239941	CELEBREX	UJC	$	0.7175

200 MG ORAL CAPSULE

00002420163	**ACT CELECOXIB**	**APH**	$	**0.2558**
00002437589	**AG-CELECOXIB**	**AGP**	$	**0.2558**
00002418940	**APO-CELECOXIB**	**APX**	$	**0.2558**
00002445689	**AURO-CELECOXIB**	**AUR**	$	**0.2558**
00002426390	**BIO-CELECOXIB**	**BMD**	$	**0.2558**
00002429683	**CELECOXIB**	**SIV**	$	**0.2558**
00002424541	**JAMP-CELECOXIB**	**JPC**	$	**0.2558**
00002420066	**MAR-CELECOXIB**	**MAR**	$	**0.2558**
00002412500	**MINT-CELECOXIB**	**MPI**	$	**0.2558**
00002479745	**NRA-CELECOXIB**	**NRA**	$	**0.2558**
00002355450	**PMS-CELECOXIB**	**PMS**	$	**0.2558**
00002412381	**RAN-CELECOXIB**	**RAN**	$	**0.2558**
00002442647	**SDZ CELECOXIB**	**SDZ**	$	**0.2558**
00002239942	CELEBREX	UJC	$	1.4352

CERTOLIZUMAB PEGOL

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 ("RA Specialist").

- Initial coverage may be approved for an initial dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) at Weeks 0, 2 and 4. As an interim measure, coverage will be provided for additional doses of 400 mg per 4 weeks up to week 12, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.
- Patients will be limited to receiving a one-month supply of certolizumab 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 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 400 mg per 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)

CERTOLIZUMAB PEGOL

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 certolizumab for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

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 an initial dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) at Weeks 0, 2 and 4. As an interim measure, coverage will be provided for additional doses of 400 mg per 4 weeks up to week 12, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.
- Patients will be limited to receiving a one-month supply of certolizumab 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:
1) The patient must be assessed by an RA Specialist after the initial 5 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 400 mg per 4 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."

CERTOLIZUMAB PEGOL

All requests (including renewal requests) for certolizumab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

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 an initial dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) at Weeks 0, 2 and 4. As an interim measure, coverage will be provided for additional doses of 400 mg per 4 weeks up to week 12, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.
- Patients will be limited to receiving a one-month supply of certolizumab 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:
1) The patient must be assessed by an RA Specialist after the initial 5 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 400 mg per 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

CERTOLIZUMAB PEGOL

- 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 certolizumab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

200 MG / SYR INJECTION SYRINGE

☒ 00002331675	CIMZIA	UCB	$	664.5100
☒ 00002465574	CIMZIA AUTO-INJECTOR	UCB	$	664.5100

CLADRIBINE

Special authorization coverage may be provided for the treatment of relapsing remitting multiple sclerosis (RRMS) to reduce the frequency of clinical relapses, 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 are refractory or intolerant to:

At least ONE of the following:
- dimethyl fumarate
- glatiramer acetate
- interferon beta
- ocrelizumab
- peginterferon beta
- teriflunomide

Definition of 'intolerant'
Demonstrating serious adverse effects or contraindications to treatments as defined in the product monograph, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of MS disease modifying therapy (DMT).

Definition of 'refractory'
-Development of neutralizing antibodies to interferon beta.
-When the above MS DMTs are taken at the recommended doses for a full and adequate course of treatment, within a consecutive 12-month period while the patient was on the MS DMT, the patient has:

1) Been adherent to the MS DMT (greater than 80% of approved doses have been administered);

2) Experienced at least two relapses* of MS confirmed by the presence of neurologic deficits on examination.

i. The first qualifying clinical relapse must have begun at least one month after treatment initiation.

ii. Both qualifying relapses must be classified with a relapse severity of moderate, severe or very severe**.

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

**Relapse severity: with moderate relapses modification or more time is required to carry out activities of daily living; with severe relapses there is inability to carry out some activities of daily living; with very severe relapses activities of daily living must be completed by others.

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist.

To register to become an MS Neurologist, please complete the Registration for MS Neurologist Status Form (ABC 60002).

Coverage may be considered only if the following criteria are met:

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during

CLADRIBINE

the previous two years or in the two years prior to starting an MS DMT. In most cases this will be satisfied by the 'refractory' to treatment criterion but if a patient failed an MS DMT more than one year earlier, ongoing active disease must be confirmed.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage will not be approved when any MS DMT or other immunosuppressive therapy is to be used in combination with cladribine.

Coverage of cladribine will not be approved if the patient was deemed to be refractory to cladribine in the past.

Following assessment of the request, cladribine may be approved for coverage at a cumulative dose of 3.5 mg/kg over 2 years, administered as 1 treatment course of 1.75 mg/kg per year. Each treatment course consists of 2 treatment weeks, with each treatment week consisting of 4 or 5 days on which a patient receives 10 mg or 20 mg (one or two tablets) as a single daily dose, depending on body weight.

- The Initial Treatment Course is administered in one treatment week at the beginning of the first month and one treatment week at the beginning of the second month of the same year.

-The Second Treatment Course is administered in the subsequent year in two treatment weeks one month apart, in the same manner as the initial treatment course.

Patients will be limited to receiving one treatment week of cladribine per prescription at their pharmacy.
Coverage is limited to two treatment courses.

All requests for cladribine must be completed using the Cladribine/Fingolimod/Natalizumab For Multiple Sclerosis Special Authorization Request Form (ABC 60000).

10 MG ORAL TABLET

00002470179	MAVENCLAD	SRO	$	3212.0000

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 % * 3 % TOPICAL GEL

00002382822	CLINDOXYL ADV	GSK	$	0.7996

"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

00002440180	**TARO-CLINDAMYCIN/BENZOYL PEROXIDE**	**TAR**	$	**0.6857**
00002243158	CLINDOXYL	GSK	$	0.9798

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				
00002464519	**TARO-BENZOYL PEROXIDE/CLINDAMYCIN KIT**	**TAR**	$	**0.7422**
00002248472	BENZACLIN	VCL	$	1.0328

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	$	0.6675
25 MG ORAL CAPSULE				
00002247073	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**1.3050**
00002150689	NEORAL	NOV	$	1.5520
50 MG ORAL CAPSULE				
00002247074	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**2.5450**
00002150662	NEORAL	NOV	$	3.0270
100 MG ORAL CAPSULE				
00002242821	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**5.0900**
00002150670	NEORAL	NOV	$	6.0560
100 MG / ML ORAL SOLUTION				
00002150697	NEORAL	NOV	$	5.3852

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**	$	**1.4000**
00002245898	**CYPROTERONE**	**AAP**	$	**1.4000**
00002390760	**MED-CYPROTERONE**	**GMP**	$	**1.4000**
100 MG / ML INJECTION				
00000704423	ANDROCUR DEPOT	PMS	$	32.8000

CYSTEAMINE BITARTRATE

"For use in patients with an established diagnosis of infantile nephropathic cystinosis with documented cystinosin, lysosomal cystine transporter gene mutation.

For coverage, this drug must be prescribed by or in consultation with physician with experience in the diagnosis and management of cystinosis.

Special authorization may be granted for 12 months."

This product is eligible for auto-renewal.

25 MG ORAL DELAYED-RELEASE CAPSULE				
00002464705	PROCYSBI	RAP	$	10.3500

"For use in patients with an established diagnosis of infantile nephropathic cystinosis with documented cystinosin, lysosomal cystine transporter gene mutation.

For coverage, this drug must be prescribed by or in consultation with physician with experience in the diagnosis and management of cystinosis.

Special authorization may be granted for 12 months."

This product is eligible for auto-renewal.

75 MG ORAL DELAYED-RELEASE CAPSULE				
00002464713	PROCYSBI	RAP	$	31.0500

CYSTEAMINE HYDROCHLORIDE

For the treatment of corneal cystine crystal deposits (CCCDs) in adults and children from 2 years of age with a diagnosis of cystinosis.

For coverage, this drug must be initiated by an ophthalmologist experienced in the management of the ocular manifestations of cystinosis.

Special authorization may be granted for 12 months.

The following product(s) are eligible for auto-renewal.

0.37 % (BASE) OPHTHALMIC SOLUTION				
00002485605	CYSTADROPS	RRD	$	397.2000

DABIGATRAN ETEXILATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): WARFARIN

For at-risk patients (CHADS2 score of greater than or equal to 1) with non-valvular atrial fibrillation (AF) for the prevention of stroke and systemic embolism AND in whom:

a) Anticoagulation is inadequate (at least 35% of INR testing results outside the desired range) following a reasonable trial on warfarin (minimum two months of therapy); OR
b) Anticoagulation with warfarin is contraindicated as per the product monograph or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate less than 30mL/min) OR hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR prosthetic heart valves.should not receive dabigatran.

Patients 75 years of age and greater should have documented stable renal function (creatinine clearance or estimated glomerular filtration rate maintained for at least three months of 30-49 ml/min for 110mg twice daily dosing or greater than or equal to 50 ml/min for 150mg twice daily dosing).

Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product Monograph).

Patients starting the drug product should have ready access to appropriate medical services to manage a major bleeding event.

There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

Special Authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

All requests for dabigatran must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

110 MG ORAL CAPSULE				
00002468905	**APO-DABIGATRAN**	**APX**	$	**1.2540**
00002312441	PRADAXA	BOE	$	1.7121
150 MG ORAL CAPSULE				
00002468913	**APO-DABIGATRAN**	**APX**	$	**1.2540**
00002358808	PRADAXA	BOE	$	1.7121

DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN OR SULFONYLUREAS
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS OR METFORMIN
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy to metformin or a sulfonylurea for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin who have a contraindication or intolerance to a sulfonylurea, OR a sulfonylurea who have a contraindication or intolerance to metformin,
- AND for whom insulin is not an option.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for dapagliflozin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

5 MG (BASE) ORAL TABLET				
00002435462	FORXIGA	AZC	$	2.7300
10 MG (BASE) ORAL TABLET				
00002435470	FORXIGA	AZC	$	2.7300

DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE/ 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 OR SULFONYLUREAS
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS OR METFORMIN
AND WHERE INSULIN IS NOT AN OPTION

"For the treatment of Type 2 diabetes in patients with inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin who have a contraindication or intolerance to a sulfonylurea, OR
- a sulfonylurea who have failed a sufficient trial of metformin, AND
- for whom insulin is not an option.

Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for dapagliflozin+metformin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

5 MG * 850 MG ORAL TABLET				
00002449935	XIGDUO	AZC	$	1.2250
5 MG * 1,000 MG ORAL TABLET				
00002449943	XIGDUO	AZC	$	1.2250

DAPTOMYCIN

For the treatment of:
- Culture confirmed gram-positive infections from sterile sites, specifically Methicillin-resistant Staphylococcus aureus (MRSA), AND
- In patients who do not respond to, or exhibit multidrug intolerance to, or allergy to vancomycin, AND
- 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.

Special Authorization may be granted for 12 months.

500 MG / VIAL INJECTION				
00002465493	CUBICIN RF	CUB	$	161.0000

DARBEPOETIN

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for twelve months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 300 mcg per month."

"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 should be reduced by about 25%. Special authorization will be granted for twelve months."

In order to comply with the first criterion information must be provided regarding the patient's hemoglobin and transferrin saturation.

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

The following product(s) are eligible for auto-renewal for the indication of the treatment of anemia of chronic renal failure.

All requests for darbepoetin must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 60006).

100 MCG / SYR INJECTION SYRINGE				
00002391775	ARANESP (0.5 ML SYRINGE)	AMG	$	268.0000
10 MCG / SYR INJECTION SYRINGE				
00002392313	ARANESP (0.4 ML SYRINGE)	AMG	$	26.8000
20 MCG / SYR INJECTION SYRINGE				
00002392321	ARANESP (0.5 ML SYRINGE)	AMG	$	53.6000
30 MCG / SYR INJECTION SYRINGE				
00002392348	ARANESP (0.3 ML SYRINGE)	AMG	$	80.4000
40 MCG / SYR INJECTION SYRINGE				
00002391740	ARANESP (0.4 ML SYRINGE)	AMG	$	107.2000
50 MCG / SYR INJECTION SYRINGE				
00002391759	ARANESP (0.5 ML SYRINGE)	AMG	$	134.0000
60 MCG / SYR INJECTION SYRINGE				
00002392356	ARANESP (0.3 ML SYRINGE)	AMG	$	160.8000
80 MCG / SYR INJECTION SYRINGE				
00002391767	ARANESP (0.4 ML SYRINGE)	AMG	$	214.4000
130 MCG / SYR INJECTION SYRINGE				
00002391783	ARANESP (0.65 ML SYRINGE)	AMG	$	348.4000
150 MCG / SYR INJECTION SYRINGE				
00002391791	ARANESP (0.3 ML SYRINGE)	AMG	$	439.7550
200 MCG / SYR INJECTION SYRINGE				
00002391805	ARANESP (0.4 ML SYRINGE)	AMG	$	621.2500
300 MCG / SYR INJECTION SYRINGE				
00002391821	ARANESP (0.6 ML SYRINGE)	AMG	$	950.6900
500 MCG / SYR INJECTION SYRINGE				
00002392364	ARANESP (1.0 ML SYR)	AMG	$	1584.4900

DARIFENACIN HYDROBROMIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

7.5 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002273217	ENABLEX	SLP	$	1.6222
15 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002273225	ENABLEX	SLP	$	1.6222

DEFERASIROX

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

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, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Jadenu (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

90 MG ORAL TABLET

00002485265	**APO-DEFERASIROX (TYPE J)**	**APX**	$	**7.8908**
00002452219	JADENU	NOV	$	10.5210

DEFERASIROX

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

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, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Jadenu (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

180 MG ORAL TABLET

00002485273	**APO-DEFERASIROX (TYPE J)**	**APX**	$	**15.7830**
00002452227	JADENU	NOV	$	21.0440

DEFERASIROX

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

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, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Jadenu (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

360 MG ORAL TABLET				
00002485281	**APO-DEFERASIROX (TYPE J)**	**APX**	$	**31.5683**
00002452235	JADENU	NOV	$	42.0910
125 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION				
00002461544	**APO-DEFERASIROX**	**APX**	$	**2.6204**
00002464454	**SANDOZ DEFERASIROX**	**SDZ**	$	**2.6204**
00002287420	EXJADE	NOV	$	10.6625

DEFERASIROX

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

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, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Exjade (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

250 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461552	**APO-DEFERASIROX**	**APX**	$	**5.2410**
00002464462	**SANDOZ DEFERASIROX**	**SDZ**	$	**5.2410**
00002287439	EXJADE	NOV	$	21.3257

DEFERASIROX

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

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, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Exjade (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

500 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461560	**APO-DEFERASIROX**	**APX**	$	**10.4824**
00002464470	**SANDOZ DEFERASIROX**	**SDZ**	$	**10.4824**
00002287447	EXJADE	NOV	$	42.6532

DEFERIPRONE

"For the treatment of transfusional iron overload due to thalassemia syndromes in patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications to deferoxamine 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, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

All requests (including renewal requests) for deferiprone must be completed using the Deferiprone Special Authorization Request Form (ABC 60054).

1,000 MG ORAL TABLET				
00002436558	FERRIPROX	CCC	$	32.8343
100 MG / ML ORAL SOLUTION				
00002436523	FERRIPROX	CCC	$	3.2834

DENOSUMAB

"For the treatment of osteoporosis in patients who have:

A high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture,
OR
A moderate 10-year fracture risk (10-20%) and have experienced a prior fragility fracture;

AND

at least one of the following:

1) For whom oral bisphosphonates are contraindicated due to drug-induced hypersensitivity (i.e., immunologically mediated),

OR

2) For whom oral bisphosphonates are contraindicated due to an abnormality of the esophagus which delays esophageal emptying,

OR

3) For whom bisphosphonates are contraindicated due to severe renal impairment (i.e. creatinine clearance < 35 mL/min),

OR

4) Who have demonstrated persistent severe gastrointestinal intolerance to a course of therapy with either alendronate or risedronate,

OR

5) Who had an unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for 1 year and evidence of a decline in BMD below pre-treatment baseline level).

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

Special authorization may be granted for 12 months.

Patients will be limited to receiving one dose of denosumab per prescription at their pharmacy.

-Coverage cannot be provided for two or more osteoporosis medications (alendronate, denosumab, raloxifene, risedronate, zoledronic acid) when these medications are intended for use as combination therapy.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

All requests for denosumab must be completed using the Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form (ABC 60007).

The following product(s) are eligible for auto-renewal.

60 MG / SYR	**INJECTION**	**SYRINGE**		
00002343541	PROLIA	AMG	$	385.3800

DIENOGEST

"For the management of pelvic pain associated with endometriosis in patients for whom one or more less costly hormonal options are either ineffective or not tolerated."

"Special authorization may be granted for 6 months."

"This Drug Product is eligible for auto-renewal."

2 MG ORAL TABLET

00002493055	**ASPEN-DIENOGEST**	**APC**	$	**1.0231**
00002498189	**JAMP DIENOGEST**	**JPC**	$	**1.0231**
00002374900	VISANNE	BAI	$	2.0461

DIMETHYL FUMARATE

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory adult patients (18 years of age or older) with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The adult patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The adult patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Adult patients will be limited to receiving a one-month supply of dimethyl fumarate per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the adult patient must meet the following criteria:

1) The adult patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The adult patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in an adult patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Adult patients may receive up to 100 days' supply of dimethyl fumarate per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

DIMETHYL FUMARATE

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the adult patient must meet the following criteria:

1) At least one relapse* per 12 month period; or

2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for dimethyl fumarate must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

120 MG ORAL DELAYED-RELEASE CAPSULE

00002404508	TECFIDERA	BIO	$	17.7064

DONEPEZIL HCL

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

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.

Special authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug."

All requests (including renewal requests) for donepezil HCI must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 60034).

5 MG ORAL TABLET

00002362260	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400561	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412853	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420597	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426846	**DONEPEZIL**	**SNS**	$	**0.4586**
00002402645	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002416948	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402092	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002408600	**MINT-DONEPEZIL**	**MPI**	$	**0.4586**
00002439557	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322331	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381508	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328666	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428482	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340607	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232043	ARICEPT	PFI	$	5.0779

10 MG ORAL TABLET

00002362279	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400588	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412861	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420600	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426854	**DONEPEZIL**	**SNS**	$	**0.4586**
00002402653	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002416956	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402106	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002408619	**MINT-DONEPEZIL**	**MPI**	$	**0.4586**
00002439565	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322358	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381516	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328682	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428490	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340615	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232044	ARICEPT	PFI	$	5.0779

ECULIZUMAB

ECULIZUMAB

1. ELIGIBILITY CRITERIA FOR ECULIZUMAB COVERAGE

In order to maintain the integrity of the ADBL, and having regard to the financial and social implications of covering eculizumab for the treatment of paroxysmal nocturnal hemoglobinuria (PNH), the following special authorization criteria must be satisfied.

In order to be eligible for eculizumab coverage for the treatment of PNH, a patient must have submitted a completed Application and have satisfied all of the following requirements:

The patient must:
1) Be diagnosed with PNH in accordance with the requirements specified in the Clinical Criteria for eculizumab;
2) Have Alberta government-sponsored drug coverage;
3) Meet the Registration Requirements;
4) Satisfy the Clinical Criteria for eculizumab (initial or continued coverage, as appropriate); AND
5) Meet the criteria specified in Contraindications to Coverage and Discontinuance of Coverage.

There is no guarantee that any application, whether for initial or continued coverage, will be approved. Depending on the circumstances of each case, the Minister or the Minister's delegate may:
- approve an Application;
- approve an Application with conditions;
- deny an Application;
- discontinue an approved Application; OR
- defer an Application pending the provision of further supporting information.

The process for review and approval is explained in further detail below.

2. REGISTRATION REQUIREMENTS

If the patient is a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of one (1) year prior to an application for coverage unless:
- the patient is less than one (1) year of age at the date of the application, then the patient's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of one (1) year; OR
- the patient 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 eculizumab in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for eculizumab as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

If the patient is not a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five (5) years prior to an application for coverage unless:
- the patient is less than five years of age at the date of the application, then the patients parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years; OR
- the patient 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 eculizumab in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for eculizumab as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

The Minister reserves the right to modify or waive the Registration Requirements applicable to a given patient if the patient or the patient's parent/guardian/legal representative can establish to

ECULIZUMAB

the satisfaction of the Minister that the patient has not moved to Alberta for the sole/primary purpose of obtaining coverage of eculizumab.

3. CLINICAL CRITERIA

In addition to meeting Sections 1 and Sections 2 herein, to be considered for coverage of eculizumab, a patient must be assessed by a Specialist in Hematology (i.e. a physician who holds specialty certification in Hematology from the Royal College of Physicians and Surgeons of Canada) and meet all of the following clinical criteria (initial or continued coverage, as appropriate).

a. Clinical Criteria - Initial Coverage
All of the following Clinical Criteria must be established on the basis of evidence to the satisfaction of the Minister or the Minister's delegate for initial coverage:

1) The diagnosis of PNH must have been established by flow cytometry and/or a FLAER test. The proportion of circulating cells of each type which are GPI-deficient and hence of the PNH clone is quantitated by flow cytometry. Patients must have a:
- PNH granulocyte or monocyte clone size equal to or greater than 10%, AND
- Raised LDH (value at least 1.5 times the upper limit of normal for the reporting laboratory).

2) Patients with a granulocyte or monocyte clone size equal to or greater than 10% also require AT LEAST ONE of the following:
- Thrombosis: Evidence that the patient has had a thrombotic or embolic event which required the institution of therapeutic anticoagulant therapy;
- Transfusions: Evidence that the patient has been transfused with at least four (4) units of red blood cells in the last twelve (12) months;
- Anemia: Evidence that the patient has chronic or recurrent anemia where causes other than hemolysis have been excluded and demonstrated by more than one measure of less than or equal to 70g/L or by more than one measure of less than or equal to 100 g/L with concurrent symptoms of anemia;
- Pulmonary insufficiency: Evidence that the patient has debilitating shortness of breath and/or chest pain resulting in limitation of normal activity (New York Heart Association Class III) and/or established diagnosis of pulmonary arterial hypertension, where causes other than PNH have been excluded;
- Renal insufficiency: Evidence that the patient has a history of renal insufficiency, demonstrated by an eGFR less than or equal to 60mL/min/1.73m^2, where causes other than PNH have been excluded; OR
- Smooth muscle spasm: Evidence that the patient has recurrent episodes of severe pain requiring hospitalisation and/or narcotic analgesia, where causes other than PNH have been excluded.

AND

3) All patients must receive meningococcal immunization with a quadravalent vaccine (A, C, Y and W135) at least two (2) weeks prior to receiving the first dose of eculizumab. Treating physicians will be required to submit confirmation of meningococcal immunizations in order for their patients to continue to be eligible for treatment with eculizumab. Pneumococcal immunization with a 23-valent polysaccharide vaccine and a 13-valent conjugate vaccine, and a Haemophilus influenza type b (Hib) vaccine must be given according to current clinical guidelines. All patients must be monitored and reimmunized according to current clinical guidelines for vaccine use.

b. Clinical Criteria - Continued Coverage
All of the following Clinical Criteria must be established on the basis of evidence to the satisfaction of the Minister or the Minister's delegate for continued coverage:
1) Patient eligibility must be reviewed six (6) months after commencing therapy and every six (6) months thereafter;

AND

ECULIZUMAB

2) Continued eligibility will be subject to the assessment of evidence, in accordance with the following monitoring requirements, which demonstrates:
- Clinical improvement in the patient, OR
- Stabilization of the patient's condition;

Monitoring requirements;

The patient's Specialist in Hematology must provide the following monitoring information every six (6) months:
- Lactate dehydrogenase (LDH);
- Full blood count and reticulocytes;
- Transfusion history for previous six months;
- Iron studies;
- Urea, electrolytes and eGFR;
- Recent clinical history; AND
- Any other information requested by the Minister, the Minister's delegate, or an Expert Advisor.

The patient's Specialist in Hematology must provide the following monitoring information every twelve (12) months:
- Confirmation that the patient has been immunized or reimmunized (meningococcal, pneumococcal 23-valent, pneumococcal 13-valent and Hib) according to current clinical guidelines for vaccine use;
- Progress reports on the clinical symptoms that formed the basis of initial eligibility;
- Quality of life, through clinical narrative;
- Granulocyte or monocyte clone size (by flow cytometry): AND
- Any other information requested by the Minister, the Minister's delegate, or an Expert Advisor.

c. Contraindications to Coverage

- Small clone size - granulocyte and monocyte clone sizes below 10%;
- Aplastic anaemia with two or more of the following: neutrophil count below 0.5 x 10^9/L, platelet count below 20 x 10^9/L, reticulocytes below 25 x 10^9/L, or severe bone marrow hypocellularity;
- Patients with a presence of another life threatening or severe disease where the long term prognosis is unlikely to be influenced by therapy (for example acute myeloid leukaemia or high-risk myelodysplastic syndrome); OR
- The presence of another medical condition that in the opinion of the Minister or Minister's delegate might reasonably be expected to compromise a response to therapy.

d. Discontinuation of Coverage

Coverage may be discontinued where one or more of the following situations apply:
- The patient or the patient's Specialist in Hematology fails to comply adequately with treatment or measures, including monitoring requirements, taken to evaluate the effectiveness of the therapy;
- There is a failure to provide the Minister, the Minister's delegate, or an Expert Advisor with information as required or as requested;
- If in the opinion of the Minister or the Minister's delegate, therapy fails to relieve the symptoms of disease that originally resulted in the patient being approved by the Minister or the Minister's delegate;
- The patient has (or develops) a condition referred to in Contraindications to Coverage.

The patient's Specialist in Hematology will be advised if their patient is at risk of being withdrawn from treatment for failure to comply with the above requirements or other perceived "non-compliance" and given a reasonable period of time to respond prior to coverage being discontinued.

4. PROCESS FOR ECULIZUMAB COVERAGE

For both initial and continued coverage the following documents (the Application) must be

ECULIZUMAB

completed and submitted:

- An Eculizumab Special Authorization Request Form completed by the patient's Specialist in Hematology;
- An Eculizumab Consent Form completed by the patient, or a patient's parent/guardian/legal representative, and the patients Specialist in Hematology (for any initial coverage application); AND
- Any other documentation that may be required by the Minister or the Minister's delegate.

a. Expert Review

Once the Minister or the Minister's delegate has confirmed that the patient meets the Registration Requirement or granted a waiver of the Registration Requirement, the Application will be given to one or more Expert Advisors for review.

The Application, together with the recommendation or recommendations of the Expert Advisor(s), is then forwarded to the Minister or the Minister's delegate for a decision regarding coverage.

After the Minister or Minister's delegate has rendered a decision, the patient's Specialist in Hematology and the patient or patient's parent/guardian/legal representative will be notified by letter of the Minister's decision.

5. APPROVAL OF COVERAGE

The Minister or the Minister's delegate's decision in respect of an Application will specify the effective date of eculizumab coverage, if coverage is approved.

Initial coverage may be approved for a period of up to six (6) months as follows: One dose of 600mg of eculizumab administered weekly for the first four (4) weeks of treatment (total of four 600mg doses), followed by one dose of 900mg of eculizumab administered every two (2) weeks from week five (5) of treatment (total of eleven 900mg doses).

Continued coverage may be approved for up to one dose of 900mg of eculizumab administered every two (2) weeks, for a period of six (6) months (total of thirteen 900mg doses). If the patient restarts treatment after a lapse in therapy, continued coverage may be approved for a period of up to six (6) months as follows: One dose of 600mg of eculizumab administered weekly for the first four (4) weeks of treatment (total of four 600mg doses), followed by one dose of 900mg of eculizumab administered every two (2) weeks from week five (5) of treatment (total of eleven 900mg doses).

If a patient is approved for coverage, prescriptions for eculizumab must be written by a Specialist in Hematology. To avoid wastage, prescription quantities are limited to a two week supply. Extended quantity and vacation supplies are not permitted. The Government is not responsible and will not pay for costs associated with wastage or improper storage of eculizumab.

Approval of coverage is granted for a specific period, to a maximum of six (6) months. If continued treatment is necessary, it is the responsibility of the patient or patient's parent/guardian/legal representative and the Specialist in Hematology to submit a new Application to re-apply for eculizumab coverage, and receive a decision thereon, prior to the expiry date of the authorization period.

6. WITHDRAWAL

Therapy may be withdrawn at the request of the patient or the patient's parent/guardian/legal representative at any time. Notification of withdrawal from therapy must be made by the Specialist in Hematology or patient in writing.

Applications, withdrawal requests, and any other information to be provided must be sent to

ECULIZUMAB

Clinical Drug Services, Alberta Blue Cross.

300 MG / VIAL INJECTION

00002322285	SOLIRIS	APG	$	6742.0000

EDARAVONE

For patients who have a probable or definite diagnosis of amyotrophic lateral sclerosis (ALS), as defined by World Federation of Neurology (WFN) criteria, and who meet ALL of the following:
- scores of at least two points on each item of the ALS Functional Rating Scale - Revised (ALSFRS-R), AND
- a forced vital capacity (FVC) greater than or equal to 80% of predicted, AND
- ALS symptoms for two years or less, AND
- not currently requiring permanent non-invasive or invasive ventilation.

For coverage, this drug must be prescribed by a Specialist in Neurology.

Initial coverage may be approved for a first treatment cycle of 60mg IV daily for 14 days, followed by a 14-day drug-free period, and 5 subsequent cycles of 60mg IV daily for 10 days out of 14-day periods, followed by 14-day drug-free periods.

Special authorization may be granted for 6 months.

Patients will be limited to receiving a 28-day supply of edaravone per prescription at their pharmacy.

Coverage cannot be renewed once the patient:
- becomes non-ambulatory (ALSFRS-R score less than or equal to 1 for item 8) AND is unable to cut food and feed themselves without assistance, irrespective of whether a gastrostomy is in place (ALSFRS-R score less than 1 for item 5a or 5b);
OR
- requires permanent non-invasive or invasive ventilation.

Continued coverage may be considered for treatment cycles of 60mg IV daily for 10 days out of 14-day periods, followed by 14-day drug-free periods, for a period of 6 months.

All requests (including renewal requests) for edaravone must be completed using the Edaravone Special Authorization Request Form (ABC 60080).

0.3 MG / ML INJECTION

00002475472	RADICAVA	MIT	$	4.6000

EDOXABAN TOSYLATE MONOHYDRATE

"AT RISK PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

For at-risk patients (CHADS2 score of greater than or equal to 1) with non-valvular atrial fibrillation (AF) for the prevention of stroke and systemic embolism AND in whom one of the following is also present:
- Inadequate anticoagulation (at least 35% of INR testing results outside the desired range) following a reasonable trial of warfarin (minimum two months of therapy); OR
- Anticoagulation with warfarin is contraindicated as per the product monograph or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, or at home).

Note: Some or all direct oral anticoagulants may have contraindications to use or precautions with use, for example: related to prosthetic heart valve disease, rheumatic valvular heart disease, renal function, or age. Refer to the product monograph for additional information.

Special Authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.
UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

The recommended dose of edoxaban for patients initiating DVT or PE treatment is 60 mg once daily following initial use of a parenteral anticoagulant for 5-10 days. A reduced dose of 30 mg once daily is recommended for patients with one or more of the following clinical factors:
- moderate renal impairment (creatinine clearance (CrCL) 30-50 mL/min)
- low body weight <= 60 kg (132 lbs)
- concomitant use of p-glycoprotein inhibitors except amiodarone and verapamil.

Drug plan coverage for edoxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, edoxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for edoxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

15 MG (BASE) ORAL TABLET				
00002458640	LIXIANA	SEV	$	2.9250
30 MG (BASE) ORAL TABLET				
00002458659	LIXIANA	SEV	$	2.9250
60 MG (BASE) ORAL TABLET				
00002458667	LIXIANA	SEV	$	2.9250

ELBASVIR/ GRAZOPREVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype 1 or genotype 4;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (2) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive, without cirrhosis or with compensated cirrhosis (3): 12 weeks*
- Treatment-experienced relapsers, without cirrhosis or with compensated cirrhosis (3): 12 weeks
- Treatment-experienced genotype 1b who have had on-treatment virologic failures (4), without cirrhosis or with compensated cirrhosis (3): 12 weeks
- Treatment-experienced genotype 1a or genotype 4 who have had on-treatment virologic failures (4), without cirrhosis or with compensated cirrhosis (3): 16 weeks in combination with ribavirin

*Note: As approved by Health Canada, 8 weeks may be considered in treatment-naive genotype 1b patients without significant fibrosis or cirrhosis as determined by liver biopsy (i.e., Metavir F0-F2) or by non-invasive tests.

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis
- Combination therapy with sofosbuvir will not be considered for any genotypes

Notes:
1. Treatment experienced for patients with genotype 1 is defined as patients who have been previously treated with a pegylated interferon + ribavirin regimen or a protease inhibitor + pegylated interferon + ribavirin regimen and have not experienced adequate response. Treatment experienced for patients with genotype 4 is defined as patients who have been previously treated with a pegylated interferon + ribavirin regimen and have not experienced adequate response.
2. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
3. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
4. On-treatment virologic failures are patients who have not experienced adequate response to prior treatment, including a null response, partial response or virologic breakthrough or rebound.
5. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the selected drug, including use in special populations."

All requests for elbasvir/grazoprevir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

50 MG * 100 MG ORAL TABLET				
00002451131	ZEPATIER	MFC	$	666.9400

EMPAGLIFLOZIN

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

"FIRST-LINE DRUG PRODUCT(S): METFORMIN

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.
Or, for whom these products are contraindicated.

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes and established cardiovascular diseases who have an inadequate glycemic control, if the following criteria are met:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- established cardiovascular disease* as defined in the EMPA-REG OUTCOME trial

* Established cardiovascular disease is defined on the basis of one of the following:
1) History of myocardial infarction (MI)
2) Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
3) Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within the last 12 months
4) Last episode of unstable angina greater than 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease
5) History of ischemic or hemorrhagic stroke
6) Occlusive peripheral artery disease

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective"

All requests for empagliflozin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

10 MG ORAL TABLET				
00002443937	JARDIANCE	BOE	$	2.7276
25 MG ORAL TABLET				
00002443945	JARDIANCE	BOE	$	2.7276

EMPAGLIFLOZIN/ 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

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes and established cardiovascular diseases who have an inadequate glycemic control, if the following criteria are met:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- established cardiovascular disease* as defined in the EMPA-REG OUTCOME trial

* Established cardiovascular disease is defined on the basis of one of the following:
1) History of myocardial infarction (MI)
2) Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
3) Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within the last 12 months
4) Last episode of unstable angina greater than 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease
5) History of ischemic or hemorrhagic stroke
6) Occlusive peripheral artery disease

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective"

All requests for empagliflozin+metformin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

5 MG * 500 MG ORAL TABLET				
00002456575	SYNJARDY	BOE	$	1.3783
5 MG * 850 MG ORAL TABLET				
00002456583	SYNJARDY	BOE	$	1.3783
5 MG * 1,000 MG ORAL TABLET				
00002456591	SYNJARDY	BOE	$	1.3783
12.5 MG * 500 MG ORAL TABLET				
00002456605	SYNJARDY	BOE	$	1.3783
12.5 MG * 850 MG ORAL TABLET				
00002456613	SYNJARDY	BOE	$	1.3783
12.5 MG * 1,000 MG ORAL TABLET				
00002456621	SYNJARDY	BOE	$	1.3783

EPLERENONE

"For persons suffering from New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction with ejection fraction less than or equal to 35 per cent, as a complement to standard therapy."

Special authorization will be granted for 12 months.

This product is eligible for auto-renewal.

All requests (including renewal requests) for eplerenone must be completed using the Eplerenone/Ivabradine/Sacubitril+Valstartan Special Authorization Request Form (ABC 60050).

25 MG ORAL TABLET				
00002471442	**MINT-EPLERENONE**	**MPI**	$	**2.0595**
00002323052	INSPRA	UJC	$	2.8373
50 MG ORAL TABLET				
00002471450	**MINT-EPLERENONE**	**MPI**	$	**2.0595**
00002323060	INSPRA	UJC	$	2.8373

EPOETIN ALFA

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (< 95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for twelve months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 60,000 units per month."

"For the treatment of anemia in AZT-treated/HIV infected patients. Special authorization will be granted for twelve months."

"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 should be reduced by about 25%. Special authorization will be granted for twelve months."

In order to comply with the first criterion information must be provided regarding the patient's hemoglobin and transferrin saturation.

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

The following product(s) are eligible for auto-renewal for the indication of treatment of anemia of chronic renal failure.

All requests for epoetin alfa must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 60006).

1,000 UNIT / SYR INJECTION SYRINGE				
00002231583	EPREX (0.5 ML SYRINGE)	JAI	$	14.2500
2,000 UNIT / SYR INJECTION SYRINGE				
00002231584	EPREX (0.5 ML SYRINGE)	JAI	$	28.5000
3,000 UNIT / SYR INJECTION SYRINGE				
00002231585	EPREX (0.3 ML SYRINGE)	JAI	$	42.7500

EPOETIN ALFA

4,000 UNIT / SYR INJECTION SYRINGE				
00002231586	EPREX (0.4 ML SYRINGE)	JAI	$	57.0000
5,000 UNIT / SYR INJECTION SYRINGE				
00002243400	EPREX (0.5 ML SYRINGE)	JAI	$	71.2500
6,000 UNIT / SYR INJECTION SYRINGE				
00002243401	EPREX (0.6 ML SYRINGE)	JAI	$	85.5000
8,000 UNIT / SYR INJECTION SYRINGE				
00002243403	EPREX (0.8 ML SYRINGE)	JAI	$	114.0000
10,000 UNIT / SYR INJECTION SYRINGE				
00002231587	EPREX (1 ML SYRINGE)	JAI	$	142.5000
20,000 UNIT / SYR INJECTION SYRINGE				
00002243239	EPREX (0.5 ML SYRINGE)	JAI	$	313.3200

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 should be reduced by about 25%. Patients may be granted a maximum allowable dose of 40,000 IU per week. Special authorization will be granted for twelve months."

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 therapy.

All requests for epoetin alfa must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 60006).

30,000 UNIT / SYR INJECTION SYRINGE				
00002288680	EPREX	JAI	$	360.8300
40,000 UNIT / SYR INJECTION SYRINGE				
00002240722	EPREX	JAI	$	470.0200

ERTAPENEM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"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."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

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	$	56.6061

ESLICARBAZEPINE ACETATE

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for brivaracetam, eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

200 MG ORAL TABLET				
00002426862	APTIOM	SUN	$	9.8700
400 MG ORAL TABLET				
00002426870	APTIOM	SUN	$	9.8700
600 MG ORAL TABLET				
00002426889	APTIOM	SUN	$	9.8700
800 MG ORAL TABLET				
00002426897	APTIOM	SUN	$	9.8700

ETANERCEPT

25 MG / VIAL INJECTION

00002242903	ENBREL	AMG	$	200.7100

Plaque Psoriasis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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.
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

ETANERCEPT

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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- 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 etanercept 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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,

ETANERCEPT

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 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology 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 ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA 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 Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

ETANERCEPT

25 MG / SYR INJECTION SYRINGE

00002462877	ERELZI	SDZ	$	120.5000

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 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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a

ETANERCEPT

'responder' as defined in criteria. ***

"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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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.
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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will

ETANERCEPT

continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- 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 etanercept 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology 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 ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

ETANERCEPT

Once a child with pJIA 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 Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 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."

ETANERCEPT

All requests (including renewal requests) for etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("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 (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:
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."

ETANERCEPT

All requests (including renewal requests) for etanercept 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).

ETANERCEPT

50 MG / SYR INJECTION SYRINGE

☒ 00002455323 BRENZYS SSB $ 241.0000

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 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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a

ETANERCEPT

'responder' as defined in criteria. ***

"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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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.
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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will

ETANERCEPT

continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- 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 etanercept 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology 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 ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

ETANERCEPT

Once a child with pJIA 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 Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 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."

ETANERCEPT

All requests (including renewal requests) for etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("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 (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:
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."

ETANERCEPT

All requests (including renewal requests) for etanercept 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).

☒ 00002455331 BRENZYS (AUTO INJECTOR) SSB $ 241.0000

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 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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile

ETANERCEPT

Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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.
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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

ETANERCEPT

Polyarticular Juvenile Idiopathic Arthritis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- 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 etanercept 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and

ETANERCEPT

2) The Pediatric RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA 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 Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 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

ETANERCEPT

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/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("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 (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:
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

ETANERCEPT

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

☒ 00002462869 ERELZI SDZ $ 241.0000

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 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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

ETANERCEPT

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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.
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."

ETANERCEPT

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- 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 etanercept 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 in each request

ETANERCEPT

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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology 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 ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA 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 Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 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

ETANERCEPT

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/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("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 (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

ETANERCEPT

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 the correct number of decimal places as indicated above."

All requests (including renewal requests) for etanercept 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).

☒ 00002462850 ERELZI (SENSOREADY AUTO INJECTOR) SDZ $ 241.0000

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 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."

ETANERCEPT

All requests (including renewal requests) for etanercept for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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.
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

ETANERCEPT

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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- 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 etanercept 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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),

ETANERCEPT

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 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology 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 ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA 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 Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 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

ETANERCEPT

- 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/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("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 (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];

ETANERCEPT

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

☒ 00002274728 ENBREL AMG $ 401.5400

Plaque Psoriasis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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

ETANERCEPT

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.
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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***All new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Enbrel will not be approved for new etanercept starts for patients with Plaque Psoriasis; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Brenzys or Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg. Coverage for Enbrel will continue for patients with the indications stated above who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria. ***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) 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 (Pediatric Rheumatology Specialist).

- 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 etanercept per prescription at their

ETANERCEPT

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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 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 Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology 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 ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA 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 Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

EVOLOCUMAB

"Special authorization coverage may be provided for the reduction of Low Density Lipoprotein Cholesterol (LDL-C) if the following clinical criteria and conditions are met:

I) Patient has a definite or probable diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) using the Simon Broome or Dutch Lipid Network criteria or genetic testing.

AND

II) Patient is unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention) despite:

a) Confirmed adherence to high dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for at least 3 months.

OR

b) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is unable to tolerate high dose statin, defined as meeting all of the following:

i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose,
AND
ii) For each statin (two statins in total), dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality (creatine kinase (CK) > 5 times the upper limit of normal) resolution rather than discontinuation of statin altogether,
AND

iii) For each statin (two statins in total), intolerable symptoms (myopathy) or abnormal biomarkers (CK > 5 times the upper limit of normal) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate,
AND
iv) One of either:
- Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out,
OR
- Patient developed confirmed and documented rhabdomyolysis.

OR

c) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is statin contraindicated, i.e., active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal.

- Initial coverage may be approved for either 140 mg every two weeks or 420 mg every month for a period of 3 months.
- Patients prescribed evolocumab 420 mg every month must use the 420 mg/dose formulation.
- Patients will be limited to receiving a one-month supply of evolocumab per prescription at their pharmacy.

For continued coverage beyond 3 months, the patient must meet the following criteria:
- Patient is adherent to therapy.
- Patient has achieved a reduction in LDL-C of at least 40% from baseline (4-8 weeks after initiation of evolocumab).

Continued coverage may be approved for 140 mg every 2 weeks or 420 mg every month for a period 12 months. Patients prescribed evolocumab 140 mg every 2 weeks are limited to 26 doses per year. Patients prescribed evolocumab 420 mg every month are limited to 12 doses per year.

EVOLOCUMAB

Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
- Patient is adherent to therapy.
- Patient continues to have a significant reduction in LDL-C (with continuation of evolocumab) of at least 40% from baseline since initiation of PCSK9 inhibitor. LDL-C should be checked periodically with continued treatment with PCSK9 inhibitors (e.g., every 6 months)."

All requests (including renewal requests) for evolocumab for Heterozygous Familial Hypercholesterolemia must be completed using the Alirocumab/Evolocumab for HeFH Special Authorization Request Form (ABC 60060).

140 MG / SYR INJECTION SYRINGE

00002446057	REPATHA AUTOINJECTOR	AMG	$	260.5650

FEBUXOSTAT

"For the treatment of symptomatic gout in patients with a documented hypersensitivity to allopurinol.

Special authorization may be granted for 6 months."

Please note: Hypersensitivity to allopurinol is a rare condition that is characterized by a major skin manifestation, fever, multi-organ involvement, lymphadenopathy and hematological abnormalities (eosinophilia, atypical lymphocytes). Intolerance or lack of response to allopurinol will not be covered by this criteria.

All requests for febuxostat must be completed using the Febuxostat Special Authorization Request Form (ABC 60037).

The following product(s) are eligible for auto-renewal.

80 MG ORAL TABLET

00002490870	**JAMP-FEBUXOSTAT**	**JPC**	$	**0.7950**
00002473607	**MAR-FEBUXOSTAT**	**MAR**	$	**0.7950**
00002357380	ULORIC	TAK	$	1.5900

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 60005).

(Please note: The following fentanyl products are benefits not requiring special authorization for individuals approved by Alberta Health for Palliative Coverage. Refer to the Palliative Coverage Drug Benefit Supplement for additional information on this coverage.)

The following product(s) are eligible for auto-renewal.

12 MCG/HR TRANSDERMAL PATCH				
00002341379	**PMS-FENTANYL MTX**	**PMS**	$	**2.2280**
00002327112	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**2.2280**
00002311925	**TEVA-FENTANYL**	**TEV**	$	**2.2280**
25 MCG/HR TRANSDERMAL PATCH				
00002341387	**PMS-FENTANYL MTX**	**PMS**	$	**3.6560**
00002327120	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**3.6560**
00002282941	**TEVA-FENTANYL**	**TEV**	$	**3.6560**
50 MCG/HR TRANSDERMAL PATCH				
00002341395	**PMS-FENTANYL MTX**	**PMS**	$	**6.8820**
00002327147	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**6.8820**
00002282968	**TEVA-FENTANYL**	**TEV**	$	**6.8820**
75 MCG/HR TRANSDERMAL PATCH				
00002341409	**PMS-FENTANYL MTX**	**PMS**	$	**9.6800**
00002327155	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**9.6800**
00002282976	**TEVA-FENTANYL**	**TEV**	$	**9.6800**
100 MCG/HR TRANSDERMAL PATCH				
00002341417	**PMS-FENTANYL MTX**	**PMS**	$	**12.0500**
00002327163	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**12.0500**
00002282984	**TEVA-FENTANYL**	**TEV**	$	**12.0500**
50 MCG / ML INJECTION				
00002240434	FENTANYL CITRATE	SDZ	$	2.7290

"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."

All requests for fentanyl must be completed using the Fentanyl Special Authorization Request Form (ABC 60005).

(Please note: The following fentanyl products are benefits not requiring special authorization for individuals approved by Alberta Health 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.

FESOTERODINE FUMARATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

4 MG ORAL EXTENDED-RELEASE TABLET				
00002380021	TOVIAZ	PFI	$	1.5000
8 MG ORAL EXTENDED-RELEASE TABLET				
00002380048	TOVIAZ	PFI	$	1.5000

FIDAXOMICIN

For the treatment of:
1) C. difficile infection (CDI) where the patient has failed, or is intolerant of oral vancomycin; or
2) Patients with third or greater recurrence of CDI (i.e. 4th or greater episode of CDI)

Note:
- Fidaxomicin should not be used as an add-on to existing therapy (metronidazole or vancomycin).
- Not studied in multiple recurrences or those with life-threatening or fulminant CDI, toxic megacolon, or inflammatory bowel disease.

Special authorization coverage for fidaxomicin will be provided for one treatment course (10 days) plus one additional treatment course for an early relapse occurring within 8 weeks of the start of the most recent fidaxomicin course.

New episode of CDI after 8 weeks will require treatment with first line therapy before fidaxomicin coverage may be considered.

All requests (including renewal requests) for fidaxomicin must be completed using the Fidaxomicin Special Authorization Request Form (ABC 60014).

200 MG ORAL TABLET				
00002387174	DIFICID	MFC	$	94.6000

FILGRASTIM

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

"Following induction and consolidation treatment for acute myeloid leukemia, for the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization."

"In patients with a diagnosis of congenital, cyclic or idiopathic neutropenia, to increase neutrophil counts and to reduce the incidence and duration of infection."

Please note for the first criterion: Coverage cannot be considered for palliative patients.

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

0.3 MG / ML INJECTION				
00002485591	NIVESTYM	PFI	$	144.3100
00002485656	NIVESTYM (1.6 ML)	PFI	$	144.3125
0.3 MG / SYR INJECTION SYRINGE				
☒ 00002485575	NIVESTYM (0.5 ML SYRINGE)	PFI	$	144.3100
☒ 00002441489	GRASTOFIL (0.5 ML SYRINGE)	APX	$	144.3135
☒ 00002485583	NIVESTYM (0.8 ML SYRINGE)	PFI	$	230.9000
☒ 00002454548	GRASTOFIL (0.8 ML SYRINGE)	APX	$	230.9017

FINGOLIMOD HYDROCHLORIDE

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the treatment of relapsing remitting multiple sclerosis (RRMS) to reduce the frequency of clinical relapses and to delay the progression of physical disability in adult patients (18 years of age or older) who are refractory or intolerant to at least ONE of the following:
- dimethyl fumarate
- glatiramer acetate
- interferon beta
- ocrelizumab
- peginterferon beta
- teriflunomide

Definition of 'intolerant'
Demonstrating serious adverse effects or contraindications to treatments as defined in the product monograph, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of MS disease modifying therapy (DMT).

Definition of 'refractory'
-Development of neutralizing antibodies to interferon beta.

-When the above MS DMTs are taken at the recommended doses for a full and adequate course of treatment, within a consecutive 12-month period while the patient was on the MS DMT, the patient has:

1) Been adherent to the MS DMT (greater than 80% of approved doses have been administered);

2) Experienced at least two relapses* of MS confirmed by the presence of neurologic deficits on examination.
i. The first qualifying clinical relapse must have begun at least one month after treatment initiation.
ii. Both qualifying relapses must be classified with a relapse severity of moderate, severe or very severe**.

* A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

**Relapse Severity: with moderate relapses modification or more time is required to carry out activities of daily living; with severe relapses there is inability to carry out some activities of daily living; with very severe relapses activities of daily living must be completed by others.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during

FINGOLIMOD HYDROCHLORIDE

the previous two years or in the two years prior to starting an MS DMT. In most cases this will be satisfied by the refractory to treatment criterion but if a patient failed an MS DMT more than one year earlier, ongoing active disease must be confirmed.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage will not be approved when any MS DMT or other immunosuppressive therapy is to be used in combination with fingolimod.

Coverage of fingolimod will not be approved if the patient was deemed to be refractory to fingolimod in the past, i.e., has not met the 'responder' criteria below in 'Continued Coverage'.

Following assessment of the request, coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of fingolimod per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more;

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

4) The registered MS Neurologist must confirm in writing that the patient is a 'responder' who has experienced no more than one inflammatory event in the last year (defined as either a clinical relapse or new T2 lesion or gadolinium-enhancing lesion). In instances where a patient has had four or more clinical relapses in the year prior to starting treatment, there must be at least a 50% reduction in relapse rate over the entire treatment period.

Following assessment of the request, continued coverage may be approved for maintenance therapy for up to 12 months. Patients may receive up to 100 days' supply of fingolimod per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption of therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for fingolimod must be completed using the Cladribine/Fingolimod/Natalizumab For Multiple Sclerosis Special Authorization Request Form (ABC 60000).

0.5 MG (BASE) ORAL CAPSULE

00002469936	**APO-FINGOLIMOD**	**APX**	$	**21.7381**
00002487772	**JAMP FINGOLIMOD**	**JPC**	$	**21.7381**

FINGOLIMOD HYDROCHLORIDE

00002474743	**MAR-FINGOLIMOD**	**MAR**	$	**21.7381**
00002469715	**MYLAN-FINGOLIMOD**	**MYP**	$	**21.7381**
00002469782	**PMS-FINGOLIMOD**	**PMS**	$	**21.7381**
00002482606	**SANDOZ FINGOLIMOD**	**SDZ**	$	**21.7381**
00002469618	**TARO-FINGOLIMOD**	**TAR**	$	**21.7381**
00002469561	**TEVA-FINGOLIMOD**	**TEV**	$	**21.7381**
00002365480	GILENYA	NOV	$	86.9525

FLUCONAZOLE

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For susceptible infections in patients who cannot swallow tablets."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

10 MG / ML ORAL SUSPENSION

00002024152	DIFLUCAN	PFI	$	1.1854

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

00002238560	FLUTAMIDE	AAP	$	1.8894

FLUTICASONE FUROATE/ UMECLIDINIUM BROMIDE/ VILANTEROL TRIFENATATE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S):
LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

SECOND-LINE DRUG PRODUCT(S):
LONG-ACTING BRONCHODILATOR DUAL THERAPY (I.E., LONG-ACTING BETA-2 AGONIST [LABA] AND LONG-ACTING MUSCARINIC ANTAGONIST [LAMA]) OR DUAL THERAPY OF INHALED CORTICOSTEROID [ICS] AND LONG-ACTING BETA-2 AGONIST [LABA])

"For the long-term maintenance treatment of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema, in patients who are not controlled on optimal dual inhaled therapy (i.e., long-acting beta-2 agonist [LABA]/long-acting muscarinic antagonist [LAMA] OR inhaled corticosteroid [ICS]/long-acting beta-2 agonist [LABA])."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the third-line therapy drug.

UP - First-line therapy ineffective

All requests for fluticasone furoate + umeclidinium + vilanterol must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

100 MCG / DOSE * 62.5 MCG / DOSE (BASE) * 25 MCG / DOSE (BASE) INHALATION POWDER			**INHALATION METERED**		
00002474522	TRELEGY ELLIPTA		GSK	$	4.4948

FLUTICASONE FUROATE/ VILANTEROL TRIFENATATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for fluticasone furoate + vilanterol trifenatate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

100 MCG / DOSE * 25 MCG / DOSE (BASE)	INHALATION	METERED INHALATION POWDER		
00002408872	BREO ELLIPTA	GSK	$	2.9372

FLUTICASONE FUROATE/ VILANTEROL TRIFENATATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for fluticasone furoate + vilanterol trifenatate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

200 MCG / DOSE * 25 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002444186	BREO ELLIPTA	GSK	$	4.5690

GALANTAMINE HYDROBROMIDE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

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.

Special authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug."

All requests (including renewal requests) for galantamine hydrobromide must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 60034).

8 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002425157	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443015	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339439	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398370	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**
16 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002425165	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443023	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339447	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398389	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**

GALANTAMINE HYDROBROMIDE

24 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002425173	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443031	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339455	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398397	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**

GLATIRAMER ACETATE

20 MG / SYR INJECTION SYRINGE

00002460661	GLATECT	PMS	$	32.4000

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of glatiramer acetate per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of glatiramer acetate per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for glatiramer acetate must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

GLATIRAMER ACETATE

GLYCEROL PHENYLBUTYRATE

"For chronic management of patients with urea cycle disorders (UCDs) who cannot be managed by dietary protein restriction and/or amino acid supplementation alone.

For coverage, this drug must be prescribed by or in consultation with a metabolic or genetic physician. The diagnosis must be confirmed by blood, enzymatic, biochemical, or genetic testing.

Special authorization may be granted for 12 months."

The following product(s) are eligible for auto-renewal.

1.1 G / ML	**ORAL**	**LIQUID**			
00002453304	RAVICTI		RAP	$	48.0000

GOLIMUMAB

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 once per month for four doses.
- Patients will be limited to receiving one dose (50 mg) of golimumab 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 four doses the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial four 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 50 mg once per month for a further 12 month period. Should continued coverage criteria be met, coverage will only be granted for 12 doses per 12 month period. 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 golimumab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Psoriatic Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms 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

GOLIMUMAB

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 month for four doses.
- Patients will be limited to receiving one dose (50 mg) of golimumab 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 four doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after four 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 50 mg per month, for a further 12 month period. Should coverage criteria be met, coverage will only be granted for 12 doses per 12-month period. 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 golimumab for Psoriatic Arthritis must be

GOLIMUMAB

completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("RA Specialist").

- Initial coverage may be approved for 50 mg per month for a total of four doses.
- Patients will be limited to receiving one dose (50 mg) of golimumab 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 four doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after four 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 50 mg per month, for a further 12 month period. Should continued coverage criteria be met, coverage will

GOLIMUMAB

only be granted for 12 doses per 12 month period. 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 the correct number of decimal places as indicated above."

All requests (including renewal requests) for golimumab 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).

Ulcerative Colitis

Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology as recognized by the College of Physicians and Surgeons and/or the Alberta Medical Association or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for 200 mg of golimumab administered by subcutaneous injection at Week 0, followed by 100 mg at Week 2. As an interim measure, an additional dose of 50 mg of golimumab will be provided at weeks 6 and 10 to allow time to determine whether the patient meets coverage criteria for maintenance dosing, see below.
- Patients will be limited to receiving a one-month supply of golimumab 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

GOLIMUMAB

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 a Specialist between week 12 and week 14 to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 50 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 a Specialist to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of golimumab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 50 mg, the maintenance dose may be adjusted from 50 mg to 100 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for golimumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

50 MG / SYR INJECTION SYRINGE

☒	00002324776	SIMPONI	JAI	$ 1516.0000
☒	00002324784	SIMPONI (AUTO INJECTOR)	JAI	$ 1516.0000

GOLIMUMAB

Ulcerative Colitis

Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology as recognized by the College of Physicians and Surgeons and/or the Alberta Medical Association or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for 200 mg of golimumab administered by subcutaneous injection at Week 0, followed by 100 mg at Week 2. As an interim measure, an additional dose of 50 mg of golimumab will be provided at weeks 6 and 10 to allow time to determine whether the patient meets coverage criteria for maintenance dosing, see below.
- Patients will be limited to receiving a one-month supply of golimumab 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 a Specialist between week 12 and week 14 to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 50 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 a Specialist to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of golimumab therapy

Note: For patients who showed a response to induction therapy then experienced

GOLIMUMAB

secondary loss of response while on maintenance dosing with 50 mg, the maintenance dose may be adjusted from 50 mg to 100 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for golimumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

100 MG / SYR INJECTION SYRINGE				
☒ 00002413175	SIMPONI	JAI	$	1516.0000
☒ 00002413183	SIMPONI (AUTO INJECTOR)	JAI	$	1516.0000

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	TSA	$	422.6778
10.8 MG / SYR (BASE) INJECTION SYRINGE				
00002225905	ZOLADEX LA	TSA	$	1204.7322

ICATIBANT ACETATE

"For the treatment of acute attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients with C1-esterase inhibitor deficiency. Icatibant is to be used for:
- acute non-laryngeal attack(s) of at least moderate severity, or
- acute laryngeal attack(s) of any severity

This medication must be prescribed by, or in consultation with, a physician experienced in the treatment of HAE.

Special authorization may be granted for 12 months.

Patients will be limited to a maximum of two doses of icatibant per prescription at their pharmacy."

This product is eligible for auto-renewal.

All requests for icatibant must be completed using the Icatibant/Lanadelumab for HAE Type I or II Special Authorization Request Form (ABC 60083).

30 MG / SYR (BASE) INJECTION				
00002425696	FIRAZYR	TAK	$	2700.0000

IMIPENEM/ CILASTATIN SODIUM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

"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 or extended spectrum beta-lactamases where there is resistance to first-line agents or

6) For use in other Health Canada approved indications in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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 * 500 MG / VIAL (BASE) INJECTION

00000717282	PRIMAXIN	MFC	$	27.1116

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 60038).

The following product(s) are eligible for auto-renewal.

50 MG/G / G TOPICAL CREAM

00002482983	**TARO-IMIQUIMOD PUMP**	**TAR**	$	**43.4350**
00002239505	ALDARA P	VCL	$	52.9314

INDACATEROL MALEATE/ GLYCOPYRRONIUM BROMIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for indacaterol maleate + glycopyrronium bromide must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

110 MCG (BASE)	* 50 MCG (BASE)	INHALATION	CAPSULE		
00002418282	ULTIBRO BREEZHALER		NOV	$	2.5830

INFANT FORMULA

ORAL POWDER

☒ 00000999543 PURAMINO A+ MJO $ 0.1275

"For the dietary management of infants with:
-cow milk protein allergy OR
-soy protein allergy OR
-multiple food protein intolerance OR
-conditions where an amino acid-based diet is indicated:
-short bowel syndrome
-gastroesophageal reflux disease (GERD)
-eosinophilic esophagitis (EoE)
-malabsorption.

AND

Who have failed or are intolerant to an appropriate trial (1 to 2 week trial is recommended) of an extensively hydrolyzed infant formula.

This product must be prescribed by or in consultation with a general pediatrician, neonatologist, pediatric gastroenterologist or pediatric allergist.

Special authorization may be granted for a maximum of 24 months."

(Refer to Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

☒ 00000999568 NEOCATE WITH DHA & ARA NUN $ 0.1581

"For the dietary management of infants with:
-cow milk protein allergy OR
-soy protein allergy OR
-multiple food protein intolerance OR
-conditions where an amino acid-based diet is indicated:
-short bowel syndrome
-gastroesophageal reflux disease (GERD)
-eosinophilic esophagitis (EoE)
-malabsorption.

AND

Who have failed or are intolerant to an appropriate trial (1 to 2 week trial is recommended) of an extensively hydrolyzed infant formula.

This product must be prescribed by or in consultation with a general pediatrician, neonatologist, pediatric gastroenterologist or pediatric allergist.

Special authorization may be granted for a maximum of 24 months."

(Refer to Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

INFLIXIMAB

100 MG / VIAL INJECTION

☒ 00002496933 AVSOLA AMG $ 493.0000

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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

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

INFLIXIMAB

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]

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

INFLIXIMAB

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.

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

INFLIXIMAB

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 Disease and Fistulizing Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 60031).

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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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

INFLIXIMAB

continuing to respond to therapy by meeting criteria as outlined in (2) above."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for infliximab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

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 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

INFLIXIMAB

the correct number of decimal places as indicated above."

All requests (including renewal requests) for infliximab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 (''RA Specialist'').

- 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 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."

INFLIXIMAB

All requests (including renewal requests) for infliximab 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).

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks
AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug 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 ('Specialist').

Initial coverage may be approved for three doses of 5 mg/kg of infliximab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a 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 a Specialist between weeks 10 and 14 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for dose of 5 mg/kg every 8 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 a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of infliximab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg/kg, the maintenance dose may be adjusted from 5 mg/kg 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 Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

INFLIXIMAB

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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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

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

INFLIXIMAB

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]

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

INFLIXIMAB

- 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.

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

INFLIXIMAB

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 Disease and Fistulizing Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 60031).

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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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."

INFLIXIMAB

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for infliximab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

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 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."

INFLIXIMAB

All requests (including renewal requests) for infliximab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("RA Specialist").

- 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 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

INFLIXIMAB

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

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks
AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug 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 ('Specialist').

Initial coverage may be approved for three doses of 5 mg/kg of infliximab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a 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 a Specialist between weeks 10 and 14 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for dose of 5 mg/kg every 8 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 a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of infliximab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg/kg, the maintenance dose may be adjusted from 5 mg/kg 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 Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

INFLIXIMAB

100 MG / VIAL INJECTION

00002419475	INFLECTRA	CHH	$	525.0000

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 another biologic agent to infliximab 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 infliximab if previously trialed and 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/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Moderately to Severely Active Crohn's 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 will be permitted to switch from another biologic to infliximab following an adequate trial

INFLIXIMAB

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 infliximab if previously trialed and 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]

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

INFLIXIMAB

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.

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

INFLIXIMAB

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 Disease and Fistulizing Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 60031).

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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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 another biologic agent to infliximab 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 infliximab if previously trialed and 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

INFLIXIMAB

continuing to respond to therapy by meeting criteria as outlined in (2) above."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for infliximab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Rizankinumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

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 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 another biologic agent to infliximab 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 infliximab if previously trialed and 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."

INFLIXIMAB

All requests (including renewal requests) for infliximab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 ("RA Specialist").

- 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 another biologic agent (with the exception of anakinra) to infliximab 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 infliximab if previously trialed and 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 the initial 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.

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 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

INFLIXIMAB

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

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks
AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug 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 ('Specialist').

Initial coverage may be approved for three doses of 5 mg/kg of infliximab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from another biologic agent to infliximab 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 infliximab if previously trialed and 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 a Specialist between weeks 10 and 14 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for dose of 5 mg/kg every 8 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 a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of infliximab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg/kg, the maintenance dose may be adjusted from 5 mg/kg 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 Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

INOTERSEN SODIUM

"For the treatment of polyneuropathy in adult patients with a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) in patients who meet the following criteria:

- Are symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II
And
- do not exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)
And
-have not previously undergone a liver transplant.

For coverage, this drug must be prescribed by a specialist with experience in the diagnosis and management of hATTR.

Initial coverage may be approved for 284 mg adminstered subcutaneously once weekly for a period of nine months.

Patients will be limited to receiving a four-week supply of inotersen per prescription at their pharmacy.

For renewal of coverage, patients must show continued benefit from treatment with inotersen and must NOT be:
- permanently bedridden and dependent on assistance for basic activities of daily living, NOR
- receiving end-of-life care.

Continued coverage may be approved for 284 mg weekly for a period of six months.

Coverage cannot be provided for use in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR."

All requests (including renewal requests) for inotersen must be completed using the Inotersen/Patisiran for HATTR-PN Special Authorization Request Form (ABC 60084).

284 MG / SYR (BASE)	INJECTION	SYRINGE		
00002481383	TEGSEDI		AKC	$ 8043.4874

INTERFERON BETA-1A

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of interferon beta-1a per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.
Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of interferon beta-1a per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

INTERFERON BETA-1A

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1a must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

44 MCG / ML INJECTION CARTRIDGE				
00002318253	REBIF (1.5 ML CARTRIDGE)	SRO	$	268.3236
88 MCG / ML INJECTION CARTRIDGE				
00002318261	REBIF (1.5 ML CARTRIDGE)	SRO	$	326.6549
6 MIU / SYR INJECTION SYRINGE				
00002269201	AVONEX PS/PEN (30 MCG/0.5 ML)	BIO	$	428.6206
22 MCG / SYR INJECTION SYRINGE				
00002237319	REBIF (0.5 ML SYRINGE)	SRO	$	134.1618
44 MCG / SYR INJECTION SYRINGE				
00002237320	REBIF (0.5 ML SYRINGE)	SRO	$	163.3273

INTERFERON BETA-1B

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.
To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of interferon beta-1b per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of interferon beta-1b per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

INTERFERON BETA-1B

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/ Interferon Beta-1a/ Interferon Beta-1b/ Teriflunomide Special Authorization Request Form (ABC 60001).

Secondary Progressive Multiple Sclerosis with Relapses (SPMS with relapses):

"Special authorization coverage may be provided for the slowing of progression in disability and the reduction of the frequency of clinical relapses in patients with secondary progressive multiple sclerosis with relapses.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of SPMS with relapses;

2) The patient must have active disease which is defined as two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms (documented by a physician), 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory to 100m without an aid (The registered MS Neurologist must provide an updated Expanded Disability Status Scale (EDSS) score of less than or equal to 5.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of interferon beta-1b per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of SPMS with relapses;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

INTERFERON BETA-1B

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of interferon beta-1b per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

9.6 MIU / VIAL INJECTION				
00002169649	**BETASERON (0.3 MG)**	**BAI**	$	**99.3593**
00002337819	**EXTAVIA (0.3 MG)**	**NOV**	$	**99.3593**

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	$	1.1505
250 MCG / ML INHALATION UNIT DOSE SOLUTION				
00002231244	**PMS-IPRATROPIUM (1ML)**	**PMS**	$	**0.6590**
00002231245	**PMS-IPRATROPIUM (2ML)**	**PMS**	$	**0.6590**
00002216221	**TEVA-IPRATROPIUM STERINEBS**	**TEV**	$	**0.6590**

ISAVUCONAZONIUM SULFATE

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of invasive aspergillosis in adult patients who are refractory to or intolerant of voriconazole and caspofungin."*

"For the treatment of invasive mucormycosis."*

"This medication must be prescribed in consultation with a specialist in Infectious Diseases."

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

100 MG ORAL CAPSULE				
00002483971	CRESEMBA	AVP	$	78.8300
200 MG / VIAL INJECTION				
00002483998	CRESEMBA	AVP	$	400.0000

ITRACONAZOLE

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"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."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

10 MG / ML ORAL SOLUTION				
00002484315	**JAMP ITRACONAZOLE**	**JPC**	$	**0.4111**
00002495988	**ODAN ITRACONAZOLE**	**ODN**	$	**0.4111**
00002231347	SPORANOX	JAI	$	0.9060

IVABRADINE HYDROCHLORIDE

"For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (less than or equal to 35%)
And
2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of optimal treatment with:
- a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)
- in combination with a beta-blocker and, if tolerated, a mineralocorticoid receptor antagonist (MRA)
And
3) Who are in sinus rhythm with a resting heart rate greater than or equal to 77 beats per minute (bpm) on average using either an ECG on at least three separate visits or by continuous monitoring
And
4) Who had at least one hospitalization due to HF in the last year

For coverage, this drug must be initiated by a Specialist in Cardiology or Internal Medicine, and the initial request must be completed by the Specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

All requests (including renewal requests) for ivabradine hydrochloride must be completed using the Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form (ABC 60050).

5 MG (BASE) ORAL TABLET				
00002459973	LANCORA	SEV	$	0.8930
7.5 MG (BASE) ORAL TABLET				
00002459981	LANCORA	SEV	$	1.6339

IVACAFTOR

"For the treatment of cystic fibrosis (CF) in patients age six (6) years and older who have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R; and

For the treatment of cystic fibrosis (CF) in patients aged 18 and older with an R117H mutation in the CFTR gene.

For coverage, this drug must be prescribed by a prescriber affiliated with one of the following Alberta Cystic Fibrosis Clinics:
- Cystic Fibrosis Clinic, Adult: Kaye Edmonton Clinic
- Cystic Fibrosis Services - Adult Outpatient: Foothills Medical Centre
- Cystic Fibrosis Clinic, Pediatric: Stollery Children's Hospital
- Pediatric Cystic Fibrosis Clinic: Alberta Children's Hospital

Initial coverage may be approved for up to 150 mg every 12 hours for 6 months. Patients will be limited to receiving a one-month supply per prescription at their pharmacy.

Renewal Criteria

The sweat chloride test will be repeated at the next routine review appointment after starting ivacaftor to determine whether sweat chloride levels are reducing and to check compliance with the drug regimen. The sweat chloride level will then be re-checked 6 months after starting treatment to determine whether the full reduction (as detailed below) has been achieved. Thereafter sweat chloride levels will be checked annually.

For continued coverage of up to 150mg every 12 hours beyond the initial 6-month authorization, the patient will be considered to have responded to treatment if either:

a) The patient's sweat chloride test falls below 60mmoL/L; OR
b) The patient's sweat chloride test falls by at least 30%

In cases where the baseline sweat chloride test is already below 60mmoL/L, the patient will be considered to have responded to treatment if either:

c) The patient's sweat chloride test falls by at least 30%; OR
d) The patient demonstrates a sustained absolute improvement in FEV1 of at least 5%. In this instance FEV1 will be compared with the baseline pre-treatment level one month and three months after starting treatment.

Following this assessment, continued coverage of up to 150 mg every 12 hours may be approved for a period of 12 months. Patients will be limited to receiving a one-month supply per prescription at their pharmacy.

If the expected reduction in sweat chloride does not occur, the patient's CF clinician will first explore any challenges in following the recommended dosing schedule for ivacaftor. The patient's sweat chloride will then be retested around one week later and funding discontinued if the patient does not meet the above criteria."

All requests (including renewal requests) for ivacaftor must be completed using the Ivacaftor Special Authorization Request Form (ABC 60004).

150 MG ORAL TABLET

00002397412	KALYDECO	VER	$	420.0000

IXEKIZUMAB

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 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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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 one 160 mg dose (two 80 mg injections) at weeks 0, followed by 80 mg (one injection) at Weeks 2, 4, 6, 8, 10, and 12.
- Patients will be limited to receiving a one-month supply of ixekizumab 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 initial 12 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 80 mg every 4 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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for ixekizumab for Plaque Psoriasis must be completed

IXEKIZUMAB

using the
Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

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 one 160 mg dose (two 80 mg injections) at week 0, followed by 80 mg (one injection) at weeks 4, 8, 12, 16, 20 & 24.

- Patients will be limited to receiving a one-month supply of ixekizumab 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 24 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial 24 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 considered for 80 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;

IXEKIZUMAB

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 ixekizumab for Psoriatic Arthritis must be completed using the
Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

80 MG / SYR INJECTION SYRINGE

☒ 00002455110	TALTZ	LIL	$	1656.1230
☒ 00002455102	TALTZ AUTOINJECTOR	LIL	$	1656.1230

LACOSAMIDE

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for brivaracetam, eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

50 MG ORAL TABLET

00002475332	**AURO-LACOSAMIDE**	**AUR**	$	**0.6313**
00002488388	**JAMP-LACOSAMIDE**	**JPC**	$	**0.6313**
00002487802	**MAR-LACOSAMIDE**	**MAR**	$	**0.6313**
00002490544	**MINT-LACOSAMIDE**	**MPI**	$	**0.6313**
00002478196	**PHARMA-LACOSAMIDE**	**PMS**	$	**0.6313**
00002474670	**SANDOZ LACOSAMIDE**	**SDZ**	$	**0.6313**
00002472902	**TEVA-LACOSAMIDE**	**TEV**	$	**0.6313**
00002357615	VIMPAT	UCB	$	2.4093

100 MG ORAL TABLET

00002475340	**AURO-LACOSAMIDE**	**AUR**	$	**0.8750**
00002488396	**JAMP-LACOSAMIDE**	**JPC**	$	**0.8750**
00002487810	**MAR-LACOSAMIDE**	**MAR**	$	**0.8750**
00002490552	**MINT-LACOSAMIDE**	**MPI**	$	**0.8750**
00002478218	**PHARMA-LACOSAMIDE**	**PMS**	$	**0.8750**
00002474689	**SANDOZ LACOSAMIDE**	**SDZ**	$	**0.8750**
00002472910	**TEVA-LACOSAMIDE**	**TEV**	$	**0.8750**
00002357623	VIMPAT	UCB	$	3.4477

LACOSAMIDE

150 MG ORAL TABLET

00002475359	**AURO-LACOSAMIDE**	**AUR**	$	**1.1763**
00002488418	**JAMP-LACOSAMIDE**	**JPC**	$	**1.1763**
00002487829	**MAR-LACOSAMIDE**	**MAR**	$	**1.1763**
00002490560	**MINT-LACOSAMIDE**	**MPI**	$	**1.1763**
00002478226	**PHARMA-LACOSAMIDE**	**PMS**	$	**1.1763**
00002474697	**SANDOZ LACOSAMIDE**	**SDZ**	$	**1.1763**
00002472929	**TEVA-LACOSAMIDE**	**TEV**	$	**1.1763**
00002357631	VIMPAT	UCB	$	4.4862

200 MG ORAL TABLET

00002475367	**AURO-LACOSAMIDE**	**AUR**	$	**1.4500**
00002488426	**JAMP-LACOSAMIDE**	**JPC**	$	**1.4500**
00002487837	**MAR-LACOSAMIDE**	**MAR**	$	**1.4500**
00002490579	**MINT-LACOSAMIDE**	**MPI**	$	**1.4500**
00002478234	**PHARMA-LACOSAMIDE**	**PMS**	$	**1.4500**
00002474700	**SANDOZ LACOSAMIDE**	**SDZ**	$	**1.4500**
00002472937	**TEVA-LACOSAMIDE**	**TEV**	$	**1.4500**
00002357658	VIMPAT	UCB	$	5.5247

LANADELUMAB

"For the routine prevention of attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients 12 years of age or older who have had at least three HAE attacks that required the use of an acute injectable treatment within any four-week period in the three months before initiating lanadelumab therapy.

This medication must be prescribed by, or in consultation with, a physician experienced in the treatment of HAE. A record of the baseline total of HAE attacks requiring use of an acute injectable treatment in the three months prior to initiating lanadelumab is required.

Initial coverage may be approved for 3 months. The patient must be assessed after the initial three months to determine response. Patients who have a response to initial treatment* may receive continued coverage with lanadelumab for six months, and should be assessed for continued response** every six months.

*Response to initial lanadelumab treatment is defined as:
- at least a 50% reduction in the number of HAE attacks requiring use of an acute injectable treatment compared to the three month baseline number of attacks prior to initiation of lanadelumab.

**Continued response is defined as:
- maintenance of a minimum improvement of a 50% reduction in the number of HAE attacks requiring use of an acute injectable treatment compared to the baseline number of attacks observed before initiating treatment with lanadelumab.

Coverage cannot be provided for lanadelumab when used in combination with other medications used for long-term prophylactic treatment of angioedema (e.g., C1-INH).

Coverage may be approved for a dosage of up to 300 mg every two weeks. Patients will be limited to receiving a one-month supply per prescription at their pharmacy."

All requests for lanadelumab must be completed using the Icatibant/Lanadelumab for HAE Type I or II Special Authorization Request Form (ABC 60083).

150 MG / ML INJECTION

00002480948	TAKHZYRO	SHB	$	10269.0000

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 12 months."

The following product(s) are eligible for auto-renewal.

60 MG / SYR INJECTION SYRINGE				
00002283395	SOMATULINE AUTOGEL (0.2 ML SYRINGE)	ISP	$	1224.6000
90 MG / SYR INJECTION SYRINGE				
00002283409	SOMATULINE AUTOGEL (0.3 ML SYRINGE)	ISP	$	1633.5400
120 MG / SYR INJECTION SYRINGE				
00002283417	SOMATULINE AUTOGEL (0.5 ML SYRINGE)	ISP	$	2044.7000

LETERMOVIR

"For the prophylaxis therapy of cytomegalovirus (CMV) infection in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT), in patients with undetectable CMV viremia at baseline, and who meet the following criteria:

- is a recipient of umbilical cord blood as stem cell source, or
- a haploidentical recipient, or
- a recipient of T-cell depleted grafts, or
- a recipient treated with antithymocyte globulin (ATG) for conditioning, or
- a recipient requiring high-dose steroids (defined as the use of greater than or equal to 1 mg/kg/day of prednisone or equivalent dose of another corticosteroid) or other immunosuppression for acute graft versus host disease (GVHD), or
- a recipient treated with ATG for steroid-refractory acute GVHD treatment, or
- a recipient with documented history of CMV disease prior to transplantation.

For coverage, this drug must be prescribed by the Director of the Alberta Blood & Marrow Transplant Program, or their designates.

Coverage may be approved at a dosage of up to 480 mg per day administered orally or intravenously.
Duration of therapy will be limited to 100 days, per patient, per HSCT procedure.
Patients will be limited to 14 days supply of letermovir per prescription at their pharmacy."

240 MG ORAL TABLET				
00002469375	PREVYMIS	MFC	$	238.7160
480 MG ORAL TABLET				
00002469383	PREVYMIS	MFC	$	238.7160
20 MG / ML INJECTION				
☒ 00002469405	PREVYMIS (24 ML)	MFC	$	19.5454
☒ 00002469367	PREVYMIS (12 ML)	MFC	$	19.8933

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	ABV	$	364.7500
5 MG / ML INJECTION				
00000727695	LUPRON	ABV	$	67.6464
7.5 MG / VIAL INJECTION				
00000836273	LUPRON DEPOT	ABV	$	387.9700
11.25 MG / VIAL INJECTION				
00002239834	LUPRON DEPOT	ABV	$	1086.7500
22.5 MG / VIAL INJECTION				
00002230248	LUPRON DEPOT	ABV	$	1071.0000

LEVOCARNITINE

"For the treatment of primary carnitine deficiency. Information is required regarding the 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 total plasma carnitine levels.

The following product(s) are eligible for auto-renewal.

330 MG ORAL TABLET				
00002144328	CARNITOR	SGM	$	1.9348
100 MG / ML ORAL SOLUTION				
00002144336	**CARNITOR**	**SGM**	$	**0.3809**
00002492105	**ODAN LEVOCARNITINE**	**ODN**	$	**0.3809**
200 MG / ML INJECTION				
00002144344	CARNITOR	SGM	$	13.8600

LEVODOPA/ CARBIDOPA

Special authorization coverage may be provided for the treatment of patients with advanced levodopa-responsive Parkinson's disease, who meet the following criteria:

1) The patient experiences severe disability associated with at least 25% of the waking day in the off state and/or ongoing, bothersome levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day). Time in the off state, frequency of motor fluctuations, and severity of associated disability should be assessed by a movement disorder subspecialist and be based on an adequate and reliable account from longitudinal specialist care, clinical interview of a patient and/or care partner, or motor symptom diary.
2) The patient has received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response.
3) The patient has failed or is intolerant to adequate trials of each of the following adjunctive medications, if not contraindicated: a catechol-O-methyl transferase (COMT) inhibitor, a dopamine agonist, a monoamine oxidase (MAO-B) inhibitor, and amantadine.
4) The patient is able to administer the medication and care for the administration port and infusion pump. Alternatively, trained personnel or a care partner must be available to perform these tasks reliably.
5) The patient does not have a contraindication to the insertion of a percutaneous endoscopic gastrostomy-jejunostomy (PEG-J) tube.
6) The patient does not have severe psychosis or dementia.
7) Levodopa/carbidopa intestinal gel is initiated by a movement disorder subspecialist who has appropriate training in its use and is practising in a movement disorder clinic that provides ongoing management and support for patients receiving treatment.

Initial coverage may be approved 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:
- The patient demonstrates a significant reduction in the time spent in the off state and/or in ongoing, bothersome levodopa-induced dyskinesias, along with an improvement in the related disability.

All requests for levodopa/carbidopa intestinal gel must be completed using the Levodopa/Carbidopa Intestinal Gel Special Authorization Request Form (ABC 60068).

2,000 MG * 500 MG	**INTRAINTESTINAL**	**GEL**			
00002292165	DUODOPA		ABV	$	169.8100

LEVOFLOXACIN

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): TOBRAMYCIN INHALATION SOLUTION

"For the treatment of chronic pulmonary Pseudomonas aeruginosa infections when used as cyclic treatment (28-day cycles) in patients 18 years of age and older with moderate to severe cystic fibrosis (CF) and deteriorating clinical condition despite treatment with inhaled tobramycin."

"Coverage will not be considered when inhaled levofloxacin and other inhaled antibiotic(s) (e.g. tobramycin, aztreonam) are intended for use in combination, either concurrently or for antibiotic cycling during off-treatment periods."

"Special authorization may be granted for 6 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

100 MG / ML INHALATION SOLUTION				
00002442302	QUINSAIR	RAP	$	26.8703

LINAGLIPTIN

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for linagliptin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

5 MG ORAL TABLET

00002370921	TRAJENTA	BOE	$	2.6571

LINAGLIPTIN/ 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
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for linagliptin+metformin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

2.5 MG * 500 MG ORAL TABLET				
00002403250	JENTADUETO	BOE	$	1.3897
2.5 MG * 850 MG ORAL TABLET				
00002403269	JENTADUETO	BOE	$	1.3897
2.5 MG * 1,000 MG ORAL TABLET				
00002403277	JENTADUETO	BOE	$	1.3897

LINEZOLID

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"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."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

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

00002426552	**APO-LINEZOLID**	**APX**	$	**37.0500**
00002422689	**SANDOZ LINEZOLID**	**SDZ**	$	**37.0500**

LIXISENATIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND INSULIN

"As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- insulin

Or, for whom these products are contraindicated."

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for lixisenatide must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

0.05 MG / ML INJECTION				
00002464276	ADLYXINE	SAV	$	18.9933
0.1 MG / ML INJECTION				
00002464284	ADLYXINE	SAV	$	18.9933

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 for Palliative Coverage. Refer to the Palliative Coverage Drug Benefit Supplement for additional information on this coverage.)

The following product(s) are eligible for auto-renewal.

40 MG ORAL TABLET				
00002195917	MEGESTROL	AAP	$	1.4290
160 MG ORAL TABLET				
00002195925	MEGESTROL	AAP	$	6.2293

MEPOLIZUMAB

"Special authorization coverage may be provided for add-on maintenance treatment of adult patients with severe eosinophilic asthma if the following clinical criteria and conditions are met:

Patient is inadequately controlled with high-dose inhaled corticosteroids (ICS) and one or more additional asthma controller(s) (e.g., a long-acting beta-agonist [LABA]).

AND

Patient has a blood eosinophil count of greater than or equal to 300 cells/mcL AND has experienced two or more clinically significant asthma exacerbations* in the 12 months prior to treatment initiation with mepolizumab;
OR

Patient has a blood eosinophil count of greater than or equal to 150 cells/mcL AND is receiving daily maintenance treatment with oral corticosteroids (OCS).

For coverage, the drug must be initiated and monitored by a respirologist or clinical immunologist or allergist.

Initial coverage may be approved for 12 months of 100 mg administered every 4 weeks.

-Patients will be limited to receiving a one-month supply of mepolizumab 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.
-Coverage cannot be provided for mepolizumab when this medication is intended for use in combination with other biologics for the treatment of asthma.

If ALL the following criteria are met, special authorization may be approved for 100 mg administered every 4 weeks for a further 12-month period.

1) An improvement in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 when compared to pre-treatment baseline or an ACQ-5 score of less than or equal to 1; AND
2) Maintenance or reduction in the number of clinically significant exacerbations* compared to the 12 months prior to initiation of treatment with mepolizumab; AND
3) For patients on daily maintenance therapy with OCS prior to initiating mepolizumab, a decrease in the OCS dose.

Continued coverage may be considered for 100 mg administered every 4 weeks if ALL of the following criteria are met at the end of each additional 12-month period:
1) The ACQ-5 score achieved during the first 12 months of therapy is at least maintained throughout treatment or the ACQ-5 score is less than or equal to 1; AND
2) Maintenance or reduction in the number of clinically significant exacerbations* compared to the previous 12-month period; AND

3) For patients on daily maintenance therapy with OCS prior to initiating mepolizumab, the reduction in the OCS dose achieved after the first 12 months of therapy is at least maintained throughout treatment.

* Clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized."

All requests (including renewal requests) for mepolizumab must be completed using the Benralizumab/Mepolizumab Special Authorization Request Form (ABC 60061).

MEPOLIZUMAB

100 MG / VIAL INJECTION				
00002449781	NUCALA	GSK	$	1996.6138
100 MG / SYR INJECTION SYRINGE				
☒ 00002492997	NUCALA	GSK	$	1977.2292
☒ 00002492989	NUCALA (AUTOINJECTOR)	GSK	$	1977.2292

MEROPENEM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

"1) For second-line therapy of infections due to gram-negative organisms producing inducible beta-lactamases or extended spectrum beta-lactamases where there is resistance to first-line agents or

2) For therapy for infections involving multi-resistant Pseudomonas aeruginosa, where there is documented susceptibility to meropenem or

3) For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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				
00002378787	MEROPENEM	SDZ	$	9.2225
1 G / VIAL INJECTION				
00002378795	MEROPENEM	SDZ	$	18.4450

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	$	0.3022

MIGALASTAT HYDROCHLORIDE

"For treatment of adults (18 years of age or older) with laboratory-confirmed diagnosis of Fabry Disease (a deficiency of alpha-galactosidase [alpha-Gal A]) who have an alpha-Gal A mutation that is determined to be amenable by an in vitro assay.

The patient must also be otherwise eligible for enzyme replacement therapy (ERT) for the treatment of Fabry Disease as determined and assessed through the Canadian Fabry Disease Initiative (CFDI).

For coverage, this drug must be prescribed by a physician affiliated with the Canadian Fabry Disease Initiative (CFDI).
Coverage cannot be provided for use in combination with any ERT.

Initial coverage may be approved up to 12 months.

For continued coverage beyond 12 months, confirmation of continued response is required. Continued coverage may be approved for a period of 12 months."

All requests (including renewal requests) for migalastat must be completed using the Migalastat Special Authorization Request Form (ABC 60071).

123 MG (BASE) ORAL CAPSULE				
00002468042	GALAFOLD	AMI	$	1700.0000

MIRABEGRON

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA.

Special authorization may be granted for 24 months.

Coverage cannot be provided for mirabegron when this medication is intended for use in combination with other overactive bladder agents."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

25 MG ORAL EXTENDED-RELEASE TABLET				
00002402874	MYRBETRIQ	ASP	$	1.4600
50 MG ORAL EXTENDED-RELEASE TABLET				
00002402882	MYRBETRIQ	ASP	$	1.4600

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**	$	**0.3427**
00002430487	**AURO-MODAFINIL**	**AUR**	$	**0.3427**
00002432560	**MAR-MODAFINIL**	**MAR**	$	**0.3427**
00002420260	**TEVA-MODAFINIL**	**TEV**	$	**0.3427**
00002239665	ALERTEC	TMP	$	1.4700

MONTELUKAST SODIUM

(Refer to 48:10.24 of the Alberta 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 60039).

The following product(s) are eligible for auto-renewal.

10 MG (BASE) ORAL TABLET				
00002374609	**APO-MONTELUKAST**	**APX**	$	**0.4231**
00002401274	**AURO-MONTELUKAST**	**AUR**	$	**0.4231**
00002391422	**JAMP-MONTELUKAST**	**JPC**	$	**0.4231**
00002399997	**MAR-MONTELUKAST**	**MAR**	$	**0.4231**
00002408643	**MINT-MONTELUKAST**	**MPI**	$	**0.4231**
00002379333	**MONTELUKAST**	**SNS**	$	**0.4231**
00002382474	**MONTELUKAST**	**SIV**	$	**0.4231**
00002379236	**MONTELUKAST SODIUM**	**AHI**	$	**0.4231**
00002489821	**NRA-MONTELUKAST**	**NRA**	$	**0.4231**
00002373947	**PMS-MONTELUKAST FC**	**PMS**	$	**0.4231**
00002389517	**RAN-MONTELUKAST**	**RAN**	$	**0.4231**
00002328593	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.4231**
00002355523	**TEVA-MONTELUKAST**	**TEV**	$	**0.4231**
00002238217	SINGULAIR	MFC	$	2.4823
5 MG (BASE) ORAL CHEWABLE TABLET				
00002377616	**APO-MONTELUKAST**	**APX**	$	**0.3082**
00002442361	**JAMP-MONTELUKAST**	**JPC**	$	**0.3082**
00002399873	**MAR-MONTELUKAST**	**MAR**	$	**0.3082**
00002408635	**MINT-MONTELUKAST**	**MPI**	$	**0.3082**
00002382466	**MONTELUKAST**	**SIV**	$	**0.3082**
00002354985	**PMS-MONTELUKAST**	**PMS**	$	**0.3082**
00002330393	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.3082**
00002355515	**TEVA-MONTELUKAST**	**TEV**	$	**0.3082**
00002238216	SINGULAIR	MFC	$	1.6902

NARATRIPTAN HCL

(Refer to 28:32.28 of the Alberta 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				
00002314290	**TEVA-NARATRIPTAN**	**TEV**	$	**12.4993**
00002237820	AMERGE	GSK	$	15.4403
2.5 MG (BASE) ORAL TABLET				
00002322323	**SANDOZ NARATRIPTAN**	**SDZ**	$	**6.1436**
00002314304	**TEVA-NARATRIPTAN**	**TEV**	$	**6.1436**
00002237821	AMERGE	GSK	$	16.2768

NATALIZUMAB

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the treatment of relapsing remitting multiple sclerosis (RRMS) to reduce the frequency of clinical relapses, 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 are refractory or intolerant to at least ONE of the following:
- dimethyl fumarate
- glatiramer acetate
- interferon beta
- ocrelizumab
- peginterferon beta
- teriflunomide

Definition of 'intolerant'
Demonstrating serious adverse effects or contraindications to treatments as defined in the product monograph, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of MS disease modifying therapy (DMT).

Definition of 'refractory'

-Development of neutralizing antibodies to interferon beta.

-When the above MS DMTs are taken at the recommended doses for a full and adequate course of treatment, within a consecutive 12-month period while the patient was on the MS DMT, the patient has:

1) Been adherent to the MS DMT (greater than 80% of approved doses have been administered);

2) Experienced at least two relapses* of MS confirmed by the presence of neurologic deficits on examination.
i. The first qualifying clinical relapse must have begun at least one month after treatment initiation.
ii. Both qualifying relapses must be classified with a relapse severity of moderate, severe or very severe**.

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

**Relapse severity: with moderate relapses modification or more time is required to carry out activities of daily living; with severe relapses there is inability to carry out some activities of daily living; with very severe relapses activities of daily living must be completed by others.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.
To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

NATALIZUMAB

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS DMT. In most cases this will be satisfied by the 'refractory' to treatment criterion but if a patient failed an MS DMT more than one year earlier, ongoing active disease must be confirmed.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage will not be approved when any MS DMT or other immunosuppressive therapy is to be used in combination with natalizumab.

Coverage of natalizumab will not be approved if the patient was deemed to be refractory to natalizumab in the past, i.e., has not met the 'responder' criteria below in 'Continued Coverage'.

Following assessment of the request, coverage may be approved for up to 13 doses of 300 mg (i.e., one dose administered every 4 weeks for a period up to 12 months). Patients will be limited to receiving one dose (4 weeks supply) of natalizumab per prescription at their pharmacy.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more;

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

4) At the first renewal there must be evidence that neutralizing antibodies to natalizumab are absent.

5) The registered MS Neurologist must confirm in writing that the patient is a 'responder' who has experienced no more than one inflammatory event in the last year (defined as either a clinical relapse or new T2 lesion or gadolinium-enhancing lesion). In instances where a patient has had four or more clinical relapses in the year prior to starting treatment, there must be at least a 50% reduction in relapse rate over the entire treatment period.

Following assessment of the request, continued coverage may be approved for maintenance therapy of 300 mg every 4 weeks for a period up to 12 months. Patients will be limited to receiving one dose of natalizumab per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for natalizumab must be completed using the Cladribine/Fingolimod/Natalizumab For Multiple Sclerosis Special Authorization Request Form (ABC 60000).

NATALIZUMAB

20 MG / ML INJECTION

00002286386	TYSABRI	BIO	$	181.4455

NINTEDANIB ESILATE

"Initial approval criteria:

Adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF):
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded.
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.
- Patient is under the care of a physician with experience in IPF.

Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests)

Initial renewal criteria (at 6 months):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 6 months

Second and subsequent renewals (at 12 months and thereafter):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

Patients who have experienced intolerance or failure to pirfenidone or nintedanib will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria."

All requests for nintedanib must be completed using the Nintedanib/Pirfenidone Special Authorization Request Form (ABC 60051).

100 MG (BASE) ORAL CAPSULE

00002443066	OFEV	BOE	$	28.3216

150 MG (BASE) ORAL CAPSULE

00002443074	OFEV	BOE	$	56.6431

NITISINONE

"For the treatment of adult and pediatric patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine, when prescribed by a physician with experience in the diagnosis and management of HT-1."

Special authorization may be granted for 12 months.

The following product(s) are eligible for auto-renewal.

2 MG ORAL TABLET				
00002458616	NITISINONE	CYC	$	12.9500
5 MG ORAL TABLET				
00002458624	NITISINONE	CYC	$	25.0600
10 MG ORAL TABLET				
00002458632	NITISINONE	CYC	$	47.4000
2 MG ORAL CAPSULE				
☒ 00002457717	MDK-NITISINONE	MEN	$	12.9500
☒ 00002459698	ORFADIN	BVM	$	12.9500
5 MG ORAL CAPSULE				
☒ 00002457725	MDK-NITISINONE	MEN	$	25.0600
☒ 00002459701	ORFADIN	BVM	$	25.0600
10 MG ORAL CAPSULE				
☒ 00002457733	MDK-NITISINONE	MEN	$	47.4000
☒ 00002459728	ORFADIN	BVM	$	47.4000
20 MG ORAL CAPSULE				
☒ 00002470055	MDK-NITISINONE	MEN	$	128.1000
☒ 00002459736	ORFADIN	BVM	$	128.1000

NUSINERSEN SODIUM

"For patients diagnosed with 5q Spinal Muscular Atrophy (SMA) under the care of a specialist with experience in the diagnosis and management of SMA, if the following clinical criteria are met:

1) Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote, AND
2) Patients who:
- are pre-symptomatic with two or three copies of SMN2, OR
- have had disease duration of less than six months, two copies of SMN2, and symptom onset after the first week after birth and on or before seven months of age, OR
- are under the age of 18 with symptom onset after six months of age, regardless of the ability to walk independently.
AND
3) Patient is not currently requiring permanent invasive ventilation*, AND
4) A baseline assessment using an age-appropriate scale (the Hammersmith Infant Neurological Examination [HINE] Section 2, Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND], or Hammersmith Functional Motor Scale-Expanded [HFMSE]) must be completed prior to initiation of nusinersen treatment.

Other patients who do not meet the expanded funding criteria may be considered in exceptional cases.

Initial coverage may be approved for three 12 mg doses at Day 0, Day 14 and Day 28, followed by one 12 mg dose at Day 63.

Patients will be limited to receiving one dose of nusinersen per prescription at their pharmacy.

For continued coverage, the patient must meet the following criteria:
1) There is demonstrated achievement or maintenance of motor milestone function (as assessed using age-appropriate scales: the [HINE] Section 2), CHOP INTEND, or HFMSE) since treatment initiation in patients who were pre-symptomatic at the time of treatment initiation;
OR
There is demonstrated maintenance of motor milestone function (as assessed using age-appropriate scales: the HINE Section 2, CHOP INTEND, or HFMSE) since treatment initiation in patients who were symptomatic at the time of treatment initiation;
AND
2) Patient does not require permanent invasive ventilation*.

Continued coverage may be considered for one 12 mg maintenance dose at a time, to be administered at 4-month intervals.
Each maintenance dose cannot be considered prior to 4 months elapsing from the date of the previous dose.
Treatment should be discontinued if, prior to the fifth dose or every subsequent dose of nusinersen, the above renewal criteria are not met.

*Permanent invasive ventilation is defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause."

All requests (including renewal requests) for nusinersen must be completed using the Nusinersen Special Authorization Request Form (ABC 60064).

2.4 MG / ML (BASE)	**INJECTION**		
00002465663	SPINRAZA	BIO	$ 23600.0000

OBETICHOLIC ACID

"For the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA, where the following criteria are met:

I. A confirmed diagnosis of PBC, defined as:
- Positive antimitochondrial antibodies (AMA); or
- Liver biopsy results consistent with PBC.

AND

II.a. The patient has received ursodeoxycholic acid (UDCA) for a minimum of 12 months and has experienced an inadequate response to UDCA and can benefit from the addition of obeticholic acid. An inadequate response is defined as:
- alkaline phosphatase (ALP) greater than or equal to 1.67 x upper limit of normal (ULN) and/or
- bilirubin > ULN and < 2 x ULN.

OR

II.b. The patient has experienced documented and unmanageable intolerance to UDCA and can benefit from switching therapy to obeticholic acid.

AND

III. Initiated by a gastroenterologist or hepatologist (or an internal medicine specialist with an interest in gastroenterology / hepatology on a case-by-case basis, in geographic areas where access to these specialities is not available).

Initial coverage may be approved for a period of 12 months.

Ongoing coverage may be considered only if the patient continues to benefit from treatment with obeticholic acid as evidenced by:

- A reduction in the ALP level to less than 1.67 x ULN; or
- A 15% reduction in the ALP level compared with values before beginning treatment with obeticholic acid.

Continued coverage may be approved for up to 12 months."

All requests (including renewal requests) for obeticholic acid must be completed using the Obeticholic Acid Special Authorization Request Form (ABC 60065).

5 MG ORAL TABLET				
00002463121	OCALIVA	ICP	$	102.8712
10 MG ORAL TABLET				
00002463148	OCALIVA	ICP	$	102.8712

OCRELIZUMAB

Relapsing Remitting Multiple Sclerosis (RRMS)

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory adult patients (18 years of age or older) with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.
To register to become an MS Neurologist, please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).
Initial coverage may be approved for an initial dose of ocrelizumab 300 mg given by intravenous (IV) infusion, followed 2 weeks later by a second 300 mg dose. A maintenance dose of ocrelizumab 600 mg at 6 months will also be provided in the initial coverage period. Patients will be limited to receiving one dose of ocrelizumab per prescription at their pharmacy.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.
Continued coverage may be approved for one dose of ocrelizumab 600 mg every 6 months for up to 12 months. Patients may receive one dose of ocrelizumab 600 mg per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the

OCRELIZUMAB

patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for ocrelizumab for RRMS must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1b/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1a for SPMS or RRMS Special Authorization Request Form (ABC 60001).

Primary Progressive Multiple Sclerosis (PPMS):

"Special authorization coverage may be provided for the management of adult patients with early primary progressive multiple sclerosis (PPMS), as defined by disease duration and level of disability in conjunction with imaging features characteristic of inflammatory activity.

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist, please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of PPMS (based on McDonald criteria 2017);

2) The patient must have an Expanded Disability Status Scale (EDSS) score between 3.0 and 6.5;

3) The patient must have a score of at least 2.0 on the Functional Systems scale for the pyramidal system due to lower extremity findings;

4) There are documented imaging features characteristic of inflammatory activity;

5) Disease duration must be less than 15 years for those with an EDSS greater than 5.0, or less than 10 years for those with an EDSS of 5.0 or less.

Initial coverage may be approved for an initial dose of ocrelizumab 300 mg given by intravenous (IV) infusion, followed 2 weeks later by a second 300 mg dose. A maintenance dose of ocrelizumab 600 mg at 6 months will also be provided in the initial coverage period. Patients will be limited to receiving one dose of ocrelizumab per prescription at their pharmacy.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must be assessed between 6 months and 12 months, and every 12 months thereafter, and the request must meet the following criteria:

1) The registered MS Neurologist must confirm a diagnosis of PPMS;

2) A current updated EDSS score must be provided and the patient must not have an EDSS score of 7.0 or above.

Continued coverage may be approved for one dose of ocrelizumab 600 mg every 6 months for up to 12 months. Patients may receive one dose of ocrelizumab 600 mg per prescription at their pharmacy."

All requests (including renewal requests) for ocrelizumab for PPMS must be completed using the Ocrelizumab for PPMS Special Authorization Request Form (ABC 60067).

OCRELIZUMAB

30 MG / ML INJECTION				
00002467224	OCREVUS	HLR	$	815.0000

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 12 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**	$	**4.0080**
00000839191	SANDOSTATIN	NOV	$	5.1460
100 MCG / ML (BASE) INJECTION				
00002248640	**OCTREOTIDE ACETATE OMEGA**	**OMG**	$	**7.5660**
00000839205	SANDOSTATIN	NOV	$	9.7135
200 MCG / ML (BASE) INJECTION				
00002248642	**OCTREOTIDE ACETATE OMEGA**	**OMG**	$	**14.5540**
00002049392	SANDOSTATIN	NOV	$	18.6861
500 MCG / ML (BASE) INJECTION				
00002248641	OCTREOTIDE ACETATE OMEGA	OMG	$	40.3019
10 MG / VIAL INJECTION				
00002239323	SANDOSTATIN LAR	NOV	$	1315.7400
20 MG / VIAL INJECTION				
00002239324	SANDOSTATIN LAR	NOV	$	1699.8900
30 MG / VIAL INJECTION				
00002239325	SANDOSTATIN LAR	NOV	$	2180.9400

OMALIZUMAB

Asthma

"Special authorization coverage may be provided for adults and adolescents (12 years of age and above) with severe persistent asthma who are identified as having severe disease despite optimized standard therapy. Optimized standard therapy defined by a full trial of, and documented compliance with:

- high dose inhaled corticosteroid (budesonide 1600 micrograms per day or fluticasone propionate 1000 micrograms per day or equivalent) for at least twelve (12) months; AND,
- long-acting beta-2 agonist therapy (at least salmeterol 50 micrograms daily or 24 micrograms of formoterol fumarate daily) for at least twelve (12) months; AND,
- Therapeutic trial with systemic corticosteroids (at least 10mg per day prednisolone (or equivalent)) for at least 4 weeks in the previous twelve (12) months, unless contraindicated or not tolerated.

For coverage, the drug must be initiated and monitored by a respirologist or clinical immunologist or allergist and meet the following clinical criteria (Initial Coverage or Continued Coverage, as appropriate). Patients will be limited to receiving a one (1) month supply of omalizumab per prescription at their pharmacy.

INITIAL COVERAGE:
Special authorization requests must meet all of the following criteria for initial approval:

1) Confirmation of severe persistent asthma through recent clinical and physiologic review with exclusion of other obstructive airways processes contributing to symptoms of severe asthma (i.e. psychogenic dyspnea; cardiac dyspnea);

2) Must be a non-smoker;

3) Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing;

4) Baseline IgE level greater than/equal to 30 IU/mL and less than/equal to 700 IU/mL;

5) A weight between 20kg and 150kg;

6) An Asthma Control Questionnaire (ACQ-5) of at least 1.25, on at least two occasions over the past 6 months in a stable state;

7) Must provide documentation:
- Spirometry measurement of FEV1;
- Asthma Quality of Life Questionnaire (AQLQ - Juniper) score;
- Number of exacerbations of asthma within the previous twelve (12) month period that resulted in:
- an emergency room visit or hospitalization;
- physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids;
- chronic use (greater than 50% of the year) of oral corticosteroids;

8) One (1) or more severe exacerbations of asthma requiring a hospital admission or Emergency Room visit within the previous year while on systemic corticosteroids; OR
- One (1) or more severe exacerbations of asthma requiring a hospital admission or Emergency Room visit requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least three (3) days, or parenteral corticosteroids); OR
- Three (3) or more severe exacerbations of asthma within the previous year which required a physician visit and resulted in courses (or chronic use greater than 50% of the year), or increased dose of systemic corticosteroids.

Initial coverage may be approved for twenty-eight (28) weeks of up to 375 mg administered every 2 weeks based on the recommended dose and dosage adjustment outlined in the Health

OMALIZUMAB

Canada approved Product Monograph.

CONTINUED MAINTENANCE TREATMENT:
A patient must be assessed for response to initial coverage of omalizumab with a minimum of twenty-four (24) weeks of therapy with omalizumab, and this assessment must be submitted to Alberta Blue Cross no later than four (4) weeks from the date of assessment.

The assessment must be done by a respirologist or clinical immunologist or allergist or such other clinicians as the Minister may designate. If the following criteria are met, special authorization may be granted for a further twelve (12) month period. Continued coverage may be considered if the following criteria are met at the end of each additional twelve (12) month period:

1) Demonstrated that the patient has an Improvement in FEV1 greater than 12% (and for adults a minimum greater than 200 mL) from initiation of therapy; OR
Unchanged FEV1 with a clinically meaningful Improvement in Asthma Quality of Life Questionnaire score from baseline (greater than/equal to 0.5 mean from baseline); AND
- a decrease in the ACQ-5 of at least 0.5; OR
- a ACQ-5 score of less than/equal to 1.

2) Patients must demonstrate at least a 25% reduction in the number of exacerbations, which required oral corticosteroids from the twelve (12) months prior to initiation of omalizumab that required systemic corticosteroids; OR
For patients that were on chronic (greater than 50% of the year) courses of oral corticosteroids in the twelve (12) months prior to initiation of omalizumab, tapering of oral corticosteroid use by at least 25% from baseline.

3) A reduction in the number of exacerbations that have led to a hospital admission or emergency room visits, compared to the twelve (12) months prior to the commencement of omalizumab."

All requests (including renewal requests) for omalizumab for Asthma must be completed using the Omalizumab for Asthma Special Authorization Request Form (ABC 60020).

Chronic Idiopathic Urticaria

"For the treatment of adults and adolescents (12 years of age and above) with moderate to severe chronic idiopathic urticaria (CIU), defined as having a baseline Urticaria Activity Score over 7 days (UAS7) of greater than or equal to 16, who remain symptomatic (presence of hives and/or associated itching) despite optimum management with available oral therapies. Oral therapies should include a therapeutic trial with H1 antihistamines, unless contraindicated or not tolerated.

For coverage, the drug must be initiated and monitored by a Specialist in Dermatology, Clinical Immunology or Allergy.

Coverage may be approved for a period of 24 weeks at a maximum dose of 300 mg every 4 weeks.
Patients will be limited to receiving a one-month supply of omalizumab per prescription at their pharmacy.
Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Continued coverage of a further 24-week treatment period may be considered if the patient has experienced:
- complete symptom control (i.e., UAS7 of 0) for less than 12 consecutive weeks; OR
- partial symptom control, with a reduction in baseline UAS7 of greater than or equal to 9.5 points.

OMALIZUMAB

Treatment cessation should be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24-week treatment period.

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation should be considered should CIU symptoms reappear."

All requests (including renewal requests) for omalizumab for Chronic Idiopathic Urticaria must be completed using the Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form (ABC 60056).

150 MG / VIAL	**INJECTION**			
00002260565	XOLAIR	NOV	$	646.4400

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

50 MG / SYR (BASE)	INJECTION SYRINGE			
00002354217	INVEGA SUSTENNA (0.5 ML SYR)	JAI	$	320.7700

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

75 MG / SYR (BASE)	INJECTION SYRINGE			
00002354225	INVEGA SUSTENNA (0.75 ML SYR)	JAI	$	481.1800

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

100 MG / SYR (BASE)	INJECTION SYRINGE			
00002354233	INVEGA SUSTENNA (1 ML SYR)	JAI	$	481.1800

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

150 MG / SYR (BASE)	INJECTION SYRINGE			
00002354241	INVEGA SUSTENNA (1.5 ML SYR)	JAI	$	641.5700

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

175 MG / SYR (BASE)	INJECTION SYRINGE			
00002455943	INVEGA TRINZA (0.875 ML SYR)	JAI	$	934.2900

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

263 MG / SYR (BASE)	INJECTION SYRINGE			
00002455986	INVEGA TRINZA (1.315 ML SYR)	JAI	$	1401.5400

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

350 MG / SYR (BASE)	INJECTION SYRINGE			
00002455994	INVEGA TRINZA (1.75 ML SYR)	JAI	$	1401.5400

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

525 MG / SYR (BASE)	INJECTION SYRINGE			
00002456001	INVEGA TRINZA (2.625 ML SYR)	JAI	$	1868.6700

PATISIRAN SODIUM

"For the treatment of polyneuropathy in adult patients with a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) in patients who meet the following criteria:

-Patients are symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II
And
- do not exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)
And
-have not previously undergone a liver transplant.

For coverage, this drug must be prescribed by a specialist with experience in the diagnosis and management of hATTR.

Initial coverage may be approved 30 mg administered intravenously once every three weeks for a period of nine months.

Patients will be limited to receiving one dose of patisiran per prescription at their pharmacy.

For renewal of coverage, patients must show continued benefit from treatment with patisiran and must NOT be:
- permanently bedridden and dependent on assistance for basic activities of daily living, NOR
- receiving end-of-life care.

Continued coverage may be approved for 30 mg every three weeks for a period of six months.

Coverage cannot be provided for use in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR."

All requests (including renewal requests) for patisiran must be completed using the Inotersen/Patisiran for HATTR-PN Special Authorization Request Form (ABC 60084).

2 MG / ML (BASE)	INJECTION		
00002489252	ONPATTRO	ANT	$ 2100.4813

PEGFILGRASTIM

"In patients with non-myeloid malignancies, receiving myelosuppressive 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		
☒ 00002484153	FULPHILA (0.6 ML SYRINGE)	BGP	$	1424.6300
☒ 00002474565	LAPELGA (0.6 ML SYRINGE)	APX	$	1424.6300
☒ 00002497395	ZIEXTENZO (0.6 ML SYRINGE)	SDZ	$	1424.6300

PEGINTERFERON ALFA-2A

The Special Authorization Criteria outlined below remain part of the Alberta Drug Benefit List to enable patients who initiated therapy with Pegasys for Chronic Hepatitis C prior to December 31, 2017 to complete their course of treatment. No new patients will be approved to initiate Pegasys therapy for the treatment of Chronic Hepatitis C after January 2, 2018.

(Refer to 08:18.20 of the Alberta 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 adult 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 60045), 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:

PEGINTERFERON ALFA-2A

- 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 presence of active liver disease is required. Information must include the patient's pre-treatment 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, or the results of transient elastography. 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 60045). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

180 MCG / SYR INJECTION SYRINGE				
00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	$	419.7000

PEGINTERFERON BETA-1A

Relapsing Remitting Multiple Sclerosis (RRMS)

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.
To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).
Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of peg-interferon beta-1a per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of peg-interferon beta-1a per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

PEGINTERFERON BETA-1A

1) At least one relapse* per 12 month period; or

2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

125 MCG / SYR INJECTION SYRINGE				
00002444399	PLEGRIDY	BIO	$	899.0730

PEGINTERFERON BETA-1A/ PEGINTERFERON BETA-1A

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).
Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of peg-interferon beta-1a per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of peg-interferon beta-1a per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or

PEGINTERFERON BETA-1A/ PEGINTERFERON BETA-1A

2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

63 MCG / SYR * 94 MCG / SYR INJECTION SYRINGE				
00002444402	PLEGRIDY	BIO	$	912.3750

PERAMPANEL

"For adjunctive therapy in patients with refractory partial-onset seizures or primary generalized tonic-clonic (PGTC) seizures who meet all of the following criteria:

- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for brivaracetam, eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination.

Each of these products are eligible for auto-renewal"

2 MG ORAL TABLET				
00002404516	FYCOMPA	EIS	$	9.9225
4 MG ORAL TABLET				
00002404524	FYCOMPA	EIS	$	9.9225
6 MG ORAL TABLET				
00002404532	FYCOMPA	EIS	$	9.9225
8 MG ORAL TABLET				
00002404540	FYCOMPA	EIS	$	9.9225
10 MG ORAL TABLET				
00002404559	FYCOMPA	EIS	$	9.9225
12 MG ORAL TABLET				
00002404567	FYCOMPA	EIS	$	9.9225

PIBRENTASVIR/ GLECAPREVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype (2) 1, 2, 3, 4, 5, 6;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months:
AND
IV) Fibrosis (3) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive, without cirrhosis: 8 weeks
- Treatment-naive, with compensated cirrhosis (4): 8 weeks
- Treatment-experienced (1) genotype 1, 2, 4, 5, or 6, without cirrhosis: 8 weeks
- Treatment-experienced (1) genotype 1, 2, 4, 5, or 6, with compensated cirrhosis (4): 12 weeks
- NS3/4A protease inhibitor treatment-experienced (5) genotype 1, without cirrhosis or with compensated cirrhosis (4): 12 weeks
- NS5A inhibitor treatment-experienced (6) genotype 1, without cirrhosis or with compensated cirrhosis (4): 16 weeks
- Treatment-experienced (1) genotype 3, without cirrhosis or with compensated cirrhosis (4): 16 weeks

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent

Notes:
1. Treatment experienced is defined as those who have previously been treated with a regimen containing interferon, peginterferon (P), ribavirin (R), and/or sofosbuvir (e.g. PR, SOF + PR, SOF + R), but have no prior treatment experience with an NS3/4A protease inhibitor or NS5A inhibitor.
2. HCV genotype testing is optional for treatment naive patients.
3. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. NS3/4A protease inhibitor treatment-experienced is defined as those who have previously been treated with a regimen containing a non-structural protein 3/4A (NS3/4A) protease inhibitor, but without an NS5A inhibitor.
6. NS5A inhibitor treatment-experienced is defined as those who have previously been treated with a regimen containing an NS5A inhibitor, but without an NS3/4A protease inhibitor, such as daclatasavir + sofosbuvir, ledipasvir/sofosbuvir, or sofosbuvir/velpatasvir.
7. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."
All requests for pibrentasvir/glecaprevir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

40 MG * 100 MG ORAL TABLET				
00002467550	MAVIRET	ABV	$	238.0952

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.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

15 MG (BASE) ORAL TABLET				
00002391600	**ACH-PIOGLITAZONE**	**AHI**	$	**0.6225**
00002302861	**ACT PIOGLITAZONE**	**TEV**	$	**0.6225**
00002302942	**APO-PIOGLITAZONE**	**APX**	$	**0.6225**
00002397307	**JAMP-PIOGLITAZONE**	**JPC**	$	**0.6225**
30 MG (BASE) ORAL TABLET				
00002339587	**ACH-PIOGLITAZONE**	**AHI**	$	**0.8721**
00002302888	**ACT PIOGLITAZONE**	**TEV**	$	**0.8721**
00002302950	**APO-PIOGLITAZONE**	**APX**	$	**0.8721**
00002365529	**JAMP-PIOGLITAZONE**	**JPC**	$	**0.8721**
45 MG (BASE) ORAL TABLET				
00002339595	**ACH-PIOGLITAZONE**	**AHI**	$	**1.3113**
00002302896	**ACT PIOGLITAZONE**	**TEV**	$	**1.3113**
00002302977	**APO-PIOGLITAZONE**	**APX**	$	**1.3113**
00002365537	**JAMP-PIOGLITAZONE**	**JPC**	$	**1.3113**

PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

"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, or

4) Therapy for infections involving multi-resistant Pseudomonas aeruginosa from pulmonary secretions in cystic fibrosis patients, lung transplant patients or patients with bronchiectasis , where there is documented susceptibility to piperacillin/tazobactam sodium, or

5) For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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.

2 G / VIAL (BASE) * 250 MG / VIAL (BASE) INJECTION				
00002308444	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**4.1727**
00002362619	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**4.1727**
00002401312	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**4.1727**
00002299623	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**4.1727**
3 G / VIAL (BASE) * 375 MG / VIAL (BASE) INJECTION				
00002308452	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**6.2591**
00002362627	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**6.2591**
00002401320	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**6.2591**
00002299631	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**6.2591**
00002370166	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**6.2591**
4 G / VIAL (BASE) * 500 MG / VIAL (BASE) INJECTION				
00002308460	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**8.3458**
00002362635	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**8.3458**
00002401339	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**8.3458**
00002299658	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**8.3458**
00002370174	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**8.3458**

PIRFENIDONE

"Initial approval criteria:

Adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF):
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.
-All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded.
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.
- Patient is under the care of a physician with experience in IPF.

Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests)

Initial renewal criteria (at 6 months):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 6 months

Second and subsequent renewals (at 12 months and thereafter):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

Patients who have experienced intolerance or failure to pirfenidone or nintedanib will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria."

All requests for pirfenidone must be completed using the Nintedanib/Pirfenidone Special Authorization Request Form (ABC 60051).

267 MG ORAL TABLET				
00002464489	ESBRIET	HLR	$	13.4240
801 MG ORAL TABLET				
00002464500	ESBRIET	HLR	$	40.2720
267 MG ORAL CAPSULE				
00002393751	ESBRIET	HLR	$	13.6251

PLERIXAFOR

"For the treatment of patients with Non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM) undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy, in combination with filgrastim, when prescribed by a designated prescriber."

Coverage may be approved for a maximum of 4 doses (0.24mg/kg given daily) for a single mobilization attempt.

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

Special authorization may be granted for 12 months.

20 MG / VIAL INJECTION				
00002377225	MOZOBIL	SAV	$	7555.0000

PROPRANOLOL HCL

"For the treatment of proliferating infantile hemangioma requiring systemic therapy and at least one of the following:

- Life- or function-threatening hemangioma, OR
- Ulcerated hemangioma with pain and/or lack of response to simple wound care measures, OR
- Hemangioma with a risk of permanent scarring or disfigurement.

Special authorization may be granted for 12 months.

Continued coverage may be approved for a period of 12 months for patients who are responding to therapy or experience relapse of symptoms after treatment discontinuation."

3.75 MG / ML ORAL SOLUTION				
00002457857	HEMANGIOL	PIE	$	2.2808

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."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

0.15 MG ORAL TABLET				
00002223775	NORPROLAC	FEI	$	1.7177

RALOXIFENE HCL

Osteoporosis:

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

All requests for raloxifene hydrochloride for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form (ABC 60043).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

60 MG ORAL TABLET

00002358840	**ACT RALOXIFENE**	**APH**	$	**1.0268**
00002279215	**APO-RALOXIFENE**	**APX**	$	**1.0268**
00002239028	EVISTA	LIL	$	1.9593

RIBAVIRIN

200 MG ORAL TABLET

00002439212	IBAVYR	PPH	$	11.8834

For use within an Alberta Drug Benefit List (ADBL) funded combination therapy regimen for the treatment of chronic hepatitis C according to specific eligibility criteria corresponding to the regimen in which it is being administered. Use of ribavirin outside of an ADBL hepatitis C funded regimen will not be reimbursed.

(Refer to Section 3 of the Alberta Drug Benefit List for specific eligibility criteria corresponding to the regimen in which ribavirin is being administered for the treatment of Chronic Hepatitis C.)

400 MG ORAL TABLET

00002425890	IBAVYR	PPH	$	23.0746

For use within an Alberta Drug Benefit List (ADBL) funded combination therapy regimen for the treatment of chronic hepatitis C according to specific eligibility criteria corresponding to the regimen in which it is being administered. Use of ribavirin outside of an ADBL hepatitis C funded regimen will not be reimbursed.

(Refer to Section 3 of the Alberta Drug Benefit List for specific eligibility criteria corresponding to the regimen in which ribavirin is being administered for the treatment of Chronic Hepatitis C.)

RIFABUTIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For susceptible infections when prescribed in consultation with a Specialist in Infectious Diseases.

Special authorization may be granted for 6 months."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

The following product(s) are eligible for auto-renewal.

150 MG ORAL CAPSULE

00002063786	MYCOBUTIN	PFI	$	5.7207

RIFAXIMIN

"For reducing the risk of recurrent Hepatic Encephalopathy (HE) (i.e. 2 or more episodes), in patients with a diagnosis of cirrhosis of the liver or presence of portal hypertension.
Patients must have tried lactulose and been unable to achieve adequate control of HE recurrence with lactulose alone.
Rifaximin must be used in combination with a maximal tolerated dose of lactulose.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

550 MG ORAL TABLET

00002410702	ZAXINE	SLX	$	8.2320

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."

50 MG ORAL TABLET

00002390299	**MYLAN-RILUZOLE**	**MYP**	$	**3.4361**
00002242763	RILUTEK	SAV	$	10.0542

RISANKIZUMAB

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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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 150 mg (two x 75 mg syringes) of risankizumab at weeks 0, 4 and 16.

- Patients will be limited to receiving one 150 mg dose of risankizumab 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 the 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

RISANKIZUMAB

equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 150 mg dose of risankizumab 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.

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for risankizumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

75 MG / SYR INJECTION SYRINGE				
00002487454	SKYRIZI	ABV	$	2467.5000

RISEDRONATE SODIUM

Osteoporosis:

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

All requests for risedronate for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form (ABC 60043).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

Paget's Disease:

"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."

5 MG ORAL TABLET				
00002298376	TEVA-RISEDRONATE	TEV	$	1.7565
30 MG ORAL TABLET				
00002298384	TEVA-RISEDRONATE	TEV	$	11.3807

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 possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one 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.

Special Authorization may be granted for six months."

All requests (including renewal requests) for risperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

The following product(s) are eligible for auto-renewal.

25 MG / VIAL INJECTION				
00002255707	RISPERDAL CONSTA	JAI	$	174.6700
37.5 MG / VIAL INJECTION				
00002255723	RISPERDAL CONSTA	JAI	$	261.9900
50 MG / VIAL INJECTION				
00002255758	RISPERDAL CONSTA	JAI	$	349.3200

RITUXIMAB

10 MG / ML INJECTION

☒ 00002498316 RIXIMYO SDZ $ 29.7000

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); AND
- One anti-tumor necrosis factor (anti-TNF) therapy (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 a dose of 1000 mg of rituximab administered at 0 and 2 weeks (total of 2 - 1000 mg doses).
- Patients will be limited to receiving one dose of rituximab 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 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 each course of therapy, between 16 and 24 weeks after receiving the initial dose of each 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] following the initial course of rituximab; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places] following the initial course of rituximab.
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 residual disease or disease activity returning to a level above a DAS28 score of 2.6.

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 Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60046).

☒ 00002495724 RUXIENCE PFI $ 29.7000

Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA)

"For use in combination with glucocorticoids for the induction of remission of severely active granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis) or microscopic polyangiitis (MPA) in adult patients who have:
- Severe active disease that is life- or organ-threatening. The organ(s) and how the organ(s) is

RITUXIMAB

(are) threatened must be specified;
AND
- A positive serum assay for either proteinase 3-ANCA (anti-neutrophil cytoplasmic antibody) or myeloperoxidase-ANCA. A copy of the lab report must be provided; AND
- Cyclophosphamide cannot be used for ONE of the following reasons:
a) The patient has failed a minimum of six intravenous pulses of cyclophosphamide; OR
b) The patient has failed three months of oral cyclophosphamide therapy; OR
c) The patient has a severe intolerance or an allergy to cyclophosphamide; OR
d) Cyclophosphamide is contraindicated; OR
e) The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide.

- Coverage may be approved for a maximum of 375 mg per square metre of body surface area weekly for 4 weeks.
- Patients will be limited to receiving two doses of rituximab per prescription at their pharmacy.
- For relapse following a remission, coverage may be provided for patients who experience a flare of severe active disease that is life- or organ-threatening; or, who experience worsening symptoms in 2 or more organs even if not life-threatening. Note: For relapse following a rituximab-induced remission, additional coverage may be approved no sooner than 6 months after previous rituximab treatment."

All requests (including renewal requests) for rituximab for Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA) must be completed using the Rituximab for Granulomatosis with Polyangiitis/Microscopic Polyangiitis Special Authorization Request Form (ABC 60018).

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); AND
- One anti-tumor necrosis factor (anti-TNF) therapy (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 a dose of 1000 mg of rituximab administered at 0 and 2 weeks (total of 2 - 1000 mg doses).
- Patients will be limited to receiving one dose of rituximab 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 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 each course of therapy, between 16 and 24 weeks after receiving the initial dose of each 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] following the

RITUXIMAB

initial course of rituximab; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places] following the initial course of rituximab.
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 residual disease or disease activity returning to a level above a DAS28 score of 2.6.

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 Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60046).

☒ 00002478382 TRUXIMA (10 ML) CTC $ 29.7000

Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA)

"For use in combination with glucocorticoids for the induction of remission of severely active granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis) or microscopic polyangiitis (MPA) in adult patients who have:
- Severe active disease that is life- or organ-threatening. The organ(s) and how the organ(s) is (are) threatened must be specified;
AND
- A positive serum assay for either proteinase 3-ANCA (anti-neutrophil cytoplasmic antibody) or myeloperoxidase-ANCA. A copy of the lab report must be provided; AND
- Cyclophosphamide cannot be used for ONE of the following reasons:
a) The patient has failed a minimum of six intravenous pulses of cyclophosphamide; OR
b) The patient has failed three months of oral cyclophosphamide therapy; OR
c) The patient has a severe intolerance or an allergy to cyclophosphamide; OR
d) Cyclophosphamide is contraindicated; OR
e) The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide.

- Coverage may be approved for a maximum of 375 mg per square metre of body surface area weekly for 4 weeks.
- Patients will be limited to receiving two doses of rituximab per prescription at their pharmacy.
- For relapse following a remission, coverage may be provided for patients who experience a flare of severe active disease that is life- or organ-threatening; or, who experience worsening symptoms in 2 or more organs even if not life-threatening. Note: For relapse following a rituximab-induced remission, additional coverage may be approved no sooner than 6 months after previous rituximab treatment."

All requests (including renewal requests) for rituximab for Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA) must be completed using the Rituximab for Granulomatosis with Polyangiitis/Microscopic Polyangiitis Special Authorization Request Form (ABC 60018).

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); AND
- One anti-tumor necrosis factor (anti-TNF) therapy (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").

RITUXIMAB

- Initial coverage may be approved for a dose of 1000 mg of rituximab administered at 0 and 2 weeks (total of 2 - 1000 mg doses).
- Patients will be limited to receiving one dose of rituximab 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 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 each course of therapy, between 16 and 24 weeks after receiving the initial dose of each 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] following the initial course of rituximab; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places] following the initial course of rituximab.
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 residual disease or disease activity returning to a level above a DAS28 score of 2.6.

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 Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60046).

☒ 00002478390 TRUXIMA (50 ML) CTC $ 29.7000

Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA)

"For use in combination with glucocorticoids for the induction of remission of severely active granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis) or microscopic polyangiitis (MPA) in adult patients who have:
- Severe active disease that is life- or organ-threatening. The organ(s) and how the organ(s) is (are) threatened must be specified;
AND
- A positive serum assay for either proteinase 3-ANCA (anti-neutrophil cytoplasmic antibody) or myeloperoxidase-ANCA. A copy of the lab report must be provided; AND
- Cyclophosphamide cannot be used for ONE of the following reasons:
a) The patient has failed a minimum of six intravenous pulses of cyclophosphamide; OR
b) The patient has failed three months of oral cyclophosphamide therapy; OR
c) The patient has a severe intolerance or an allergy to cyclophosphamide; OR
d) Cyclophosphamide is contraindicated; OR
e) The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide.

- Coverage may be approved for a maximum of 375 mg per square metre of body surface area weekly for 4 weeks.
- Patients will be limited to receiving two doses of rituximab per prescription at their pharmacy.
- For relapse following a remission, coverage may be provided for patients who experience a flare of severe active disease that is life- or organ-threatening; or, who experience worsening symptoms in 2 or more organs even if not life-threatening. Note: For relapse following a rituximab-induced remission, additional coverage may be approved no sooner than 6 months after previous rituximab treatment."

All requests (including renewal requests) for rituximab for Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA) must be completed using the Rituximab for Granulomatosis with Polyangiitis/Microscopic Polyangiitis Special Authorization Request Form (ABC 60018).

RITUXIMAB

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); AND
- One anti-tumor necrosis factor (anti-TNF) therapy (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 a dose of 1000 mg of rituximab administered at 0 and 2 weeks (total of 2 - 1000 mg doses).
- Patients will be limited to receiving one dose of rituximab 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 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 each course of therapy, between 16 and 24 weeks after receiving the initial dose of each 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] following the initial course of rituximab; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places] following the initial course of rituximab.
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 residual disease or disease activity returning to a level above a DAS28 score of 2.6.

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 Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60046).

RIVAROXABAN

For use in combination with acetylsalicylic acid (ASA; 75 mg to 100 mg) for the prevention of stroke, myocardial infarction, and cardiovascular death, and for the prevention of acute limb ischemia and mortality in patients with concomitant coronary artery disease (CAD) and peripheral artery disease (PAD) as defined below.

Patients with CAD are defined as having one or more of the following:
1) myocardial infarction within the last 20 years
2) multi-vessel coronary disease (i.e., stenosis of greater than or equal to 50 per cent in two or more coronary arteries, or in one coronary territory if at least one other territory has been revascularized) with symptoms or history of stable or unstable angina
3) multi-vessel percutaneous coronary intervention
4) multi-vessel coronary artery bypass graft surgery.

For coverage, patients with CAD as defined above must also meet one of the following criteria:
- aged 65 years or older, or
- aged younger than 65 years with documented atherosclerosis or revascularization involving at least two vascular beds (coronary and other vascular) or at least two additional risk factors (current smoker, diabetes mellitus, estimated glomerular filtration rate less than 60 mL/min, heart failure, non-lacunar ischemic stroke 1 month or more ago).

Patients with PAD are defined as having one or more of the following:
1) previous aorto-femoral bypass surgery, limb bypass surgery, or percutaneous transluminal angioplasty revascularization of the iliac or infrainguinal arteries
2) previous limb or foot amputation for arterial vascular disease
3) history of intermittent claudication and one or more of the following:
- an anklebrachial index less than 0.90
- significant peripheral stenosis (greater than or equal to 50%) documented by angiography or by duplex ultrasound
4) previous carotid revascularization or asymptomatic carotid artery stenosis greater than or equal to 50%, as diagnosed by duplex ultrasound or angiography.

Exclusions from coverage:
- Patients who have CAD or PAD alone, OR;
- Patients with any one of the following characteristics:
1) at high risk of bleeding
2) a history of stroke within one month of treatment initiation or any history of hemorrhagic or lacunar stroke
3) severe heart failure with a known ejection fraction less than 30% or New York Heart Association (NYHA) class III or IV symptoms
4) an estimated glomerular filtration rate less than 15 mL/min
5) require dual antiplatelet therapy, other non-ASA antiplatelet therapy, or oral anticoagulant therapy.

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

All requests for rivaroxaban 2.5 mg must be completed using the Rivaroxaban 2.5 mg Special Authorization Request Form (ABC 60081).

2.5 MG ORAL TABLET

00002480808	XARELTO	BAI	$	1.4200

RIVAROXABAN
NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage

Members of Alberta Government Sponsored Drug Plans who are at-risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following a Reasonable Trial on Warfarin; OR
- Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

At-risk patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Although the ROCKET-AF trial included patients with higher CHADS2 scores (greater than or equal to 2), other landmark studies with the other newer oral anticoagulants demonstrated a therapeutic benefit in patients with a CHADS2 score of 1. Coverage may be considered for an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.

Exclusion from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <30 mL/min) OR
- Greater than or equal to 75 years of age and without Documented Stable Renal Function; OR
- hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR
- prosthetic heart valves.

Definitions:
- Documented Stable Renal Function is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months (i.e. 30-49 mL/min for 15 mg once daily dosing or greater than or equal to 50 mL/Min for 20 mg once daily dosing).
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- Reasonable Trial on Warfarin is defined as at least 2 months of therapy.

OTHER CRITERIA:
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product monograph).
- Patients starting the Drug Product should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

Special Authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

RIVAROXABAN

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

OTHER CRITERIA:

The recommended dose of rivaroxaban for patients initiating DVT or PE treatment is 15 mg twice daily for 3 weeks, followed by 20 mg once daily.

Drug plan coverage for rivaroxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, rivaroxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for rivaroxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

15 MG ORAL TABLET

00002378604	XARELTO	BAI	$	2.8700

RIVAROXABAN
NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage

Members of Alberta Government Sponsored Drug Plans who are at-risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following a Reasonable Trial on Warfarin; OR
- Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

At-risk patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Although the ROCKET-AF trial included patients with higher CHADS2 scores (greater than or equal to 2), other landmark studies with the other newer oral anticoagulants demonstrated a therapeutic benefit in patients with a CHADS2 score of 1. Coverage may be considered for an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.

Exclusion from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <30 mL/min) OR
- Greater than or equal to 75 years of age and without Documented Stable Renal Function; OR
- hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR
- prosthetic heart valves.

Definitions:
- Documented Stable Renal Function is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months (i.e. 30-49 mL/min for 15 mg once daily dosing or greater than or equal to 50 mL/Min for 20 mg once daily dosing).
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- Reasonable Trial on Warfarin is defined as at least 2 months of therapy.

OTHER CRITERIA:
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product monograph).
- Patients starting the Drug Product should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

Special Authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

RIVAROXABAN

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

OTHER CRITERIA:

The recommended dose of rivaroxaban for patients initiating DVT or PE treatment is 15 mg twice daily for 3 weeks, followed by 20 mg once daily.

Drug plan coverage for rivaroxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, rivaroxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for rivaroxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

20 MG ORAL TABLET

00002378612	XARELTO	BAI	$	2.8700

RIVASTIGMINE HYDROGEN TARTRATE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

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.

Special authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug."

All requests (including renewal requests) for rivastigmine hydrogen tartrate must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 60034).

1.5 MG (BASE) ORAL CAPSULE				
00002336715	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485362	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401614	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324563	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242115	EXELON	NOV	$	2.8425
3 MG (BASE) ORAL CAPSULE				
00002336723	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485370	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401622	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324571	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242116	EXELON	NOV	$	2.8425
4.5 MG (BASE) ORAL CAPSULE				
00002336731	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485389	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401630	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324598	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242117	EXELON	NOV	$	2.8425
6 MG (BASE) ORAL CAPSULE				
00002336758	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485397	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401649	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324601	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242118	EXELON	NOV	$	2.8425
2 MG / ML (BASE) ORAL SOLUTION				
00002245240	EXELON	NOV	$	1.4945

RIZATRIPTAN BENZOATE

(Refer to 28:32.28 of the Alberta 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				
00002393468	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002380455	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429233	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
10 MG (BASE) ORAL TABLET				
00002381702	**ACT RIZATRIPTAN**	**APH**	$	**3.7050**
00002393476	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002441144	**AURO-RIZATRIPTAN**	**AUR**	$	**3.7050**
00002380463	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429241	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
00002379678	**MAR-RIZATRIPTAN**	**MAR**	$	**3.7050**
00002240521	MAXALT	MFC	$	16.5163
5 MG (BASE) ORAL DISINTEGRATING TABLET				
00002483270	**ACCEL-RIZATRIPTAN ODT**	**ACP**	$	**2.9633**
00002458764	**CCP-RIZATRIPTAN ODT**	**CEL**	$	**2.9633**
00002379198	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**2.9633**
00002465086	JAMP-RIZATRIPTAN ODT	JPC	$	3.7050
00002462788	MAR-RIZATRIPTAN ODT	MAR	$	3.7050
00002436604	NAT-RIZATRIPTAN ODT	NTP	$	3.7050
00002393360	PMS-RIZATRIPTAN RDT	PMS	$	3.7050
00002442906	RIZATRIPTAN ODT	SNS	$	3.7050
00002446111	RIZATRIPTAN ODT	SIV	$	3.7050
00002351870	SANDOZ RIZATRIPTAN ODT	SDZ	$	3.7050
00002396661	TEVA-RIZATRIPTAN ODT	TEV	$	3.7050
00002240518	MAXALT RPD	MFC	$	16.5163
10 MG (BASE) ORAL DISINTEGRATING TABLET				
00002483289	**ACCEL-RIZATRIPTAN ODT**	**ACP**	$	**2.9633**
00002458772	**CCP-RIZATRIPTAN ODT**	**CEL**	$	**2.9633**
00002379201	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**2.9633**
00002465094	JAMP-RIZATRIPTAN ODT	JPC	$	3.7050
00002462796	MAR-RIZATRIPTAN ODT	MAR	$	3.7050
00002436612	NAT-RIZATRIPTAN ODT	NTP	$	3.7050
00002393379	PMS-RIZATRIPTAN RDT	PMS	$	3.7050
00002442914	RIZATRIPTAN ODT	SNS	$	3.7050
00002446138	RIZATRIPTAN ODT	SIV	$	3.7050
00002351889	SANDOZ RIZATRIPTAN ODT	SDZ	$	3.7050
00002396688	TEVA-RIZATRIPTAN ODT	TEV	$	3.7050
00002240519	MAXALT RPD	MFC	$	16.5163

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.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

2 MG (BASE) ORAL TABLET				
00002403366	ROSIGLITAZONE	AAP	$	1.0316
4 MG (BASE) ORAL TABLET				
00002403374	ROSIGLITAZONE	AAP	$	1.6188
8 MG (BASE) ORAL TABLET				
00002403382	ROSIGLITAZONE	AAP	$	2.3150

ROTIGOTINE

"For adjunctive therapy to levodopa for the treatment of patients with advanced stage Parkinson's disease (APD).

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

2 MG/24HR TRANSDERMAL PATCH				
00002403900	NEUPRO	UCB	$	3.5400
4 MG/24HR TRANSDERMAL PATCH				
00002403927	NEUPRO	UCB	$	6.5000
6 MG/24HR TRANSDERMAL PATCH				
00002403935	NEUPRO	UCB	$	7.2700
8 MG/24HR TRANSDERMAL PATCH				
00002403943	NEUPRO	UCB	$	7.2700

RUFINAMIDE

"For the treatment of seizures associated with Lennox-Gastaut Syndrome (LGS) in patients who meet the following criteria:
- are currently taking two or more anti-epileptic drugs (AEDs) without optimal seizure control; AND
- have failed or demonstrated intolerance to adequate trials of both lamotrigine AND topiramate; AND
- therapy must be initiated by a Neurologist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

100 MG ORAL TABLET				
00002369613	BANZEL	EIS	$	0.7541
200 MG ORAL TABLET				
00002369621	BANZEL	EIS	$	1.5082
400 MG ORAL TABLET				
00002369648	BANZEL	EIS	$	3.2863

SACUBITRIL/ VALSARTAN

"For the treatment of heart failure (HF) in patients with the following criteria:

1) reduced left ventricular ejection fraction (LVEF) (< 40%)
And
2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of treatment with:
- a stable dose of an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)
- in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)
And
3) who have Plasma B-type natriuretic peptide (BNP) >= 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) >= 600 pg/mL; or
- if the patient has been hospitalized for HF within the past 12 months and has plasma BNP >= 100 pg/mL or NT-proBNP >= 400 pg/mL levels

For coverage, this drug must be initiated by a Specialist in Cardiology or Internal Medicine, and the initial request must be completed by the Specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

All requests (including renewal requests) for sacubitril+valsartan must be completed using the Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form (ABC 60050).

24.3 MG * 25.7 MG ORAL TABLET				
00002446928	ENTRESTO	NOV	$	3.7060
48.6 MG * 51.4 MG ORAL TABLET				
00002446936	ENTRESTO	NOV	$	3.7060
97.2 MG * 102.8 MG ORAL TABLET				
00002446944	ENTRESTO	NOV	$	3.7060

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

25 MCG / DOSE (BASE)	* 125 MCG / DOSE	INHALATION	METERED DOSE AEROSOL		
00002245126	ADVAIR 125		GSK	$	0.8846

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

25 MCG / DOSE (BASE)	* 250 MCG / DOSE	INHALATION	METERED DOSE AEROSOL		
00002245127	ADVAIR 250		GSK	$	1.2558

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

50 MCG / DOSE (BASE)	* 100 MCG / DOSE	INHALATION	METERED INHALATION POWDER		
00002494507	**PMS-FLUTICASONE/SALMETEROL DPI**	**PMS**	$	**0.7068**
00002495597	**WIXELA INHUB**	**MYP**	$	**0.7068**
00002240835	ADVAIR 100 DISKUS	GSK	$	1.4779

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

50 MCG / DOSE (BASE) * 250 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002494515	**PMS-FLUTICASONE/SALMETEROL DPI**	**PMS**	$	**0.8460**
00002495600	**WIXELA INHUB**	**MYP**	$	**0.8460**
00002240836	ADVAIR 250 DISKUS	GSK	$	1.7693

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

50 MCG / DOSE (BASE) * 500 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002494523	**PMS-FLUTICASONE/SALMETEROL DPI**	**PMS**	$	**1.2010**
00002495619	**WIXELA INHUB**	**MYP**	$	**1.2010**
00002240837	ADVAIR 500 DISKUS	GSK	$	2.5116

SARILUMAB

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.

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.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

Initial coverage may be approved for up to 200 mg of sarilumab given subcutaneously every 2 weeks for 12 weeks.
- Patients will be limited to receiving a one-month supply of sarilumab 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 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 one subcutaneous dose of up to 200 mg every 2 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

SARILUMAB

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 sarilumab 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).

150 MG / SYR INJECTION				
00002472961	KEVZARA (PREFILLED PEN)	SAV	$	737.5800
200 MG / SYR INJECTION				
00002472988	KEVZARA (PREFILLED PEN)	SAV	$	737.5800
150 MG / SYR INJECTION SYRINGE				
00002460521	KEVZARA	SAV	$	737.5800
200 MG / SYR INJECTION SYRINGE				
00002460548	KEVZARA	SAV	$	737.5800

SAXAGLIPTIN HCL

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for saxagliptin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

2.5 MG ORAL TABLET				
00002375842	ONGLYZA	AZC	$	2.4910
5 MG (BASE) ORAL TABLET				
00002333554	ONGLYZA	AZC	$	2.9540

SAXAGLIPTIN HCL/ 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
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for saxagliptin+metformin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

2.5 MG (BASE) * 500 MG ORAL TABLET				
00002389169	KOMBOGLYZE	AZC	$	1.2700
2.5 MG (BASE) * 850 MG ORAL TABLET				
00002389177	KOMBOGLYZE	AZC	$	1.2700
2.5 MG (BASE) * 1,000 MG ORAL TABLET				
00002389185	KOMBOGLYZE	AZC	$	1.2700

SECUKINUMAB

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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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 12 weeks as follows:
- Four weekly doses of 300 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8 and 12.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter. Each 300 mg dose is provided as two subcutaneous injections of 150 mg.
- 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 the 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 seven doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial seven 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 300 mg dose of secukinumab every month 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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

SECUKINUMAB

All requests (including renewal requests) for secukinumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

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 16 weeks as follows:
- Four weekly doses of 150 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8, 12 and 16. A dose of 300 mg (given as 2 subcutaneous injections of 150 mg each) may be considered for anti-TNF alpha inadequate responders.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter.
- 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 eight doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial eight 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 considered for one 150 mg (or 300 mg for anti-TNF alpha inadequate responders) dose of secukinumab every month 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;

SECUKINUMAB

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 secukinumab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

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 16 weeks as follows:
- Four weekly doses of 150 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8, 12 and 16.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter.
- 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 eight doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial eight 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 considered for one 150 mg dose of secukinumab every month for a period of 12 months. Ongoing coverage may be considered if

SECUKINUMAB

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 secukinumab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

150 MG / ML INJECTION SYRINGE

00002438070	COSENTYX	NOV	$	840.0000

SEMAGLUTIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for semaglutide must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

1.34 MG / ML INJECTION

☒ 00002471469	OZEMPIC (1 MG DOSE)	NNA	$	67.5100
☒ 00002471477	OZEMPIC (0.25MG OR 0.5MG DOSE)	NNA	$	135.0200

SILTUXIMAB

"For the treatment of multicentric Castleman's disease (MCD) in patients who are human immunodeficiency virus (HIV) negative and human herpes virus-8 (HHV-8) negative and who have an ECOG performance status of less than or equal to 2.

Initial coverage may be approved for a period of 6 months.

Continued coverage may be approved for a period of 12 months for patients who continue to meet initial coverage criteria.

Coverage for siltuximab will be provided for one intravenous dose of 11 mg/kg every 3 weeks. Patients will be limited to receiving one dose of siltuximab per prescription at their pharmacy."

100 MG / VIAL INJECTION				
00002435128	SYLVANT	JAI	$	697.7000
400 MG / VIAL INJECTION				
00002435136	SYLVANT	JAI	$	2790.8000

SITAGLIPTIN PHOSPHATE MONOHYDRATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for sitagliptin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

25 MG ORAL TABLET				
00002388839	JANUVIA	MFC	$	3.2229
50 MG ORAL TABLET				
00002388847	JANUVIA	MFC	$	3.2229
100 MG ORAL TABLET				
00002303922	JANUVIA	MFC	$	3.2229

SITAGLIPTIN PHOSPHATE MONOHYDRATE/ 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
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for sitagliptin+metformin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

50 MG (BASE) * 500 MG ORAL TABLET				
00002333856	JANUMET	MFC	$	1.7465
50 MG (BASE) * 850 MG ORAL TABLET				
00002333864	JANUMET	MFC	$	1.7465
50 MG (BASE) * 1,000 MG ORAL TABLET				
00002333872	JANUMET	MFC	$	1.7465
50 MG (BASE) * 500 MG ORAL EXTENDED-RELEASE TABLET				
00002416786	JANUMET XR	MFC	$	1.7345
50 MG (BASE) * 1,000 MG ORAL EXTENDED-RELEASE TABLET				
00002416794	JANUMET XR	MFC	$	1.7345
100 MG (BASE) * 1,000 MG ORAL EXTENDED-RELEASE TABLET				
00002416808	JANUMET XR	MFC	$	3.4691

SODIUM PHENYLBUTYRATE

"For chronic management of patients with urea cycle disorders (UCDs) who cannot be managed by dietary protein restriction and/or amino acid supplementation alone.

For coverage, this drug must be prescribed by or in consultation with a metabolic or genetic physician. The diagnosis must be confirmed by blood, enzymatic, biochemical, or genetic testing.

Special authorization may be granted for 12 months."

The following product(s) are eligible for auto-renewal.

483 MG / G ORAL GRANULE				
00002436663	PHEBURANE	MDK	$	9.2690

SOFOSBUVIR

"For use as combination therapy with ribavirin for treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:

I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype 2 or genotype 3;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (2) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive or treatment experienced genotype 2, without cirrhosis or with compensated cirrhosis (3): 12 weeks in combination with ribavirin
- Treatment-naive or treatment-experienced genotype 3, without cirrhosis or with compensated cirrhosis (3), or with decompensated cirrhosis (4), or post-liver transplant: 24 weeks in combination with ribavirin

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis
- Combination therapy with elbasvir/grazoprevir will not be considered

Notes:
1. Treatment-experienced are those who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor.
2. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
3. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
4. Decompensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh B or C (i.e. score 7 or above).
5. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG ORAL TABLET				
00002418355	SOVALDI	GIL	$	654.7619

SOFOSBUVIR/ LEDIPASVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype 1;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (2) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive, without cirrhosis, recent quantitative hepatitis C viral load less than 6 M IU/mL: 8 weeks or 12 weeks (3)
- Treatment-naive, without cirrhosis, viral load greater than or equal to 6 M IU/mL: 12 weeks
- Treatment-naive, with compensated cirrhosis (4): 12 weeks
- Treatment-experienced, without cirrhosis: 12 weeks
- Treatment-naive or treatment-experienced with decompensated cirrhosis (5): 12 weeks in combination with ribavirin
- Treatment-naive or treatment-experienced liver transplant recipients, without cirrhosis or with compensated cirrhosis (4): 12 weeks in combination with ribavirin
- Treatment-experienced, with compensated cirrhosis (4): 24 weeks

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis

Notes:
1. Treatment-experienced are those who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor.
2. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
3. For this population cohort, evidence has shown that the SVR rates with 8-week and 12-week treatment regimens are similar. Treatment regimens of up to 12 weeks are recognized by Health Canada as an approved treatment option. 12-week treatment regimens may be considered for patients with advanced liver fibrosis.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. Decompensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh B or C (i.e. score 7 or above).
6. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir/ledipasvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG * 90 MG ORAL TABLET				
00002432226	HARVONI	GIL	$	797.6190

SOFOSBUVIR/ VELPATASVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype (2) 1, 2, 3, 4, 5, 6 or mixed genotypes;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (3) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive or treatment-experienced, without cirrhosis or with compensated cirrhosis (4): 12 weeks
- Treatment-naive or treatment-experienced, with decompensated cirrhosis (5): 12 weeks in combination with ribavirin

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis

Notes:
1. Treatment-experienced is defined as those who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor.
2. HCV genotype testing is optional.
3. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. Decompensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh B or C (i.e. score 7 or above).
6. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir/velpatasvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG * 100 MG ORAL TABLET				
00002456370	EPCLUSA	GIL	$	714.2857

SOFOSBUVIR/ VELPATASVIR/ VOXILAPREVIR

"For treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype (2) 1, 2, 3, 4, 5, 6 or mixed genotypes and have previously been treated with a CHC antiviral drug regimen containing a non-structural protein 5A (NS5A) inhibitor;
OR
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4 and have previously been treated with a CHC antiviral drug regimen containing sofosbuvir without an NS5A inhibitor;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (3) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-experienced, without cirrhosis or with compensated cirrhosis (4): 12 weeks

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent

Notes:
1. Treatment-experienced is defined as those who have previously been treated with a CHC antiviral drug regimen.
2. HCV genotype testing is optional for patients previously treated with a CHC antiviral drug regimen containing a non-structural protein 5A (NS5A) inhibitor.
3. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir/velpatasvir/voxilaprevir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG * 100 MG * 100 MG ORAL TABLET				
00002467542	VOSEVI	GIL	$	714.2857

SOMATROPIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of either a diagnostic insulin tolerance test or a glucagon stimulation test. Growth hormone values less than 3 mcg/litre are indicative of severe growth hormone deficiency.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

0.6 MG / SYR INJECTION				
00002401762	GENOTROPIN MINIQUICK	PFI	$	16.7400
0.8 MG / SYR INJECTION				
00002401770	GENOTROPIN MINIQUICK	PFI	$	22.3200
1 MG / SYR INJECTION				
00002401789	GENOTROPIN MINIQUICK	PFI	$	27.9000
1.2 MG / SYR INJECTION				
00002401797	GENOTROPIN MINIQUICK	PFI	$	33.4800

SOMATROPIN

1.4 MG / SYR INJECTION				
00002401800	GENOTROPIN MINIQUICK	PFI	$	39.0600
1.6 MG / SYR INJECTION				
00002401819	GENOTROPIN MINIQUICK	PFI	$	44.6400
1.8 MG / SYR INJECTION				
00002401827	GENOTROPIN MINIQUICK	PFI	$	50.2200
2 MG / SYR INJECTION				
00002401835	GENOTROPIN MINIQUICK	PFI	$	55.8000
5.3 MG / SYR INJECTION				
00002401703	GENOTROPIN GOQUICK	PFI	$	147.8700
12 MG / SYR INJECTION				
00002401711	GENOTROPIN GOQUICK	PFI	$	334.8000

SOMATROPIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of either a diagnostic insulin tolerance test or a glucagon stimulation test. Growth hormone values less than 3 mcg/litre 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	$	288.4206
12 MG / VIAL INJECTION				
00002243078	HUMATROPE	LIL	$	576.8412

SOMATROPIN R-DNA ORIGIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of either a diagnostic insulin tolerance test or a glucagon stimulation test. Growth hormone values less than 3 mcg/litre 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 / ML INJECTION				
00002325063	OMNITROPE	SDZ	$	103.8667
5 MG / VIAL INJECTION				
00002237971	SAIZEN	SRO	$	220.7828
5.83 MG / ML INJECTION				
00002350122	SAIZEN	SRO	$	264.9150
6.7 MG / ML INJECTION				
00002325071	OMNITROPE	SDZ	$	207.7333
8 MG / ML INJECTION				
☒ 00002350130	SAIZEN (1.5 ML)	SRO	$	353.2200
☒ 00002350149	SAIZEN (2.5 ML)	SRO	$	353.2200

STIRIPENTOL

"For use in combination with clobazam and valproate as adjunctive therapy of refractory generalized tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy (Dravet Syndrome), whose seizures are not adequately controlled with clobazam and valproate alone.

This medication must be prescribed in consultation with a Neurologist.

Special authorization may be granted for 6 months."

Each of these products is eligible for auto-renewal.

250 MG ORAL CAPSULE				
00002398958	DIACOMIT	BCF	$	5.8984
500 MG ORAL CAPSULE				
00002398966	DIACOMIT	BCF	$	11.7783
250 MG ORAL POWDER PACKET				
00002398974	DIACOMIT	BCF	$	5.8984

SUMATRIPTAN HEMISULFATE

(Refer to 28:32.28 of the Alberta 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	$	16.0217
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230420	IMITREX	GSK	$	16.4842

SUMATRIPTAN SUCCINATE

(Refer to 28:32.28 of the Alberta 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**	$	**2.7732**
00002268914	**MYLAN-SUMATRIPTAN**	**MYP**	$	**2.7732**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**2.7732**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**2.7732**
00002286521	**SUMATRIPTAN**	**SNS**	$	**2.7732**
00002385570	**SUMATRIPTAN DF**	**SIV**	$	**2.7732**
00002286823	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**2.7732**
00002212153	IMITREX DF	GSK	$	16.5165
100 MG (BASE) ORAL TABLET				
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**3.0549**
00002268922	**MYLAN-SUMATRIPTAN**	**MYP**	$	**3.0549**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**3.0549**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**3.0549**
00002286548	**SUMATRIPTAN**	**SNS**	$	**3.0549**
00002385589	**SUMATRIPTAN DF**	**SIV**	$	**3.0549**
00002239367	**TEVA-SUMATRIPTAN**	**TEV**	$	**3.0549**
00002286831	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**3.0549**
00002212161	IMITREX DF	GSK	$	18.1947
6 MG / SYR (BASE) INJECTION SYRINGE				
00002361698	**TARO-SUMATRIPTAN (0.5 ML)**	**TAR**	$	**37.9982**
00002212188	IMITREX (0.5 ML)	GSK	$	48.3778

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 criterion, information is also required regarding the area(s) affected. In order to comply with the fourth criterion, information is also required regarding the percentage body surface area affected.

The following product(s) are eligible for auto-renewal.

All requests for tacrolimus topical ointment must be completed using the Tacrolimus Topical Ointment Special Authorization Request Form (ABC 60047).

0.03 % TOPICAL OINTMENT

00002244149	PROTOPIC	LEO	$	2.3252

"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 criterion, information is also required regarding the area(s) affected. In order to comply with the second criterion, information is also required regarding the percentage body surface area affected.

The following product(s) are eligible for auto-renewal.

All requests for tacrolimus topical ointment must be completed using the Tacrolimus Topical Ointment Special Authorization Request Form (ABC 60047).

0.1 % TOPICAL OINTMENT

00002244148	PROTOPIC	LEO	$	2.4686

TALIGLUCERASE ALFA

For long-term enzyme replacement therapy (ERT) for pediatric and adult patients with type 1 Gaucher disease (GD) when the following criteria are met:

1. The diagnosis of GD must have been established by the demonstration of specific deficiency of glucocerebrosidase (GCase) in tissue or cultured skin fibroblasts, or by demonstration of the presence, in tissue or peripheral blood leukocytes, of mutations in the GCase gene known to result in severe enzyme deficiency.

2. Other potentially confounding diagnoses, such as Hodgkin disease or other storage disorders, must have been ruled out. The symptoms experienced by the patient should be shown to be attributable to GD and not some other condition that might mimic it. A trial of therapy would normally be considered in situations of uncertainty only if the symptoms were accompanied by objective evidence (hematological or imaging changes consistent with complaints).

3. The patient should not have any GD-related or other medical condition that might reasonably be expected to compromise their response to treatment. In some patients with GD, secondary pathologic changes, such as avascular necrosis of bone, may already have occurred that would not be expected to respond to enzyme replacement. In such patients, reversal of the pathology is unlikely. Treatment of patients with significant secondary pathology would be directed at preventing further progression of the disease. In these cases, the extent to which symptoms, such as bone pain, are due to active progression of the disease, rather than the secondary pathology, may only be established by a trial of therapy.

4. Treatment should be provided under the care of a specialist with experience in the diagnosis and management of GD.

5. None of the following exclusion criteria apply:
a. The presence of any GD-related condition that might reasonably be expected to compromise a response to therapy
b. The presence of another medical condition that might reasonably be expected to compromise a response to therapy
c. Asymptomatic GD
d. The presence of primary neurological disease due to GD

6. Patients must have the following baseline parameters assessed prior to initiating therapy on taliglucerase alfa:
- Hemoglobin level and platelet count
- Presence of splenic infarction, bone crises, radiographic or MRI evidence of incipient destruction of any major joint, spontaneous fractures, chronic bone pain, major joint replacement, liver synthetic dysfunction, symptomatic hepatosplenomegaly, progressive pulmonary disease due to GD, or growth failure in children.

7. The patient is unable to receive ERT with velaglucerase alfa, including:
a. Rare cases of severe allergic reactions or hypersensitivity to velaglucerase alfa.
b. Patients who are sub-optimally responsive despite maximum doses of velaglucerase alfa for at least 12 months.
c. Patients unable to receive velaglucerase alfa for medical reasons.

Notes:
- Pregnancy is not considered a contraindication to ERT.
- Patients to be considered for reimbursement of drug costs for ERT must be willing to participate in the long term evaluation of the efficacy of treatment by periodic medical assessment. Failure to comply with recommended medical assessment and investigations may result in withdrawal of financial support of drug therapy.

Initial coverage may be approved at a dosage of up to 60 units/kg every 2 weeks for a period of 6 months.

Ongoing coverage may be considered for up to 60 units/kg every 2 weeks for a period of 6 months at a time during the first 2 years of treatment, and thereafter for 12-month periods, only if

TALIGLUCERASE ALFA

the following criteria are met:

- The patient demonstrates all of the following expected treatment outcomes, where applicable:
1. For patients with baseline hemoglobin <85% of lower limit of age- and sex-appropriate normal: Increase hemoglobin levels to >110 g/L for women and children and >120 g/L for men
2. For patients with a baseline platelet count <50 x 10^9/L on two separate occasions at least one month apart:
a. Increase platelet count to level sufficient to prevent spontaneous bleeding
b. Normalization of platelet count in splenectomized patients
c. In patients with intact spleen, an increase of at least 1.5X in baseline platelet count
3. For patients with a prior splenic infarct at baseline:
a. Reduction of spleen volume by at least 50%
b. Prevention of further splenic infarcts
4. Prevention of bone crises
5. For patients with radiographic or MRI evidence of incipient destruction of any major joint at baseline: Improvement in imaging parameters (either MRI, QCSI2, or BMD)
6. Prevention of spontaneous fractures
7. Reduced bone pain in patients with chronic bone pain at baseline
8. No major joint replacement surgery
9. Improvement in liver function in patients with liver synthetic dysfunction at baseline
10. For patients with symptomatic hepatosplenomegaly at baseline:
a. Reduction of spleen volume by at least 50%
b. Reduction in liver volume by at least 30%
11. For patients with progressive pulmonary disease due to GD at baseline:
c. Improvement in pulmonary hypertension
d. Improvement in oxygenation
e. Reversal of hepatopulmonary syndrome
12. For children with growth failure at baseline: Return to normal range on height percentiles

- Treatment should be discontinued if the above treatment outcomes have not been demonstrated, as evidenced by readings consistent over the previous 12-month period at the maximum dosage of 60 units/kg every 2 weeks.

Patients will be limited to receiving a one-month supply of taliglucerase alfa per prescription at their pharmacy.
Coverage cannot be provided for taliglucerase alfa when this medication is intended for use in combination with other ERT.
Patients will not be permitted to switch back to a previously trialed ERT if they were deemed sub-optimally responsive despite maximum doses.

The dosage of taliglucerase alfa prescribed would depend on the severity of the disease and would be at the discretion of the specialist. The efficacy of treatment should be re-evaluated every 6 months and dosage adjustments made as appropriate. If there has been insufficient response to treatment after 6 months on a lower dose, the dosage may be increased to a maximum of 60 units/kg every 2 weeks. In the event of severe drug reaction, treatment may have to be discontinued. ERT has been shown to be well tolerated with minimal toxicity reported.

All requests for Taliglucerase Alfa must be completed using the Velaglucerase Alfa/Taliglucerase Alfa for Gaucher Disease Special Authorization Request Form (ABC 60070).

200 UNIT / VIAL	**INJECTION**			
00002425637	ELELYSO	PFI	$	648.3600

TEDUGLUTIDE

"Special authorization coverage may be provided for the treatment of adult patients (18 years of age or older) with short bowel syndrome (SBS) if all of the following criteria are met:

- SBS is a result of major intestinal resection (e.g., due to injury, volvulus, vascular disease, cancer, Crohn's Disease), and

- Resection has resulted in dependency on parenteral nutrition (PN) for at least 12 months, and

- PN is required at least three times weekly to meet caloric, fluid or electrolyte needs due to ongoing malabsorption, and

- PN frequency and volume have been stable for at least one month.

For coverage, the drug must be initiated and monitored by a specialist in gastroenterology or an internal medicine specialist with an interest in gastroenterology on a case-by-case basis, in geographic areas where access to this specialty is not available ('Specialist').

Initial coverage may be approved for up to 24 weeks of 0.05 mg/kg/day administered subcutaneously once daily.

- Patients will be limited to receiving a four week supply of teduglutide per prescription at their pharmacy.

For continued coverage beyond 24 weeks, the patient must meet the following criteria:

1) The patient must be assessed by the Specialist between weeks 20 and 24, after initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' as demonstrated by:
- at least a 20% reduction in weekly PN volume from baseline.

Following this assessment, continued coverage may be provided for 0.05 mg/kg/day administered subcutaneously 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 the Specialist to determine response;

2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:

- confirmation of maintenance of at least a 20% reduction in weekly PN volume from baseline."

5 MG / VIAL INJECTION

00002445727	REVESTIVE	TAK	$	904.0000

TERIFLUNOMIDE

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse 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. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of teriflunomide per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of teriflunomide per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the

TERIFLUNOMIDE

patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for teriflunomide must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

14 MG ORAL TABLET

00002416328	AUBAGIO	GZM	$	59.0711

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)	ALL	$	2.2217

24.3 MG TRANSDERMAL PATCH

00002245972	ANDRODERM (5 MG/DAY)	ALL	$	4.4433

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

00002322498	**PMS-TESTOSTERONE**	**PMS**	$	**0.4700**
00002421186	**TARO-TESTOSTERONE**	**TAR**	$	**0.4700**

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

00002407590	**APO-TETRABENAZINE**	**APX**	$	**3.3746**
00002402424	**PMS-TETRABENAZINE**	**PMS**	$	**3.3746**
00002199270	NITOMAN	VCL	$	7.4995

TICAGRELOR

(Refer to 20:12.18 of the Alberta Drug Benefit List for coverage of ticagrelor when prescribed by a specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.)

For the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction, when initiated in hospital in consultation with a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA. Special authorization may be granted for 6 months.*

*Special Authorization is only required when the initiating prescriber is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.

The following product(s) are eligible for auto-renewal.

90 MG ORAL TABLET

00002368544	BRILINTA	AZC	$	1.5620

TIOTROPIUM BROMIDE MONOHYDRATE/ OLODATEROL HYDROCHLORIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for tiotropium bromide monohydrate + olodaterol hydrochloride must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

2.5 MCG / DOSE * 2.5 MCG / DOSE INHALATION SOLUTION

00002441888	INSPIOLTO RESPIMAT	BOE	$	1.0576

TOCILIZUMAB

80 MG / VIAL INJECTION

00002350092	ACTEMRA (4 ML)	HLR	$	182.8000

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 ("RA Specialist").

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab 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 the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 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 a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). 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

TOCILIZUMAB

- 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 tocilizumab 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 severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 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 (Pediatric Rheumatology Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks.
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered every 3 weeks for patients less than 30 kg, or administered every other week for patients 30 kg or greater.
- Patients will be limited to receiving up to a one-month supply of tocilizumab 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 in each request.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 8 mg/kg to 10 mg/kg every 4 weeks, or one 162 mg subcutaneous dose administered every two to three weeks (based on weight). After twelve months, in order to be considered for continued coverage, the patient must be

TOCILIZUMAB

re-assessed every twelve months by a Pediatric Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Systemic Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, 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 RA Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 12 mg/kg/dose for patients weighing less than 30 kg, or 8 mg/kg/dose for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered once every 2 weeks for patients less than 30 kg, or administered once every week for patients 30 kg or greater.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage 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 as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].
Following this assessment, continued coverage may be approved for a period of 12 months.
Coverage for tocilizumab will be provided for:
- One intravenous dose of 12 mg/kg for patients weighing less than 30 kg or 8 mg/kg for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- One 162 mg subcutaneous dose administered every one to two weeks (based on weight).
After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months 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."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60048).

TOCILIZUMAB

200 MG / VIAL INJECTION

00002350106 ACTEMRA (10 ML) HLR $ 457.0000

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 ("RA Specialist").

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab 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 the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 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 a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). 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

TOCILIZUMAB

- 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 tocilizumab 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 severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 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 (Pediatric Rheumatology Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks.
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered every 3 weeks for patients less than 30 kg, or administered every other week for patients 30 kg or greater.
- Patients will be limited to receiving up to a one-month supply of tocilizumab 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 in each request.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 8 mg/kg to 10 mg/kg every 4 weeks, or one 162 mg subcutaneous dose administered every two to three weeks (based on weight). After twelve months, in order to be considered for continued coverage, the patient must be

TOCILIZUMAB

re-assessed every twelve months by a Pediatric Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Systemic Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, 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 RA Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 12 mg/kg/dose for patients weighing less than 30 kg, or 8 mg/kg/dose for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered once every 2 weeks for patients less than 30 kg, or administered once every week for patients 30 kg or greater.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage 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 as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].
Following this assessment, continued coverage may be approved for a period of 12 months.
Coverage for tocilizumab will be provided for:
- One intravenous dose of 12 mg/kg for patients weighing less than 30 kg or 8 mg/kg for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- One 162 mg subcutaneous dose administered every one to two weeks (based on weight).
After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months 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."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60048).

TOCILIZUMAB

400 MG / VIAL INJECTION

00002350114	ACTEMRA (20 ML)	HLR	$	914.0000

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 ("RA Specialist").

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab 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 the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 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 a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). 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

TOCILIZUMAB

- 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 tocilizumab for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Systemic Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, 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 RA Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 12 mg/kg/dose for patients weighing less than 30 kg, or 8 mg/kg/dose for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered once every 2 weeks for patients less than 30 kg, or administered once every week for patients 30 kg or greater.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage 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 as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].
Following this assessment, continued coverage may be approved for a period of 12 months.
Coverage for tocilizumab will be provided for:
- One intravenous dose of 12 mg/kg for patients weighing less than 30 kg or 8 mg/kg for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- One 162 mg subcutaneous dose administered every one to two weeks (based on weight).
After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months 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."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60048).

TOCILIZUMAB

162 MG / SYR INJECTION SYRINGE

☒ 00002483327 ACTEMRA (0.9 ML AUTO INJECTOR) HLR $ 355.0000

Giant Cell Arteritis

"Special authorization coverage may be provided for use in combination with glucocorticoids for the treatment of giant cell arteritis (GCA) in adult patients.

For coverage, this drug must be initiated in consultation with a Specialist in Internal Medicine, Rheumatology or Neurology.

Initial coverage may be approved for 12 weeks as follows:
-Coverage may be approved for one 162 mg subcutaneous dose of tocilizumab administered every week.
-As an interim measure, coverage will be provided for additional doses up to week 16, to allow time to determine whether the patient meets criteria for continued coverage below.
-Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab per prescription at their pharmacy.
-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 the initial 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed after 12 weeks, but no longer than 16 weeks after treatment to determine response; AND
2) The patient must be a `responder' that meets the following criteria:
-Patient has achieved remission which is defined as the absence of flare* AND normalization of C-reactive protein (CRP) to <1 mg/dL (<10 mg/L).
*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) greater or equal to 30 mm/hr attributable to GCA.

Following this assessment, continued coverage may be approved for one 162 mg subcutaneous dose administered every week for a period of 36 weeks.

Duration of therapy with tocilizumab will be limited to 52 weeks per treatment course. Re-treatment may be considered for patients who experience a disease flare after treatment discontinuation."

All requests (including renewal requests) for tocilizumab for Giant Cell Arteritis must be completed using the Tocilizumab for Giant Cell Arteritis Special Authorization Request Form (ABC 60066).

Polyarticular Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 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 (Pediatric Rheumatology Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks.
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered every 3 weeks for patients less than 30 kg, or administered every other week for patients 30 kg or greater.
- Patients will be limited to receiving up to a one-month supply of tocilizumab 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.

TOCILIZUMAB

- 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 in each request.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 8 mg/kg to 10 mg/kg every 4 weeks, or one 162 mg subcutaneous dose administered every two to three weeks (based on weight). After twelve months, in order to be considered for continued coverage, the patient must be re-assessed every twelve months by a Pediatric Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 ("RA Specialist").

- Initial coverage may be approved for 16 weeks as follows:

TOCILIZUMAB

- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab 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 the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 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 a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). 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 the correct number of decimal places as indicated above."

All requests (including renewal requests) for tocilizumab 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).

Systemic Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, 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

TOCILIZUMAB

Clinic in Edmonton or Calgary (Pediatric RA Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 12 mg/kg/dose for patients weighing less than 30 kg, or 8 mg/kg/dose for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered once every 2 weeks for patients less than 30 kg, or administered once every week for patients 30 kg or greater.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage 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 as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for:
- One intravenous dose of 12 mg/kg for patients weighing less than 30 kg or 8 mg/kg for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- One 162 mg subcutaneous dose administered every one to two weeks (based on weight).

After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months 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."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60048).

☒	00002424770	ACTEMRA (0.9 ML SYRINGE)	HLR	$ 358.9050

Giant Cell Arteritis

"Special authorization coverage may be provided for use in combination with glucocorticoids for the treatment of giant cell arteritis (GCA) in adult patients.

For coverage, this drug must be initiated in consultation with a Specialist in Internal Medicine, Rheumatology or Neurology.

Initial coverage may be approved for 12 weeks as follows:
-Coverage may be approved for one 162 mg subcutaneous dose of tocilizumab administered every week.
-As an interim measure, coverage will be provided for additional doses up to week 16, to allow time to determine whether the patient meets criteria for continued coverage below.
-Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab per prescription at their pharmacy.
-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 the initial 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed after 12 weeks, but no longer than 16 weeks after treatment to determine response; AND
2) The patient must be a `responder' that meets the following criteria:
-Patient has achieved remission which is defined as the absence of flare* AND normalization of C-reactive protein (CRP) to <1 mg/dL (<10 mg/L).
*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) greater or equal to 30 mm/hr attributable to GCA.

Following this assessment, continued coverage may be approved for one 162 mg subcutaneous dose administered every week for a period of 36 weeks.

TOCILIZUMAB

Duration of therapy with tocilizumab will be limited to 52 weeks per treatment course. Re-treatment may be considered for patients who experience a disease flare after treatment discontinuation."

All requests (including renewal requests) for tocilizumab for Giant Cell Arteritis must be completed using the Tocilizumab for Giant Cell Arteritis Special Authorization Request Form (ABC 60066).

Polyarticular Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 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 (Pediatric Rheumatology Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks.
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered every 3 weeks for patients less than 30 kg, or administered every other week for patients 30 kg or greater.
- Patients will be limited to receiving up to a one-month supply of tocilizumab 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 continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
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 in each request.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 8 mg/kg to 10 mg/kg every 4 weeks, or one 162 mg subcutaneous dose administered every two to three weeks (based on weight). After twelve months, in order to be considered for continued coverage, the patient must be re-assessed every twelve months by a Pediatric Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,

TOCILIZUMAB

3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

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 ("RA Specialist").

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab 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 the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 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 a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a

TOCILIZUMAB

maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). 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 the correct number of decimal places as indicated above."

All requests (including renewal requests) for tocilizumab 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).

Systemic Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, 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 RA Specialist).

- Initial coverage may be approved for 12 weeks as follows:
- Tocilizumab intravenous infusion: 12 mg/kg/dose for patients weighing less than 30 kg, or 8 mg/kg/dose for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- Tocilizumab subcutaneous injection: one 162 mg dose of tocilizumab administered once every 2 weeks for patients less than 30 kg, or administered once every week for patients 30 kg or greater.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage 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 as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].
Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for:
- One intravenous dose of 12 mg/kg for patients weighing less than 30 kg or 8 mg/kg for patients weighing greater than or equal to 30 kg (up to a maximum of 800 mg per dose), administered every two weeks, OR
- One 162 mg subcutaneous dose administered every one to two weeks (based on weight).
After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months 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."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special

TOCILIZUMAB

Authorization Request Form (ABC 60048).

TOFACITINIB CITRATE

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 ("RA Specialist").

- Initial coverage may be approved for three months as follows:
- Tofacitinib 5 mg tablet: one tablet twice daily.
- Tofacitinib 11 mg extended-release tablet: one tablet daily.
- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond three months, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three months 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 5 mg twice daily or 11 mg 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;
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

TOFACITINIB CITRATE

rounded to the correct number of decimal places as indicated above.

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent."

All requests (including renewal requests) for tofacitinib 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).

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug 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 ('Specialist').

Initial coverage may be approved for an initial dose of 10 mg twice daily for 8 weeks. As an interim measure, coverage will be provided for additional doses of 5 mg twice daily for 4 weeks, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.

- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist after 8 weeks but no longer than 12 weeks after treatment to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 5 mg twice 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 a Specialist in Gastroenterology to determine response;

TOFACITINIB CITRATE

2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of tofacitinib therapy.

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent."

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg, the maintenance dose may be adjusted from 5 mg to 10 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for tofacitinib for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

5 MG (BASE)	**ORAL**	**TABLET**			
00002423898	XELJANZ		PFI	$	23.9589

TOFACITINIB CITRATE

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:

- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug 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 ('Specialist').

Initial coverage may be approved for an initial dose of 10 mg twice daily for 8 weeks. As an interim measure, coverage will be provided for additional doses of 5 mg twice daily for 4 weeks, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.

- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist after 8 weeks but no longer than 12 weeks after treatment to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 5 mg twice 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 a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of tofacitinib therapy.

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent."

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg, the maintenance

TOFACITINIB CITRATE

dose may be adjusted from 5 mg to 10 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for tofacitinib for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

10 MG (BASE)	**ORAL**	**TABLET**			
00002480786	XELJANZ		PFI	$	42.3436

TOFACITINIB CITRATE

"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 ("RA Specialist").

- Initial coverage may be approved for three months as follows:
- Tofacitinib 5 mg tablet: one tablet twice daily.
- Tofacitinib 11 mg extended-release tablet: one tablet daily.
- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond three months, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three months 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 5 mg twice daily or 11 mg 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;
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.

TOFACITINIB CITRATE

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent."

All requests (including renewal requests) for tofacitinib 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).

11 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002470608	XELJANZ XR	PFI	$	47.9178

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.

0.025 % TOPICAL GEL

00001926470	VITAMIN A ACID	VCL	$	0.3429

0.05 % TOPICAL GEL

00001926489	VITAMIN A ACID	VCL	$	0.3429

0.01 % TOPICAL CREAM

00000657204	STIEVA-A	GSK	$	0.3176

0.025 % TOPICAL CREAM

00000578576	STIEVA-A	GSK	$	0.3176

0.05 % TOPICAL CREAM

00000518182	STIEVA-A	GSK	$	0.2120

0.01 % TOPICAL GEL

00001926462	VITAMIN A ACID	VCL	$	0.3429

TROSPIUM CHLORIDE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

20 MG ORAL TABLET

00002488353	**MAR-TROSPIUM**	**MAR**	$	**0.6108**
00002275066	TROSEC	SUN	$	0.7820

UMECLIDINIUM BROMIDE/ VILANTEROL TRIFENATATE

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective

All requests for umeclidinium bromide + vilanterol trifenatate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

62.5 MCG / DOSE (BASE)	* 25 MCG / DOSE (BASE)	INHALATION	METERED INHALATION POWDER		
00002418401	ANORO ELLIPTA		GSK	$	2.8938

USTEKINUMAB

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 to or intolerant to:

at least THREE of the following:
- adalimumab
- etanercept
- infliximab
- ixekizumab
- risankizumab
- secukinumab

AND

- 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)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'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 (90 mg for patients weighing greater than 100 kg) 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 initial 16 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.

USTEKINUMAB

Following this assessment, continued coverage may be considered for 45 mg (90 mg for patients weighing greater than 100 kg) 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."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

All requests (including renewal requests) for ustekinumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

45 MG INJECTION VIAL OR SYRINGE				
00002320673	STELARA (0.5 ML VIAL OR SYRINGE)	JAI	$	4465.5800
For this product - pricing has been established on a per vial or syringe basis.				
90 MG / SYR INJECTION SYRINGE				
00002320681	STELARA (1 ML SYRINGE)	JAI	$	4465.5800

VARENICLINE TARTRATE

For subsequent prescriptions, patients may obtain this product via special authorization with the following criteria for coverage:

"For use in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling.

Special authorization coverage may be granted for a maximum of 24 weeks of therapy per year."

This product is not eligible for auto-renewal.

0.5 MG (BASE) ORAL TABLET				
00002419882	**APO-VARENICLINE**	**APX**	$	**0.9237**
00002426226	**TEVA-VARENICLINE**	**TEV**	$	**0.9237**
00002291177	CHAMPIX	PFI	$	1.8437
1 MG (BASE) ORAL TABLET				
00002419890	**APO-VARENICLINE**	**APX**	$	**0.9235**
00002426234	**TEVA-VARENICLINE**	**TEV**	$	**0.9235**
00002291185	CHAMPIX	PFI	$	1.8432

VARENICLINE TARTRATE/ VARENICLINE TARTRATE

For subsequent prescriptions, patients may obtain this product via special authorization with the following criteria for coverage:

"For use in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling.

Special authorization coverage may be granted for a maximum of 24 weeks of therapy per year."

This product is not eligible for auto-renewal.

0.5 MG * 1 MG ORAL TABLET

00002435675	**APO-VARENICLINE (STARTER PACK)**	**APX**	$	**0.9203**
00002426781	**TEVA-VARENICLINE (STARTER PACK)**	**TEV**	$	**0.9203**
00002298309	CHAMPIX (STARTER PACK)	PFI	$	1.8370

VEDOLIZUMAB

Moderately to Severely Active Crohn's Disease

"Special authorization coverage may be approved for coverage of vedolizumab 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:

- vedolizumab 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 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 vedolizumab.
- Patients will be limited to receiving one dose of vedolizumab 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 vedolizumab therapy for New Patients:
'New Patients' are patients who have never been treated with vedolizumab by any health care provider.
Moderately to Severely Active Crohn's Disease:
Prior to initiation of vedolizumab 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]

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

VEDOLIZUMAB

been treated with vedolizumab by any health care provider).
- 'Induction Dosing' means a maximum of one 300 mg dose of vedolizumab per New Patient at 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 300 mg dose of vedolizumab per patient every eight (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 vedolizumab.

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
- 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 at least 4 to 8 weeks after the day the last dose of vedolizumab 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
- 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 300 mg dose of vedolizumab 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 vedolizumab 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
- 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 vedolizumab for Moderately to Severely Active Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Special Authorization Request Form (ABC 60031).

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks

AND

- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent

VEDOLIZUMAB

i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).
'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug 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 ('Specialist').

Initial coverage may be approved for three doses of 300 mg of vedolizumab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a one dose of vedolizumab 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 a Specialist between weeks 10 and 12 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 300 mg every 8 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 a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of vedolizumab therapy."

All requests (including renewal requests) for vedolizumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

300 MG / VIAL INJECTION

00002436841	ENTYVIO	TAK	$ 3290.0000

VELAGLUCERASE ALFA

For long-term enzyme replacement therapy (ERT) for pediatric and adult patients with type 1 Gaucher disease (GD) when the following criteria are met:

1. The diagnosis of GD must have been established by the demonstration of specific deficiency of glucocerebrosidase (GCase) in tissue or cultured skin fibroblasts, or by demonstration of the presence, in tissue or peripheral blood leukocytes, of mutations in the GCase gene known to result in severe enzyme deficiency.

2. Other potentially confounding diagnoses, such as Hodgkin disease or other storage disorders, must have been ruled out. The symptoms experienced by the patient should be shown to be attributable to GD and not some other condition that might mimic it. A trial of therapy would normally be considered in situations of uncertainty only if the symptoms were accompanied by objective evidence (hematological or imaging changes consistent with complaints).

3. The patient should not have any GD-related or other medical condition that might reasonably be expected to compromise their response to treatment. In some patients with GD, secondary pathologic changes, such as avascular necrosis of bone, may already have occurred that would not be expected to respond to enzyme replacement. In such patients, reversal of the pathology is unlikely. Treatment of patients with significant secondary pathology would be directed at preventing further progression of the disease. In these cases, the extent to which symptoms, such as bone pain, are due to active progression of the disease, rather than the secondary pathology, may only be established by a trial of therapy.

4. Treatment should be provided under the care of a specialist with experience in the diagnosis and management of GD.

5. None of the following exclusion criteria apply:
a. The presence of any GD-related condition that might reasonably be expected to compromise a response to therapy
b. The presence of another medical condition that might reasonably be expected to compromise a response to therapy
c. Asymptomatic GD
d. The presence of primary neurological disease due to GD

6. Patients must have the following baseline parameters assessed prior to initiating therapy on velaglucerase alfa:
a. Hemoglobin level and platelet count
b. Presence of splenic infarction, bone crises, radiographic or MRI evidence of incipient destruction of any major joint, spontaneous fractures, chronic bone pain, major joint replacement, liver synthetic dysfunction, symptomatic hepatosplenomegaly, progressive pulmonary disease due to GD, or growth failure in children.

Notes:
- Pregnancy is not considered a contraindication to ERT.
- Patients to be considered for reimbursement of drug costs for ERT must be willing to participate in the long term evaluation of the efficacy of treatment by periodic medical assessment. Failure to comply with recommended medical assessment and investigations may result in withdrawal of financial support of drug therapy.

Initial coverage may be approved at a dosage of up to 60 units/kg every 2 weeks for a period of 6 months.

Ongoing coverage may be considered for up to 60 units/kg every 2 weeks for a period of 6 months at a time during the first 2 years of treatment, and thereafter for 12-month periods, only if the following criteria are met:

- The patient demonstrates all of the following expected treatment outcomes, where applicable:
1. For patients with baseline hemoglobin <85% of lower limit of age- and sex-appropriate normal: Increase hemoglobin levels to >110 g/L for women and children and >120 g/L for men
2. For patients with a baseline platelet count <50 x 10^9/L on two separate occasions at least

VELAGLUCERASE ALFA

one month apart:
a. Increase platelet count to level sufficient to prevent spontaneous bleeding
b. Normalization of platelet count in splenectomized patients
c. In patients with intact spleen, an increase of at least 1.5X in baseline platelet count
3. For patients with a prior splenic infarct at baseline:
a. Reduction of spleen volume by at least 50%
b. Prevention of further splenic infarcts
4. Prevention of bone crises
5. For patients with radiographic or MRI evidence of incipient destruction of any major joint at baseline: Improvement in imaging parameters (either MRI, QCSI2, or BMD)
6. Prevention of spontaneous fractures
7. Reduced bone pain in patients with chronic bone pain at baseline
8. Optimize surgical outcome for major joint replacement surgery where required at baseline. No new major joint replacement surgery thereafter.
9. Improvement in liver function in patients with liver synthetic dysfunction at baseline
10. For patients with symptomatic hepatosplenomegaly at baseline:
a. Reduction of spleen volume by at least 50%
b. Reduction in liver volume by at least 30%
11. For patients with progressive pulmonary disease due to GD at baseline:
a. Improvement in pulmonary hypertension
b. Improvement in oxygenation
c. Reversal of hepatopulmonary syndrome
12. For children with growth failure at baseline: Return to normal range on height percentiles

- Treatment should be discontinued if the above treatment outcomes have not been demonstrated, as evidenced by readings consistent over the previous 12-month period at the maximum dosage of 60 units/kg every 2 weeks.

Patients will be limited to receiving a one-month supply of velaglucerase alfa per prescription at their pharmacy.
Coverage cannot be provided for velaglucerase alfa when this medication is intended for use in combination with other ERT.
Patients will not be permitted to switch back to a previously trialed ERT if they were deemed sub-optimally responsive despite maximum doses.

The dosage of velaglucerase alfa prescribed would depend on the severity of the disease and would be at the discretion of the specialist. The efficacy of treatment should be re-evaluated every 6 months and dosage adjustments made as appropriate. If there has been insufficient response to treatment after 6 months on a lower dose, the dosage may be increased to a maximum of 60 units/kg every 2 weeks. In the event of severe drug reaction, treatment may have to be discontinued. ERT has been shown to be well tolerated with minimal toxicity reported.

All requests for Velaglucerase Alfa must be completed using the Velaglucerase Alfa/Taliglucerase Alfa for Gaucher Disease Special Authorization Request Form (ABC 60070).

400 UNIT / VIAL	INJECTION			
00002357119	VPRIV		TAK	$ 1955.0000

VORICONAZOLE

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"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."

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

50 MG ORAL TABLET				
00002399245	**SANDOZ VORICONAZOLE**	**SDZ**	$	**6.7818**
00002396866	**TEVA-VORICONAZOLE**	**TEV**	$	**6.7818**
00002256460	VFEND	PFI	$	13.3516
200 MG ORAL TABLET				
00002399253	**SANDOZ VORICONAZOLE**	**SDZ**	$	**26.4807**
00002396874	**TEVA-VORICONAZOLE**	**TEV**	$	**26.4807**
00002256479	VFEND	PFI	$	53.3843
40 MG / ML ORAL SUSPENSION				
00002279991	VFEND	PFI	$	10.7992
200 MG / VIAL INJECTION				
00002477696	**VORICONAZOLE INJECTION**	**JPC**	$	**136.5800**
00002256487	VFEND	PFI	$	160.0204

ZOLEDRONIC ACID

Osteoporosis:

"For the treatment of osteoporosis in patients who have:

A high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture, OR
A moderate 10-year fracture risk (10-20%) and have experienced a prior fragility fracture;

AND

at least one of the following:

1) For whom oral bisphosphonates are contraindicated due to an abnormality of the esophagus which delays esophageal emptying;

OR

2) Who have demonstrated persistent severe gastrointestinal intolerance to a course of therapy with either alendronate or risedronate;

OR

3) Who had an unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for 1 year and evidence of a decline in BMD below pre-treatment baseline level).

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

Special Authorization may be granted for 12 months.

-Patients will be limited to receiving one dose of zoledronic acid per prescription at their pharmacy.

-Coverage cannot be provided for two or more osteoporosis medications (alendronate, denosumab, raloxifene, risedronate, zoledronic acid) when these medications are intended for use as combination therapy.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

-This product is eligible for auto-renewal for the treatment of osteoporosis.

All requests for zoledronic acid for osteoporosis must be completed using the Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form (ABC 60007).

Paget's Disease:

"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

ZOLEDRONIC ACID

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

00002415100	**TARO-ZOLEDRONIC ACID**	**TAR**	$	**3.3540**
00002422433	**ZOLEDRONIC ACID**	**DRL**	$	**3.3540**
00002269198	ACLASTA	NOV	$	7.0850

"For the treatment of tumor-induced hypercalcemia in patients with documented evidence of intolerance or lack of response to clodronate or pamidronate.

For the prevention of skeletal-related events in patients with metastatic castration-resistant prostate cancer (CRPC) with one or more bony metastases.

Special authorization may be granted for 6 months."

The following product(s) are eligible for auto-renewal.

0.8 MG / ML INJECTION

00002482525	**JAMP-ZOLEDRONIC ACID**	**JPC**	$	**38.7856**
00002415186	**TARO-ZOLEDRONIC ACID CONCENTRATE**	**TAR**	$	**38.7856**
00002407639	**ZOLEDRONIC ACID**	**TEV**	$	**38.7856**
00002444739	**ZOLEDRONIC ACID**	**JUN**	$	**38.7856**
00002401606	**ZOLEDRONIC ACID - Z**	**SDZ**	$	**38.7856**
00002422425	**ZOLEDRONIC ACID CONCENTRATE**	**DRL**	$	**38.7856**
00002472805	**ZOLEDRONIC ACID FOR INJECTION**	**MAR**	$	**38.7856**
00002248296	ZOMETA CONCENTRATE	NOV	$	119.0360

ZOLMITRIPTAN

(Refer to 28:32.28 of the Alberta 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				
00002458780	**CCP-ZOLMITRIPTAN**	**CEL**	$	**3.5375**
00002477106	**JAMP ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002421623	**JAMP-ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002419521	**MINT-ZOLMITRIPTAN**	**MPI**	$	**3.5375**
00002421534	**NAT-ZOLMITRIPTAN**	**NTP**	$	**3.5375**
00002324229	**PMS-ZOLMITRIPTAN**	**PMS**	$	**3.5375**
00002362988	**SANDOZ ZOLMITRIPTAN**	**SDZ**	$	**3.5375**
00002313960	**TEVA-ZOLMITRIPTAN**	**TEV**	$	**3.5375**
00002238660	ZOMIG	AZC	$	14.9600
2.5 MG ORAL DISPERSIBLE TABLET				
00002428237	**JAMP-ZOLMITRIPTAN ODT**	**JPC**	$	**1.7532**
00002428474	**SEPTA-ZOLMITRIPTAN-ODT**	**SEP**	$	**1.7532**
00002243045	ZOMIG RAPIMELT	AZC	$	14.9600
5 MG / DOSE NASAL UNIT DOSE SPRAY				
00002248993	ZOMIG	AZC	$	14.9600

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-sponsored drug programs. (For Alberta Human Services 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 Human Services 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 Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health. 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.

Registration for Designated Prescriber Status – Select Quinolone Antibiotics

On the reverse is the official *Registration for Designated Prescriber Status – Select Quinolone Antibiotics* (ABC 60041).

- All requests to become a "Registered Designated Prescriber" must be submitted using the *Registration for Designated Prescriber Status – Select Quinolone Antibiotics 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®

ALBERTA GOVERNMENT SPONSORED DRUG BENEFIT PROGRAMS
OPTIONAL SPECIAL AUTHORIZATION

REGISTRATION FOR DESIGNATED PRESCRIBER STATUS
for *Alberta Drug Benefit List* Claim Coverage

Select Quinolone Antibiotics
ciprofloxacin, levofloxacin, moxifloxacin

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 LAST NAME	FIRST NAME	INITIAL	OFFICE PHONE	FAX

OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER
OR PROFESSIONAL REGISTRATION NUMBER

I have reviewed the criteria for coverage of select quinolone products and I agree to abide by and only prescribe in accordance with such criteria as updated from time to time in the Optional Special Authorization section of the *Alberta Drug Benefit List*.

SIGNATURE OF PRESCRIBER (required) _____ **DATE** _____

The information on this form is being collected and 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 purposes 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 or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 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 patient' s 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 60042).

100 MG / ML	ORAL	SUSPENSION			
00002237514	CIPRO		BAI	$	0.5750

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,
- 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 60042).

250 MG (BASE) ORAL TABLET

00002247339	**ACT CIPROFLOXACIN**	**APH**	$	**0.4454**
00002381907	**AURO-CIPROFLOXACIN**	**AUR**	$	**0.4454**
00002353318	**CIPROFLOXACIN**	**SNS**	$	**0.4454**
00002386119	**CIPROFLOXACIN**	**SIV**	$	**0.4454**
00002380358	**JAMP-CIPROFLOXACIN**	**JPC**	$	**0.4454**
00002379686	**MAR-CIPROFLOXACIN**	**MAR**	$	**0.4454**
00002423553	**MINT-CIPROFLOX**	**MPI**	$	**0.4454**
00002248437	**PMS-CIPROFLOXACIN**	**PMS**	$	**0.4454**
00002303728	**RAN-CIPROFLOX**	**RAN**	$	**0.4454**
00002248756	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**0.4454**

500 MG ORAL TABLET

00002247340	**ACT CIPROFLOXACIN**	**APH**	$	**0.5025**
00002381923	**AURO-CIPROFLOXACIN**	**AUR**	$	**0.5025**
00002353326	**CIPROFLOXACIN**	**SNS**	$	**0.5025**
00002386127	**CIPROFLOXACIN**	**SIV**	$	**0.5025**
00002380366	**JAMP-CIPROFLOXACIN**	**JPC**	$	**0.5025**
00002379694	**MAR-CIPROFLOXACIN**	**MAR**	$	**0.5025**
00002492008	**NRA-CIPROFLOXACIN**	**NRA**	$	**0.5025**
00002248438	**PMS-CIPROFLOXACIN**	**PMS**	$	**0.5025**
00002303736	**RAN-CIPROFLOX**	**RAN**	$	**0.5025**
00002248757	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**0.5025**

CIPROFLOXACIN HCL

750 MG (BASE) ORAL TABLET

00002247341	ACT CIPROFLOXACIN	APH	$	0.9201
00002380374	JAMP-CIPROFLOXACIN	JPC	$	0.9201
00002379708	MAR-CIPROFLOXACIN	MAR	$	0.9201
00002423588	MINT-CIPROFLOX	MPI	$	0.9201
00002248439	PMS-CIPROFLOXACIN	PMS	$	0.9201
00002303744	RAN-CIPROFLOX	RAN	$	0.9201
00002248758	SANDOZ CIPROFLOXACIN	SDZ	$	0.9201

LEVOFLOXACIN

250 MG ORAL TABLET

00002315424	**ACT LEVOFLOXACIN**	**TEV**	$	**1.2038**
00002284707	**APO-LEVOFLOXACIN**	**APX**	$	**1.2038**
00002298635	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**1.2038**

"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 60042).

LEVOFLOXACIN

500 MG ORAL TABLET

00002315432	**ACT LEVOFLOXACIN**	**TEV**	$	**1.3718**
00002284715	**APO-LEVOFLOXACIN**	**APX**	$	**1.3718**
00002298643	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**1.3718**

"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 60042).

LEVOFLOXACIN

750 MG ORAL TABLET

00002315440	**ACT LEVOFLOXACIN**	**TEV**	$	**4.8478**
00002325942	**APO-LEVOFLOXACIN**	**APX**	$	**4.8478**
00002298651	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**4.8478**

"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 60042).

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 60042).

400 MG (BASE) ORAL TABLET

00002478137	**AG-MOXIFLOXACIN**	**AGP**	$	**1.5230**
00002404923	**APO-MOXIFLOXACIN**	**APX**	$	**1.5230**
00002432242	**AURO-MOXIFLOXACIN**	**AUR**	$	**1.5230**
00002443929	**JAMP-MOXIFLOXACIN**	**JPC**	$	**1.5230**
00002447061	**JAMP-MOXIFLOXACIN**	**JPC**	$	**1.5230**
00002447053	**MAR-MOXIFLOXACIN**	**MAR**	$	**1.5230**
00002457814	**MED-MOXIFLOXACIN**	**GMP**	$	**1.5230**
00002383381	**SANDOZ MOXIFLOXACIN**	**SDZ**	$	**1.5230**
00002375702	**TEVA-MOXIFLOXACIN**	**TEV**	$	**1.5230**

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 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 ADBL 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, lysosomal 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).

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.

The Review Panel's functions include:

- Providing advice to Alberta Health 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 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.

00:00

Non-Classified Drugs

00:00 NON-CLASSIFIED DRUGS

00:00.02

(DIABETES SUPPLIES)

DIABETES SUPPLIES

☒ 00000999955	BLOOD GLUCOSE TEST STRIPS	XXX	$	0.0000
☒ 00000999941	BLOOD LETTING LANCET	XXX	$	0.0000
☒ 00000999985	INSULIN PEN NEEDLES	XXX	$	0.0000
☒ 00000999952	INSULIN SYRINGES	XXX	$	0.0000
☒ 00000999957	URINE TEST STRIPS	XXX	$	0.0000

This product is a benefit for patients with diabetes who are currently and regularly using insulin.

Eligible individuals will have coverage to a maximum of $600 per person each benefit year for eligible diabetic supplies purchased from a licensed pharmacy.

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	$	4.0400

04:00 ANTIHISTAMINE DRUGS

04:04.12 FIRST GENERATION ANTIHISTAMINES (PHENOTHIAZINE DERIVATIVES)

TRIMEPRAZINE TARTRATE

2.5 MG (BASE) ORAL TABLET

00001926306	PANECTYL	ERF	$	0.3123

5 MG (BASE) ORAL TABLET

00001926292	PANECTYL	ERF	$	0.3831

04:00 ANTIHISTAMINE DRUGS

04:92 OTHER ANTIHISTAMINES

KETOTIFEN FUMARATE

1 MG (BASE) ORAL TABLET

00000577308	ZADITEN	TEV	$	1.8452

08:00

Anti-Infective Agents

08:00 ANTI-INFECTIVE AGENTS

08:08 ANTHELMINTICS

MEBENDAZOLE

100 MG ORAL CHEWABLE TABLET				
00000556734	VERMOX	JAI	$	5.5400

08:00 ANTI-INFECTIVE AGENTS

08:12.02 ANTIBACTERIALS (AMINOGLYCOSIDES)

GENTAMICIN SULFATE

40 MG / ML (BASE) INJECTION				
☒ 00002242652	GENTAMICIN	SDZ	$	8.9447

TOBRAMYCIN

28 MG INHALATION CAPSULE				
00002365154	TOBI PODHALER	BGP	$	13.4510

TOBRAMYCIN SULFATE

60 MG / ML (BASE) INHALATION SOLUTION				
00002389622	**TEVA-TOBRAMYCIN**	**TEV**	$	**5.4763**
00002443368	**TOBRAMYCIN**	**SDZ**	$	**5.4763**
00002239630	TOBI	BGP	$	10.7608
40 MG / ML (BASE) INJECTION				
☒ 00002420287	JAMP-TOBRAMYCIN	JPC	$	2.7250

08:00 ANTI-INFECTIVE AGENTS

08:12.06.04 ANTIBACTERIALS CEPHALOSPORINS (FIRST GENERATION CEPHALOSPORINS)

CEFADROXIL

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

500 MG ORAL CAPSULE				
00002240774	**APO-CEFADROXIL**	**APX**	$	**0.8421**
00002235134	**TEVA-CEFADROXIL**	**TEV**	$	**0.8421**

CEFAZOLIN SODIUM

This Drug Product is a benefit for use by Home Parenteral Therapy (HPT) programs only.

500 MG / VIAL (BASE) INJECTION				
☒ 00002308932	CEFAZOLIN	SDZ	$	2.5000
1 G / VIAL (BASE) INJECTION				
00002297205	**CEFAZOLIN**	**APX**	$	**3.2308**
00002308959	**CEFAZOLIN**	**SDZ**	$	**3.2308**
00002108127	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**3.2308**

08:00 ANTI-INFECTIVE AGENTS

08:12.06.04 ANTIBACTERIALS
CEPHALOSPORINS
(FIRST GENERATION CEPHALOSPORINS)

CEFAZOLIN SODIUM

10 G / VIAL (BASE) INJECTION				
00002237140	**CEFAZOLIN**	**FKC**	$	**30.1500**
00002297213	**CEFAZOLIN**	**APX**	$	**30.1500**
00002308967	**CEFAZOLIN**	**SDZ**	$	**30.1500**
00002437120	**CEFAZOLIN**	**STM**	$	**30.1500**
00002108135	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**30.1500**
100 G / G INJECTION				
00002401029	CEFAZOLIN	FKC	$	3.0150

CEPHALEXIN

250 MG ORAL TABLET				
00000768723	**APO-CEPHALEX**	**APX**	$	**0.0866**
00002470578	**AURO-CEPHALEXIN**	**AUR**	$	**0.0866**
00000583413	**TEVA-CEPHALEXIN**	**TEV**	$	**0.0866**
500 MG ORAL TABLET				
00000768715	**APO-CEPHALEX**	**APX**	$	**0.1731**
00002470586	**AURO-CEPHALEXIN**	**AUR**	$	**0.1731**
00002495651	**CEPHALEXIN**	**SIV**	$	**0.1731**
00000583421	**TEVA-CEPHALEXIN**	**TEV**	$	**0.1731**
250 MG ORAL CAPSULE				
00000342084	TEVA-CEPHALEXIN	TEV	$	0.4229
500 MG ORAL CAPSULE				
00000342114	TEVA-CEPHALEXIN	TEV	$	0.7996
25 MG / ML ORAL SUSPENSION				
00000342106	TEVA-CEPHALEXIN 125	TEV	$	0.2561
50 MG / ML ORAL SUSPENSION				
00000342092	TEVA-CEPHALEXIN 250	TEV	$	0.4926

08:00 ANTI-INFECTIVE AGENTS

08:12.06.08 ANTIBACTERIALS
CEPHALOSPORINS
(SECOND GENERATION CEPHALOSPORINS)

CEFPROZIL

250 MG ORAL TABLET				
00002293528	RAN-CEFPROZIL	RAN	$	1.0220
500 MG ORAL TABLET				
00002347253	**AURO-CEFPROZIL**	**AUR**	$	**0.8494**
00002293536	**RAN-CEFPROZIL**	**RAN**	$	**0.8494**
25 MG / ML ORAL SUSPENSION				
00002329204	RAN-CEFPROZIL	RAN	$	0.1682
50 MG / ML ORAL SUSPENSION				
00002293579	RAN-CEFPROZIL	RAN	$	0.3360

08:00 ANTI-INFECTIVE AGENTS

08:12.06.08 ANTIBACTERIALS
CEPHALOSPORINS
(SECOND GENERATION CEPHALOSPORINS)

CEFUROXIME AXETIL

250 MG (BASE) ORAL TABLET				
00002244393	**APO-CEFUROXIME**	**APX**	$	**0.8388**
00002344823	**AURO-CEFUROXIME**	**AUR**	$	**0.8388**
500 MG (BASE) ORAL TABLET				
00002244394	**APO-CEFUROXIME**	**APX**	$	**1.4337**
00002344831	**AURO-CEFUROXIME**	**AUR**	$	**1.4337**

08:00 ANTI-INFECTIVE AGENTS

08:12.06.12 ANTIBACTERIALS
CEPHALOSPORINS
(THIRD GENERATION CEPHALOSPORINS)

CEFIXIME

400 MG ORAL TABLET				
00002432773	**AURO-CEFIXIME**	**AUR**	$	**3.0796**
00000868981	SUPRAX	ODN	$	3.0800
20 MG / ML ORAL SUSPENSION				
00002468689	**AURO-CEFIXIME**	**AUR**	$	**0.3899**
00000868965	**SUPRAX**	**ODN**	$	**0.3899**

CEFOTAXIME SODIUM

1 G / VIAL (BASE) INJECTION				
00002434091	CEFOTAXIME SODIUM	STM	$	9.1830
2 G / VIAL (BASE) INJECTION				
00002434105	CEFOTAXIME SODIUM	STM	$	18.3660

CEFTRIAXONE SODIUM

0.25 G / VIAL (BASE) INJECTION				
00002292866	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$	**3.9500**
00002325594	**CEFTRIAXONE SODIUM FOR INJECTION BP**	**STM**	$	**3.9500**
1 G / VIAL (BASE) INJECTION				
00002292270	**CEFTRIAXONE FOR INJECTION USP**	**SDZ**	$	**12.4900**
00002292874	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$	**12.4900**
00002287633	**CEFTRIAXONE SODIUM FOR INJECTION**	**TEV**	$	**12.4900**
00002325616	**CEFTRIAXONE SODIUM FOR INJECTION BP**	**STM**	$	**12.4900**
2 G / VIAL (BASE) INJECTION				
00002292289	**CEFTRIAXONE FOR INJECTION USP**	**SDZ**	$	**24.1300**
00002292882	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$	**24.1300**
00002325624	**CEFTRIAXONE SODIUM FOR INJECTION BP**	**STM**	$	**24.1300**
10 G / VIAL (BASE) INJECTION				
00002325632	CEFTRIAXONE SODIUM	STM	$	153.0000

08:00 ANTI-INFECTIVE AGENTS

08:12.07.08 ANTIBACTERIALS
MISCELLANEOUS B-LACTAMS
(CARBAPENEMS)

ERTAPENEM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

1 G / VIAL INJECTION				
00002247437	INVANZ	MFC	$	56.6061

IMIPENEM/ CILASTATIN SODIUM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

500 MG / VIAL * 500 MG / VIAL (BASE) INJECTION				
☒ 00000717282	PRIMAXIN	MFC	$	27.1116

MEROPENEM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

500 MG / VIAL INJECTION				
☒ 00002378787	MEROPENEM	SDZ	$	9.2225
1 G / VIAL INJECTION				
☒ 00002378795	MEROPENEM	SDZ	$	18.4450

08:00 ANTI-INFECTIVE AGENTS

08:12.07.12 ANTIBACTERIALS
MISCELLANEOUS B-LACTAMS
(CEPHAMYCINS)

CEFOXITIN SODIUM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

1 G / VIAL (BASE)	**INJECTION**			
00002291711	**CEFOXITIN**	**APX**	$	**10.6000**
00002128187	**CEFOXITIN SODIUM**	**TEV**	$	**10.6000**
2 G / VIAL (BASE)	**INJECTION**			
00002291738	**CEFOXITIN**	**APX**	$	**21.2500**
00002128195	**CEFOXITIN SODIUM**	**TEV**	$	**21.2500**

08:00 ANTI-INFECTIVE AGENTS

08:12.08 ANTIBACTERIALS
(CHLORAMPHENICOL)

CHLORAMPHENICOL SODIUM SUCCINATE

1 G / VIAL (BASE)	**INJECTION**			
00000312363	CHLOROMYCETIN	ERF	$	21.2130

08:00 ANTI-INFECTIVE AGENTS

08:12.12.04 ANTIBACTERIALS
MACROLIDES
(ERYTHROMYCINS)

ERYTHROMYCIN

250 MG ORAL TABLET				
00000682020	ERYTHRO-BASE	AAP	$	0.2089
333 MG ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000873454	ERYC	PFI	$	0.7700

08:00 ANTI-INFECTIVE AGENTS

08:12.12.92 ANTIBACTERIALS
MACROLIDES
(OTHER MACROLIDES)

AZITHROMYCIN

250 MG ORAL TABLET

00002480700	**AG-AZITHROMYCIN**	**AGP**	$	**0.9410**
00002415542	**APO-AZITHROMYCIN Z**	**APX**	$	**0.9410**
00002330881	**AZITHROMYCIN**	**SNS**	$	**0.9410**
00002442434	**AZITHROMYCIN**	**SIV**	$	**0.9410**
00002452308	**JAMP-AZITHROMYCIN**	**JPC**	$	**0.9410**
00002452324	**MAR-AZITHROMYCIN**	**MAR**	$	**0.9410**
00002267845	**NOVO-AZITHROMYCIN**	**TEV**	$	**0.9410**
00002479680	**NRA-AZITHROMYCIN**	**NRA**	$	**0.9410**
00002261634	**PMS-AZITHROMYCIN**	**PMS**	$	**0.9410**
00002265826	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.9410**
00002212021	ZITHROMAX	PFI	$	5.2318

600 MG ORAL TABLET

00002261642	PMS-AZITHROMYCIN	PMS	$	10.6652

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

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20 MG / ML ORAL SUSPENSION

00002482363	**AURO-AZITHROMYCIN**	**AUR**	$	**0.3726**
00002332388	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.3726**
00002223716	ZITHROMAX	PFI	$	1.1310

40 MG / ML ORAL SUSPENSION

00002482371	**AURO-AZITHROMYCIN**	**AUR**	$	**0.5280**
00002332396	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.5280**
00002223724	ZITHROMAX	PFI	$	1.6026

CLARITHROMYCIN

250 MG ORAL TABLET

00002442469	**CLARITHROMYCIN**	**SIV**	$	**0.4122**
00002466120	**CLARITHROMYCIN**	**SNS**	$	**0.4122**
00002247573	**PMS-CLARITHROMYCIN**	**PMS**	$	**0.4122**
00002361426	**RAN-CLARITHROMYCIN**	**RAN**	$	**0.4122**
00002266539	**SANDOZ CLARITHROMYCIN**	**SDZ**	$	**0.4122**
00001984853	BIAXIN BID	BGP	$	1.6833

500 MG ORAL TABLET

00002442485	**CLARITHROMYCIN**	**SIV**	$	**0.8318**
00002247574	**PMS-CLARITHROMYCIN**	**PMS**	$	**0.8318**
00002361434	**RAN-CLARITHROMYCIN**	**RAN**	$	**0.8318**
00002266547	**SANDOZ CLARITHROMYCIN**	**SDZ**	$	**0.8318**
00002126710	BIAXIN BID	BGP	$	3.3271

500 MG ORAL EXTENDED-RELEASE TABLET

00002403196	**ACT CLARITHROMYCIN XL**	**APH**	$	**1.2572**
00002413345	**APO-CLARITHROMYCIN XL**	**APX**	$	**1.2572**
00002244756	BIAXIN XL	BGP	$	2.5671

08:00 ANTI-INFECTIVE AGENTS

08:12.12.92 ANTIBACTERIALS
MACROLIDES
(OTHER MACROLIDES)

CLARITHROMYCIN

25 MG / ML ORAL SUSPENSION				
00002408988	**CLARITHROMYCIN**	**SNS**	$	**0.2047**
00002390442	**TARO-CLARITHROMYCIN**	**TAR**	$	**0.2047**
00002146908	BIAXIN	BGP	$	0.3029
50 MG / ML ORAL SUSPENSION				
00002408996	**CLARITHROMYCIN**	**SNS**	$	**0.3998**
00002390450	**TARO-CLARITHROMYCIN**	**TAR**	$	**0.3998**
00002244641	BIAXIN	BGP	$	0.5932

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**	$	**2.4000**
00002220261	**PENICILLIN G SODIUM**	**FKC**	$	**2.4000**
5,000,000 IU / VIAL INJECTION				
00000883751	**PENICILLIN G SODIUM**	**TEV**	$	**5.1000**
00002220288	**PENICILLIN G SODIUM**	**FKC**	$	**5.1000**
10,000,000 IU / VIAL INJECTION				
00001930680	**PENICILLIN G SODIUM**	**TEV**	$	**8.9000**
00002220296	**PENICILLIN G SODIUM**	**FKC**	$	**8.9000**

PENICILLIN V POTASSIUM

300 MG ORAL TABLET				
00000642215	PEN-VK	AAP	$	0.2098

08:00 ANTI-INFECTIVE AGENTS

08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE

250 MG (BASE) ORAL CHEWABLE TABLET				
00002036355	NOVAMOXIN	TEV	$	0.7888
250 MG (BASE) ORAL CAPSULE				
00002352710	**AMOXICILLIN**	**SNS**	$	**0.0672**
00000628115	**APO-AMOXI**	**APX**	$	**0.0672**
00002388073	**AURO-AMOXICILLIN**	**AUR**	$	**0.0672**
00002433060	**JAMP-AMOXICILLIN**	**JPC**	$	**0.0672**
00000406724	**NOVAMOXIN**	**TEV**	$	**0.0672**

08:00 ANTI-INFECTIVE AGENTS

08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE

500 MG (BASE) ORAL CAPSULE				
00002477726	**AG-AMOXICILLIN**	**AGP**	$	**0.1308**
00002352729	**AMOXICILLIN**	**SNS**	$	**0.1308**
00002401509	**AMOXICILLIN**	**SIV**	$	**0.1308**
00000628123	**APO-AMOXI**	**APX**	$	**0.1308**
00002388081	**AURO-AMOXICILLIN**	**AUR**	$	**0.1308**
00002433079	**JAMP-AMOXICILLIN**	**JPC**	$	**0.1308**
00000406716	**NOVAMOXIN**	**TEV**	$	**0.1308**
25 MG / ML (BASE) ORAL SUSPENSION				
00000628131	APO-AMOXI	APX	$	0.0352
50 MG / ML (BASE) ORAL SUSPENSION				
00002352753	**AMOXICILLIN**	**SNS**	$	**0.0540**
00002401541	**AMOXICILLIN**	**SIV**	$	**0.0540**
00002352788	**AMOXICILLIN SUGAR-REDUCED**	**SNS**	$	**0.0540**
00000628158	**APO-AMOXI**	**APX**	$	**0.0540**
00000452130	**NOVAMOXIN**	**TEV**	$	**0.0540**
00001934163	**NOVAMOXIN SUGAR-REDUCED**	**TEV**	$	**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**	$	**0.7555**
00002482576	**SANDOZ AMOXI-CLAV**	**SDZ**	$	**0.7555**
00001916858	CLAVULIN-500F	GSK	$	1.5866
875 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002245623	**APO-AMOXI CLAV**	**APX**	$	**1.1103**
00002482584	**SANDOZ AMOXI-CLAV**	**SDZ**	$	**1.1103**
00002238829	CLAVULIN-875	GSK	$	2.3315
40 MG / ML (BASE) * 5.7 MG / ML (BASE) ORAL SUSPENSION				
00002238831	CLAVULIN-200	GSK	$	0.1559
80 MG / ML (BASE) * 11.4 MG / ML (BASE) ORAL SUSPENSION				
00002238830	CLAVULIN-400	GSK	$	0.3000

AMPICILLIN

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

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250 MG ORAL CAPSULE				
00000020877	NOVO-AMPICILLIN	TEV	$	0.4434
500 MG ORAL CAPSULE				
00000020885	NOVO-AMPICILLIN	TEV	$	0.8406

08:00 ANTI-INFECTIVE AGENTS

08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMPICILLIN SODIUM

250 MG / VIAL (BASE) INJECTION				
☒ 00000872644	AMPICILLIN SODIUM	TEV	$	3.1830
500 MG / VIAL (BASE) INJECTION				
☒ 00000872652	AMPICILLIN SODIUM	TEV	$	3.3384
1 G / VIAL (BASE) INJECTION				
☒ 00001933345	AMPICILLIN SODIUM	TEV	$	5.5886
2 G / VIAL (BASE) INJECTION				
☒ 00001933353	AMPICILLIN SODIUM	TEV	$	11.1781

08:00 ANTI-INFECTIVE AGENTS

08:12.16.12 ANTIBACTERIALS
PENICILLINS
(PENICILLINASE-RESISTANT PENICILLINS)

CLOXACILLIN SODIUM

250 MG (BASE) ORAL CAPSULE				
00000337765	NOVO-CLOXIN	TEV	$	0.5196
500 MG (BASE) ORAL CAPSULE				
00000337773	NOVO-CLOXIN	TEV	$	0.9825
25 MG / ML (BASE) ORAL LIQUID				
00000337757	NOVO-CLOXIN	TEV	$	0.1294
500 MG / VIAL (BASE) INJECTION				
00002367408	CLOXACILLIN	STM	$	5.2780
1 G / VIAL (BASE) INJECTION				
00002367416	CLOXACILLIN	STM	$	6.4820
2 G / VIAL (BASE) INJECTION				
00002367424	CLOXACILLIN	STM	$	8.4610

08:00 ANTI-INFECTIVE AGENTS

08:12.16.16 ANTIBACTERIALS
PENICILLINS
(EXTENDED-SPECTRUM PENICILLINS)

PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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2 G / VIAL (BASE) * 250 MG / VIAL (BASE) INJECTION				
00002308444	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**4.1727**
00002362619	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**4.1727**
00002401312	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**4.1727**
00002299623	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**4.1727**
3 G / VIAL (BASE) * 375 MG / VIAL (BASE) INJECTION				
00002308452	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**6.2591**
00002362627	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**6.2591**
00002401320	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**6.2591**
00002299631	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**6.2591**
00002370166	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**6.2591**
4 G / VIAL (BASE) * 500 MG / VIAL (BASE) INJECTION				
00002308460	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**8.3458**
00002362635	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**8.3458**
00002401339	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**8.3458**
00002299658	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**8.3458**
00002370174	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**8.3458**

08:00 ANTI-INFECTIVE AGENTS

08:12.18 ANTIBACTERIALS
(QUINOLONES)

NORFLOXACIN

400 MG ORAL TABLET				
00002229524	NORFLOXACIN	AAP	$	1.0933

08:00 ANTI-INFECTIVE AGENTS

08:12.20 ANTIBACTERIALS
(SULFONAMIDES)

SULFAMETHOXAZOLE/ TRIMETHOPRIM

100 MG * 20 MG ORAL TABLET				
00000445266	SULFATRIM	AAP	$	0.0976
400 MG * 80 MG ORAL TABLET				
00000445274	SULFATRIM	AAP	$	0.0482
800 MG * 160 MG ORAL TABLET				
00000445282	SULFATRIM DS	AAP	$	0.2074

08:00 ANTI-INFECTIVE AGENTS

08:12.20 ANTIBACTERIALS (SULFONAMIDES)

SULFAMETHOXAZOLE/ TRIMETHOPRIM

40 MG / ML * 8 MG / ML ORAL SUSPENSION				
00000726540	TEVA-TRIMEL	TEV	$	0.1309
80 MG / ML * 16 MG / ML INJECTION				
00000550086	SEPTRA	APC	$	1.6880

SULFASALAZINE

500 MG ORAL TABLET				
00000598461	PMS-SULFASALAZINE	PMS	$	0.2678
500 MG ORAL ENTERIC-COATED TABLET				
00000598488	PMS-SULFASALAZINE	PMS	$	0.4074

08:00 ANTI-INFECTIVE AGENTS

08:12.24 ANTIBACTERIALS (TETRACYCLINES)

DOXYCYCLINE HYCLATE

100 MG (BASE) ORAL TABLET				
00000874256	**APO-DOXY**	**APX**	$	**0.5860**
00002351242	**DOXYCYCLINE**	**SNS**	$	**0.5860**
00002158574	**TEVA-DOXYCYCLINE**	**TEV**	$	**0.5860**
100 MG (BASE) ORAL CAPSULE				
00000740713	**APO-DOXY**	**APX**	$	**0.5860**
00002351234	**DOXYCYCLINE**	**SNS**	$	**0.5860**
00000725250	**TEVA-DOXYCYCLINE**	**TEV**	$	**0.5860**

MINOCYCLINE HCL

50 MG (BASE) ORAL CAPSULE				
00002084090	MINOCYCLINE	AAP	$	0.1101
100 MG (BASE) ORAL CAPSULE				
00002084104	MINOCYCLINE	AAP	$	0.2125

TETRACYCLINE HCL

250 MG ORAL CAPSULE				
00000580929	TETRACYCLINE	AAP	$	0.0750

08:00 ANTI-INFECTIVE AGENTS

08:12.28 ANTIBACTERIALS (MISCELLANEOUS ANTIBACTERIALS)

SPIRAMYCIN

750,000 IU ORAL CAPSULE				
00001927825	ROVAMYCINE-250	ODN	$	1.4729
1,500,000 IU ORAL CAPSULE				
00001927817	ROVAMYCINE-500	ODN	$	2.8799

08:00 ANTI-INFECTIVE AGENTS

08:12.28.16 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(GLYCOPEPTIDES)

VANCOMYCIN HCL

125 MG (BASE) ORAL CAPSULE				
00002407744	**JAMP-VANCOMYCIN**	**JPC**	$	**5.1800**
00000800430	**VANCOCIN**	**SLP**	$	**5.1800**
250 MG (BASE) ORAL CAPSULE				
00002407752	**JAMP-VANCOMYCIN**	**JPC**	$	**10.3600**
00000788716	**VANCOCIN**	**SLP**	$	**10.3600**
500 MG / VIAL (BASE) INJECTION				
☒ 00002342855	VANCOMYCIN HCL	STM	$	31.0500
1 G / VIAL (BASE) INJECTION				
☒ 00002342863	VANCOMYCIN HCL	STM	$	58.9900
10 G / VIAL INJECTION				
00002241807	**STERILE VANCOMYCIN HCL**	**FKC**	$	**589.9000**
00002405830	**VANCOMYCIN HCL**	**STM**	$	**589.9000**

RESTRICTED BENEFIT

This Drug Product is a benefit for use by Home Parenteral Therapy (HPT) programs only.

08:00 ANTI-INFECTIVE AGENTS

08:12.28.20 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(LINCOMYCINS)

CLINDAMYCIN HCL

150 MG (BASE) ORAL CAPSULE				
00002436906	**AURO-CLINDAMYCIN**	**AUR**	$	**0.2217**
00002483734	**JAMP CLINDAMYCIN**	**JPC**	$	**0.2217**
00002493748	**NRA-CLINDAMYCIN**	**NRA**	$	**0.2217**
00002241709	**TEVA-CLINDAMYCIN**	**TEV**	$	**0.2217**
300 MG (BASE) ORAL CAPSULE				
00002436914	**AURO-CLINDAMYCIN**	**AUR**	$	**0.4434**
00002483742	**JAMP CLINDAMYCIN**	**JPC**	$	**0.4434**
00002493756	**NRA-CLINDAMYCIN**	**NRA**	$	**0.4434**
00002241710	**TEVA-CLINDAMYCIN**	**TEV**	$	**0.4434**

CLINDAMYCIN PALMITATE HCL

15 MG / ML (BASE) ORAL SOLUTION				
00000225851	DALACIN C PALMITATE	PFI	$	0.3152

CLINDAMYCIN PHOSPHATE

150 MG / ML (BASE) INJECTION				
00002230540	CLINDAMYCIN	SDZ	$	3.7799
00002230535	CLINDAMYCIN (60 & 120 ML)	SDZ	$	3.7799
00000260436	DALACIN C PHOSPHATE	PFI	$	4.4469

08:00 ANTI-INFECTIVE AGENTS

08:12.28.24 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(OXAZOLIDINONES)

LINEZOLID

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

600 MG ORAL TABLET

00002426552	**APO-LINEZOLID**	**APX**	$	**37.0500**
00002422689	**SANDOZ LINEZOLID**	**SDZ**	$	**37.0500**

08:00 ANTI-INFECTIVE AGENTS

08:12.28.28 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(POLYMYXINS)

COLISTIMETHATE SODIUM

150 MG / VIAL INJECTION

☒ 00002244849	COLISTIMETHATE FOR INJECTION	STM	$	33.7397

08:00 ANTI-INFECTIVE AGENTS

08:14.04 ANTIFUNGALS
(ALLYLAMINES)

TERBINAFINE HCL

250 MG (BASE) ORAL TABLET

00002254727	**ACT TERBINAFINE**	**APH**	$	**0.7714**
00002239893	**APO-TERBINAFINE**	**APX**	$	**0.7714**
00002320134	**AURO-TERBINAFINE**	**AUR**	$	**0.7714**
00002294273	**PMS-TERBINAFINE**	**PMS**	$	**0.7714**
00002353121	**TERBINAFINE**	**SNS**	$	**0.7714**
00002385279	**TERBINAFINE**	**SIV**	$	**0.7714**
00002031116	LAMISIL	NOV	$	4.4225

08:00 ANTI-INFECTIVE AGENTS

08:14.08 ANTIFUNGALS (AZOLES)

FLUCONAZOLE

50 MG ORAL TABLET

00002281260	**ACT FLUCONAZOLE**	**APH**	$	**1.2904**
00002237370	**APO-FLUCONAZOLE**	**APX**	$	**1.2904**
00002245292	**MYLAN-FLUCONAZOLE**	**MYP**	$	**1.2904**
00002236978	**NOVO-FLUCONAZOLE**	**TEV**	$	**1.2904**
00002245643	**PMS-FLUCONAZOLE**	**PMS**	$	**1.2904**

100 MG ORAL TABLET

00002281279	**ACT FLUCONAZOLE**	**APH**	$	**2.2890**
00002237371	**APO-FLUCONAZOLE**	**APX**	$	**2.2890**
00002245293	**MYLAN-FLUCONAZOLE**	**MYP**	$	**2.2890**
00002236979	**NOVO-FLUCONAZOLE**	**TEV**	$	**2.2890**
00002245644	**PMS-FLUCONAZOLE**	**PMS**	$	**2.2890**

10 MG / ML ORAL SUSPENSION

00002024152	DIFLUCAN	PFI	$	1.1854

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

2 MG / ML INJECTION

☒ 00000891835	DIFLUCAN	PFI	$	0.4085

ISAVUCONAZONIUM SULFATE

This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

100 MG ORAL CAPSULE

00002483971	CRESEMBA	AVP	$	78.8300

200 MG / VIAL INJECTION

00002483998	CRESEMBA	AVP	$	400.0000

ITRACONAZOLE

100 MG ORAL CAPSULE

00002462559	**MINT-ITRACONAZOLE**	**MPI**	$	**4.2075**
00002047454	SPORANOX	JAI	$	9.4246

10 MG / ML ORAL SOLUTION

00002484315	**JAMP ITRACONAZOLE**	**JPC**	$	**0.4111**
00002495988	**ODAN ITRACONAZOLE**	**ODN**	$	**0.4111**
00002231347	SPORANOX	JAI	$	0.9060

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

08:00 ANTI-INFECTIVE AGENTS

08:14.08 ANTIFUNGALS (AZOLES)

KETOCONAZOLE

200 MG ORAL TABLET				
00002237235	**APO-KETOCONAZOLE**	**APX**	$	**0.9393**
00002231061	**TEVA-KETOCONAZOLE**	**TEV**	$	**0.9393**

VORICONAZOLE

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

50 MG ORAL TABLET				
00002399245	**SANDOZ VORICONAZOLE**	**SDZ**	$	**6.7818**
00002396866	**TEVA-VORICONAZOLE**	**TEV**	$	**6.7818**
00002256460	VFEND	PFI	$	13.3516
200 MG ORAL TABLET				
00002399253	**SANDOZ VORICONAZOLE**	**SDZ**	$	**26.4807**
00002396874	**TEVA-VORICONAZOLE**	**TEV**	$	**26.4807**
00002256479	VFEND	PFI	$	53.3843
40 MG / ML ORAL SUSPENSION				
00002279991	VFEND	PFI	$	10.7992
200 MG / VIAL INJECTION				
00002477696	**VORICONAZOLE INJECTION**	**JPC**	$	**136.5800**
00002256487	VFEND	PFI	$	160.0204

08:00 ANTI-INFECTIVE AGENTS

08:14.16 ANTIFUNGALS (ECHINOCANDINS)

CASPOFUNGIN

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

50 MG / VIAL INJECTION				
00002460947	**CASPOFUNGIN**	**JUN**	$	**188.7000**
00002244265	CANCIDAS	MFC	$	222.0000
70 MG / VIAL INJECTION				
00002460955	**CASPOFUNGIN**	**JUN**	$	**188.7000**
00002244266	CANCIDAS	MFC	$	222.0000

08:00 ANTI-INFECTIVE AGENTS

08:14.28 ANTIFUNGALS

(POLYENES)

AMPHOTERICIN B

50 MG / VIAL INJECTION

00000029149	FUNGIZONE IV	CAG	$	80.0438

NYSTATIN

100,000 UNIT / ML ORAL SUSPENSION

☒ 00002433443	JAMP-NYSTATIN	JPC	$	0.0518
00000792667	**PMS-NYSTATIN**	**PMS**	$	**0.0518**
00002194201	**TEVA-NYSTATIN**	**TEV**	$	**0.0518**

08:00 ANTI-INFECTIVE AGENTS

08:16.92 ANTIMYCOBACTERIALS

(MISCELLANEOUS ANTIMYCOBACTERIALS)

DAPSONE

100 MG ORAL TABLET

00002481227	**MAR-DAPSONE**	**MAR**	$	**0.7031**
00002489058	**RIVA-DAPSONE**	**RIV**	$	**0.7031**
00002041510	DAPSONE	NTI	$	1.4061

RIFABUTIN

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

150 MG ORAL CAPSULE

00002063786	MYCOBUTIN	PFI	$	5.7207

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

00002393239	**APO-LAMIVUDINE HBV**	**APX**	$	**3.5316**
00002239193	HEPTOVIR	GSK	$	5.0810

08:00 ANTI-INFECTIVE AGENTS

08:18.08.20 ANTIVIRALS

ANTIRETROVIRALS

(NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS)

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				
00002451980	**APO-TENOFOVIR**	**APX**	$	**4.8884**
00002460173	**AURO-TENOFOVIR**	**AUR**	$	**4.8884**
00002479087	**JAMP-TENOFOVIR**	**JPC**	$	**4.8884**
00002452634	**MYLAN-TENOFOVIR DISOPROXIL**	**MYP**	$	**4.8884**
00002472511	**NAT-TENOFOVIR**	**NTP**	$	**4.8884**
00002453940	**PMS-TENOFOVIR**	**PMS**	$	**4.8884**
00002403889	**TEVA-TENOFOVIR**	**TEV**	$	**4.8884**
00002247128	VIREAD	GIL	$	18.4879

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 Human Services Drug Benefit Supplement for Alberta Human Services clients.)

180 MCG / SYR INJECTION SYRINGE				
00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	$	419.7000

08:00 ANTI-INFECTIVE AGENTS

08:18.32 ANTIVIRALS

(NUCLEOSIDES AND NUCLEOTIDES)

ACYCLOVIR

200 MG ORAL TABLET				
00002207621	**APO-ACYCLOVIR**	**APX**	$	**0.6397**
00002242784	**MYLAN-ACYCLOVIR**	**MYP**	$	**0.6397**
00002285959	**TEVA-ACYCLOVIR**	**TEV**	$	**0.6397**
400 MG ORAL TABLET				
00002207648	**APO-ACYCLOVIR**	**APX**	$	**1.2700**
00002242463	**MYLAN-ACYCLOVIR**	**MYP**	$	**1.2700**
00002285967	**TEVA-ACYCLOVIR**	**TEV**	$	**1.2700**
800 MG ORAL TABLET				
00002207656	**APO-ACYCLOVIR**	**APX**	$	**1.2673**
00002242464	**MYLAN-ACYCLOVIR**	**MYP**	$	**1.2673**
00002285975	**TEVA-ACYCLOVIR**	**TEV**	$	**1.2673**
40 MG / ML ORAL SUSPENSION				
00000886157	ZOVIRAX	GSK	$	0.2673

08:00 ANTI-INFECTIVE AGENTS

08:18.32 ANTIVIRALS

(NUCLEOSIDES AND NUCLEOTIDES)

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

00002420333	**APO-ADEFOVIR**	**APX**	$	**18.2518**
00002247823	HEPSERA	GIL	$	23.8405

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

00002479907	**ACCEL-ENTECAVIR**	**ACP**	$	**4.4000**
00002396955	APO-ENTECAVIR	APX	$	5.5000
00002448777	AURO-ENTECAVIR	AUR	$	5.5000
00002453797	ENTECAVIR	STR	$	5.5000
00002467232	JAMP-ENTECAVIR	JPC	$	5.5000
00002485907	MINT-ENTECAVIR	MPI	$	5.5000
00002430576	PMS-ENTECAVIR	PMS	$	5.5000
00002282224	BARACLUDE	BMS	$	22.6601

GANCICLOVIR SODIUM

500 MG / VIAL (BASE) INJECTION

00002162695	CYTOVENE	CAG	$	44.5480

VALACYCLOVIR

500 MG ORAL TABLET

00002295822	**APO-VALACYCLOVIR (CAPLET)**	**APX**	$	**0.6198**
00002405040	**AURO-VALACYCLOVIR**	**AUR**	$	**0.6198**
00002441454	**JAMP-VALACYCLOVIR**	**JPC**	$	**0.6198**
00002351579	**MYLAN-VALACYCLOVIR (CAPLET)**	**MYP**	$	**0.6198**
00002298457	**PMS-VALACYCLOVIR (CAPLET)**	**PMS**	$	**0.6198**
00002347091	**SANDOZ VALACYCLOVIR**	**SDZ**	$	**0.6198**
00002357534	**TEVA-VALACYCLOVIR**	**TEV**	$	**0.6198**
00002442000	**VALACYCLOVIR**	**SIV**	$	**0.6198**
00002454645	**VALACYCLOVIR**	**SNS**	$	**0.6198**
00002219492	VALTREX (CAPLET)	GSK	$	3.6158

1,000 MG ORAL TABLET

00002354705	**APO-VALACYCLOVIR (CAPLET)**	**APX**	$	**1.7218**
00002351560	**MYLAN-VALACYCLOVIR (CAPLET)**	**MYP**	$	**1.7218**
00002381230	**PMS-VALACYCLOVIR (CAPLET)**	**PMS**	$	**1.7218**

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

50 MG / ML ORAL SUSPENSION

00002306085	VALCYTE	HLR	$	2.7452

08:00 ANTI-INFECTIVE AGENTS

08:30.08 ANTIPROTOZOALS (ANTIMALARIALS)

CHLOROQUINE PHOSPHATE

250 MG ORAL TABLET				
00000021261	TEVA-CHLOROQUINE	TEV	$	1.4170

HYDROXYCHLOROQUINE SULFATE

200 MG ORAL TABLET				
00002246691	**APO-HYDROXYQUINE**	**APX**	$	**0.1576**
00002491427	**JAMP HYDROXYCHLOROQUINE SULFATE**	**JPC**	$	**0.1576**
00002424991	**MINT-HYDROXYCHLOROQUINE**	**MPI**	$	**0.1576**
00002017709	PLAQUENIL SULFATE	SAV	$	0.6302

PRIMAQUINE PHOSPHATE

15 MG (BASE) ORAL TABLET				
00002017776	PRIMAQUINE PHOSPHATE	SAV	$	0.4498

QUININE SULFATE

200 MG ORAL CAPSULE				
00002254514	**APO-QUININE**	**APX**	$	**0.2390**
00002445190	**JAMP-QUININE**	**JPC**	$	**0.2390**
00000021008	**TEVA-QUININE**	**TEV**	$	**0.2390**
300 MG ORAL CAPSULE				
00002445204	**JAMP-QUININE**	**JPC**	$	**0.3750**
00000021016	**TEVA-QUININE**	**TEV**	$	**0.3750**

08:00 ANTI-INFECTIVE AGENTS

08:30.92 ANTIPROTOZOALS (MISCELLANEOUS ANTIPROTOZOALS)

ATOVAQUONE

150 MG / ML ORAL SUSPENSION				
00002217422	MEPRON	GSK	$	2.9136

METRONIDAZOLE

250 MG ORAL TABLET				
00000545066	METRONIDAZOLE	AAP	$	0.0680
5 MG / ML INJECTION				
00000870420	**FLAGYL**	**BAX**	$	**0.0271**
00000649074	METRONIDAZOLE	PFI	$	0.1740

08:00 ANTI-INFECTIVE AGENTS

08:36 URINARY ANTI-INFECTIVES

FOSFOMYCIN TROMETHAMINE

3 G (BASE) ORAL POWDER PACKET				
00002473801	**JAMP-FOSFOMYCIN**	**JPC**	$	**14.0250**
00002240335	MONUROL	PAL	$	18.6480

NITROFURANTOIN

50 MG ORAL TABLET				
00000319511	NITROFURANTOIN	AAP	$	0.1908
100 MG ORAL TABLET				
00000312738	NITROFURANTOIN	AAP	$	0.2545

08:00 ANTI-INFECTIVE AGENTS

08:36 URINARY ANTI-INFECTIVES

NITROFURANTOIN

50 MG ORAL CAPSULE (MACROCRYSTALS)

00002231015	TEVA-NITROFURANTOIN	TEV	$	0.3841

100 MG ORAL CAPSULE (MACROCRYSTALS)

00002231016	TEVA-NITROFURANTOIN	TEV	$	0.7761

100 MG ORAL CAPSULE (MACROCRYSTALS/MONOHYDRATE)

00002455676	**PMS-NITROFURANTOIN**	**PMS**	$	**0.5974**
00002063662	MACROBID	ALL	$	0.8082

TRIMETHOPRIM

100 MG ORAL TABLET

00002243116	TRIMETHOPRIM	AAP	$	0.2931

200 MG ORAL TABLET

00002243117	TRIMETHOPRIM	AAP	$	0.6024

10:00

Antineoplastic Agents

10:00 ANTINEOPLASTIC AGENTS

10:00

5-FLUOROURACIL/ SALICYLIC ACID

0.5 % * 10 % TOPICAL SOLUTION

00002428946	ACTIKERALL	CIP	$	1.6103

METHOTREXATE

2.5 MG ORAL TABLET

00002182963	**APO-METHOTREXATE**	**APX**	$	**0.6325**
00002170698	PMS-METHOTREXATE	PMS	$	0.6641

10 MG ORAL TABLET

00002182750	METHOTREXATE	PFI	$	2.7067

METHOTREXATE SODIUM

25 MG / ML (BASE) INJECTION

00002099705	METHOTREXATE SOD.(UNPRESERVED)	TEV	$	3.5101
00002182955	METHOTREXATE SOD.(UNPRESERVED)	PFI	$	5.6250

25 MG / ML (BASE) INJECTION

00002182777	METHOTREXATE SOD. (PRESERVED)	PFI	$	8.4472

10 MG / SYR (BASE) INJECTION SYRINGE

00002454831	METOJECT SUBCUTANEOUS	MDX	$	29.6400

12.5 MG / SYR INJECTION SYRINGE

00002454750	METOJECT SUBCUTANEOUS	MDX	$	31.2000

15 MG / SYR (BASE) INJECTION SYRINGE

00002454858	METOJECT SUBCUTANEOUS	MDX	$	24.5700

17.5 MG / SYR (BASE) INJECTION SYRINGE

00002454769	METOJECT SUBCUTANEOUS	MDX	$	24.0000

20 MG / SYR (BASE) INJECTION SYRINGE

00002454866	METOJECT SUBCUTANEOUS	MDX	$	26.2500

22.5 MG / SYR (BASE) INJECTION SYRINGE

00002454777	METOJECT SUBCUTANEOUS	MDX	$	26.2500

25 MG / SYR (BASE) INJECTION SYRINGE

00002454874	METOJECT SUBCUTANEOUS	MDX	$	29.2500

12:00

Autonomic Drugs

12:00 AUTONOMIC DRUGS

12:04 PARASYMPATHOMIMETIC (CHOLINERGIC) AGENTS

PILOCARPINE HCL

5 MG ORAL TABLET

00002496119	**ACCEL-PILOCARPINE**	**ACP**	$	**1.1713**
00002216345	SALAGEN	AMD	$	1.2445

PYRIDOSTIGMINE BROMIDE

60 MG ORAL TABLET

00002495643	**RIVA-PYRIDOSTIGMINE**	**RIV**	$	**0.4009**
00000869961	MESTINON	VCL	$	0.4986

180 MG ORAL SUSTAINED-RELEASE TABLET

00000869953	MESTINON-SR	VCL	$	1.1062

12:00 AUTONOMIC DRUGS

12:08.08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS / ANTISPASMODICS)

ACLIDINIUM BROMIDE

400 MCG / DOSE INHALATION METERED INHALATION POWDER

00002409720	TUDORZA GENUAIR	AZC	$	0.8850

ATROPINE SULFATE

0.4 MG / ML INJECTION

00000392782	ATROPINE SULFATE	SDZ	$	2.2880

0.6 MG / ML INJECTION

00000392693	ATROPINE SULFATE	SDZ	$	2.4880

GLYCOPYRROLATE

0.2 MG / ML INJECTION

☒ 00002039508	GLYCOPYRROLATE	SDZ	$	3.9780

HYOSCINE BUTYLBROMIDE

10 MG ORAL TABLET

00000363812	BUSCOPAN	SAV	$	0.3430

20 MG / ML INJECTION

00000363839	BUSCOPAN	SAV	$	4.5860

IPRATROPIUM BROMIDE

20 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002247686	ATROVENT HFA	BOE	$	0.1013

250 MCG / ML INHALATION SOLUTION

00002126222	**APO-IPRAVENT**	**APX**	$	**0.3155**
00002231136	**PMS-IPRATROPIUM**	**PMS**	$	**0.3155**

0.03 % NASAL SPRAY

00002239627	PMS-IPRATROPIUM	PMS	$	0.9127

IPRATROPIUM BROMIDE/ SALBUTAMOL SULFATE

0.2 MG / ML * 1 MG / ML (BASE) INHALATION SOLUTION

00002483394	**IPRATROPIUM BROMIDE/SALBUTAMOL SULPHATE**	**JUN**	$	**0.3226**
00002272695	**TEVA-COMBO STERINEBS**	**TEV**	$	**0.3226**

12:00 AUTONOMIC DRUGS

12:08.08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS / ANTISPASMODICS)

TIOTROPIUM BROMIDE MONOHYDRATE

2.5 MCG / DOSE INHALATION SOLUTION

00002435381	SPIRIVA RESPIMAT	BOE	$	0.9013

18 MCG INHALATION CAPSULE

00002246793	SPIRIVA	BOE	$	1.8027

UMECLIDINIUM BROMIDE

62.5 MCG / DOSE INHALATION METERED INHALATION POWDER

00002423596	INCRUSE ELLIPTA	GSK	$	1.6667

12:00 AUTONOMIC DRUGS

12:12.04 SYMPATHOMIMETIC (ADRENERGIC) AGENTS (ALPHA-ADRENERGIC AGONISTS)

MIDODRINE HCL

2.5 MG ORAL TABLET

00002278677	**APO-MIDODRINE**	**APX**	$	**0.2305**
00002473984	**MAR-MIDODRINE**	**MAR**	$	**0.2305**

5 MG ORAL TABLET

00002278685	**APO-MIDODRINE**	**APX**	$	**0.3842**
00002473992	**MAR-MIDODRINE**	**MAR**	$	**0.3842**

12:00 AUTONOMIC DRUGS

12:12.08.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS BETA-ADRENERGIC AGONISTS (SELECTIVE BETA 2-ADRENERGIC AGONISTS)

FORMOTEROL FUMARATE

12 MCG INHALATION CAPSULE

00002230898	FORADIL	NOV	$	0.8755

FORMOTEROL FUMARATE DIHYDRATE

6 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237225	OXEZE TURBUHALER	AZC	$	0.5588

12 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237224	OXEZE TURBUHALER	AZC	$	0.7445

INDACATEROL MALEATE

75 MCG (BASE) INHALATION CAPSULE

00002376938	ONBREZ BREEZHALER	NOV	$	1.5500

SALBUTAMOL

100 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002232570	**AIROMIR CFC-FREE**	**VCL**	$	**0.0273**
00002245669	**APO-SALBUTAMOL HFA**	**APX**	$	**0.0273**
00002419858	**SALBUTAMOL HFA**	**SNS**	$	**0.0273**
00002241497	VENTOLIN HFA	GSK	$	0.0309

12:00 AUTONOMIC DRUGS

12:12.08.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS
BETA-ADRENERGIC AGONISTS
(SELECTIVE BETA 2-ADRENERGIC AGONISTS)

SALBUTAMOL SULFATE

0.5 MG / ML (BASE) INHALATION SOLUTION				
00002208245	PMS-SALBUTAMOL	PMS	$	0.1492
1 MG / ML (BASE) INHALATION SOLUTION				
00002208229	**PMS-SALBUTAMOL**	**PMS**	$	**0.1446**
00001926934	**TEVA-SALBUTAMOL STERINEBS P.F.**	**TEV**	$	**0.1446**
00002213419	VENTOLIN NEBULES P.F.	GSK	$	0.2415
5 MG / ML (BASE) INHALATION SOLUTION				
00002213486	VENTOLIN	GSK	$	0.2415
2 MG / ML (BASE) INHALATION UNIT DOSE SOLUTION				
00002208237	**PMS-SALBUTAMOL POLYNEB**	**PMS**	$	**0.2700**
00002173360	**TEVA-SALBUTAMOL STERINEBS P.F.**	**TEV**	$	**0.2700**
00002213427	VENTOLIN NEBULES P.F.	GSK	$	0.2835

SALMETEROL XINAFOATE

50 MCG / DOSE (BASE) INHALATION METERED INHALATION POWDER				
00002231129	SEREVENT DISKUS	GSK	$	1.0260

TERBUTALINE SULFATE

0.5 MG / DOSE INHALATION METERED INHALATION POWDER				
00000786616	BRICANYL TURBUHALER	AZC	$	0.0834

12:00 AUTONOMIC DRUGS

12:12.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS
(ALPHA- AND BETA-ADRENERGIC AGONISTS)

EPINEPHRINE

0.15 MG / SYR INJECTION SYRINGE				
00000578657	EPIPEN JR	MYS	$	88.5588
0.3 MG / SYR INJECTION SYRINGE				
☒ 00002458446	EMERADE	VCL	$	81.0000
☒ 00000509558	EPIPEN	MYS	$	88.5588
0.5 MG / SYR INJECTION SYRINGE				
00002458454	EMERADE	VCL	$	81.0000

12:00 AUTONOMIC DRUGS

12:16 SYMPATHOLYTIC (ADRENERGIC BLOCKING) AGENTS

DIHYDROERGOTAMINE MESYLATE

4 MG / ML NASAL SPRAY				
00002228947	MIGRANAL	STM	$	16.0685
1 MG / ML INJECTION				
00000027243	DIHYDROERGOTAMINE (DHE)	STM	$	12.9486

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

00002177145	**APO-CYCLOBENZAPRINE**	**APX**	$	**0.1022**
00002348853	**AURO-CYCLOBENZAPRINE**	**AUR**	$	**0.1022**
00002287064	**CYCLOBENZAPRINE**	**SNS**	$	**0.1022**
00002424584	**CYCLOBENZAPRINE**	**SIV**	$	**0.1022**
00002495422	**FLEXERIL**	**ORI**	$	**0.1022**
00002357127	**JAMP-CYCLOBENZAPRINE**	**JPC**	$	**0.1022**
00002212048	**PMS-CYCLOBENZAPRINE**	**PMS**	$	**0.1022**
00002080052	**TEVA-CYCLOBENZAPRINE**	**TEV**	$	**0.1022**

12:00 AUTONOMIC DRUGS

12:20.08 SKELETAL MUSCLE RELAXANTS

(DIRECT-ACTING SKELETAL MUSCLE RELAXANTS)

DANTROLENE SODIUM

25 MG ORAL CAPSULE

00001997602	DANTRIUM	PAL	$	0.4200

12:00 AUTONOMIC DRUGS

12:20.12 SKELETAL MUSCLE RELAXANTS

(GABA-DERIVATIVE SKELETAL MUSCLE RELAXANTS)

BACLOFEN

10 MG ORAL TABLET

00002139332	**APO-BACLOFEN**	**APX**	$	**0.1595**
00002287021	**BACLOFEN**	**SNS**	$	**0.1595**
00002088398	**MYLAN-BACLOFEN**	**MYP**	$	**0.1595**
00002063735	**PMS-BACLOFEN**	**PMS**	$	**0.1595**

20 MG ORAL TABLET

00002139391	**APO-BACLOFEN**	**APX**	$	**0.3104**
00002287048	**BACLOFEN**	**SNS**	$	**0.3104**
00002088401	**MYLAN-BACLOFEN**	**MYP**	$	**0.3104**
00002063743	**PMS-BACLOFEN**	**PMS**	$	**0.3104**

0.05 MG / ML INJECTION

00002457059	**BACLOFEN INJECTION**	**TGT**	$	**7.5160**
00002413620	**BACLOFEN INTRATHECAL**	**STM**	$	**7.5160**
00002131048	LIORESAL INTRATHECAL	NOV	$	15.6920

0.5 MG / ML INJECTION

00002457067	**BACLOFEN INJECTION**	**TGT**	$	**5.6328**
00002413639	**BACLOFEN INTRATHECAL**	**STM**	$	**5.6328**
00002131056	LIORESAL INTRATHECAL	NOV	$	11.7585

2 MG / ML INJECTION

00002457075	**BACLOFEN INJECTION**	**TGT**	$	**22.5334**
00002413647	**BACLOFEN INTRATHECAL**	**STM**	$	**22.5334**
00002131064	LIORESAL INTRATHECAL	NOV	$	47.0420

12:00 AUTONOMIC DRUGS

12:92 MISCELLANEOUS AUTONOMIC DRUGS

VARENICLINE TARTRATE

RESTRICTED BENEFIT - This product is a benefit in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling. Coverage will be granted for a total of 12 weeks."

0.5 MG (BASE) ORAL TABLET				
00002419882	**APO-VARENICLINE**	**APX**	$	**0.9237**
00002426226	**TEVA-VARENICLINE**	**TEV**	$	**0.9237**
00002291177	CHAMPIX	PFI	$	1.8437
1 MG (BASE) ORAL TABLET				
00002419890	**APO-VARENICLINE**	**APX**	$	**0.9235**
00002426234	**TEVA-VARENICLINE**	**TEV**	$	**0.9235**
00002291185	CHAMPIX	PFI	$	1.8432

VARENICLINE TARTRATE/ VARENICLINE TARTRATE

RESTRICTED BENEFIT - This product is a benefit in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling. Coverage will be granted for a total of 12 weeks.

0.5 MG * 1 MG ORAL TABLET				
00002435675	**APO-VARENICLINE (STARTER PACK)**	**APX**	$	**0.9203**
00002426781	**TEVA-VARENICLINE (STARTER PACK)**	**TEV**	$	**0.9203**
00002298309	CHAMPIX (STARTER PACK)	PFI	$	1.8370

20:00

Blood Formulation, Coagulation and Thrombosis

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.08 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(COUMARIN DERIVATIVES)

ACENOCOUMAROL

1 MG ORAL TABLET				
00000010383	SINTROM	PAL	$	0.5808
4 MG ORAL TABLET				
00000010391	SINTROM	PAL	$	1.8266

WARFARIN SODIUM

1 MG ORAL TABLET				
00002242924	**APO-WARFARIN**	**APX**	$	**0.0780**
00002242680	**TARO-WARFARIN**	**TAR**	$	**0.0780**
2 MG ORAL TABLET				
00002242925	**APO-WARFARIN**	**APX**	$	**0.0825**
00002242681	**TARO-WARFARIN**	**TAR**	$	**0.0825**
2.5 MG ORAL TABLET				
00002242926	**APO-WARFARIN**	**APX**	$	**0.0660**
00002242682	**TARO-WARFARIN**	**TAR**	$	**0.0660**
3 MG ORAL TABLET				
00002245618	**APO-WARFARIN**	**APX**	$	**0.1023**
00002242683	**TARO-WARFARIN**	**TAR**	$	**0.1023**
4 MG ORAL TABLET				
00002242927	**APO-WARFARIN**	**APX**	$	**0.1023**
00002242684	**TARO-WARFARIN**	**TAR**	$	**0.1023**
5 MG ORAL TABLET				
00002242928	**APO-WARFARIN**	**APX**	$	**0.0662**
00002242685	**TARO-WARFARIN**	**TAR**	$	**0.0662**
6 MG ORAL TABLET				
00002242686	TARO-WARFARIN	TAR	$	0.3972
7.5 MG ORAL TABLET				
00002242697	TARO-WARFARIN	TAR	$	0.3953
10 MG ORAL TABLET				
00002242929	**APO-WARFARIN**	**APX**	$	**0.1187**
00002242687	**TARO-WARFARIN**	**TAR**	$	**0.1187**

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	$	17.6580
25,000 IU / ML INJECTION				
00002231171	FRAGMIN	PFI	$	44.1421
2,500 IU / SYR INJECTION SYRINGE				
00002132621	FRAGMIN (0.2 ML SYRINGE)	PFI	$	5.5920
3,500 IU / SYR INJECTION SYRINGE				
00002430789	FRAGMIN (0.28 ML SYRINGE)	PFI	$	7.8270
5,000 IU / SYR INJECTION SYRINGE				
00002132648	FRAGMIN (0.2 ML SYRINGE)	PFI	$	11.1820

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.16 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(HEPARINS)

DALTEPARIN SODIUM

7,500 IU / SYR INJECTION SYRINGE				
00002352648	FRAGMIN (0.3 ML SYRINGE)	PFI	$	16.7740
10,000 IU / SYR INJECTION SYRINGE				
00002352656	FRAGMIN (0.4 ML SYRINGE)	PFI	$	22.3640
12,500 IU / SYR INJECTION SYRINGE				
00002352664	FRAGMIN (0.5 ML SYRINGE)	PFI	$	27.9560
15,000 IU / SYR INJECTION SYRINGE				
00002352672	FRAGMIN (0.6 ML SYRINGE)	PFI	$	33.5480
16,500 IU / SYR INJECTION SYRINGE				
00002494582	FRAGMIN	PFI	$	36.9037
18,000 IU / SYR INJECTION SYRINGE				
00002352680	FRAGMIN (0.72 ML SYRINGE)	PFI	$	40.2580

ENOXAPARIN SODIUM

100 MG / ML INJECTION				
00002236564	LOVENOX	SAV	$	22.0567
30 MG / SYR INJECTION SYRINGE				
00002012472	LOVENOX (0.3 ML SYRINGE)	SAV	$	6.6170
40 MG / SYR INJECTION SYRINGE				
00002236883	LOVENOX (0.4 ML SYRINGE)	SAV	$	8.8220
60 MG / SYR INJECTION SYRINGE				
00002378426	LOVENOX (0.6 ML SYRINGE)	SAV	$	13.2330
80 MG / SYR INJECTION SYRINGE				
00002378434	LOVENOX (0.8 ML SYRINGE)	SAV	$	17.6450
100 MG / SYR INJECTION SYRINGE				
00002378442	LOVENOX (1 ML SYRINGE)	SAV	$	22.0560
120 MG / SYR INJECTION SYRINGE				
00002242692	LOVENOX (0.8 ML SYRINGE)	SAV	$	26.4670
150 MG / SYR INJECTION SYRINGE				
00002378469	LOVENOX HP (1 ML SYRINGE)	SAV	$	33.0850

HEPARIN SODIUM

1,000 UNIT / ML INJECTION				
00000453811	HEPARIN LEO	LEO	$	0.5547
100 UNIT / ML INJECTION LOCK FLUSH				
00000727520	HEPARIN LEO	LEO	$	0.4717

NADROPARIN CALCIUM

9,500 IU / SYR INJECTION SYRINGE				
00002236913	FRAXIPARINE (0.3-1 ML SYR)	APC	$	9.0580
19,000 IU / SYR INJECTION SYRINGE				
00002240114	FRAXIPARINE FORTE (0.6-1 ML SYR)	APC	$	18.1170

TINZAPARIN SODIUM

10,000 IU / ML INJECTION				
00002167840	INNOHEP	LEO	$	18.7607
20,000 IU / ML INJECTION				
00002229515	INNOHEP	LEO	$	38.1258
2,500 IU / SYR INJECTION SYRINGE				
00002229755	INNOHEP (0.25 ML SYRINGE)	LEO	$	4.7335

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.16 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(HEPARINS)

TINZAPARIN SODIUM

3,500 IU / SYR INJECTION SYRINGE				
00002358158	INNOHEP (0.35 ML SYRINGE)	LEO	$	6.6221
4,500 IU / SYR INJECTION SYRINGE				
00002358166	INNOHEP (0.45 ML SYRINGE)	LEO	$	8.5161
8,000 IU / SYR INJECTION SYRINGE				
00002429462	INNOHEP (0.4 ML SYRINGE)	LEO	$	15.4663
10,000 IU / SYR INJECTION SYRINGE				
00002231478	INNOHEP (0.5 ML SYRINGE)	LEO	$	19.3208
12,000 IU / SYR INJECTION SYRINGE				
00002429470	INNOHEP (0.6 ML SYRINGE)	LEO	$	23.1994
14,000 IU / SYR INJECTION SYRINGE				
00002358174	INNOHEP (0.7 ML SYRINGE)	LEO	$	27.0661
16,000 IU / SYR INJECTION SYRINGE				
00002429489	INNOHEP (0.8 ML SYRINGE)	LEO	$	30.9327
18,000 IU / SYR INJECTION SYRINGE				
00002358182	INNOHEP (0.9 ML SYRINGE)	LEO	$	34.7937

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.92 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(MISCELLANEOUS ANTICOAGULANTS)

FONDAPARINUX SODIUM

2.5 MG / SYR INJECTION SYRINGE				
00002406853	**FONDAPARINUX SODIUM (0.5 ML SYRINGE)**	**DRL**	$	**9.8620**
00002245531	ARIXTRA (0.5 ML SYRINGE)	APC	$	10.6000
7.5 MG / SYR INJECTION SYRINGE				
00002406896	**FONDAPARINUX SODIUM (0.6 ML SYRINGE)**	**DRL**	$	**17.5000**
00002258056	ARIXTRA (0.6 ML SYRINGE)	APC	$	18.8100

RIVAROXABAN

10 MG ORAL TABLET				
00002316986	XARELTO	BAI	$	2.8700

RESTRICTED BENEFIT -This product is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total knee replacement surgery. Coverage is restricted to two 14-day courses of therapy per patient per year.

This product is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total hip replacement surgery. Coverage is restricted to two 35-day courses of therapy per patient per year.

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.18 ANTITHROMBOTIC AGENTS (PLATELET AGGREGATION INHIBITORS)

CLOPIDOGREL BISULFATE

75 MG (BASE) ORAL TABLET

00002252767	**APO-CLOPIDOGREL**	**APX**	$	**0.2631**
00002416387	**AURO-CLOPIDOGREL**	**AUR**	$	**0.2631**
00002385813	**CLOPIDOGREL**	**SIV**	$	**0.2631**
00002400553	**CLOPIDOGREL**	**SNS**	$	**0.2631**
00002415550	**JAMP-CLOPIDOGREL**	**JPC**	$	**0.2631**
00002422255	**MAR-CLOPIDOGREL**	**MAR**	$	**0.2631**
00002482037	**NRA-CLOPIDOGREL**	**NRA**	$	**0.2631**
00002348004	**PMS-CLOPIDOGREL**	**PMS**	$	**0.2631**
00002379813	**RAN-CLOPIDOGREL**	**RAN**	$	**0.2631**
00002359316	**SANDOZ CLOPIDOGREL**	**SDZ**	$	**0.2631**
00002293161	**TEVA-CLOPIDOGREL**	**TEV**	$	**0.2631**
00002238682	PLAVIX	SAV	$	2.7125

DIPYRIDAMOLE/ ASA

200 MG * 25 MG ORAL CAPSULE

00002471051	TARO-DIPYRIDAMOLE/ASA	TAR	$	0.6815

TICAGRELOR

RESTRICTED BENEFIT - This product is a benefit for the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction when initiated in hospital and prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the initiating prescriber is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.)

90 MG ORAL TABLET

00002368544	BRILINTA	AZC	$	1.5620

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:24 HEMORRHEOLOGIC AGENTS

PENTOXIFYLLINE

400 MG ORAL SUSTAINED-RELEASE TABLET

00002230090	PENTOXIFYLLINE SR	AAP	$	0.8614

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:28.16 ANTIHEMORRHAGIC AGENTS (HEMOSTATICS)

TRANEXAMIC ACID

500 MG ORAL TABLET

00002409097	**GD-TRANEXAMIC ACID**	**GMD**	$	**0.2967**
00002496232	**MAR-TRANEXAMIC ACID**	**MAR**	$	**0.2967**
00002401231	**TRANEXAMIC ACID**	**STM**	$	**0.2967**

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	CAG	$	0.2950

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	$	1.5661
200 MG ORAL CAPSULE				
00002230360	NOVO-MEXILETINE	TEV	$	2.0973

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**	$	**0.1389**
00002459957	**AURO-FLECAINIDE**	**AUR**	$	**0.1389**
00002493705	**JAMP FLECAINIDE**	**JPC**	$	**0.1389**
100 MG ORAL TABLET				
00002275546	**APO-FLECAINIDE**	**APX**	$	**0.2779**
00002459965	**AURO-FLECAINIDE**	**AUR**	$	**0.2779**
00002493713	**JAMP FLECAINIDE**	**JPC**	$	**0.2779**

PROPAFENONE HCL

150 MG ORAL TABLET				
00002243324	**APO-PROPAFENONE**	**APX**	$	**0.2965**
00002457172	**MYLAN-PROPAFENONE**	**MYP**	$	**0.2965**
00002343053	**PROPAFENONE**	**SNS**	$	**0.2965**
00000603708	RYTHMOL	BGP	$	1.2546
300 MG ORAL TABLET				
00002243325	**APO-PROPAFENONE**	**APX**	$	**0.5227**
00002457164	**MYLAN-PROPAFENONE**	**MYP**	$	**0.5227**
00002343061	**PROPAFENONE**	**SNS**	$	**0.5227**
00000603716	RYTHMOL	BGP	$	2.2114

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	$	0.8593
200 MG ORAL TABLET				
00002364336	**AMIODARONE**	**SNS**	$	**0.3706**
00002385465	**AMIODARONE**	**SIV**	$	**0.3706**
00002246194	**APO-AMIODARONE**	**APX**	$	**0.3706**
00002242472	**PMS-AMIODARONE**	**PMS**	$	**0.3706**
00002243836	**SANDOZ AMIODARONE**	**SDZ**	$	**0.3706**
00002239835	**TEVA-AMIODARONE**	**TEV**	$	**0.3706**

24:00 CARDIOVASCULAR DRUGS

24:04.08 CARDIAC DRUGS
(CARDIOTONIC AGENTS)

DIGOXIN

0.0625 MG ORAL TABLET				
00002335700	TOLOXIN	PPH	$	0.3018
0.125 MG ORAL TABLET				
00002335719	TOLOXIN	PPH	$	0.3018
0.05 MG / ML ORAL ELIXIR				
00002242320	TOLOXIN PEDIATRIC	PPH	$	1.4454

24:00 CARDIOVASCULAR DRUGS

24:06.04 ANTILIPEMIC AGENTS
(BILE ACID SEQUESTRANTS)

CHOLESTYRAMINE RESIN

4 G ORAL POWDER PACKET				
00002455609	**CHOLESTYRAMINE-ODAN**	**ODN**	$	**0.3693**
00002478595	**JAMP-CHOLESTYRAMINE**	**JPC**	$	**0.3693**
00000890960	**OLESTYR LIGHT**	**PMS**	$	**0.3693**
00002210320	**OLESTYR REGULAR**	**PMS**	$	**0.3693**

COLESEVELAM HCL

625 MG ORAL TABLET				
00002373955	LODALIS	VCL	$	1.1855
3.75 G ORAL POWDER PACKET				
00002432463	LODALIS	VCL	$	7.1129

COLESTIPOL HCL

1 G ORAL TABLET				
00002132680	COLESTID	PFI	$	0.3596

24:00 CARDIOVASCULAR DRUGS

24:06.05 ANTILIPEMIC AGENTS (CHOLESTEROL ABSORPTION INHIBITORS)

EZETIMIBE

10 MG ORAL TABLET

00002425610	ACH-EZETIMIBE	AHI	$	0.1811
00002475898	AG-EZETIMIBE	AGP	$	0.1811
00002427826	APO-EZETIMIBE	APX	$	0.1811
00002469286	AURO-EZETIMIBE	AUR	$	0.1811
00002429659	EZETIMIBE	SIV	$	0.1811
00002431300	EZETIMIBE	SNS	$	0.1811
00002460750	GLN-EZETIMIBE	GLM	$	0.1811
00002423235	JAMP-EZETIMIBE	JPC	$	0.1811
00002422662	MAR-EZETIMIBE	MAR	$	0.1811
00002423243	MINT-EZETIMIBE	MPI	$	0.1811
00002481669	NRA-EZETIMIBE	NRA	$	0.1811
00002416409	PMS-EZETIMIBE	PMS	$	0.1811
00002419548	RAN-EZETIMIBE	RAN	$	0.1811
00002416778	SANDOZ EZETIMIBE	SDZ	$	0.1811
00002354101	TEVA-EZETIMIBE	TEV	$	0.1811
00002247521	**EZETROL**	**MFC**	$	**1.9180**

24:00 CARDIOVASCULAR DRUGS

24:06.06 ANTILIPEMIC AGENTS (FIBRIC ACID DERIVATIVES)

BEZAFIBRATE

400 MG ORAL SUSTAINED-RELEASE TABLET

00002453312	**JAMP-BEZAFIBRATE**	**JPC**	$	**1.7460**
00002083523	BEZALIP	ALR	$	2.2188

FENOFIBRATE

100 MG ORAL TABLET

00002246859	APO-FENO-SUPER	APX	$	0.5406

67 MG ORAL CAPSULE

00002243180	AA-FENO-MICRO	AAP	$	0.5479

200 MG ORAL CAPSULE

00002239864	AA-FENO-MICRO	AAP	$	0.2722

160 MG ORAL CAPSULE/TABLET

00002246860	**APO-FENO-SUPER (TABLET)**	**APX**	$	**0.2723**
00002241602	LIPIDIL SUPRA (TABLET)	BGP	$	1.3362

GEMFIBROZIL

600 MG ORAL TABLET

00002142074	TEVA-GEMFIBROZIL	TEV	$	0.5970

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS

(HMG-COA REDUCTASE INHIBITORS)

ATORVASTATIN CALCIUM

10 MG (BASE) ORAL TABLET

00002457741	**ACH-ATORVASTATIN**	**AHI**	$	**0.1743**
00002478145	**AG-ATORVASTATIN**	**AGP**	$	**0.1743**
00002295261	**APO-ATORVASTATIN**	**APX**	$	**0.1743**
00002411350	**ATORVASTATIN-10**	**SIV**	$	**0.1743**
00002407256	**AURO-ATORVASTATIN**	**AUR**	$	**0.1743**
00002391058	**JAMP-ATORVASTATIN**	**JPC**	$	**0.1743**
00002454017	**MAR-ATORVASTATIN**	**MAR**	$	**0.1743**
00002479508	**MINT-ATORVASTATIN**	**MPI**	$	**0.1743**
00002392933	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.1743**
00002476517	**NRA-ATORVASTATIN**	**NRA**	$	**0.1743**
00002399377	**PMS-ATORVASTATIN**	**PMS**	$	**0.1743**
00002477149	**PMS-ATORVASTATIN**	**PMS**	$	**0.1743**
00002313707	**RAN-ATORVASTATIN**	**RAN**	$	**0.1743**
00002417936	**REDDY-ATORVASTATIN**	**DRL**	$	**0.1743**
00002324946	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.1743**
00002310899	**TEVA-ATORVASTATIN**	**TEV**	$	**0.1743**
00002230711	LIPITOR	UJC	$	1.8588

20 MG (BASE) ORAL TABLET

00002457768	**ACH-ATORVASTATIN**	**AHI**	$	**0.2179**
00002478153	**AG-ATORVASTATIN**	**AGP**	$	**0.2179**
00002295288	**APO-ATORVASTATIN**	**APX**	$	**0.2179**
00002411369	**ATORVASTATIN-20**	**SIV**	$	**0.2179**
00002407264	**AURO-ATORVASTATIN**	**AUR**	$	**0.2179**
00002391066	**JAMP-ATORVASTATIN**	**JPC**	$	**0.2179**
00002454025	**MAR-ATORVASTATIN**	**MAR**	$	**0.2179**
00002479516	**MINT-ATORVASTATIN**	**MPI**	$	**0.2179**
00002392941	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2179**
00002476525	**NRA-ATORVASTATIN**	**NRA**	$	**0.2179**
00002399385	**PMS-ATORVASTATIN**	**PMS**	$	**0.2179**
00002477157	**PMS-ATORVASTATIN**	**PMS**	$	**0.2179**
00002313715	**RAN-ATORVASTATIN**	**RAN**	$	**0.2179**
00002417944	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2179**
00002324954	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2179**
00002310902	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2179**
00002230713	LIPITOR	UJC	$	2.3234

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS

(HMG-COA REDUCTASE INHIBITORS)

ATORVASTATIN CALCIUM

40 MG (BASE) ORAL TABLET

00002457776	**ACH-ATORVASTATIN**	**AHI**	$	**0.2342**
00002478161	**AG-ATORVASTATIN**	**AGP**	$	**0.2342**
00002295296	**APO-ATORVASTATIN**	**APX**	$	**0.2342**
00002411377	**ATORVASTATIN-40**	**SIV**	$	**0.2342**
00002407272	**AURO-ATORVASTATIN**	**AUR**	$	**0.2342**
00002391074	**JAMP-ATORVASTATIN**	**JPC**	$	**0.2342**
00002454033	**MAR-ATORVASTATIN**	**MAR**	$	**0.2342**
00002479524	**MINT-ATORVASTATIN**	**MPI**	$	**0.2342**
00002392968	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2342**
00002476533	**NRA-ATORVASTATIN**	**NRA**	$	**0.2342**
00002399393	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002477165	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002313723	**RAN-ATORVASTATIN**	**RAN**	$	**0.2342**
00002417952	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2342**
00002324962	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2342**
00002310910	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2342**
00002230714	LIPITOR	UJC	$	2.4973

80 MG (BASE) ORAL TABLET

00002457784	**ACH-ATORVASTATIN**	**AHI**	$	**0.2342**
00002478188	**AG-ATORVASTATIN**	**AGP**	$	**0.2342**
00002295318	**APO-ATORVASTATIN**	**APX**	$	**0.2342**
00002411385	**ATORVASTATIN-80**	**SIV**	$	**0.2342**
00002407280	**AURO-ATORVASTATIN**	**AUR**	$	**0.2342**
00002391082	**JAMP-ATORVASTATIN**	**JPC**	$	**0.2342**
00002454041	**MAR-ATORVASTATIN**	**MAR**	$	**0.2342**
00002392976	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2342**
00002476541	**NRA-ATORVASTATIN**	**NRA**	$	**0.2342**
00002399407	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002477173	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002313758	**RAN-ATORVASTATIN**	**RAN**	$	**0.2342**
00002417960	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2342**
00002324970	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2342**
00002310929	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2342**
00002243097	LIPITOR	UJC	$	2.4973

FLUVASTATIN SODIUM

80 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002250527	LESCOL XL	NOV	***$ 0.1354***	$	1.5896

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.

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.

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS

(HMG-COA REDUCTASE INHIBITORS)

LOVASTATIN

20 MG ORAL TABLET

00002248572	CO LOVASTATIN	APH	***$ 0.1354***	$	0.4919
00002220172	LOVASTATIN	AAP	***$ 0.1354***	$	0.4919
00002353229	LOVASTATIN	SNS	***$ 0.1354***	$	0.4919

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 ORAL TABLET

00002248573	CO LOVASTATIN	APH	***$ 0.1354***	$	0.8985
00002220180	LOVASTATIN	AAP	***$ 0.1354***	$	0.8985
00002353237	LOVASTATIN	SNS	***$ 0.1354***	$	0.8985

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.

PRAVASTATIN SODIUM

10 MG ORAL TABLET

00002440644	ACH-PRAVASTATIN	AHI	***$ 0.1354***	$	0.2916
00002476142	AG-PRAVASTATIN	AGP	***$ 0.1354***	$	0.2916
00002243506	APO-PRAVASTATIN	APX	***$ 0.1354***	$	0.2916
00002458977	AURO-PRAVASTATIN	AUR	***$ 0.1354***	$	0.2916
00002330954	JAMP-PRAVASTATIN	JPC	***$ 0.1354***	$	0.2916
00002432048	MAR-PRAVASTATIN	MAR	***$ 0.1354***	$	0.2916
00002317451	MINT-PRAVASTATIN	MPI	***$ 0.1354***	$	0.2916
00002247655	PMS-PRAVASTATIN	PMS	***$ 0.1354***	$	0.2916
00002356546	PRAVASTATIN	SNS	***$ 0.1354***	$	0.2916
00002389703	PRAVASTATIN	SIV	***$ 0.1354***	$	0.2916
00002284421	RAN-PRAVASTATIN	RAN	***$ 0.1354***	$	0.2916
00002468700	SANDOZ PRAVASTATIN	SDZ	***$ 0.1354***	$	0.2916
00002247008	TEVA-PRAVASTATIN	TEV	***$ 0.1354***	$	0.2916

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.

20 MG ORAL TABLET

00002440652	ACH-PRAVASTATIN	AHI	***$ 0.1354***	$	0.3440
00002476150	AG-PRAVASTATIN	AGP	***$ 0.1354***	$	0.3440
00002243507	APO-PRAVASTATIN	APX	***$ 0.1354***	$	0.3440
00002458985	AURO-PRAVASTATIN	AUR	***$ 0.1354***	$	0.3440
00002330962	JAMP-PRAVASTATIN	JPC	***$ 0.1354***	$	0.3440
00002432056	MAR-PRAVASTATIN	MAR	***$ 0.1354***	$	0.3440
00002317478	MINT-PRAVASTATIN	MPI	***$ 0.1354***	$	0.3440
00002247656	PMS-PRAVASTATIN	PMS	***$ 0.1354***	$	0.3440
00002356554	PRAVASTATIN	SNS	***$ 0.1354***	$	0.3440
00002389738	PRAVASTATIN	SIV	***$ 0.1354***	$	0.3440
00002284448	RAN-PRAVASTATIN	RAN	***$ 0.1354***	$	0.3440
00002468719	SANDOZ PRAVASTATIN	SDZ	***$ 0.1354***	$	0.3440
00002247009	TEVA-PRAVASTATIN	TEV	***$ 0.1354***	$	0.3440

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.

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS

(HMG-COA REDUCTASE INHIBITORS)

PRAVASTATIN SODIUM

40 MG ORAL TABLET

00002440660	ACH-PRAVASTATIN	AHI	***$ 0.1354***	$ 0.4143
00002476169	AG-PRAVASTATIN	AGP	***$ 0.1354***	$ 0.4143
00002243508	APO-PRAVASTATIN	APX	***$ 0.1354***	$ 0.4143
00002458993	AURO-PRAVASTATIN	AUR	***$ 0.1354***	$ 0.4143
00002330970	JAMP-PRAVASTATIN	JPC	***$ 0.1354***	$ 0.4143
00002432064	MAR-PRAVASTATIN	MAR	***$ 0.1354***	$ 0.4143
00002317486	MINT-PRAVASTATIN	MPI	***$ 0.1354***	$ 0.4143
00002247657	PMS-PRAVASTATIN	PMS	***$ 0.1354***	$ 0.4143
00002356562	PRAVASTATIN	SNS	***$ 0.1354***	$ 0.4143
00002389746	PRAVASTATIN	SIV	***$ 0.1354***	$ 0.4143
00002284456	RAN-PRAVASTATIN	RAN	***$ 0.1354***	$ 0.4143
00002468727	SANDOZ PRAVASTATIN	SDZ	***$ 0.1354***	$ 0.4143
00002247010	TEVA-PRAVASTATIN	TEV	***$ 0.1354***	$ 0.4143

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.

ROSUVASTATIN CALCIUM

5 MG (BASE) ORAL TABLET

00002438917	**ACH-ROSUVASTATIN**	**AHI**	$	**0.1284**
00002477033	**AG-ROSUVASTATIN**	**AGP**	$	**0.1284**
00002337975	**APO-ROSUVASTATIN**	**APX**	$	**0.1284**
00002442574	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1284**
00002391252	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1284**
00002378523	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1284**
00002382644	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1284**
00002405628	**ROSUVASTATIN**	**SNS**	$	**0.1284**
00002411628	**ROSUVASTATIN-5**	**SIV**	$	**0.1284**
00002338726	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1284**
00002354608	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1284**
00002265540	CRESTOR	AZC	$	1.3210

10 MG (BASE) ORAL TABLET

00002438925	**ACH-ROSUVASTATIN**	**AHI**	$	**0.1354**
00002477041	**AG-ROSUVASTATIN**	**AGP**	$	**0.1354**
00002337983	**APO-ROSUVASTATIN**	**APX**	$	**0.1354**
00002442582	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1354**
00002391260	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1354**
00002378531	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1354**
00002382652	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1354**
00002405636	**ROSUVASTATIN**	**SNS**	$	**0.1354**
00002411636	**ROSUVASTATIN-10**	**SIV**	$	**0.1354**
00002338734	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1354**
00002354616	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1354**
00002247162	CRESTOR	AZC	$	1.3722

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS

(HMG-COA REDUCTASE INHIBITORS)

ROSUVASTATIN CALCIUM

20 MG (BASE) ORAL TABLET

00002438933	**ACH-ROSUVASTATIN**	**AHI**	$	**0.1692**
00002477068	**AG-ROSUVASTATIN**	**AGP**	$	**0.1692**
00002337991	**APO-ROSUVASTATIN**	**APX**	$	**0.1692**
00002442590	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1692**
00002391279	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1692**
00002378558	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1692**
00002382660	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1692**
00002405644	**ROSUVASTATIN**	**SNS**	$	**0.1692**
00002411644	**ROSUVASTATIN-20**	**SIV**	$	**0.1692**
00002338742	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1692**
00002354624	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1692**
00002247163	CRESTOR	AZC	$	1.7152

40 MG (BASE) ORAL TABLET

00002438941	**ACH-ROSUVASTATIN**	**AHI**	$	**0.1990**
00002477076	**AG-ROSUVASTATIN**	**AGP**	$	**0.1990**
00002338009	**APO-ROSUVASTATIN**	**APX**	$	**0.1990**
00002442604	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1990**
00002391287	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1990**
00002378566	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1990**
00002382679	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1990**
00002405652	**ROSUVASTATIN**	**SNS**	$	**0.1990**
00002411652	**ROSUVASTATIN-40**	**SIV**	$	**0.1990**
00002338750	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1990**
00002354632	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1990**
00002247164	CRESTOR	AZC	$	2.0076

SIMVASTATIN

5 MG ORAL TABLET

00002480050	**AG-SIMVASTATIN**	**AGP**	$	**0.1023**
00002247011	**APO-SIMVASTATIN**	**APX**	$	**0.1023**
00002405148	**AURO-SIMVASTATIN**	**AUR**	$	**0.1023**
00002375591	**JAMP-SIMVASTATIN**	**JPC**	$	**0.1023**
00002372932	**MINT-SIMVASTATIN**	**MPI**	$	**0.1023**
00002469979	**PHARMA-SIMVASTATIN**	**PMS**	$	**0.1023**
00002329131	**RAN-SIMVASTATIN**	**RAN**	$	**0.1023**
00002386291	**SIMVASTATIN**	**SIV**	$	**0.1023**
00002250144	**TEVA-SIMVASTATIN**	**TEV**	$	**0.1023**

10 MG ORAL TABLET

00002480069	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2023
00002247012	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2023
00002405156	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2023
00002375605	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2023
00002375044	MAR-SIMVASTATIN	MAR	***$ 0.1354***	$	0.2023
00002372940	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2023
00002469987	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2023
00002329158	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2023
00002386305	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2023
00002250152	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2023
00000884332	ZOCOR	MFC	***$ 0.1354***	$	2.2268

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.

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS

(HMG-COA REDUCTASE INHIBITORS)

SIMVASTATIN

20 MG ORAL TABLET

00002480077	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2501
00002247013	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2501
00002405164	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2501
00002375613	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2501
00002375052	MAR-SIMVASTATIN	MAR	***$ 0.1354***	$	0.2501
00002372959	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2501
00002469995	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2501
00002329166	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2501
00002386313	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2501
00002250160	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2501
00000884340	ZOCOR	MFC	***$ 0.1354***	$	2.7521

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 ORAL TABLET

00002480085	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2501
00002247014	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2501
00002405172	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2501
00002375621	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2501
00002375060	MAR-SIMVASTATIN	MAR	***$ 0.1354***	$	0.2501
00002372967	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2501
00002470004	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2501
00002329174	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2501
00002386321	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2501
00002250179	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2501
00000884359	ZOCOR	MFC	***$ 0.1354***	$	2.7521

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.

80 MG ORAL TABLET

00002480093	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2501
00002247015	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2501
00002405180	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2501
00002375648	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2501
00002372975	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2501
00002470012	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2501
00002329182	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2501
00002386348	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2501
00002250187	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2501

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.

24:00 CARDIOVASCULAR DRUGS

24:08.16 HYPOTENSIVE AGENTS (CENTRAL ALPHA-AGONISTS)

CLONIDINE HCL

0.1 MG ORAL TABLET				
00002462192	**MINT-CLONIDINE**	**MPI**	$	**0.1358**
00002046121	**TEVA-CLONIDINE**	**TEV**	$	**0.1358**
0.2 MG ORAL TABLET				
00002462206	**MINT-CLONIDINE**	**MPI**	$	**0.2424**
00002046148	**TEVA-CLONIDINE**	**TEV**	$	**0.2424**

METHYLDOPA

125 MG ORAL TABLET				
00000360252	METHYLDOPA	AAP	$	0.1130
250 MG ORAL TABLET				
00000360260	METHYLDOPA	AAP	$	0.1691
500 MG ORAL TABLET				
00000426830	METHYLDOPA	AAP	$	0.2898

24:00 CARDIOVASCULAR DRUGS

24:08.20 HYPOTENSIVE AGENTS (DIRECT VASODILATORS)

HYDRALAZINE HCL

10 MG ORAL TABLET				
00000441619	**APO-HYDRALAZINE**	**APX**	$	**0.0355**
00002457865	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0355**
00002468778	**MINT-HYDRALAZINE**	**MPI**	$	**0.0355**
25 MG ORAL TABLET				
00000441627	**APO-HYDRALAZINE**	**APX**	$	**0.0609**
00002457873	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0609**
00002468786	**MINT-HYDRALAZINE**	**MPI**	$	**0.0609**
50 MG ORAL TABLET				
00000441635	**APO-HYDRALAZINE**	**APX**	$	**0.0956**
00002457881	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0956**
00002468794	**MINT-HYDRALAZINE**	**MPI**	$	**0.0956**

MINOXIDIL

2.5 MG ORAL TABLET				
00000514497	LONITEN	PFI	$	0.4886
10 MG ORAL TABLET				
00000514500	LONITEN	PFI	$	1.0772

24:00 CARDIOVASCULAR DRUGS

24:08.24.08 HYPOTENSIVE AGENTS DIURETICS (LOOP DIURETICS)

ETHACRYNIC ACID

25 MG ORAL TABLET				
00002258528	EDECRIN	VCL	$	0.9556

24:00 CARDIOVASCULAR DRUGS

24:08.24.08 HYPOTENSIVE AGENTS
DIURETICS
(LOOP DIURETICS)

FUROSEMIDE

20 MG ORAL TABLET				
00000396788	**APO-FUROSEMIDE**	**APX**	$	**0.0218**
00002351420	**FUROSEMIDE**	**SNS**	$	**0.0218**
00002466759	**MINT-FUROSEMIDE**	**MPI**	$	**0.0218**
00000337730	**TEVA-FUROSEMIDE**	**TEV**	$	**0.0218**
40 MG ORAL TABLET				
00000362166	**APO-FUROSEMIDE**	**APX**	$	**0.0327**
00002351439	**FUROSEMIDE**	**SNS**	$	**0.0327**
00002466767	**MINT-FUROSEMIDE**	**MPI**	$	**0.0327**
00000337749	**TEVA-FUROSEMIDE**	**TEV**	$	**0.0327**
80 MG ORAL TABLET				
00000707570	**APO-FUROSEMIDE**	**APX**	$	**0.0703**
00002351447	**FUROSEMIDE**	**SNS**	$	**0.0703**
00002466775	**MINT-FUROSEMIDE**	**MPI**	$	**0.0703**
00000765953	**TEVA-FUROSEMIDE**	**TEV**	$	**0.0703**
500 MG ORAL TABLET				
00002224755	LASIX SPECIAL	SAV	$	3.4035
10 MG / ML ORAL SOLUTION				
00002224720	LASIX	SAV	$	0.3303
10 MG / ML INJECTION				
00000527033	**FUROSEMIDE**	**SDZ**	$	**0.8650**
00002382539	**FUROSEMIDE INJECTION SDZ**	**SDZ**	$	**0.8650**

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

00002456311	**ACH-OLMESARTAN**	**AHI**	$	**0.3019**
00002442191	**ACT OLMESARTAN**	**APH**	$	**0.3019**
00002453452	**APO-OLMESARTAN**	**APX**	$	**0.3019**
00002443864	**AURO-OLMESARTAN**	**AUR**	$	**0.3019**
00002469812	**GLN-OLMESARTAN**	**GLM**	$	**0.3019**
00002461641	**JAMP-OLMESARTAN**	**JPC**	$	**0.3019**
00002499258	**NRA-OLMESARTAN**	**NRA**	$	**0.3019**
00002481057	**OLMESARTAN**	**SNS**	$	**0.3019**
00002461307	**PMS-OLMESARTAN**	**PMS**	$	**0.3019**
00002443414	**SANDOZ OLMESARTAN**	**SDZ**	$	**0.3019**
00002318660	OLMETEC	MFC	$	1.1607

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**
00002469820	**GLN-OLMESARTAN**	**GLM**	$	**0.3019**
00002461668	**JAMP-OLMESARTAN**	**JPC**	$	**0.3019**
00002499266	**NRA-OLMESARTAN**	**NRA**	$	**0.3019**
00002481065	**OLMESARTAN**	**SNS**	$	**0.3019**
00002461315	**PMS-OLMESARTAN**	**PMS**	$	**0.3019**
00002443422	**SANDOZ OLMESARTAN**	**SDZ**	$	**0.3019**
00002318679	OLMETEC	MFC	$	1.1607

OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE

20 MG * 12.5 MG ORAL TABLET

00002468948	**ACH-OLMESARTAN HCTZ**	**AHI**	$	**0.3019**
00002443112	**ACT OLMESARTAN HCT**	**APH**	$	**0.3019**
00002453606	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.3019**
00002476487	**AURO-OLMESARTAN HCTZ**	**AUR**	$	**0.3019**
00002475707	**GLN-OLMESARTAN HCTZ**	**GLM**	$	**0.3019**
00002319616	OLMETEC PLUS	MFC	$	1.1607

40 MG * 12.5 MG ORAL TABLET

00002468956	**ACH-OLMESARTAN HCTZ**	**AHI**	$	**0.3019**
00002443120	**ACT OLMESARTAN HCT**	**APH**	$	**0.3019**
00002453614	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.3019**
00002476495	**AURO-OLMESARTAN HCTZ**	**AUR**	$	**0.3019**
00002475715	**GLN-OLMESARTAN HCTZ**	**GLM**	$	**0.3019**
00002319624	OLMETEC PLUS	MFC	$	1.1607

40 MG * 25 MG ORAL TABLET

00002468964	**ACH-OLMESARTAN HCTZ**	**AHI**	$	**0.3019**
00002443139	**ACT OLMESARTAN HCT**	**APH**	$	**0.3019**
00002453622	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.3019**
00002476509	**AURO-OLMESARTAN HCTZ**	**AUR**	$	**0.3019**
00002475723	**GLN-OLMESARTAN HCTZ**	**GLM**	$	**0.3019**
00002319632	OLMETEC PLUS	MFC	$	1.1607

24:00 CARDIOVASCULAR DRUGS

24:12.08 VASODILATING AGENTS (NITRATES AND NITRITES)

ISOSORBIDE DINITRATE

10 MG ORAL TABLET				
00000441686	ISDN	AAP	$	0.0417
30 MG ORAL TABLET				
00000441694	ISDN	AAP	$	0.0978

ISOSORBIDE-5-MONONITRATE

60 MG ORAL EXTENDED-RELEASE TABLET				
00002272830	**APO-ISMN**	**APX**	$	**0.3523**
00002301288	**PMS-ISMN**	**PMS**	$	**0.3523**
00002126559	IMDUR	JUN	$	0.7350

NITROGLYCERIN

0.3 MG ORAL SUBLINGUAL TABLET				
00000037613	NITROSTAT	UJC	$	0.1576
0.6 MG ORAL SUBLINGUAL TABLET				
00000037621	NITROSTAT	UJC	$	0.1576
0.4 MG / DOSE SUBLINGUAL METERED DOSE SPRAY				
00002243588	**MYLAN-NITRO**	**MYP**	$	**0.0421**
00002238998	**RHO-NITRO PUMPSPRAY**	**SDZ**	$	**0.0421**
00002231441	NITROLINGUAL PUMPSPRAY	SAV	$	0.0762
0.2 MG/HR TRANSDERMAL PATCH				
00002407442	**MYLAN-NITRO PATCH**	**MYP**	$	**0.4463**
00001911910	**NITRO-DUR 0.2**	**DRL**	$	**0.4463**
☒ 00002162806	MINITRAN 0.2	VCL	$	0.6573
☒ 00002230732	TRINIPATCH 0.2	PAL	$	0.6600
0.4 MG/HR TRANSDERMAL PATCH				
00002407450	**MYLAN-NITRO PATCH**	**MYP**	$	**0.4937**
00001911902	**NITRO-DUR 0.4**	**DRL**	$	**0.4937**
☒ 00002163527	MINITRAN 0.4	VCL	$	0.7427
☒ 00002230733	TRINIPATCH 0.4	PAL	$	0.7454
0.6 MG/HR TRANSDERMAL PATCH				
00002407469	**MYLAN-NITRO PATCH**	**MYP**	$	**0.4937**
00001911929	**NITRO-DUR 0.6**	**DRL**	$	**0.4937**
☒ 00002163535	MINITRAN 0.6	VCL	$	0.7431
☒ 00002230734	TRINIPATCH 0.6	PAL	$	0.7454
☒ 00002046156	TRANSDERM-NITRO 0.6	NOV	$	0.8460
0.8 MG/HR TRANSDERMAL PATCH				
00002407477	**MYLAN-NITRO PATCH**	**MYP**	$	**0.8743**
00002011271	**NITRO-DUR 0.8**	**DRL**	$	**0.8743**

24:00 CARDIOVASCULAR DRUGS

24:12.92 VASODILATING AGENTS (MISCELLANEOUS VASODILATING AGENTS)

ALPROSTADIL

500 MCG / ML INJECTION				
00000559253	PROSTIN VR	PFI	$	268.1784

24:00 CARDIOVASCULAR DRUGS

24:20 ALPHA-ADRENERGIC BLOCKING AGENTS

DOXAZOSIN MESYLATE

1 MG (BASE) ORAL TABLET				
00002240588	**APO-DOXAZOSIN**	**APX**	$	**0.1719**
00002489937	**JAMP-DOXAZOSIN**	**JPC**	$	**0.1719**
00002242728	**TEVA-DOXAZOSIN**	**TEV**	$	**0.1719**
2 MG (BASE) ORAL TABLET				
00002240589	**APO-DOXAZOSIN**	**APX**	$	**0.2062**
00002489945	**JAMP-DOXAZOSIN**	**JPC**	$	**0.2062**
00002242729	**TEVA-DOXAZOSIN**	**TEV**	$	**0.2062**
4 MG (BASE) ORAL TABLET				
00002240590	**APO-DOXAZOSIN**	**APX**	$	**0.2681**
00002489953	**JAMP-DOXAZOSIN**	**JPC**	$	**0.2681**
00002242730	**TEVA-DOXAZOSIN**	**TEV**	$	**0.2681**

PRAZOSIN HCL

1 MG (BASE) ORAL TABLET				
00000882801	**APO-PRAZO**	**APX**	$	**0.2743**
00001934198	**TEVA-PRAZOSIN**	**TEV**	$	**0.2743**
2 MG (BASE) ORAL TABLET				
00000882828	**APO-PRAZO**	**APX**	$	**0.3725**
00001934201	**TEVA-PRAZOSIN**	**TEV**	$	**0.3725**
5 MG (BASE) ORAL TABLET				
00000882836	**APO-PRAZO**	**APX**	$	**0.5121**
00001934228	**TEVA-PRAZOSIN**	**TEV**	$	**0.5121**

TAMSULOSIN HCL

0.4 MG ORAL EXTENDED-RELEASE TABLET				
00002362406	**APO-TAMSULOSIN CR**	**APX**	$	**0.1500**
00002340208	**SANDOZ TAMSULOSIN CR**	**SDZ**	$	**0.1500**
00002427117	**TAMSULOSIN CR**	**SNS**	$	**0.1500**
00002429667	**TAMSULOSIN CR**	**SIV**	$	**0.1500**
00002368242	**TEVA-TAMSULOSIN CR**	**TEV**	$	**0.1500**
00002270102	FLOMAX CR	BOE	$	0.6627
0.4 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002319217	SANDOZ TAMSULOSIN	SDZ	$	0.1500

TERAZOSIN HCL

1 MG (BASE) ORAL TABLET				
00002234502	**APO-TERAZOSIN**	**APX**	$	**0.1835**
00002243518	**PMS-TERAZOSIN**	**PMS**	$	**0.1835**
00002350475	**TERAZOSIN**	**SNS**	$	**0.1835**
00002230805	**TEVA-TERAZOSIN**	**TEV**	$	**0.1835**
2 MG (BASE) ORAL TABLET				
00002234503	**APO-TERAZOSIN**	**APX**	$	**0.2333**
00002243519	**PMS-TERAZOSIN**	**PMS**	$	**0.2333**
00002350483	**TERAZOSIN**	**SNS**	$	**0.2333**
00002230806	**TEVA-TERAZOSIN**	**TEV**	$	**0.2333**
5 MG (BASE) ORAL TABLET				
00002234504	**APO-TERAZOSIN**	**APX**	$	**0.3168**
00002243520	**PMS-TERAZOSIN**	**PMS**	$	**0.3168**
00002350491	**TERAZOSIN**	**SNS**	$	**0.3168**
00002230807	**TEVA-TERAZOSIN**	**TEV**	$	**0.3168**

24:00 CARDIOVASCULAR DRUGS

24:20 ALPHA-ADRENERGIC BLOCKING AGENTS

TERAZOSIN HCL

10 MG (BASE) ORAL TABLET

00002234505	**APO-TERAZOSIN**	**APX**	$	**0.4637**
00002243521	**PMS-TERAZOSIN**	**PMS**	$	**0.4637**
00002350505	**TERAZOSIN**	**SNS**	$	**0.4637**
00002230808	**TEVA-TERAZOSIN**	**TEV**	$	**0.4637**

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL HCL

100 MG (BASE) ORAL TABLET

00002147602	**APO-ACEBUTOLOL**	**APX**	$	**0.0787**
00002204517	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.0787**

200 MG (BASE) ORAL TABLET

00002147610	**APO-ACEBUTOLOL**	**APX**	$	**0.1177**
00002204525	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.1177**

400 MG (BASE) ORAL TABLET

00002147629	**APO-ACEBUTOLOL**	**APX**	$	**0.2466**
00002204533	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.2466**

ATENOLOL

25 MG ORAL TABLET

00002367556	**JAMP-ATENOLOL**	**JPC**	$	**0.0521**
00002371979	**MAR-ATENOLOL**	**MAR**	$	**0.0521**
00002368013	**MINT-ATENOL**	**MPI**	$	**0.0521**
00002246581	**PMS-ATENOLOL**	**PMS**	$	**0.0521**
00002373963	**RAN-ATENOLOL**	**RAN**	$	**0.0521**
00002266660	**TEVA-ATENOLOL**	**TEV**	$	**0.0521**

50 MG ORAL TABLET

00002369184	**AG-ATENOLOL**	**AGP**	$	**0.1107**
00000773689	**APO-ATENOL**	**APX**	$	**0.1107**
00002238316	**ATENOLOL**	**SIV**	$	**0.1107**
00002466465	**ATENOLOL**	**SNS**	$	**0.1107**
00002367564	**JAMP-ATENOLOL**	**JPC**	$	**0.1107**
00002371987	**MAR-ATENOLOL**	**MAR**	$	**0.1107**
00002368021	**MINT-ATENOL**	**MPI**	$	**0.1107**
00002237600	**PMS-ATENOLOL**	**PMS**	$	**0.1107**
00002267985	**RAN-ATENOLOL**	**RAN**	$	**0.1107**
00002171791	**TEVA-ATENOLOL**	**TEV**	$	**0.1107**
00002039532	TENORMIN	AZC	$	0.6086

100 MG ORAL TABLET

00002369192	**AG-ATENOLOL**	**AGP**	$	**0.1821**
00000773697	**APO-ATENOL**	**APX**	$	**0.1821**
00002238318	**ATENOLOL**	**SIV**	$	**0.1821**
00002466473	**ATENOLOL**	**SNS**	$	**0.1821**
00002367572	**JAMP-ATENOLOL**	**JPC**	$	**0.1821**
00002371995	**MAR-ATENOLOL**	**MAR**	$	**0.1821**
00002368048	**MINT-ATENOL**	**MPI**	$	**0.1821**
00002237601	**PMS-ATENOLOL**	**PMS**	$	**0.1821**
00002267993	**RAN-ATENOLOL**	**RAN**	$	**0.1821**
00002171805	**TEVA-ATENOLOL**	**TEV**	$	**0.1821**
00002039540	TENORMIN	AZC	$	1.0006

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

ATENOLOL/ CHLORTHALIDONE

50 MG * 25 MG ORAL TABLET

00002248763	AA-ATENIDONE	AAP	$	0.3195

100 MG * 25 MG ORAL TABLET

00002248764	AA-ATENIDONE	AAP	$	0.5236

BISOPROLOL FUMARATE

5 MG ORAL TABLET

00002256134	**APO-BISOPROLOL**	**APX**	$	**0.0715**
00002383055	**BISOPROLOL**	**SIV**	$	**0.0715**
00002391589	**BISOPROLOL**	**SNS**	$	**0.0715**
00002495562	**BISOPROLOL**	**SIV**	$	**0.0715**
00002465612	**MINT-BISOPROLOL**	**MPI**	$	**0.0715**
00002247439	**SANDOZ BISOPROLOL**	**SDZ**	$	**0.0715**
00002494035	**SANDOZ BISOPROLOL**	**SDZ**	$	**0.0715**
00002267470	**TEVA-BISOPROLOL**	**TEV**	$	**0.0715**

10 MG ORAL TABLET

00002256177	**APO-BISOPROLOL**	**APX**	$	**0.1044**
00002383063	**BISOPROLOL**	**SIV**	$	**0.1044**
00002391597	**BISOPROLOL**	**SNS**	$	**0.1044**
00002495570	**BISOPROLOL**	**SIV**	$	**0.1044**
00002465620	**MINT-BISOPROLOL**	**MPI**	$	**0.1044**
00002494043	**SANDOZ BISOPROLOL**	**SDZ**	$	**0.1044**
00002267489	**TEVA-BISOPROLOL**	**TEV**	$	**0.1044**

CARVEDILOL

3.125 MG ORAL TABLET

00002247933	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418495	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248752	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364913	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368897	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245914	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252309	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

6.25 MG ORAL TABLET

00002247934	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418509	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248753	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364921	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368900	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245915	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252317	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

12.5 MG ORAL TABLET

00002247935	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418517	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248754	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364948	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368919	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245916	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252325	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

CARVEDILOL

25 MG ORAL TABLET

00002247936	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418525	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248755	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364956	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368927	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245917	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252333	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

LABETALOL HCL

100 MG ORAL TABLET

00002243538	**APO-LABETALOL**	**APX**	$	**0.1983**
00002489406	**RIVA-LABETALOL**	**RIV**	$	**0.1983**
00002106272	TRANDATE	PAL	$	0.3057

200 MG ORAL TABLET

00002243539	**APO-LABETALOL**	**APX**	$	**0.3504**
00002489414	**RIVA-LABETALOL**	**RIV**	$	**0.3504**
00002106280	TRANDATE	PAL	$	0.5404

METOPROLOL TARTRATE

25 MG ORAL TABLET

00002246010	**APO-METOPROLOL**	**APX**	$	**0.0643**
00002356813	**JAMP-METOPROLOL-L**	**JPC**	$	**0.0643**
00002248855	**PMS-METOPROLOL-L**	**PMS**	$	**0.0643**

50 MG ORAL TABLET

00002481316	**AG-METOPROLOL-L**	**AGP**	$	**0.0624**
00000618632	**APO-METOPROLOL**	**APX**	$	**0.0624**
00000749354	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.0624**
00002356821	**JAMP-METOPROLOL-L**	**JPC**	$	**0.0624**
00002350394	**METOPROLOL**	**SNS**	$	**0.0624**
00002442124	**METOPROLOL-L**	**SIV**	$	**0.0624**
00002230803	**PMS-METOPROLOL-L**	**PMS**	$	**0.0624**
00000842648	**TEVA-METOPROL**	**TEV**	$	**0.0624**
00000648035	**TEVA-METOPROL (FC)**	**TEV**	$	**0.0624**

100 MG ORAL TABLET

00002481324	**AG-METOPROLOL-L**	**AGP**	$	**0.1250**
00000618640	**APO-METOPROLOL**	**APX**	$	**0.1250**
00000751170	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.1250**
00002356848	**JAMP-METOPROLOL-L**	**JPC**	$	**0.1250**
00002350408	**METOPROLOL**	**SNS**	$	**0.1250**
00002442132	**METOPROLOL-L**	**SIV**	$	**0.1250**
00002230804	**PMS-METOPROLOL-L**	**PMS**	$	**0.1250**
00000842656	**TEVA-METOPROL**	**TEV**	$	**0.1250**
00000648043	**TEVA-METOPROL (FC)**	**TEV**	$	**0.1250**

100 MG ORAL SUSTAINED-RELEASE TABLET

00002285169	**APO-METOPROLOL SR**	**APX**	$	**0.1871**
00002303396	**SANDOZ METOPROLOL SR**	**SDZ**	$	**0.1871**
00000658855	LOPRESOR SR	NOV	$	0.3394

200 MG (BASE) ORAL SUSTAINED-RELEASE TABLET

00002285177	**APO-METOPROLOL SR**	**APX**	$	**0.3396**
00002303418	**SANDOZ METOPROLOL SR**	**SDZ**	$	**0.3396**
00000534560	LOPRESOR SR	NOV	$	0.6162

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

NADOLOL

40 MG ORAL TABLET				
00000782505	**APO-NADOLOL**	**APX**	$	**0.2375**
00002496380	**MINT-NADOLOL**	**MPI**	$	**0.2375**
80 MG ORAL TABLET				
00000782467	**APO-NADOLOL**	**APX**	$	**0.3410**
00002496399	**MINT-NADOLOL**	**MPI**	$	**0.3410**
160 MG ORAL TABLET				
00000782475	APO-NADOLOL	APX	$	1.3035

PROPRANOLOL HCL

10 MG ORAL TABLET				
00000496480	TEVA-PROPRANOLOL	TEV	$	0.0696
20 MG ORAL TABLET				
00000740675	TEVA-PROPRANOLOL	TEV	$	0.1140
40 MG ORAL TABLET				
00000496499	TEVA-PROPRANOLOL	TEV	$	0.1259
80 MG ORAL TABLET				
00000496502	TEVA-PROPRANOLOL	TEV	$	0.1990

SOTALOL HCL

80 MG ORAL TABLET				
00002210428	**APO-SOTALOL**	**APX**	$	**0.2966**
00002368617	**JAMP-SOTALOL**	**JPC**	$	**0.2966**
00002238326	**PMS-SOTALOL**	**PMS**	$	**0.2966**
160 MG ORAL TABLET				
00002167794	**APO-SOTALOL**	**APX**	$	**0.1623**
00002368625	**JAMP-SOTALOL**	**JPC**	$	**0.1623**
00002238327	**PMS-SOTALOL**	**PMS**	$	**0.1623**

24:00 CARDIOVASCULAR DRUGS

24:28.08 CALCIUM-CHANNEL BLOCKING AGENTS (DIHYDROPYRIDINES)

AMLODIPINE BESYLATE

2.5 MG (BASE) ORAL TABLET				
00002385783	**AMLODIPINE**	**SIV**	$	**0.0767**
00002492199	**AMLODIPINE**	**JPC**	$	**0.0767**
00002419556	**AMLODIPINE BESYLATE**	**AHI**	$	**0.0767**
00002371707	**MAR-AMLODIPINE**	**MAR**	$	**0.0767**
00002476452	**NRA-AMLODIPINE**	**NRA**	$	**0.0767**
00002469022	**PHARMA-AMLODIPINE**	**PMS**	$	**0.0767**
00002295148	**PMS-AMLODIPINE**	**PMS**	$	**0.0767**
00002330474	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.0767**
5 MG (BASE) ORAL TABLET				
00002297485	**ACT AMLODIPINE**	**APH**	$	**0.1343**
00002331284	**AMLODIPINE**	**SNS**	$	**0.1343**
00002385791	**AMLODIPINE**	**SIV**	$	**0.1343**
00002429217	**AMLODIPINE**	**JPC**	$	**0.1343**
00002419564	**AMLODIPINE BESYLATE**	**AHI**	$	**0.1343**
00002273373	**APO-AMLODIPINE**	**APX**	$	**0.1343**
00002397072	**AURO-AMLODIPINE**	**AUR**	$	**0.1343**
00002371715	**MAR-AMLODIPINE**	**MAR**	$	**0.1343**
00002362651	**MINT-AMLODIPINE**	**MPI**	$	**0.1343**
00002272113	**MYLAN-AMLODIPINE**	**MYP**	$	**0.1343**
00002476460	**NRA-AMLODIPINE**	**NRA**	$	**0.1343**
00002469030	**PHARMA-AMLODIPINE**	**PMS**	$	**0.1343**
00002321858	**RAN-AMLODIPINE**	**RAN**	$	**0.1343**
00002284383	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.1343**
00002357712	**SEPTA-AMLODIPINE**	**SEP**	$	**0.1343**
00000878928	NORVASC	UJC	$	1.4345
10 MG (BASE) ORAL TABLET				
00002297493	**ACT AMLODIPINE**	**APH**	$	**0.1993**
00002331292	**AMLODIPINE**	**SNS**	$	**0.1993**
00002385805	**AMLODIPINE**	**SIV**	$	**0.1993**
00002429225	**AMLODIPINE**	**JPC**	$	**0.1993**
00002419572	**AMLODIPINE BESYLATE**	**AHI**	$	**0.1993**
00002273381	**APO-AMLODIPINE**	**APX**	$	**0.1993**
00002397080	**AURO-AMLODIPINE**	**AUR**	$	**0.1993**
00002371723	**MAR-AMLODIPINE**	**MAR**	$	**0.1993**
00002362678	**MINT-AMLODIPINE**	**MPI**	$	**0.1993**
00002272121	**MYLAN-AMLODIPINE**	**MYP**	$	**0.1993**
00002476479	**NRA-AMLODIPINE**	**NRA**	$	**0.1993**
00002469049	**PHARMA-AMLODIPINE**	**PMS**	$	**0.1993**
00002321866	**RAN-AMLODIPINE**	**RAN**	$	**0.1993**
00002284391	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.1993**
00002357720	**SEPTA-AMLODIPINE**	**SEP**	$	**0.1993**
00000878936	NORVASC	UJC	$	2.0939

24:00 CARDIOVASCULAR DRUGS

24:28.08 CALCIUM-CHANNEL BLOCKING AGENTS (DIHYDROPYRIDINES)

FELODIPINE

2.5 MG ORAL EXTENDED-RELEASE TABLET

00002452367	APO-FELODIPINE	APX	***$ 0.1993***	$	0.4050
00002057778	PLENDIL	AZC	***$ 0.1993***	$	0.5670

MAC pricing will be applied based on the LCA Price for Amlodipine Besylate 1 x 10 mg tablet.

5 MG ORAL EXTENDED-RELEASE TABLET

00002452375	APO-FELODIPINE	APX	***$ 0.1993***	$	0.3565
00002280264	SANDOZ FELODIPINE	SDZ	***$ 0.1993***	$	0.3565
00000851779	PLENDIL	AZC	***$ 0.1993***	$	0.7483

MAC pricing will be applied based on the LCA Price for Amlodipine Besylate 1 x 10 mg tablet.

10 MG ORAL EXTENDED-RELEASE TABLET

00002452383	APO-FELODIPINE	APX	***$ 0.1993***	$	0.5350
00002280272	SANDOZ FELODIPINE	SDZ	***$ 0.1993***	$	0.5350
00000851787	PLENDIL	AZC	***$ 0.1993***	$	1.1233

MAC pricing will be applied based on the LCA Price for Amlodipine Besylate 1 x 10 mg tablet.

NIFEDIPINE

30 MG ORAL EXTENDED-RELEASE TABLET

00002155907	ADALAT XL	BAI	***$ 0.1993***	$	0.6171
00002349167	MYLAN-NIFEDIPINE ERT	MYP	***$ 0.1993***	$	0.6171

MAC pricing will be applied based on the LCA Price for Amlodipine Besylate 1 x 10 mg tablet.

60 MG ORAL EXTENDED-RELEASE TABLET

00002321149	MYLAN-NIFEDIPINE ERT	MYP	***$ 0.1993***	$	0.9374

MAC pricing will be applied based on the LCA Price for Amlodipine Besylate 1 x 10 mg tablet.

5 MG ORAL CAPSULE

00000725110	NIFEDIPINE	AAP		$	0.4120

10 MG ORAL CAPSULE

00000755907	NIFEDIPINE	AAP		$	0.5461

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

30 MG ORAL TABLET

00000771376	**AA-DILTIAZ**	**AAP**		$	**0.1866**
00000862924	**TEVA-DILTIAZEM**	**TEV**		$	**0.1866**

60 MG ORAL TABLET

00000771384	**AA-DILTIAZ**	**AAP**		$	**0.3273**
00000862932	**TEVA-DILTIAZEM**	**TEV**		$	**0.3273**

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

120 MG ORAL EXTENDED-RELEASE TABLET				
00002256738	TIAZAC XC	VCL	$	0.8910
180 MG ORAL EXTENDED-RELEASE TABLET				
00002256746	TIAZAC XC	VCL	$	1.1839
240 MG ORAL EXTENDED-RELEASE TABLET				
00002256754	TIAZAC XC	VCL	$	1.5736
300 MG ORAL EXTENDED-RELEASE TABLET				
00002256762	TIAZAC XC	VCL	$	1.5705
360 MG ORAL EXTENDED-RELEASE TABLET				
00002256770	TIAZAC XC	VCL	$	1.5712
120 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002370611	**ACT DILTIAZEM CD**	**APH**	$	**0.3529**
00002230997	**APO-DILTIAZ CD**	**APX**	$	**0.3529**
00002445999	**DILTIAZEM CD**	**SIV**	$	**0.3529**
00002484064	**MAR-DILTIAZEM CD**	**MAR**	$	**0.3529**
00002243338	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.3529**
00002242538	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.3529**
180 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002230998	**APO-DILTIAZ CD**	**APX**	$	**0.4684**
00002446006	**DILTIAZEM CD**	**SIV**	$	**0.4684**
00002484072	**MAR-DILTIAZEM CD**	**MAR**	$	**0.4684**
00002243339	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.4684**
00002242539	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.4684**
240 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002370646	**ACT DILTIAZEM CD**	**APH**	$	**0.6213**
00002230999	**APO-DILTIAZ CD**	**APX**	$	**0.6213**
00002446014	**DILTIAZEM CD**	**SIV**	$	**0.6213**
00002484080	**MAR-DILTIAZEM CD**	**MAR**	$	**0.6213**
00002243340	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.6213**
00002242540	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.6213**
300 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002370654	**ACT DILTIAZEM CD**	**APH**	$	**0.7766**
00002229526	**APO-DILTIAZ CD**	**APX**	$	**0.7766**
00002446022	**DILTIAZEM CD**	**SIV**	$	**0.7766**
00002484099	**MAR-DILTIAZEM CD**	**MAR**	$	**0.7766**
00002243341	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.7766**
00002242541	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.7766**
120 MG ORAL EXTENDED-RELEASE CAPSULE				
00002495376	**JAMP DILTIAZEM T**	**JPC**	$	**0.2133**
00002465353	**MAR-DILTIAZEM T**	**MAR**	$	**0.2133**
00002271605	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.2133**
00002231150	TIAZAC	VCL	$	0.9488
180 MG ORAL EXTENDED-RELEASE CAPSULE				
00002495384	**JAMP DILTIAZEM T**	**JPC**	$	**0.2889**
00002465361	**MAR-DILTIAZEM T**	**MAR**	$	**0.2889**
00002271613	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.2889**
00002231151	TIAZAC	VCL	$	1.2675

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

240 MG ORAL EXTENDED-RELEASE CAPSULE				
00002495392	**JAMP DILTIAZEM T**	**JPC**	$	**0.3832**
00002465388	**MAR-DILTIAZEM T**	**MAR**	$	**0.3832**
00002271621	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.3832**
00002231152	TIAZAC	VCL	$	1.6812
300 MG ORAL EXTENDED-RELEASE CAPSULE				
00002495406	**JAMP DILTIAZEM T**	**JPC**	$	**0.4719**
00002465396	**MAR-DILTIAZEM T**	**MAR**	$	**0.4719**
00002271648	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.4719**
00002231154	TIAZAC	VCL	$	2.1056
360 MG ORAL EXTENDED-RELEASE CAPSULE				
00002495414	**JAMP DILTIAZEM T**	**JPC**	$	**0.5778**
00002465418	**MAR-DILTIAZEM T**	**MAR**	$	**0.5778**
00002271656	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.5778**
00002231155	TIAZAC	VCL	$	2.5350

VERAPAMIL HCL

80 MG ORAL TABLET				
00000782483	**APO-VERAP**	**APX**	$	**0.2735**
00002237921	**MYLAN-VERAPAMIL**	**MYP**	$	**0.2735**
120 MG ORAL TABLET				
00000782491	**APO-VERAP**	**APX**	$	**0.4250**
00002237922	**MYLAN-VERAPAMIL**	**MYP**	$	**0.4250**
120 MG ORAL SUSTAINED-RELEASE TABLET				
00002246893	**APO-VERAP SR**	**APX**	$	**0.5078**
00002210347	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.5078**
00001907123	ISOPTIN SR	BGP	$	1.5178
180 MG ORAL SUSTAINED-RELEASE TABLET				
00002450488	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.5204**
00001934317	ISOPTIN SR	BGP	$	1.7139
240 MG ORAL SUSTAINED-RELEASE TABLET				
00002246895	**APO-VERAP SR**	**APX**	$	**0.5075**
00002450496	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.5075**
00000742554	ISOPTIN SR	BGP	$	2.2944

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

BENAZEPRIL HCL

5 MG ORAL TABLET					
00002290332	BENAZEPRIL	AAP	***$ 0.1945***	$	0.8927

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

10 MG ORAL TABLET					
00002290340	BENAZEPRIL	AAP	***$ 0.1945***	$	1.0573

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

20 MG ORAL TABLET					
00002273918	BENAZEPRIL	AAP	***$ 0.1945***	$	1.2117

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

BENAZEPRIL HCL

20 MG ORAL TABLET

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

CAPTOPRIL

12.5 MG ORAL TABLET

00001942964	TEVA-CAPTOPRIL	TEV		$	0.1113

25 MG ORAL TABLET

00001942972	TEVA-CAPTOPRIL	TEV		$	0.1575

50 MG ORAL TABLET

00001942980	TEVA-CAPTOPRIL	TEV	***$ 0.1945***	$	0.2935

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet or the current price or LCA price whichever is the lowest.

100 MG ORAL TABLET

00001942999	TEVA-CAPTOPRIL	TEV	***$ 0.1945***	$	0.5458

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet or the current price or LCA price whichever is the lowest.

CILAZAPRIL

1 MG ORAL TABLET

00002283778	MYLAN-CILAZAPRIL	MYP	***$ 0.1945***	$	0.3115

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

2.5 MG ORAL TABLET

00002291142	APO-CILAZAPRIL	APX	***$ 0.1945***	$	0.4295
00002283786	MYLAN-CILAZAPRIL	MYP	***$ 0.1945***	$	0.4295

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

5 MG ORAL TABLET

00002291150	APO-CILAZAPRIL	APX	***$ 0.1945***	$	0.4989
00002283794	MYLAN-CILAZAPRIL	MYP	***$ 0.1945***	$	0.4989
00001911481	INHIBACE	CAG	***$ 0.1945***	$	0.9978

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

CILAZAPRIL/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002284987	APO-CILAZAPRIL/HCTZ	APX	***$ 0.2503***	$	0.4170
00002313731	TEVA-CILAZAPRIL/HCTZ	TEV	***$ 0.2503***	$	0.4170
00002181479	INHIBACE PLUS	CAG	***$ 0.2503***	$	0.9975

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

ENALAPRIL MALEATE

2.5 MG ORAL TABLET

00002291878	**ACT ENALAPRIL**	**APH**		**$ 0.1863**
00002020025	**APO-ENALAPRIL**	**APX**		**$ 0.1863**
00002400650	**ENALAPRIL**	**SNS**		**$ 0.1863**
00002442957	**ENALAPRIL**	**SIV**		**$ 0.1863**
00002474786	**JAMP ENALAPRIL**	**JPC**		**$ 0.1863**
00002459450	**MAR-ENALAPRIL**	**MAR**		**$ 0.1863**
00002352230	**RAN-ENALAPRIL**	**RAN**		**$ 0.1863**
00002299933	**SANDOZ ENALAPRIL**	**SDZ**		**$ 0.1863**

5 MG ORAL TABLET

00002291886	ACT ENALAPRIL	APH	***$ 0.1945***	$ 0.2203
00002019884	APO-ENALAPRIL	APX	***$ 0.1945***	$ 0.2203
00002400669	ENALAPRIL	SNS	***$ 0.1945***	$ 0.2203
00002442965	ENALAPRIL	SIV	***$ 0.1945***	$ 0.2203
00002474794	JAMP ENALAPRIL	JPC	***$ 0.1945***	$ 0.2203
00002459469	MAR-ENALAPRIL	MAR	***$ 0.1945***	$ 0.2203
00002352249	RAN-ENALAPRIL	RAN	***$ 0.1945***	$ 0.2203
00002299941	SANDOZ ENALAPRIL	SDZ	***$ 0.1945***	$ 0.2203
00000708879	VASOTEC	MFC	***$ 0.1945***	$ 1.0256

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet or the current price or LCA price whichever is the lowest.

10 MG ORAL TABLET

00002291894	ACT ENALAPRIL	APH	***$ 0.1945***	$ 0.2647
00002019892	APO-ENALAPRIL	APX	***$ 0.1945***	$ 0.2647
00002400677	ENALAPRIL	SNS	***$ 0.1945***	$ 0.2647
00002442973	ENALAPRIL	SIV	***$ 0.1945***	$ 0.2647
00002474808	JAMP ENALAPRIL	JPC	***$ 0.1945***	$ 0.2647
00002444771	MAR-ENALAPRIL	MAR	***$ 0.1945***	$ 0.2647
00002352257	RAN-ENALAPRIL	RAN	***$ 0.1945***	$ 0.2647
00002299968	SANDOZ ENALAPRIL	SDZ	***$ 0.1945***	$ 0.2647
00000670901	VASOTEC	MFC	***$ 0.1945***	$ 1.2325

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet or the current price or LCA price whichever is the lowest.

20 MG ORAL TABLET

00002291908	ACT ENALAPRIL	APH	***$ 0.1945***	$ 0.3195
00002019906	APO-ENALAPRIL	APX	***$ 0.1945***	$ 0.3195
00002400685	ENALAPRIL	SNS	***$ 0.1945***	$ 0.3195
00002442981	ENALAPRIL	SIV	***$ 0.1945***	$ 0.3195
00002474816	JAMP ENALAPRIL	JPC	***$ 0.1945***	$ 0.3195
00002444798	MAR-ENALAPRIL	MAR	***$ 0.1945***	$ 0.3195
00002352265	RAN-ENALAPRIL	RAN	***$ 0.1945***	$ 0.3195
00002299976	SANDOZ ENALAPRIL	SDZ	***$ 0.1945***	$ 0.3195
00000670928	VASOTEC	MFC	***$ 0.1945***	$ 1.4874

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet or the current price or LCA price whichever is the lowest.

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002352923	ENALAPRIL MALEATE/HCTZ	AAP	***$ 0.2503***	$	0.7673

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

10 MG * 25 MG ORAL TABLET

00002352931	ENALAPRIL MALEATE/HCTZ	AAP	***$ 0.2503***	$	1.0741
00000657298	VASERETIC	MFC	***$ 0.2503***	$	1.2895

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

FOSINOPRIL SODIUM

10 MG ORAL TABLET

00002266008	APO-FOSINOPRIL	APX	***$ 0.1945***	$	0.2177
00002459388	FOSINOPRIL	SNS	***$ 0.1945***	$	0.2177
00002331004	JAMP-FOSINOPRIL	JPC	***$ 0.1945***	$	0.2177
00002247802	TEVA-FOSINOPRIL	TEV	***$ 0.1945***	$	0.2177

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

20 MG ORAL TABLET

00002266016	APO-FOSINOPRIL	APX	***$ 0.1945***	$	0.2619
00002459396	FOSINOPRIL	SNS	***$ 0.1945***	$	0.2619
00002331012	JAMP-FOSINOPRIL	JPC	***$ 0.1945***	$	0.2619
00002247803	TEVA-FOSINOPRIL	TEV	***$ 0.1945***	$	0.2619

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

LISINOPRIL

5 MG ORAL TABLET

00002217481	**APO-LISINOPRIL**	**APX**	$	**0.1347**
00002394472	**AURO-LISINOPRIL**	**AUR**	$	**0.1347**
00002361531	**JAMP-LISINOPRIL**	**JPC**	$	**0.1347**
00002386232	**LISINOPRIL**	**SIV**	$	**0.1347**
00002294230	**RAN-LISINOPRIL**	**RAN**	$	**0.1347**
00002285118	**TEVA-LISINOPRIL (TYPE Z)**	**TEV**	$	**0.1347**
00002049333	ZESTRIL	AZC	$	0.5710

10 MG ORAL TABLET

00002217503	**APO-LISINOPRIL**	**APX**	$	**0.1619**
00002394480	**AURO-LISINOPRIL**	**AUR**	$	**0.1619**
00002361558	**JAMP-LISINOPRIL**	**JPC**	$	**0.1619**
00002386240	**LISINOPRIL**	**SIV**	$	**0.1619**
00002294249	**RAN-LISINOPRIL**	**RAN**	$	**0.1619**
00002285126	**TEVA-LISINOPRIL (TYPE Z)**	**TEV**	$	**0.1619**
00002049376	ZESTRIL	AZC	$	0.6861

20 MG ORAL TABLET

00002217511	**APO-LISINOPRIL**	**APX**	$	**0.1945**
00002394499	**AURO-LISINOPRIL**	**AUR**	$	**0.1945**
00002386259	**LISINOPRIL**	**SIV**	$	**0.1945**
00002294257	**RAN-LISINOPRIL**	**RAN**	$	**0.1945**
00002285134	**TEVA-LISINOPRIL (TYPE Z)**	**TEV**	$	**0.1945**
00002049384	ZESTRIL	AZC	$	0.8241

LISINOPRIL/ HYDROCHLOROTHIAZIDE

10 MG * 12.5 MG ORAL TABLET

00002362945	**LISINOPRIL/HCTZ (TYPE Z)**	**SNS**	$	**0.2083**
00002302365	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.2083**
00002301768	**TEVA-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.2083**
00002103729	ZESTORETIC	AZC	$	0.9286

20 MG * 12.5 MG ORAL TABLET

00002362953	**LISINOPRIL/HCTZ (TYPE Z)**	**SNS**	$	**0.2503**
00002302373	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.2503**
00002301776	**TEVA-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.2503**
00002045737	ZESTORETIC	AZC	$	1.1159

20 MG * 25 MG ORAL TABLET

00002362961	**LISINOPRIL/HCTZ (TYPE Z)**	**SNS**	$	**0.2503**
00002302381	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.2503**
00002301784	**TEVA-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.2503**
00002045729	ZESTORETIC	AZC	$	1.1159

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

PERINDOPRIL ERBUMINE

2 MG ORAL TABLET

00002481677	**AG-PERINDOPRIL**	**AGP**	$	**0.1632**
00002289261	**APO-PERINDOPRIL**	**APX**	$	**0.1632**
00002459817	**AURO-PERINDOPRIL**	**AUR**	$	**0.1632**
00002477009	**JAMP PERINDOPRIL**	**JPC**	$	**0.1632**
00002474824	**MAR-PERINDOPRIL**	**MAR**	$	**0.1632**
00002476762	**MINT-PERINDOPRIL**	**MPI**	$	**0.1632**
00002489015	**NRA-PERINDOPRIL**	**NRA**	$	**0.1632**
00002479877	**PERINDOPRIL ERBUMINE**	**SIV**	$	**0.1632**
00002481634	**PERINDOPRIL ERBUMINE**	**SNS**	$	**0.1632**
00002470675	**PMS-PERINDOPRIL**	**PMS**	$	**0.1632**
00002470225	**SANDOZ PERINDOPRIL ERBUMINE**	**SDZ**	$	**0.1632**
00002464985	**TEVA-PERINDOPRIL**	**TEV**	$	**0.1632**
00002123274	COVERSYL	SEV	$	0.7154

4 MG ORAL TABLET

00002481685	AG-PERINDOPRIL	AGP	***$ 0.1945***	$	0.2042
00002289288	APO-PERINDOPRIL	APX	***$ 0.1945***	$	0.2042
00002459825	AURO-PERINDOPRIL	AUR	***$ 0.1945***	$	0.2042
00002477017	JAMP PERINDOPRIL	JPC	***$ 0.1945***	$	0.2042
00002474832	MAR-PERINDOPRIL	MAR	***$ 0.1945***	$	0.2042
00002476770	MINT-PERINDOPRIL	MPI	***$ 0.1945***	$	0.2042
00002489023	NRA-PERINDOPRIL	NRA	***$ 0.1945***	$	0.2042
00002479885	PERINDOPRIL ERBUMINE	SIV	***$ 0.1945***	$	0.2042
00002481642	PERINDOPRIL ERBUMINE	SNS	***$ 0.1945***	$	0.2042
00002470683	PMS-PERINDOPRIL	PMS	***$ 0.1945***	$	0.2042
00002470233	SANDOZ PERINDOPRIL ERBUMINE	SDZ	***$ 0.1945***	$	0.2042
00002464993	TEVA-PERINDOPRIL	TEV	***$ 0.1945***	$	0.2042
00002123282	COVERSYL	SEV	***$ 0.1945***	$	0.8957

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

8 MG ORAL TABLET

00002481693	AG-PERINDOPRIL	AGP	***$ 0.1945***	$	0.2831
00002289296	APO-PERINDOPRIL	APX	***$ 0.1945***	$	0.2831
00002459833	AURO-PERINDOPRIL	AUR	***$ 0.1945***	$	0.2831
00002477025	JAMP PERINDOPRIL	JPC	***$ 0.1945***	$	0.2831
00002474840	MAR-PERINDOPRIL	MAR	***$ 0.1945***	$	0.2831
00002476789	MINT-PERINDOPRIL	MPI	***$ 0.1945***	$	0.2831
00002489031	NRA-PERINDOPRIL	NRA	***$ 0.1945***	$	0.2831
00002479893	PERINDOPRIL ERBUMINE	SIV	***$ 0.1945***	$	0.2831
00002481650	PERINDOPRIL ERBUMINE	SNS	***$ 0.1945***	$	0.2831
00002470691	PMS-PERINDOPRIL	PMS	***$ 0.1945***	$	0.2831
00002470241	SANDOZ PERINDOPRIL ERBUMINE	SDZ	***$ 0.1945***	$	0.2831
00002465000	TEVA-PERINDOPRIL	TEV	***$ 0.1945***	$	0.2831
00002246624	COVERSYL	SEV	***$ 0.1945***	$	1.2541

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

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

00002297574	APO-PERINDOPRIL-INDAPAMIDE	APX	***$ 0.2503***	$	0.2556
00002470438	SANDOZ PERINDOPRIL/INDAPAMIDE	SDZ	***$ 0.2503***	$	0.2556
00002464020	TEVA-PERINDOPRIL/INDAPAMIDE	TEV	***$ 0.2503***	$	0.2556
00002246569	COVERSYL PLUS	SEV	***$ 0.2503***	$	1.0796

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

8 MG * 2.5 MG ORAL TABLET

00002453061	APO-PERINDOPRIL-INDAPAMIDE	APX	***$ 0.2503***	$	0.2859
00002470446	SANDOZ PERINDOPRIL/INDAPAMIDE HD	SDZ	***$ 0.2503***	$	0.2859
00002464039	TEVA-PERINDOPRIL/INDAPAMIDE	TEV	***$ 0.2503***	$	0.2859
00002321653	COVERSYL PLUS HD	SEV	***$ 0.2503***	$	1.2541

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

QUINAPRIL

5 MG (BASE) ORAL TABLET

00002248499	APO-QUINAPRIL	APX	***$ 0.1945***	$	0.4642
00002340550	PMS-QUINAPRIL	PMS	***$ 0.1945***	$	0.4642
00001947664	ACCUPRIL	PFI	***$ 0.1945***	$	1.0131

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

10 MG (BASE) ORAL TABLET

00002248500	APO-QUINAPRIL	APX	***$ 0.1945***	$	0.4642
00002340569	PMS-QUINAPRIL	PMS	***$ 0.1945***	$	0.4642
00001947672	ACCUPRIL	PFI	***$ 0.1945***	$	0.9990

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

20 MG (BASE) ORAL TABLET

00002248501	APO-QUINAPRIL	APX	***$ 0.1945***	$	0.4642
00002340577	PMS-QUINAPRIL	PMS	***$ 0.1945***	$	0.4642
00001947680	ACCUPRIL	PFI	***$ 0.1945***	$	0.9990

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

40 MG (BASE) ORAL TABLET

00002248502	APO-QUINAPRIL	APX	***$ 0.1945***	$	0.4642
00002340585	PMS-QUINAPRIL	PMS	***$ 0.1945***	$	0.4642
00001947699	ACCUPRIL	PFI	***$ 0.1945***	$	0.9990

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

QUINAPRIL/ HYDROCHLOROTHIAZIDE

10 MG (BASE) * 12.5 MG ORAL TABLET

00002408767	APO-QUINAPRIL/HCTZ	APX	***$ 0.2503***	$	0.4786
00002473291	AURO-QUINAPRIL HCTZ	AUR	***$ 0.2503***	$	0.4786
00002237367	ACCURETIC 10/12.5	PFI	***$ 0.2503***	$	1.0091

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

20 MG (BASE) * 12.5 MG ORAL TABLET

00002408775	APO-QUINAPRIL/HCTZ	APX	***$ 0.2503***	$	0.4786
00002473305	AURO-QUINAPRIL HCTZ	AUR	***$ 0.2503***	$	0.4786
00002237368	ACCURETIC 20/12.5	PFI	***$ 0.2503***	$	1.0091

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

20 MG * 25 MG ORAL TABLET

00002408783	APO-QUINAPRIL/HCTZ	APX	***$ 0.2503***	$	0.4602
00002473321	AURO-QUINAPRIL HCTZ	AUR	***$ 0.2503***	$	0.4602
00002237369	ACCURETIC 20/25	PFI	***$ 0.2503***	$	0.9663

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

RAMIPRIL

1.25 MG ORAL CAPSULE/TABLET

00002251515	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.0708**
00002387387	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.0708**
00002420457	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.0708**
00002469057	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.0708**
00002308363	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.0708**
00002310503	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.0708**
00002221829	ALTACE (CAPSULE)	VCL	$	0.7756

2.5 MG ORAL CAPSULE/TABLET

00002477572	**AG-RAMIPRIL (CAPSULE)**	**AGP**	$	**0.0817**
00002251531	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.0817**
00002387395	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.0817**
00002331128	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.0817**
00002420465	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.0817**
00002421305	**MINT-RAMIPRIL (CAPSULE)**	**MPI**	$	**0.0817**
00002469065	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.0817**
00002287927	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.0817**
00002374846	**RAMIPRIL (CAPSULE)**	**SNS**	$	**0.0817**
00002310511	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.0817**
00002247945	**TEVA-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.0817**
00002221837	ALTACE (CAPSULE)	VCL	$	0.8726

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

RAMIPRIL

5 MG ORAL CAPSULE/TABLET

00002477580	**AG-RAMIPRIL (CAPSULE)**	**AGP**	$	**0.0817**
00002251574	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.0817**
00002387409	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.0817**
00002331136	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.0817**
00002420473	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.0817**
00002421313	**MINT-RAMIPRIL (CAPSULE)**	**MPI**	$	**0.0817**
00002469073	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.0817**
00002287935	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.0817**
00002374854	**RAMIPRIL (CAPSULE)**	**SNS**	$	**0.0817**
00002310538	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.0817**
00002247946	**TEVA-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.0817**
00002221845	ALTACE (CAPSULE)	VCL	$	0.8954

10 MG ORAL CAPSULE/TABLET

00002477599	**AG-RAMIPRIL (CAPSULE)**	**AGP**	$	**0.1034**
00002251582	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.1034**
00002387417	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.1034**
00002331144	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.1034**
00002420481	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.1034**
00002421321	**MINT-RAMIPRIL (CAPSULE)**	**MPI**	$	**0.1034**
00002469081	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.1034**
00002287943	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.1034**
00002374862	**RAMIPRIL (CAPSULE)**	**SNS**	$	**0.1034**
00002310546	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.1034**
00002247947	**TEVA-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.1034**
00002221853	ALTACE (CAPSULE)	VCL	$	1.1501

RAMIPRIL/ HYDROCHLOROTHIAZIDE

2.5 MG * 12.5 MG ORAL TABLET

00002449439	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.2242**
00002283131	ALTACE HCT	VCL	$	0.3138

5 MG * 12.5 MG ORAL TABLET

00002449447	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.3016**
00002283158	ALTACE HCT	VCL	$	0.4020

5 MG * 25 MG ORAL TABLET

00002449463	RAN-RAMIPRIL HCTZ	RAN	***$ 0.2503***	$	0.2872
00002283174	ALTACE HCT	VCL	***$ 0.2503***	$	0.4020

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

10 MG * 12.5 MG ORAL TABLET

00002342154	**PMS-RAMIPRIL-HCTZ**	**PMS**	$	**0.2634**
00002449455	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.2634**
00002283166	ALTACE HCT	VCL	$	0.5265

10 MG * 25 MG ORAL TABLET

00002342170	**PMS-RAMIPRIL-HCTZ**	**PMS**	$	**0.2634**
00002449471	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.2634**
00002283182	ALTACE HCT	VCL	$	0.5265

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

TRANDOLAPRIL

0.5 MG ORAL CAPSULE

00002471868	**AURO-TRANDOLAPRIL**	**AUR**		$	**0.0698**
00002357755	**PMS-TRANDOLAPRIL**	**PMS**		$	**0.0698**
00002325721	**SANDOZ TRANDOLAPRIL**	**SDZ**		$	**0.0698**
00002231457	MAVIK	BGP		$	0.2790

1 MG ORAL CAPSULE

00002471876	**AURO-TRANDOLAPRIL**	**AUR**		$	**0.1762**
00002357763	**PMS-TRANDOLAPRIL**	**PMS**		$	**0.1762**
00002325748	**SANDOZ TRANDOLAPRIL**	**SDZ**		$	**0.1762**
00002231459	MAVIK	BGP		$	0.7046

2 MG ORAL CAPSULE

00002471884	AURO-TRANDOLAPRIL	AUR	***$ 0.1945***	$	0.2025
00002357771	PMS-TRANDOLAPRIL	PMS	***$ 0.1945***	$	0.2025
00002325756	SANDOZ TRANDOLAPRIL	SDZ	***$ 0.1945***	$	0.2025
00002231460	MAVIK	BGP	***$ 0.1945***	$	0.8098

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet or the current price or LCA price whichever is the lowest.

4 MG ORAL CAPSULE

00002471892	AURO-TRANDOLAPRIL	AUR	***$ 0.1945***	$	0.2498
00002357798	PMS-TRANDOLAPRIL	PMS	***$ 0.1945***	$	0.2498
00002325764	SANDOZ TRANDOLAPRIL	SDZ	***$ 0.1945***	$	0.2498
00002239267	MAVIK	BGP	***$ 0.1945***	$	0.9990

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet or the current price or LCA price whichever is the lowest.

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

CANDESARTAN CILEXETIL

8 MG ORAL TABLET

00002365359	**APO-CANDESARTAN**	**APX**	$	**0.2281**
00002445794	**AURO-CANDESARTAN**	**AUR**	$	**0.2281**
00002388707	**CANDESARTAN**	**SIV**	$	**0.2281**
00002388928	**CANDESARTAN**	**SNS**	$	**0.2281**
00002379279	**CANDESARTAN CILEXETIL**	**AHI**	$	**0.2281**
00002386518	**JAMP-CANDESARTAN**	**JPC**	$	**0.2281**
00002476916	**MINT-CANDESARTAN**	**MPI**	$	**0.2281**
00002391198	**PMS-CANDESARTAN**	**PMS**	$	**0.2281**
00002380692	**RAN-CANDESARTAN**	**RAN**	$	**0.2281**
00002326965	**SANDOZ CANDESARTAN**	**SDZ**	$	**0.2281**
00002366312	**TEVA-CANDESARTAN**	**TEV**	$	**0.2281**
00002239091	ATACAND	AZC	$	1.2847

16 MG ORAL TABLET

00002365367	**APO-CANDESARTAN**	**APX**	$	**0.2281**
00002445808	**AURO-CANDESARTAN**	**AUR**	$	**0.2281**
00002388715	**CANDESARTAN**	**SIV**	$	**0.2281**
00002388936	**CANDESARTAN**	**SNS**	$	**0.2281**
00002379287	**CANDESARTAN CILEXETIL**	**AHI**	$	**0.2281**
00002386526	**JAMP-CANDESARTAN**	**JPC**	$	**0.2281**
00002476924	**MINT-CANDESARTAN**	**MPI**	$	**0.2281**
00002391201	**PMS-CANDESARTAN**	**PMS**	$	**0.2281**
00002380706	**RAN-CANDESARTAN**	**RAN**	$	**0.2281**
00002326973	**SANDOZ CANDESARTAN**	**SDZ**	$	**0.2281**
00002366320	**TEVA-CANDESARTAN**	**TEV**	$	**0.2281**
00002239092	ATACAND	AZC	$	1.2847

32 MG ORAL TABLET

00002399105	**APO-CANDESARTAN**	**APX**	$	**0.2281**
00002445816	**AURO-CANDESARTAN**	**AUR**	$	**0.2281**
00002435845	**CANDESARTAN**	**SNS**	$	**0.2281**
00002379295	**CANDESARTAN CILEXETIL**	**AHI**	$	**0.2281**
00002386534	**JAMP-CANDESARTAN**	**JPC**	$	**0.2281**
00002391228	**PMS-CANDESARTAN**	**PMS**	$	**0.2281**
00002380714	**RAN-CANDESARTAN**	**RAN**	$	**0.2281**
00002417340	**SANDOZ CANDESARTAN**	**SDZ**	$	**0.2281**
00002366339	**TEVA-CANDESARTAN**	**TEV**	$	**0.2281**
00002311658	ATACAND	AZC	$	1.2847

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE

16 MG * 12.5 MG ORAL TABLET

00002421038	**AURO-CANDESARTAN HCT**	**AUR**	$	**0.2156**
00002394812	**CANDESARTAN HCT**	**SIV**	$	**0.2156**
00002394804	**CANDESARTAN/HCTZ**	**SNS**	$	**0.2156**
00002473240	**JAMP CANDESARTAN-HCT**	**JPC**	$	**0.2156**
00002391295	**PMS-CANDESARTAN HCTZ**	**PMS**	$	**0.2156**
00002327902	**SANDOZ CANDESARTAN PLUS**	**SDZ**	$	**0.2156**
00002395541	**TEVA-CANDESARTAN/HCTZ**	**TEV**	$	**0.2156**
00002244021	ATACAND PLUS	AZC	$	1.3077

32 MG * 12.5 MG ORAL TABLET

00002421046	**AURO-CANDESARTAN HCT**	**AUR**	$	**0.2156**
00002473259	**JAMP CANDESARTAN-HCT**	**JPC**	$	**0.2156**
00002420732	**SANDOZ CANDESARTAN PLUS**	**SDZ**	$	**0.2156**
00002395568	**TEVA-CANDESARTAN/HCTZ**	**TEV**	$	**0.2156**
00002332922	ATACAND PLUS	AZC	$	1.3077

32 MG * 25 MG ORAL TABLET

00002421054	**AURO-CANDESARTAN HCT**	**AUR**	$	**0.3008**
00002473267	**JAMP CANDESARTAN-HCT**	**JPC**	$	**0.3008**
00002420740	**SANDOZ CANDESARTAN PLUS**	**SDZ**	$	**0.3008**
00002332957	ATACAND PLUS	AZC	$	1.3077

EPROSARTAN MESYLATE

400 MG (BASE) ORAL TABLET

00002240432	TEVETEN	BGP	$	0.7760

600 MG (BASE) ORAL TABLET

00002243942	TEVETEN	BGP	$	1.1864

EPROSARTAN MESYLATE/ HYDROCHLOROTHIAZIDE

600 MG * 12.5 MG ORAL TABLET

00002253631	TEVETEN PLUS	BGP	$	1.1864

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

IRBESARTAN

75 MG ORAL TABLET

00002406098	**AURO-IRBESARTAN**	**AUR**	$	**0.2281**
00002372347	**IRBESARTAN**	**SNS**	$	**0.2281**
00002385287	**IRBESARTAN**	**SIV**	$	**0.2281**
00002418193	**JAMP-IRBESARTAN**	**JPC**	$	**0.2281**
00002422980	**MINT-IRBESARTAN**	**MPI**	$	**0.2281**
00002317060	**PMS-IRBESARTAN**	**PMS**	$	**0.2281**
00002406810	**RAN-IRBESARTAN**	**RAN**	$	**0.2281**
00002328461	**SANDOZ IRBESARTAN**	**SDZ**	$	**0.2281**
00002316390	**TEVA-IRBESARTAN**	**TEV**	$	**0.2281**
00002237923	AVAPRO	SAV	$	1.2671

150 MG ORAL TABLET

00002406101	**AURO-IRBESARTAN**	**AUR**	$	**0.2281**
00002372371	**IRBESARTAN**	**SNS**	$	**0.2281**
00002385295	**IRBESARTAN**	**SIV**	$	**0.2281**
00002418207	**JAMP-IRBESARTAN**	**JPC**	$	**0.2281**
00002422999	**MINT-IRBESARTAN**	**MPI**	$	**0.2281**
00002317079	**PMS-IRBESARTAN**	**PMS**	$	**0.2281**
00002406829	**RAN-IRBESARTAN**	**RAN**	$	**0.2281**
00002328488	**SANDOZ IRBESARTAN**	**SDZ**	$	**0.2281**
00002316404	**TEVA-IRBESARTAN**	**TEV**	$	**0.2281**
00002237924	AVAPRO	SAV	$	1.2671

300 MG ORAL TABLET

00002406128	**AURO-IRBESARTAN**	**AUR**	$	**0.2281**
00002372398	**IRBESARTAN**	**SNS**	$	**0.2281**
00002385309	**IRBESARTAN**	**SIV**	$	**0.2281**
00002418215	**JAMP-IRBESARTAN**	**JPC**	$	**0.2281**
00002423006	**MINT-IRBESARTAN**	**MPI**	$	**0.2281**
00002317087	**PMS-IRBESARTAN**	**PMS**	$	**0.2281**
00002406837	**RAN-IRBESARTAN**	**RAN**	$	**0.2281**
00002328496	**SANDOZ IRBESARTAN**	**SDZ**	$	**0.2281**
00002316412	**TEVA-IRBESARTAN**	**TEV**	$	**0.2281**
00002237925	AVAPRO	SAV	$	1.2671

IRBESARTAN/ HYDROCHLOROTHIAZIDE

150 MG * 12.5 MG ORAL TABLET

00002447878	**AURO-IRBESARTAN HCT**	**AUR**	$	**0.2281**
00002385317	**IRBESARTAN HCT**	**SIV**	$	**0.2281**
00002372886	**IRBESARTAN/HCTZ**	**SNS**	$	**0.2281**
00002418223	**JAMP-IRBESARTAN-HCTZ**	**JPC**	$	**0.2281**
00002328518	**PMS-IRBESARTAN-HCTZ**	**PMS**	$	**0.2281**
00002337428	**SANDOZ IRBESARTAN HCT**	**SDZ**	$	**0.2281**
00002330512	**TEVA-IRBESARTAN HCTZ**	**TEV**	$	**0.2281**
00002241818	AVALIDE 150/12.5	SAV	$	1.2671

300 MG * 12.5 MG ORAL TABLET

00002447886	**AURO-IRBESARTAN HCT**	**AUR**	$	**0.2281**
00002385325	**IRBESARTAN HCT**	**SIV**	$	**0.2281**
00002372894	**IRBESARTAN/HCTZ**	**SNS**	$	**0.2281**
00002418231	**JAMP-IRBESARTAN-HCTZ**	**JPC**	$	**0.2281**
00002328526	**PMS-IRBESARTAN-HCTZ**	**PMS**	$	**0.2281**
00002337436	**SANDOZ IRBESARTAN HCT**	**SDZ**	$	**0.2281**
00002330520	**TEVA-IRBESARTAN HCTZ**	**TEV**	$	**0.2281**
00002241819	AVALIDE 300/12.5	SAV	$	1.2671

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

IRBESARTAN/ HYDROCHLOROTHIAZIDE

300 MG * 25 MG ORAL TABLET

00002447894	**AURO-IRBESARTAN HCT**	**AUR**	$	**0.2184**
00002385333	**IRBESARTAN HCT**	**SIV**	$	**0.2184**
00002372908	**IRBESARTAN/HCTZ**	**SNS**	$	**0.2184**
00002418258	**JAMP-IRBESARTAN-HCTZ**	**JPC**	$	**0.2184**
00002328534	**PMS-IRBESARTAN-HCTZ**	**PMS**	$	**0.2184**
00002337444	**SANDOZ IRBESARTAN HCT**	**SDZ**	$	**0.2184**
00002330539	**TEVA-IRBESARTAN HCTZ**	**TEV**	$	**0.2184**

LOSARTAN POTASSIUM

25 MG ORAL TABLET

00002379058	**APO-LOSARTAN**	**APX**	$	**0.1616**
00002403323	**AURO-LOSARTAN**	**AUR**	$	**0.1616**
00002445964	**BIO-LOSARTAN**	**BMD**	$	**0.1616**
00002398834	**JAMP-LOSARTAN**	**JPC**	$	**0.1616**
00002388790	**LOSARTAN**	**SIV**	$	**0.1616**
00002388863	**LOSARTAN**	**SNS**	$	**0.1616**
00002405733	**MINT-LOSARTAN**	**MPI**	$	**0.1616**
00002309750	**PMS-LOSARTAN**	**PMS**	$	**0.1616**
00002313332	**SANDOZ LOSARTAN**	**SDZ**	$	**0.1616**
00002424967	**SEPTA-LOSARTAN**	**SEP**	$	**0.1616**
00002380838	**TEVA-LOSARTAN**	**TEV**	$	**0.1616**
00002182815	COZAAR	MFC	$	1.4346

50 MG ORAL TABLET

00002353504	**APO-LOSARTAN**	**APX**	$	**0.1616**
00002403331	**AURO-LOSARTAN**	**AUR**	$	**0.1616**
00002445972	**BIO-LOSARTAN**	**BMD**	$	**0.1616**
00002398842	**JAMP-LOSARTAN**	**JPC**	$	**0.1616**
00002388804	**LOSARTAN**	**SIV**	$	**0.1616**
00002388871	**LOSARTAN**	**SNS**	$	**0.1616**
00002405741	**MINT-LOSARTAN**	**MPI**	$	**0.1616**
00002309769	**PMS-LOSARTAN**	**PMS**	$	**0.1616**
00002313340	**SANDOZ LOSARTAN**	**SDZ**	$	**0.1616**
00002424975	**SEPTA-LOSARTAN**	**SEP**	$	**0.1616**
00002357968	**TEVA-LOSARTAN**	**TEV**	$	**0.1616**
00002182874	COZAAR	MFC	$	1.4346

100 MG ORAL TABLET

00002353512	**APO-LOSARTAN**	**APX**	$	**0.1616**
00002403358	**AURO-LOSARTAN**	**AUR**	$	**0.1616**
00002445980	**BIO-LOSARTAN**	**BMD**	$	**0.1616**
00002398850	**JAMP-LOSARTAN**	**JPC**	$	**0.1616**
00002388812	**LOSARTAN**	**SIV**	$	**0.1616**
00002388898	**LOSARTAN**	**SNS**	$	**0.1616**
00002405768	**MINT-LOSARTAN**	**MPI**	$	**0.1616**
00002309777	**PMS-LOSARTAN**	**PMS**	$	**0.1616**
00002313359	**SANDOZ LOSARTAN**	**SDZ**	$	**0.1616**
00002424983	**SEPTA-LOSARTAN**	**SEP**	$	**0.1616**
00002357976	**TEVA-LOSARTAN**	**TEV**	$	**0.1616**
00002182882	COZAAR	MFC	$	1.4346

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

00002423642	**AURO-LOSARTAN HCT**	**AUR**	$	**0.3146**
00002408244	**JAMP-LOSARTAN HCTZ**	**JPC**	$	**0.3146**
00002388960	**LOSARTAN/HCT**	**SIV**	$	**0.3146**
00002427648	**LOSARTAN/HCTZ**	**SNS**	$	**0.3146**
00002389657	**MINT-LOSARTAN/HCTZ**	**MPI**	$	**0.3146**
00002392224	**PMS-LOSARTAN-HCTZ**	**PMS**	$	**0.3146**
00002313375	**SANDOZ LOSARTAN HCT**	**SDZ**	$	**0.3146**
00002358263	**TEVA-LOSARTAN/HCTZ**	**TEV**	$	**0.3146**
00002230047	HYZAAR	MFC	$	1.4346

100 MG * 12.5 MG ORAL TABLET

00002423650	**AURO-LOSARTAN HCT**	**AUR**	$	**0.3082**
00002388979	**LOSARTAN/HCT**	**SIV**	$	**0.3082**
00002427656	**LOSARTAN/HCTZ**	**SNS**	$	**0.3082**
00002389665	**MINT-LOSARTAN/HCTZ**	**MPI**	$	**0.3082**
00002392232	**PMS-LOSARTAN-HCTZ**	**PMS**	$	**0.3082**
00002362449	**SANDOZ LOSARTAN HCT**	**SDZ**	$	**0.3082**
00002377144	**TEVA-LOSARTAN/HCTZ**	**TEV**	$	**0.3082**
00002297841	HYZAAR	MFC	$	1.4047

100 MG * 25 MG ORAL TABLET

00002423669	**AURO-LOSARTAN HCT**	**AUR**	$	**0.3146**
00002408252	**JAMP-LOSARTAN HCTZ**	**JPC**	$	**0.3146**
00002388987	**LOSARTAN/HCT**	**SIV**	$	**0.3146**
00002427664	**LOSARTAN/HCTZ**	**SNS**	$	**0.3146**
00002389673	**MINT-LOSARTAN/HCTZ DS**	**MPI**	$	**0.3146**
00002392240	**PMS-LOSARTAN-HCTZ**	**PMS**	$	**0.3146**
00002313383	**SANDOZ LOSARTAN HCT DS**	**SDZ**	$	**0.3146**
00002428547	**SEPTA-LOSARTAN HCTZ**	**SEP**	$	**0.3146**
00002377152	**TEVA-LOSARTAN/HCTZ**	**TEV**	$	**0.3146**
00002241007	HYZAAR DS	MFC	$	1.4346

TELMISARTAN

40 MG ORAL TABLET

00002453568	**AURO-TELMISARTAN**	**AUR**	$	**0.2161**
00002386755	**JAMP TELMISARTAN**	**JPC**	$	**0.2161**
00002486369	**MINT-TELMISARTAN**	**MPI**	$	**0.2161**
00002375958	**SANDOZ TELMISARTAN**	**SDZ**	$	**0.2161**
00002388944	**TELMISARTAN**	**SNS**	$	**0.2161**
00002390345	**TELMISARTAN**	**SIV**	$	**0.2161**
00002407485	**TELMISARTAN**	**AHI**	$	**0.2161**
00002320177	**TEVA-TELMISARTAN**	**TEV**	$	**0.2161**
00002240769	MICARDIS	BOE	$	1.2474

80 MG ORAL TABLET

00002453576	**AURO-TELMISARTAN**	**AUR**	$	**0.2161**
00002386763	**JAMP TELMISARTAN**	**JPC**	$	**0.2161**
00002486377	**MINT-TELMISARTAN**	**MPI**	$	**0.2161**
00002375966	**SANDOZ TELMISARTAN**	**SDZ**	$	**0.2161**
00002388952	**TELMISARTAN**	**SNS**	$	**0.2161**
00002390353	**TELMISARTAN**	**SIV**	$	**0.2161**
00002407493	**TELMISARTAN**	**AHI**	$	**0.2161**
00002320185	**TEVA-TELMISARTAN**	**TEV**	$	**0.2161**
00002240770	MICARDIS	BOE	$	1.2474

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

TELMISARTAN/ AMLODIPINE BESYLATE

40 MG * 5 MG ORAL TABLET

00002371022	TWYNSTA	BOE	$	0.7296

40 MG * 10 MG ORAL TABLET

00002371030	TWYNSTA	BOE	$	0.7296

80 MG * 5 MG ORAL TABLET

00002371049	TWYNSTA	BOE	$	0.7296

80 MG * 10 MG ORAL TABLET

00002371057	TWYNSTA	BOE	$	0.7296

TELMISARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET

00002419114	**ACH-TELMISARTAN HCTZ**	**AHI**	$	**0.2098**
00002456389	**AURO-TELMISARTAN HCTZ**	**AUR**	$	**0.2098**
00002389940	**JAMP TELMISARTAN-HCT**	**JPC**	$	**0.2098**
00002393557	**SANDOZ TELMISARTAN HCT**	**SDZ**	$	**0.2098**
00002390302	**TELMISARTAN HCTZ**	**SIV**	$	**0.2098**
00002395355	**TELMISARTAN/HCTZ**	**SNS**	$	**0.2098**
00002330288	**TEVA-TELMISARTAN HCTZ**	**TEV**	$	**0.2098**
00002244344	MICARDIS PLUS	BOE	$	1.2474

80 MG * 25 MG ORAL TABLET

00002419122	**ACH-TELMISARTAN HCTZ**	**AHI**	$	**0.2098**
00002456397	**AURO-TELMISARTAN HCTZ**	**AUR**	$	**0.2098**
00002389959	**JAMP TELMISARTAN-HCT**	**JPC**	$	**0.2098**
00002393565	**SANDOZ TELMISARTAN HCT**	**SDZ**	$	**0.2098**
00002390310	**TELMISARTAN HCTZ**	**SIV**	$	**0.2098**
00002395363	**TELMISARTAN/HCTZ**	**SNS**	$	**0.2098**
00002379252	**TEVA-TELMISARTAN HCTZ**	**TEV**	$	**0.2098**
00002318709	MICARDIS PLUS	BOE	$	1.2474

VALSARTAN

80 MG ORAL TABLET

00002414228	**AURO-VALSARTAN**	**AUR**	$	**0.2159**
00002363100	**RAN-VALSARTAN**	**RAN**	$	**0.2159**
00002356759	**SANDOZ VALSARTAN**	**SDZ**	$	**0.2159**
00002356651	**TEVA-VALSARTAN**	**TEV**	$	**0.2159**
00002366959	**VALSARTAN**	**SNS**	$	**0.2159**
00002244781	DIOVAN	NOV	$	1.3150

160 MG ORAL TABLET

00002414236	**AURO-VALSARTAN**	**AUR**	$	**0.2159**
00002363119	**RAN-VALSARTAN**	**RAN**	$	**0.2159**
00002356767	**SANDOZ VALSARTAN**	**SDZ**	$	**0.2159**
00002356678	**TEVA-VALSARTAN**	**TEV**	$	**0.2159**
00002366967	**VALSARTAN**	**SNS**	$	**0.2159**
00002244782	DIOVAN	NOV	$	1.3150

320 MG ORAL TABLET

00002414244	**AURO-VALSARTAN**	**AUR**	$	**0.2098**
00002356775	**SANDOZ VALSARTAN**	**SDZ**	$	**0.2098**
00002356686	**TEVA-VALSARTAN**	**TEV**	$	**0.2098**
00002366975	**VALSARTAN**	**SNS**	$	**0.2098**
00002289504	DIOVAN	NOV	$	1.2650

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

VALSARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET				
00002408112	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2213**
00002356694	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2213**
00002356996	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2213**
00002367009	**VALSARTAN HCT**	**SNS**	$	**0.2213**
00002384736	**VALSARTAN HCT**	**SIV**	$	**0.2213**
00002241900	DIOVAN-HCT	NOV	$	1.3075
160 MG * 12.5 MG ORAL TABLET				
00002408120	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2240**
00002356708	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2240**
00002357003	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2240**
00002367017	**VALSARTAN HCT**	**SNS**	$	**0.2240**
00002384744	**VALSARTAN HCT**	**SIV**	$	**0.2240**
00002241901	DIOVAN-HCT	NOV	$	1.3125
160 MG * 25 MG ORAL TABLET				
00002408139	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2238**
00002356716	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2238**
00002357011	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2238**
00002367025	**VALSARTAN HCT**	**SNS**	$	**0.2238**
00002384752	**VALSARTAN HCT**	**SIV**	$	**0.2238**
00002246955	DIOVAN-HCT	NOV	$	1.3175
320 MG * 12.5 MG ORAL TABLET				
00002408147	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2235**
00002356724	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2235**
00002357038	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2235**
00002367033	**VALSARTAN HCT**	**SNS**	$	**0.2235**
00002384760	**VALSARTAN HCT**	**SIV**	$	**0.2235**
00002308908	DIOVAN-HCT	NOV	$	1.2975
320 MG * 25 MG ORAL TABLET				
00002408155	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2231**
00002356732	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2231**
00002357046	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2231**
00002367041	**VALSARTAN HCT**	**SNS**	$	**0.2231**
00002308916	DIOVAN-HCT	NOV	$	1.2975

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	TEVA-SPIRONOLACTONE/HCTZ	TEV	$	0.1372
50 MG * 50 MG ORAL TABLET				
00000657182	TEVA-SPIRONOLACTONE/HCTZ	TEV	$	0.2903

24:00 CARDIOVASCULAR DRUGS

24:32.20 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONISTS)

SPIRONOLACTONE

25 MG ORAL TABLET				
00002488140	**MINT-SPIRONOLACTONE**	**MPI**	$	**0.0810**
00000613215	**TEVA-SPIRONOLACTONE**	**TEV**	$	**0.0810**
100 MG ORAL TABLET				
00002488159	**MINT-SPIRONOLACTONE**	**MPI**	$	**0.1910**
00000613223	**TEVA-SPIRONOLACTONE**	**TEV**	$	**0.1910**

28:00

Central Nervous System Agents

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08 ANALGESICS AND ANTIPYRETICS

COMPOUND PRESCRIPTION

TOPICAL

00000999105	COMPD- NSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)-TOPICAL	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999205	COMPD-NSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)-TOPICAL	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound 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 determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999202 COMPOUND-DICLOFENAC (TOPICAL) XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.24 ANALGESICS AND ANTIPYRETICS NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (SALICYLATES)

BUTALBITAL/ CAFFEINE/ ASA

50 MG * 40 MG * 330 MG ORAL TABLET					
00000608211	TEVA-TECNAL	TEV		$	1.2146
50 MG * 40 MG * 330 MG ORAL CAPSULE					
00000608238	**TEVA-TECNAL**	**TEV**		$	**1.5421**
00000226327	FIORINAL	ARA		$	1.6981

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					
00002162814	**APO-DICLO SR**	**APX**		$	**0.2320**
00002231504	**PMS-DICLOFENAC-SR**	**PMS**		$	**0.2320**
00002261901	**SANDOZ DICLOFENAC SR**	**SDZ**		$	**0.2320**
00002158582	**TEVA-DICLOFENAC SR**	**TEV**		$	**0.2320**
100 MG ORAL SUSTAINED-RELEASE TABLET					
00002091194	APO-DICLO SR	APX	***$ 0.3124***	$	0.4048
00002231505	PMS-DICLOFENAC-SR	PMS	***$ 0.3124***	$	0.4048
00002261944	SANDOZ DICLOFENAC SR	SDZ	***$ 0.3124***	$	0.4048

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					
00000839175	**APO-DICLO**	**APX**		$	**0.0781**
00002302616	**PMS-DICLOFENAC**	**PMS**		$	**0.0781**
00000808539	**TEVA-DICLOFENAC EC**	**TEV**		$	**0.0781**
50 MG ORAL ENTERIC-COATED TABLET					
00000839183	APO-DICLO	APX	***$ 0.1562***	$	0.2024
00002302624	PMS-DICLOFENAC	PMS	***$ 0.1562***	$	0.2024
00000808547	TEVA-DICLOFENAC EC	TEV	***$ 0.1562***	$	0.2024

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**		$	**0.4339**
00002261928	**SANDOZ DICLOFENAC**	**SDZ**		$	**0.4339**
00000632724	VOLTAREN	NOV		$	1.4750
100 MG RECTAL SUPPOSITORY					
00002231508	PMS-DICLOFENAC	PMS		$	0.5840

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM/ MISOPROSTOL

50 MG * 200 MCG ORAL ENTERIC-COATED TABLET				
00002341689	**GD-DICLOFENAC/MISOPROSTOL 50**	**GMD**	$	**0.3149**
00002413469	**PMS-DICLOFENAC-MISOPROSTOL**	**PMS**	$	**0.3149**
00001917056	ARTHROTEC-50	PFI	$	0.6996
75 MG * 200 MCG ORAL ENTERIC-COATED TABLET				
00002341697	**GD-DICLOFENAC/MISOPROSTOL 75**	**GMD**	$	**0.4286**
00002413477	**PMS-DICLOFENAC-MISOPROSTOL**	**PMS**	$	**0.4286**
00002229837	ARTHROTEC-75	PFI	$	0.9521

FLURBIPROFEN

50 MG ORAL TABLET				
00001912046	FLURBIPROFEN	AAP	$	0.4530
100 MG ORAL TABLET				
00001912038	FLURBIPROFEN	AAP	$	0.3039

IBUPROFEN

300 MG ORAL TABLET				
00000441651	APO-IBUPROFEN	APX	$	0.1377
400 MG ORAL TABLET				
☒ 00000506052	APO-IBUPROFEN	APX	$	0.0936
600 MG ORAL TABLET				
00000585114	APO-IBUPROFEN	APX	$	0.1313

INDOMETHACIN

25 MG ORAL CAPSULE				
00002461811	**MINT-INDOMETHACIN**	**MPI**	$	**0.1519**
00000337420	**TEVA-INDOMETHACIN**	**TEV**	$	**0.1519**
50 MG ORAL CAPSULE				
00002461536	**MINT-INDOMETHACIN**	**MPI**	$	**0.2469**
00000337439	**TEVA-INDOMETHACIN**	**TEV**	$	**0.2469**
50 MG RECTAL SUPPOSITORY				
00002231799	SANDOZ INDOMETHACIN	SDZ	$	1.0235
100 MG RECTAL SUPPOSITORY				
00002231800	SANDOZ INDOMETHACIN	SDZ	$	1.2033

KETOPROFEN

200 MG ORAL SUSTAINED-RELEASE TABLET					
00002172577	KETOPROFEN SR	AAP	***$ 1.4210***	$	1.5868

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	KETOPROFEN-E	AAP	$	0.3852
100 MG ORAL ENTERIC-COATED TABLET				
00000842664	KETOPROFEN-E	AAP	$	0.7795

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

KETOROLAC TROMETHAMINE

10 MG ORAL TABLET

00002229080	**APO-KETOROLAC**	**APX**		$	**0.3546**
00002465124	**MAR-KETOROLAC**	**MAR**		$	**0.3546**
00002162660	TORADOL	AAP		$	0.7241

10 MG / ML INJECTION

00002162644	TORADOL	AMP		$	1.3560

30 MG / ML INJECTION

☒ 00002239944	KETOROLAC TROMETHAMINE	SDZ		$	4.4100

MEFENAMIC ACID

250 MG ORAL CAPSULE

00002229452	MEFENAMIC	AAP		$	0.4275

NABUMETONE

500 MG ORAL TABLET

00002238639	NABUMETONE	AAP		$	0.6130

NAPROXEN

250 MG ORAL TABLET

00000522651	**APO-NAPROXEN**	**APX**		$	**0.1068**
00002350750	**NAPROXEN**	**SNS**		$	**0.1068**
00000565350	**TEVA-NAPROX**	**TEV**		$	**0.1068**

375 MG ORAL TABLET

00000600806	**APO-NAPROXEN**	**APX**		$	**0.1458**
00002350769	**NAPROXEN**	**SNS**		$	**0.1458**
00000627097	**TEVA-NAPROX**	**TEV**		$	**0.1458**

500 MG ORAL TABLET

00000592277	**APO-NAPROXEN**	**APX**		$	**0.2110**
00002350777	**NAPROXEN**	**SNS**		$	**0.2110**
00000589861	**TEVA-NAPROX**	**TEV**		$	**0.2110**

750 MG ORAL SUSTAINED-RELEASE TABLET

00002162466	NAPROSYN SR	AMP	***$ 0.2916***	$	1.4086

MAC pricing has been applied based on the LCA price for 2 x 375 mg oral tablets.

250 MG ORAL ENTERIC-COATED TABLET

00002350785	**NAPROXEN EC**	**SNS**	***$ 0.1068***	$	**0.1068**
00002243312	**TEVA-NAPROX EC**	**TEV**	***$ 0.1068***	$	**0.1068**

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***	$	**0.1458**
00002350793	**NAPROXEN EC**	**SNS**	***$ 0.1458***	$	**0.1458**
00002243313	**TEVA-NAPROX EC**	**TEV**	***$ 0.1458***	$	**0.1458**
00002162415	NAPROSYN E	AMP	***$ 0.1458***	$	0.5841

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***	$	**0.2110**
00002350807	**NAPROXEN EC**	**SNS**	***$ 0.2110***	$	**0.2110**
00002243314	**TEVA-NAPROX EC**	**TEV**	***$ 0.2110***	$	**0.2110**
00002162423	NAPROSYN E	AMP	***$ 0.2110***	$	1.0537

MAC pricing has been applied based on the LCA price for 1 x 500 mg oral tablet.

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**
00002351013	**NAPROXEN SODIUM**	**SNS**	$	**0.3422**
00000778389	**TEVA-NAPROX SODIUM**	**TEV**	$	**0.3422**
00002162725	ANAPROX	AMP	$	0.6652
550 MG ORAL TABLET				
00001940309	**APO-NAPRO-NA DS**	**APX**	$	**0.6667**
00002351021	**NAPROXEN SODIUM DS**	**SNS**	$	**0.6667**
00002026600	**TEVA-NAPROX SODIUM DS**	**TEV**	$	**0.6667**
00002162717	ANAPROX DS	AMP	$	1.2808

PIROXICAM

10 MG ORAL CAPSULE				
00000695718	TEVA-PIROXICAM	TEV	$	0.2324
20 MG ORAL CAPSULE				
00000695696	TEVA-PIROXICAM	TEV	$	0.3897

SULINDAC

150 MG ORAL TABLET				
00000745588	TEVA-SULINDAC	TEV	$	0.4427
200 MG ORAL TABLET				
00000745596	TEVA-SULINDAC	TEV	$	0.5253

TIAPROFENIC ACID

200 MG ORAL TABLET				
00002179679	TEVA-TIAPROFENIC ACID	TEV	$	0.5728
300 MG ORAL TABLET				
00002179687	TEVA-TIAPROFENIC ACID	TEV	$	0.8474

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS
(OPIATE AGONISTS)

BUTALBITAL/ CODEINE PHOSPHATE/ ASA/ CAFFEINE

50 MG * 15 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608203	**TEVA-TECNAL-C 1/4**	**TEV**	$	**1.6536**
00000176192	FIORINAL-C 1/4	ARA	$	1.8211
50 MG * 30 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608181	**TEVA-TECNAL-C 1/2**	**TEV**	$	**2.0249**
00000176206	FIORINAL-C 1/2	ARA	$	2.2299

CODEINE PHOSPHATE

15 MG ORAL TABLET				
00000593435	TEVA-CODEINE	TEV	$	0.0863
30 MG ORAL TABLET				
00000593451	TEVA-CODEINE	TEV	$	0.1522
30 MG / ML INJECTION				
00000544884	CODEINE PHOSPHATE	SDZ	$	4.1828

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

CODEINE PHOSPHATE/ ACETAMINOPHEN

30 MG * 300 MG ORAL TABLET				
00000608882	TEVA-EMTEC-30	TEV	$	0.1738
60 MG * 300 MG ORAL TABLET				
00000621463	TEVA-LENOLTEC NO. 4	TEV	$	0.1685
1.6 MG / ML * 32 MG / ML ORAL ELIXIR				
00000816027	PMS-ACETAMINOPHEN WITH CODEINE	PMS	$	0.1184

RESTRICTED BENEFIT

This Drug Product is a benefit for patients 12 years of age and older

CODEINE PHOSPHATE/ ACETAMINOPHEN/ CAFFEINE

15 MG * 300 MG * 15 MG ORAL TABLET				
00000653241	TEVA-LENOLTEC NO.2	TEV	$	0.0889
30 MG * 300 MG * 15 MG ORAL TABLET				
00000653276	TEVA-LENOLTEC NO.3	TEV	$	0.0933

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 determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

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 determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

HYDROMORPHONE HCL

1 MG ORAL TABLET				
00002364115	**APO-HYDROMORPHONE**	**APX**	$	**0.0950**
00000705438	**DILAUDID**	**PUR**	$	**0.0950**
00000885444	**PMS-HYDROMORPHONE**	**PMS**	$	**0.0950**
2 MG ORAL TABLET				
00002364123	**APO-HYDROMORPHONE**	**APX**	$	**0.1416**
00000125083	**DILAUDID**	**PUR**	$	**0.1416**
00000885436	**PMS-HYDROMORPHONE**	**PMS**	$	**0.1416**
4 MG ORAL TABLET				
00002364131	**APO-HYDROMORPHONE**	**APX**	$	**0.2240**
00000125121	**DILAUDID**	**PUR**	$	**0.2240**
00000885401	**PMS-HYDROMORPHONE**	**PMS**	$	**0.2240**
8 MG ORAL TABLET				
00002364158	**APO-HYDROMORPHONE**	**APX**	$	**0.3528**
00000786543	**DILAUDID**	**PUR**	$	**0.3528**
00000885428	**PMS-HYDROMORPHONE**	**PMS**	$	**0.3528**
3 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125323	HYDROMORPH CONTIN	PUR	$	0.6325
4.5 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002359502	HYDROMORPH CONTIN	PUR	$	0.7640
6 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125331	HYDROMORPH CONTIN	PUR	$	0.9480
9 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002359510	HYDROMORPH CONTIN	PUR	$	1.2520
12 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125366	HYDROMORPH CONTIN	PUR	$	1.6440
18 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002243562	HYDROMORPH CONTIN	PUR	$	2.3720
24 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125382	HYDROMORPH CONTIN	PUR	$	2.7445
30 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125390	HYDROMORPH CONTIN	PUR	$	3.2875
1 MG / ML ORAL LIQUID				
00001916386	PMS-HYDROMORPHONE	PMS	$	0.0827
2 MG / ML INJECTION				
00002145901	HYDROMORPHONE	SDZ	$	2.0591
10 MG / ML INJECTION				
00002145928	HYDROMORPHONE HP	SDZ	$	4.3460
20 MG / ML INJECTION				
00002145936	HYDROMORPHONE HP 20	SDZ	$	9.3753
50 MG / ML INJECTION				
00002146126	HYDROMORPHONE HP 50	SDZ	$	6.9525

MEPERIDINE HCL

50 MG / ML INJECTION				
00000725765	MEPERIDINE HYDROCHLORIDE	SDZ	$	2.6151

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

METHADONE HCL

1 MG ORAL TABLET				
00002247698	METADOL	PAL	$	0.1857
5 MG ORAL TABLET				
00002247699	METADOL	PAL	$	0.6191
10 MG ORAL TABLET				
00002247700	METADOL	PAL	$	0.9904
25 MG ORAL TABLET				
00002247701	METADOL	PAL	$	1.8402
1 MG / ML ORAL SOLUTION				
⊠ 00002247374	METADOL-D	PAL	$	0.0589
⊠ 00002247694	METADOL	PAL	$	0.1161
10 MG / ML ORAL LIQUID				
⊠ 00002481979	METHADONE HYDROCHLORIDE	SDZ	$	0.0525
⊠ 00002495880	ODAN-METHADONE (UNFLAVOURED)	ODN	$	0.0525
⊠ 00002394596	METHADOSE	MAL	$	0.1125
⊠ 00002394618	METHADOSE SUGAR FREE	MAL	$	0.1125
⊠ 00002244290	METADOL-D	PAL	$	0.1500
⊠ 00002241377	METADOL CONCENTRATE	PAL	$	0.4198

MORPHINE SULFATE

5 MG ORAL TABLET				
00002014203	**MS.IR**	**PUR**	$	**0.1100**
00000594652	STATEX	PAL	$	0.1155
10 MG ORAL TABLET				
00002014211	**MS.IR**	**PUR**	$	**0.1700**
00000594644	STATEX	PAL	$	0.1785
20 MG ORAL TABLET				
00002014238	MS.IR	PUR	$	0.3685
25 MG ORAL TABLET				
00000594636	STATEX	PAL	$	0.2363
30 MG ORAL TABLET				
00002014254	MS.IR	PUR	$	0.4725
50 MG ORAL TABLET				
00000675962	STATEX	PAL	$	0.3623
15 MG ORAL SUSTAINED-RELEASE TABLET				
00002244790	**SANDOZ MORPHINE SR**	**SDZ**	$	**0.2317**
00002302764	**TEVA-MORPHINE SR**	**TEV**	$	**0.2317**
00002015439	MS CONTIN	PUR	$	0.7700
30 MG ORAL SUSTAINED-RELEASE TABLET				
00002244791	**SANDOZ MORPHINE SR**	**SDZ**	$	**0.3500**
00002302772	**TEVA-MORPHINE SR**	**TEV**	$	**0.3500**
00002014297	MS CONTIN	PUR	$	1.1650
60 MG ORAL SUSTAINED-RELEASE TABLET				
00002350912	**MORPHINE SR**	**SNS**	$	**0.6167**
00002244792	**SANDOZ MORPHINE SR**	**SDZ**	$	**0.6167**
00002302780	**TEVA-MORPHINE SR**	**TEV**	$	**0.6167**
00002014300	MS CONTIN	PUR	$	2.0525
100 MG ORAL SUSTAINED-RELEASE TABLET				
00002478889	**SANDOZ MORPHINE SR**	**SDZ**	$	**1.5395**
00002302799	**TEVA-MORPHINE SR**	**TEV**	$	**1.5395**
00002014319	MS CONTIN	PUR	$	3.1300

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE SULFATE

200 MG ORAL SUSTAINED-RELEASE TABLET				
00002478897	**SANDOZ MORPHINE SR**	**SDZ**	$	**2.7718**
00002302802	**TEVA-MORPHINE SR**	**TEV**	$	**2.7718**
00002014327	MS CONTIN	PUR	$	5.8205
10 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019930	M-ESLON	ETP	$	0.3250
15 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177749	M-ESLON	ETP	$	0.3750
30 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019949	M-ESLON	ETP	$	0.5590
60 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019957	M-ESLON	ETP	$	0.9950
100 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019965	M-ESLON	ETP	$	2.1460
200 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177757	M-ESLON	ETP	$	4.2960
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002242163	KADIAN	BGP	$	0.4014
20 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184435	KADIAN	BGP	$	0.7798
50 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184443	KADIAN	BGP	$	1.4335
100 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184451	KADIAN	BGP	$	2.5002
1 MG / ML INJECTION				
00002021048	MORPHINE LP EPIDURAL	SDZ	$	7.0831
10 MG / ML INJECTION				
00000392588	MORPHINE SULFATE	SDZ	$	2.7610
15 MG / ML INJECTION				
00000392561	MORPHINE SULFATE	SDZ	$	3.0727
50 MG / ML INJECTION				
00000617288	MORPHINE HP 50	SDZ	$	8.2891
5 MG RECTAL SUPPOSITORY				
00000632228	STATEX	PAL	$	1.8776
10 MG RECTAL SUPPOSITORY				
00000632201	STATEX	PAL	$	2.0970
20 MG RECTAL SUPPOSITORY				
00000596965	STATEX	PAL	$	2.4964
30 MG RECTAL SUPPOSITORY				
00000639389	STATEX	PAL	$	2.7381

OPIUM/ BELLADONNA

65 MG * 15 MG RECTAL SUPPOSITORY				
00001901869	SANDOZ OPIUM & BELLADONNA	SDZ	$	5.0204

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

OXYCODONE HCL

5 MG ORAL TABLET				
00000789739	**SUPEUDOL**	**SDZ**	$	**0.1434**
00002319977	PMS-OXYCODONE	PMS	$	0.1565
10 MG ORAL TABLET				
00000443948	**SUPEUDOL**	**SDZ**	$	**0.2283**
00002319985	PMS-OXYCODONE	PMS	$	0.2517
00002240131	OXY-IR	PUR	$	0.4260
20 MG ORAL TABLET				
00002262983	SUPEUDOL	SDZ	$	0.3965
00002319993	**PMS-OXYCODONE**	**PMS**	$	**0.4371**
00002240132	OXY-IR	PUR	$	0.7410
10 MG ORAL CONTROLLED-RELEASE TABLET				
00002372525	OXYNEO	PUR	$	0.9635
15 MG ORAL CONTROLLED-RELEASE TABLET				
00002372533	OXYNEO	PUR	$	1.1630
20 MG ORAL CONTROLLED-RELEASE TABLET				
00002372797	OXYNEO	PUR	$	1.4455
30 MG ORAL CONTROLLED-RELEASE TABLET				
00002372541	OXYNEO	PUR	$	1.9100
40 MG ORAL CONTROLLED-RELEASE TABLET				
00002372568	OXYNEO	PUR	$	2.4920
60 MG ORAL CONTROLLED-RELEASE TABLET				
00002372576	OXYNEO	PUR	$	3.4585
80 MG ORAL CONTROLLED-RELEASE TABLET				
00002372584	OXYNEO	PUR	$	4.6280
10 MG RECTAL SUPPOSITORY				
00000392480	SUPEUDOL	SDZ	$	4.0035
20 MG RECTAL SUPPOSITORY				
00000392472	SUPEUDOL	SDZ	$	5.7794

OXYCODONE HCL/ ACETAMINOPHEN

5 MG * 325 MG ORAL TABLET				
00002324628	**APO-OXYCODONE**	**APX**	$	**0.1285**
00002307898	**SANDOZ-OXYCODONE ACET**	**SDZ**	$	**0.1285**
00000608165	**TEVA-OXYCOCET**	**TEV**	$	**0.1285**

OXYCODONE HCL/ ASA

5 MG * 325 MG ORAL TABLET				
00000608157	TEVA-OXYCODAN	TEV	$	0.4599

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

00002453908	**ACT BUPRENORPHINE/NALOXONE**	**APH**	$	**1.3350**
00002424851	**PMS-BUPRENORPHINE/NALOXONE**	**PMS**	$	**1.3350**
00002295695	SUBOXONE	IUK	$	2.7261

8 MG (BASE) * 2 MG (BASE) ORAL SUBLINGUAL TABLET

00002453916	**ACT BUPRENORPHINE/NALOXONE**	**APH**	$	**2.3650**
00002424878	**PMS-BUPRENORPHINE/NALOXONE**	**PMS**	$	**2.3650**
00002295709	SUBOXONE	IUK	$	4.8293

PENTAZOCINE HCL

50 MG (BASE) ORAL TABLET

00002137984	TALWIN	SAV	$	0.4900

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:10 OPIATE ANTAGONISTS

NALTREXONE HCL

50 MG ORAL TABLET

00002444275	**APO-NALTREXONE**	**APX**	$	**2.8075**
00002451883	**NALTREXONE HYDROCHLORIDE**	**JPC**	$	**2.8075**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.04 ANTICONVULSANTS (BARBITURATES)

PRIMIDONE

125 MG ORAL TABLET

00000399310	PRIMIDONE	AAP	$	0.0632

250 MG ORAL TABLET

00000396761	PRIMIDONE	AAP	$	0.0994

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.08 ANTICONVULSANTS (BENZODIAZEPINES)

CLOBAZAM

10 MG ORAL TABLET

00002244638	**APO-CLOBAZAM**	**APX**	$	**0.2197**
00002238334	**TEVA-CLOBAZAM**	**TEV**	$	**0.2197**

CLONAZEPAM

0.25 MG ORAL TABLET

00002179660	PMS-CLONAZEPAM	PMS	$	0.0850

0.5 MG ORAL TABLET

00002177889	**APO-CLONAZEPAM**	**APX**	$	**0.0418**
00002048701	**PMS-CLONAZEPAM**	**PMS**	$	**0.0418**
00002207818	**PMS-CLONAZEPAM-R**	**PMS**	$	**0.0418**
00000382825	RIVOTRIL	HLR	$	0.2479

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.08 ANTICONVULSANTS (BENZODIAZEPINES)

CLONAZEPAM

1 MG ORAL TABLET				
00002048728	PMS-CLONAZEPAM	PMS	$	0.1639
2 MG ORAL TABLET				
00002177897	**APO-CLONAZEPAM**	**APX**	$	**0.0721**
00002048736	**PMS-CLONAZEPAM**	**PMS**	$	**0.0721**
00000382841	RIVOTRIL	HLR	$	0.4274

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.12 ANTICONVULSANTS (HYDANTOINS)

PHENYTOIN

50 MG ORAL CHEWABLE TABLET				
00000023698	DILANTIN INFATABS	UJC	$	0.0905
6 MG / ML ORAL SUSPENSION				
00000023442	DILANTIN-30	UJC	$	0.0494
25 MG / ML ORAL SUSPENSION				
00002250896	**TARO-PHENYTOIN**	**TAR**	$	**0.0457**
00000023450	DILANTIN-125	UJC	$	0.0582

PHENYTOIN SODIUM

30 MG ORAL CAPSULE				
00000022772	DILANTIN	UJC	$	0.1429
100 MG ORAL CAPSULE				
00002460912	**PHENYTOIN SODIUM**	**AAP**	$	**0.0665**
00000022780	DILANTIN	UJC	$	0.0913

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.20 ANTICONVULSANTS (SUCCINIMIDES)

ETHOSUXIMIDE

250 MG ORAL CAPSULE				
00000022799	ZARONTIN	ERF	$	0.5000
50 MG / ML ORAL SYRUP				
00000023485	ZARONTIN	ERF	$	0.0737

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS (MISCELLANEOUS ANTICONVULSANTS)

CARBAMAZEPINE

200 MG ORAL TABLET				
00002407515	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.2432**
00000782718	**TEVA-CARBAMAZ**	**TEV**	$	**0.2432**
00000010405	TEGRETOL	NOV	$	0.4386
100 MG ORAL CHEWABLE TABLET				
00002244403	TARO-CARBAMAZEPINE	TAR	$	0.1702

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

CARBAMAZEPINE

200 MG ORAL CHEWABLE TABLET				
00002244404	TARO-CARBAMAZEPINE	TAR	$	0.3302
200 MG ORAL SUSTAINED-RELEASE TABLET				
00002231543	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.0930**
00002261839	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.0930**
00000773611	TEGRETOL CR	NOV	$	0.4422
400 MG ORAL SUSTAINED-RELEASE TABLET				
00002231544	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.1859**
00002261847	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.1859**
00000755583	TEGRETOL CR	NOV	$	0.8845
20 MG / ML ORAL SUSPENSION				
00002367394	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.0728**
00002194333	TEGRETOL	NOV	$	0.0848

DIVALPROEX SODIUM (VALPROIC ACID EQUIV.)

125 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239698	**APO-DIVALPROEX**	**APX**	$	**0.1539**
00002458926	**MYLAN-DIVALPROEX**	**MYP**	$	**0.1539**
00000596418	EPIVAL	BGP	$	0.3140
250 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239699	**APO-DIVALPROEX**	**APX**	$	**0.2767**
00002458934	**MYLAN-DIVALPROEX**	**MYP**	$	**0.2767**
00000596426	EPIVAL	BGP	$	0.5644
500 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239700	**APO-DIVALPROEX**	**APX**	$	**0.5537**
00002459019	**MYLAN-DIVALPROEX**	**MYP**	$	**0.5537**
00000596434	EPIVAL	BGP	$	1.1296

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

GABAPENTIN

100 MG ORAL CAPSULE				
00002477912	**AG-GABAPENTIN**	**AGP**	$	**0.0416**
00002244304	**APO-GABAPENTIN**	**APX**	$	**0.0416**
00002321203	**AURO-GABAPENTIN**	**AUR**	$	**0.0416**
00002246314	**GABAPENTIN**	**SIV**	$	**0.0416**
00002353245	**GABAPENTIN**	**SNS**	$	**0.0416**
00002416840	**GABAPENTIN**	**AHI**	$	**0.0416**
00002361469	**JAMP-GABAPENTIN**	**JPC**	$	**0.0416**
00002391473	**MAR-GABAPENTIN**	**MAR**	$	**0.0416**
00002243446	**PMS-GABAPENTIN**	**PMS**	$	**0.0416**
00002244513	**TEVA-GABAPENTIN**	**TEV**	$	**0.0416**
00002084260	NEURONTIN	UJC	$	0.4772
300 MG ORAL CAPSULE				
00002477920	**AG-GABAPENTIN**	**AGP**	$	**0.1012**
00002244305	**APO-GABAPENTIN**	**APX**	$	**0.1012**
00002321211	**AURO-GABAPENTIN**	**AUR**	$	**0.1012**
00002246315	**GABAPENTIN**	**SIV**	$	**0.1012**
00002353253	**GABAPENTIN**	**SNS**	$	**0.1012**
00002416859	**GABAPENTIN**	**AHI**	$	**0.1012**
00002361485	**JAMP-GABAPENTIN**	**JPC**	$	**0.1012**
00002391481	**MAR-GABAPENTIN**	**MAR**	$	**0.1012**
00002243447	**PMS-GABAPENTIN**	**PMS**	$	**0.1012**
00002319063	**RAN-GABAPENTIN**	**RAN**	$	**0.1012**
00002244514	**TEVA-GABAPENTIN**	**TEV**	$	**0.1012**
00002084279	NEURONTIN	UJC	$	1.1418
400 MG ORAL CAPSULE				
00002477939	**AG-GABAPENTIN**	**AGP**	$	**0.1206**
00002244306	**APO-GABAPENTIN**	**APX**	$	**0.1206**
00002321238	**AURO-GABAPENTIN**	**AUR**	$	**0.1206**
00002246316	**GABAPENTIN**	**SIV**	$	**0.1206**
00002353261	**GABAPENTIN**	**SNS**	$	**0.1206**
00002416867	**GABAPENTIN**	**AHI**	$	**0.1206**
00002361493	**JAMP-GABAPENTIN**	**JPC**	$	**0.1206**
00002391503	**MAR-GABAPENTIN**	**MAR**	$	**0.1206**
00002243448	**PMS-GABAPENTIN**	**PMS**	$	**0.1206**
00002244515	**TEVA-GABAPENTIN**	**TEV**	$	**0.1206**
00002084287	NEURONTIN	UJC	$	1.3607

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

LAMOTRIGINE

25 MG ORAL TABLET				
00002245208	**APO-LAMOTRIGINE**	**APX**	$	**0.0698**
00002381354	**AURO-LAMOTRIGINE**	**AUR**	$	**0.0698**
00002343010	**LAMOTRIGINE**	**SNS**	$	**0.0698**
00002428202	**LAMOTRIGINE**	**SIV**	$	**0.0698**
00002265494	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.0698**
00002246897	**PMS-LAMOTRIGINE**	**PMS**	$	**0.0698**
00002142082	LAMICTAL	GSK	$	0.4157
100 MG ORAL TABLET				
00002245209	**APO-LAMOTRIGINE**	**APX**	$	**0.2787**
00002381362	**AURO-LAMOTRIGINE**	**AUR**	$	**0.2787**
00002343029	**LAMOTRIGINE**	**SNS**	$	**0.2787**
00002428210	**LAMOTRIGINE**	**SIV**	$	**0.2787**
00002265508	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.2787**
00002246898	**PMS-LAMOTRIGINE**	**PMS**	$	**0.2787**
00002142104	LAMICTAL	GSK	$	1.6597
150 MG ORAL TABLET				
00002245210	**APO-LAMOTRIGINE**	**APX**	$	**0.4107**
00002381370	**AURO-LAMOTRIGINE**	**AUR**	$	**0.4107**
00002343037	**LAMOTRIGINE**	**SNS**	$	**0.4107**
00002428229	**LAMOTRIGINE**	**SIV**	$	**0.4107**
00002265516	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.4107**
00002246899	**PMS-LAMOTRIGINE**	**PMS**	$	**0.4107**
00002142112	LAMICTAL	GSK	$	2.4461
5 MG ORAL CHEWABLE TABLET				
00002240115	LAMICTAL	GSK	$	0.1770

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

LEVETIRACETAM

250 MG ORAL TABLET				
00002274183	**ACT LEVETIRACETAM**	**APH**	$	**0.3210**
00002285924	**APO-LEVETIRACETAM**	**APX**	$	**0.3210**
00002375249	**AURO-LEVETIRACETAM**	**AUR**	$	**0.3210**
00002403005	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.3210**
00002353342	**LEVETIRACETAM**	**SNS**	$	**0.3210**
00002399776	**LEVETIRACETAM**	**AHI**	$	**0.3210**
00002442531	**LEVETIRACETAM**	**SIV**	$	**0.3210**
00002454653	**LEVETIRACETAM**	**PMS**	$	**0.3210**
00002440202	**NAT-LEVETIRACETAM**	**NTP**	$	**0.3210**
00002482274	**RIVA-LEVETIRACETAM**	**RIV**	$	**0.3210**
00002461986	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.3210**
00002247027	KEPPRA	UCB	$	1.7252
500 MG ORAL TABLET				
00002274191	**ACT LEVETIRACETAM**	**APH**	$	**0.3911**
00002285932	**APO-LEVETIRACETAM**	**APX**	$	**0.3911**
00002375257	**AURO-LEVETIRACETAM**	**AUR**	$	**0.3911**
00002403021	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.3911**
00002353350	**LEVETIRACETAM**	**SNS**	$	**0.3911**
00002399784	**LEVETIRACETAM**	**AHI**	$	**0.3911**
00002442558	**LEVETIRACETAM**	**SIV**	$	**0.3911**
00002454661	**LEVETIRACETAM**	**PMS**	$	**0.3911**
00002440210	**NAT-LEVETIRACETAM**	**NTP**	$	**0.3911**
00002482282	**RIVA-LEVETIRACETAM**	**RIV**	$	**0.3911**
00002461994	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.3911**
00002247028	KEPPRA	UCB	$	2.1213
750 MG ORAL TABLET				
00002274205	**ACT LEVETIRACETAM**	**APH**	$	**0.5416**
00002285940	**APO-LEVETIRACETAM**	**APX**	$	**0.5416**
00002375265	**AURO-LEVETIRACETAM**	**AUR**	$	**0.5416**
00002403048	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.5416**
00002353369	**LEVETIRACETAM**	**SNS**	$	**0.5416**
00002399792	**LEVETIRACETAM**	**AHI**	$	**0.5416**
00002442566	**LEVETIRACETAM**	**SIV**	$	**0.5416**
00002454688	**LEVETIRACETAM**	**PMS**	$	**0.5416**
00002440229	**NAT-LEVETIRACETAM**	**NTP**	$	**0.5416**
00002482290	**RIVA-LEVETIRACETAM**	**RIV**	$	**0.5416**
00002462001	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.5416**
00002247029	KEPPRA	UCB	$	2.9371
1,000 MG ORAL TABLET				
00002462028	SANDOZ LEVETIRACETAM	SDZ	$	0.7221

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

PREGABALIN

25 MG ORAL CAPSULE

00002480727	AG-PREGABALIN	AGP	$	0.1481
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

00002480735	AG-PREGABALIN	AGP	$	0.2324
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

00002480743	AG-PREGABALIN	AGP	$	0.3007
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

00002480751	AG-PREGABALIN	AGP	$	0.4145
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

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

PREGABALIN

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**

TOPIRAMATE

25 MG ORAL TABLET

00002475936	**AG-TOPIRAMATE**	**AGP**	$	**0.2433**
00002279614	**APO-TOPIRAMATE**	**APX**	$	**0.2433**
00002345803	**AURO-TOPIRAMATE**	**AUR**	$	**0.2433**
00002435608	**JAMP-TOPIRAMATE**	**JPC**	$	**0.2433**
00002315645	**MINT-TOPIRAMATE**	**MPI**	$	**0.2433**
00002263351	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.2433**
00002262991	**PMS-TOPIRAMATE**	**PMS**	$	**0.2433**
00002431807	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.2433**
00002248860	**TEVA-TOPIRAMATE**	**TEV**	$	**0.2433**
00002356856	**TOPIRAMATE**	**SNS**	$	**0.2433**
00002389460	**TOPIRAMATE**	**SIV**	$	**0.2433**
00002395738	**TOPIRAMATE**	**AHI**	$	**0.2433**
00002230893	TOPAMAX	JAI	$	1.5550

50 MG ORAL TABLET

00002312085	PMS-TOPIRAMATE	PMS	$	1.2434

100 MG ORAL TABLET

00002475944	**AG-TOPIRAMATE**	**AGP**	$	**0.4583**
00002279630	**APO-TOPIRAMATE**	**APX**	$	**0.4583**
00002345838	**AURO-TOPIRAMATE**	**AUR**	$	**0.4583**
00002435616	**JAMP-TOPIRAMATE**	**JPC**	$	**0.4583**
00002315653	**MINT-TOPIRAMATE**	**MPI**	$	**0.4583**
00002263378	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.4583**
00002263009	**PMS-TOPIRAMATE**	**PMS**	$	**0.4583**
00002431815	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.4583**
00002248861	**TEVA-TOPIRAMATE**	**TEV**	$	**0.4583**
00002356864	**TOPIRAMATE**	**SNS**	$	**0.4583**
00002389487	**TOPIRAMATE**	**SIV**	$	**0.4583**
00002395746	**TOPIRAMATE**	**AHI**	$	**0.4583**
00002230894	TOPAMAX	JAI	$	2.9200

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS
(MISCELLANEOUS ANTICONVULSANTS)

TOPIRAMATE

200 MG ORAL TABLET				
00002279649	**APO-TOPIRAMATE**	**APX**	$	**0.6748**
00002345846	**AURO-TOPIRAMATE**	**AUR**	$	**0.6748**
00002435624	**JAMP-TOPIRAMATE**	**JPC**	$	**0.6748**
00002315661	**MINT-TOPIRAMATE**	**MPI**	$	**0.6748**
00002263386	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.6748**
00002263017	**PMS-TOPIRAMATE**	**PMS**	$	**0.6748**
00002431823	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.6748**
00002248862	**TEVA-TOPIRAMATE**	**TEV**	$	**0.6748**
00002356872	**TOPIRAMATE**	**SNS**	$	**0.6748**
00002395754	**TOPIRAMATE**	**AHI**	$	**0.6748**
00002230896	TOPAMAX	JAI	$	4.3100
15 MG ORAL CAPSULE				
00002239907	TOPAMAX SPRINKLE	JAI	$	1.4550
25 MG ORAL CAPSULE				
00002239908	TOPAMAX SPRINKLE	JAI	$	1.5320

VALPROIC ACID

250 MG ORAL CAPSULE				
00002238048	**APO-VALPROIC**	**APX**	$	**0.2905**
00002230768	**PMS-VALPROIC ACID**	**PMS**	$	**0.2905**
500 MG ORAL ENTERIC-COATED CAPSULE				
00002229628	PMS-VALPROIC ACID E.C.	PMS	$	0.8102
50 MG / ML ORAL SYRUP				
00002238370	**APO-VALPROIC**	**APX**	$	**0.0605**
00002236807	**PMS-VALPROIC ACID**	**PMS**	$	**0.0605**
00000443832	DEPAKENE	BGP	$	0.1235

VIGABATRIN

500 MG ORAL TABLET				
00002065819	SABRIL	LUI	$	0.9566
500 MG ORAL POWDER PACKET				
00002068036	SABRIL	LUI	$	0.9566

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.12 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MONOAMINE OXIDASE INHIBITORS)

MOCLOBEMIDE

100 MG ORAL TABLET				
00002232148	MOCLOBEMIDE	AAP	$	0.3482
150 MG ORAL TABLET				
00002232150	MOCLOBEMIDE	AAP	$	0.5295
300 MG ORAL TABLET				
00002240456	MOCLOBEMIDE	AAP	$	1.0399

PHENELZINE SULFATE

15 MG (BASE) ORAL TABLET				
☒ 00000476552	NARDIL	ERF	$	0.3888

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.12 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MONOAMINE OXIDASE INHIBITORS)

TRANYLCYPROMINE SULFATE

10 MG (BASE) ORAL TABLET				
00001919598	PARNATE	GSK	$	0.4158

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.16 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE SEROTONIN- AND NOREPINEPHRINE-REUPTAKE INHIBITORS)

DULOXETINE HYDROCHLORIDE

30 MG (BASE) ORAL DELAYED-RELEASE CAPSULE				
00002475308	**AG-DULOXETINE**	**AGP**	$	**0.4814**
00002440423	**APO-DULOXETINE**	**APX**	$	**0.4814**
00002436647	**AURO-DULOXETINE**	**AUR**	$	**0.4814**
00002453630	**DULOXETINE**	**SIV**	$	**0.4814**
00002490889	**DULOXETINE**	**SNS**	$	**0.4814**
00002451913	**JAMP-DULOXETINE**	**JPC**	$	**0.4814**
00002446081	**MAR-DULOXETINE**	**MAR**	$	**0.4814**
00002438984	**MINT-DULOXETINE**	**MPI**	$	**0.4814**
00002482126	**NRA-DULOXETINE**	**NRA**	$	**0.4814**
00002429446	**PMS-DULOXETINE**	**PMS**	$	**0.4814**
00002438259	**RAN-DULOXETINE**	**RAN**	$	**0.4814**
00002439948	**SANDOZ DULOXETINE**	**SDZ**	$	**0.4814**
00002456753	**TEVA-DULOXETINE**	**TEV**	$	**0.4814**
00002301482	CYMBALTA	LIL	$	2.0640
60 MG (BASE) ORAL DELAYED-RELEASE CAPSULE				
00002475316	**AG-DULOXETINE**	**AGP**	$	**0.9769**
00002440431	**APO-DULOXETINE**	**APX**	$	**0.9769**
00002436655	**AURO-DULOXETINE**	**AUR**	$	**0.9769**
00002453649	**DULOXETINE**	**SIV**	$	**0.9769**
00002490897	**DULOXETINE**	**SNS**	$	**0.9769**
00002451921	**JAMP-DULOXETINE**	**JPC**	$	**0.9769**
00002446103	**MAR-DULOXETINE**	**MAR**	$	**0.9769**
00002438992	**MINT-DULOXETINE**	**MPI**	$	**0.9769**
00002482134	**NRA-DULOXETINE**	**NRA**	$	**0.9769**
00002429454	**PMS-DULOXETINE**	**PMS**	$	**0.9769**
00002438267	**RAN-DULOXETINE**	**RAN**	$	**0.9769**
00002439956	**SANDOZ DULOXETINE**	**SDZ**	$	**0.9769**
00002456761	**TEVA-DULOXETINE**	**TEV**	$	**0.9769**
00002301490	CYMBALTA	LIL	$	4.1890

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				
00002304317	**ACT VENLAFAXINE XR**	**TEV**	$	**0.0913**
00002331683	**APO-VENLAFAXINE XR**	**APX**	$	**0.0913**
00002452839	**AURO-VENLAFAXINE XR**	**AUR**	$	**0.0913**
00002278545	**PMS-VENLAFAXINE XR**	**PMS**	$	**0.0913**
00002380072	**RAN-VENLAFAXINE XR**	**RAN**	$	**0.0913**
00002310317	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**0.0913**
00002275023	**TEVA-VENLAFAXINE XR**	**TEV**	$	**0.0913**
00002354713	**VENLAFAXINE XR**	**SNS**	$	**0.0913**
00002385929	**VENLAFAXINE XR**	**SIV**	$	**0.0913**
00002237279	EFFEXOR XR	UJC	$	1.0159
75 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002304325	**ACT VENLAFAXINE XR**	**TEV**	$	**0.1825**
00002331691	**APO-VENLAFAXINE XR**	**APX**	$	**0.1825**
00002452847	**AURO-VENLAFAXINE XR**	**AUR**	$	**0.1825**
00002278553	**PMS-VENLAFAXINE XR**	**PMS**	$	**0.1825**
00002380080	**RAN-VENLAFAXINE XR**	**RAN**	$	**0.1825**
00002310325	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**0.1825**
00002354721	**VENLAFAXINE XR**	**SNS**	$	**0.1825**
00002385937	**VENLAFAXINE XR**	**SIV**	$	**0.1825**
00002237280	EFFEXOR XR	UJC	$	2.0410
150 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002304333	**ACT VENLAFAXINE XR**	**TEV**	$	**0.1927**
00002331705	**APO-VENLAFAXINE XR**	**APX**	$	**0.1927**
00002452855	**AURO-VENLAFAXINE XR**	**AUR**	$	**0.1927**
00002278561	**PMS-VENLAFAXINE XR**	**PMS**	$	**0.1927**
00002380099	**RAN-VENLAFAXINE XR**	**RAN**	$	**0.1927**
00002310333	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**0.1927**
00002275058	**TEVA-VENLAFAXINE XR**	**TEV**	$	**0.1927**
00002354748	**VENLAFAXINE XR**	**SNS**	$	**0.1927**
00002385945	**VENLAFAXINE XR**	**SIV**	$	**0.1927**
00002237282	EFFEXOR XR	UJC	$	2.1547

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

CITALOPRAM HYDROBROMIDE

10 MG (BASE) ORAL TABLET				
00002387948	**CITALOPRAM**	**SIV**	$	**0.0796**
00002430517	**CITALOPRAM**	**JPC**	$	**0.0796**
00002445719	**CITALOPRAM**	**SNS**	$	**0.0796**
00002371871	**MAR-CITALOPRAM**	**MAR**	$	**0.0796**
00002429691	**MINT-CITALOPRAM**	**MPI**	$	**0.0796**
00002409003	**NAT-CITALOPRAM**	**NTP**	$	**0.0796**
00002270609	**PMS-CITALOPRAM**	**PMS**	$	**0.0796**
00002312336	**TEVA-CITALOPRAM**	**TEV**	$	**0.0796**
20 MG (BASE) ORAL TABLET				
00002246056	**APO-CITALOPRAM**	**APX**	$	**0.1332**
00002275562	**AURO-CITALOPRAM**	**AUR**	$	**0.1332**
00002459914	**CCP-CITALOPRAM**	**CEL**	$	**0.1332**
00002353660	**CITALOPRAM**	**SNS**	$	**0.1332**
00002387956	**CITALOPRAM**	**SIV**	$	**0.1332**
00002430541	**CITALOPRAM**	**JPC**	$	**0.1332**
00002371898	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429705	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409011	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002248010	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002285622	**RAN-CITALO**	**RAN**	$	**0.1332**
00002248170	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.1332**
00002355272	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293218	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239607	CELEXA	LBC	$	1.4654
30 MG (BASE) ORAL TABLET				
00002296152	CTP 30	SUN	$	0.8961
40 MG (BASE) ORAL TABLET				
00002246057	**APO-CITALOPRAM**	**APX**	$	**0.1332**
00002275570	**AURO-CITALOPRAM**	**AUR**	$	**0.1332**
00002459922	**CCP-CITALOPRAM**	**CEL**	$	**0.1332**
00002353679	**CITALOPRAM**	**SNS**	$	**0.1332**
00002387964	**CITALOPRAM**	**SIV**	$	**0.1332**
00002430568	**CITALOPRAM**	**JPC**	$	**0.1332**
00002371901	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429713	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409038	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002248011	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002248171	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.1332**
00002355280	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293226	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239608	CELEXA	LBC	$	1.4654

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

ESCITALOPRAM

10 MG ORAL TABLET

00002434652	**ACH-ESCITALOPRAM**	**AHI**	$	**0.3109**
00002295016	**APO-ESCITALOPRAM**	**APX**	$	**0.3109**
00002397358	**AURO-ESCITALOPRAM**	**AUR**	$	**0.3109**
00002429039	**ESCITALOPRAM**	**SIV**	$	**0.3109**
00002430118	**ESCITALOPRAM**	**SNS**	$	**0.3109**
00002429780	**JAMP-ESCITALOPRAM**	**JPC**	$	**0.3109**
00002423480	**MAR-ESCITALOPRAM**	**MAR**	$	**0.3109**
00002407418	**MINT-ESCITALOPRAM**	**MPI**	$	**0.3109**
00002309467	**MYLAN-ESCITALOPRAM**	**MYP**	$	**0.3109**
00002440296	**NAT-ESCITALOPRAM**	**NTP**	$	**0.3109**
00002476851	**NRA-ESCITALOPRAM**	**NRA**	$	**0.3109**
00002469243	**PHARMA-ESCITALOPRAM**	**PMS**	$	**0.3109**
00002303949	**PMS-ESCITALOPRAM**	**PMS**	$	**0.3109**
00002385481	**RAN-ESCITALOPRAM**	**RAN**	$	**0.3109**
00002364077	**SANDOZ ESCITALOPRAM**	**SDZ**	$	**0.3109**
00002318180	**TEVA-ESCITALOPRAM**	**TEV**	$	**0.3109**
00002263238	CIPRALEX	LBC	$	1.8795

20 MG ORAL TABLET

00002434660	**ACH-ESCITALOPRAM**	**AHI**	$	**0.3310**
00002295024	**APO-ESCITALOPRAM**	**APX**	$	**0.3310**
00002397374	**AURO-ESCITALOPRAM**	**AUR**	$	**0.3310**
00002429047	**ESCITALOPRAM**	**SIV**	$	**0.3310**
00002430126	**ESCITALOPRAM**	**SNS**	$	**0.3310**
00002429799	**JAMP-ESCITALOPRAM**	**JPC**	$	**0.3310**
00002423502	**MAR-ESCITALOPRAM**	**MAR**	$	**0.3310**
00002407434	**MINT-ESCITALOPRAM**	**MPI**	$	**0.3310**
00002309475	**MYLAN-ESCITALOPRAM**	**MYP**	$	**0.3310**
00002440318	**NAT-ESCITALOPRAM**	**NTP**	$	**0.3310**
00002476878	**NRA-ESCITALOPRAM**	**NRA**	$	**0.3310**
00002469251	**PHARMA-ESCITALOPRAM**	**PMS**	$	**0.3310**
00002303965	**PMS-ESCITALOPRAM**	**PMS**	$	**0.3310**
00002385503	**RAN-ESCITALOPRAM**	**RAN**	$	**0.3310**
00002364085	**SANDOZ ESCITALOPRAM**	**SDZ**	$	**0.3310**
00002318202	**TEVA-ESCITALOPRAM**	**TEV**	$	**0.3310**
00002263254	CIPRALEX	LBC	$	2.0067

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

FLUOXETINE HCL

10 MG (BASE) ORAL CAPSULE

00002485052	**AG-FLUOXETINE**	**AGP**	$	**0.3404**
00002216353	**APO-FLUOXETINE**	**APX**	$	**0.3404**
00002385627	**AURO-FLUOXETINE**	**AUR**	$	**0.3404**
00002286068	**FLUOXETINE**	**SNS**	$	**0.3404**
00002374447	**FLUOXETINE**	**SIV**	$	**0.3404**
00002393441	**FLUOXETINE BP**	**AHI**	$	**0.3404**
00002401894	**JAMP-FLUOXETINE**	**JPC**	$	**0.3404**
00002503875	**NRA-FLUOXETINE**	**NRA**	$	**0.3404**
00002177579	**PMS-FLUOXETINE**	**PMS**	$	**0.3404**
00002479486	**SANDOZ FLUOXETINE**	**SDZ**	$	**0.3404**
00002216582	**TEVA-FLUOXETINE**	**TEV**	$	**0.3404**
00002018985	PROZAC	LIL	$	1.9522

20 MG (BASE) ORAL CAPSULE

00002485060	**AG-FLUOXETINE**	**AGP**	$	**0.3311**
00002216361	**APO-FLUOXETINE**	**APX**	$	**0.3311**
00002385635	**AURO-FLUOXETINE**	**AUR**	$	**0.3311**
00002448432	**BIO-FLUOXETINE**	**BMD**	$	**0.3311**
00002286076	**FLUOXETINE**	**SNS**	$	**0.3311**
00002374455	**FLUOXETINE**	**SIV**	$	**0.3311**
00002383241	**FLUOXETINE BP**	**AHI**	$	**0.3311**
00002386402	**JAMP-FLUOXETINE**	**JPC**	$	**0.3311**
00002503883	**NRA-FLUOXETINE**	**NRA**	$	**0.3311**
00002177587	**PMS-FLUOXETINE**	**PMS**	$	**0.3311**
00002479494	**SANDOZ FLUOXETINE**	**SDZ**	$	**0.3311**
00002216590	**TEVA-FLUOXETINE**	**TEV**	$	**0.3311**
00000636622	PROZAC	LIL	$	1.9522

4 MG / ML (BASE) ORAL LIQUID

00002231328	**APO-FLUOXETINE**	**APX**	$	**0.3084**
00002459361	**ODAN-FLUOXETINE**	**ODN**	$	**0.3084**

FLUVOXAMINE MALEATE

50 MG ORAL TABLET

00002255529	**ACT FLUVOXAMINE**	**APH**	$	**0.2105**
00002231329	**APO-FLUVOXAMINE**	**APX**	$	**0.2105**
00001919342	LUVOX	BGP	$	0.9873

100 MG ORAL TABLET

00002255537	**ACT FLUVOXAMINE**	**APH**	$	**0.3783**
00002231330	**APO-FLUVOXAMINE**	**APX**	$	**0.3783**
00001919369	LUVOX	BGP	$	1.7753

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

PAROXETINE HCL

20 MG (BASE) ORAL TABLET

00002475545	**AG-PAROXETINE**	**AGP**	$	**0.3250**
00002240908	**APO-PAROXETINE**	**APX**	$	**0.3250**
00002383284	**AURO-PAROXETINE**	**AUR**	$	**0.3250**
00002368870	**JAMP-PAROXETINE**	**JPC**	$	**0.3250**
00002411954	**MAR-PAROXETINE**	**MAR**	$	**0.3250**
00002421380	**MINT-PAROXETINE**	**MPI**	$	**0.3250**
00002479761	**NRA-PAROXETINE**	**NRA**	$	**0.3250**
00002282852	**PAROXETINE**	**SNS**	$	**0.3250**
00002388235	**PAROXETINE**	**SIV**	$	**0.3250**
00002247751	**PMS-PAROXETINE**	**PMS**	$	**0.3250**
00002248557	**TEVA-PAROXETINE**	**TEV**	$	**0.3250**
00001940481	PAXIL	GSK	$	1.9357

30 MG (BASE) ORAL TABLET

00002475553	**AG-PAROXETINE**	**AGP**	$	**0.3453**
00002240909	**APO-PAROXETINE**	**APX**	$	**0.3453**
00002383292	**AURO-PAROXETINE**	**AUR**	$	**0.3453**
00002368889	**JAMP-PAROXETINE**	**JPC**	$	**0.3453**
00002411962	**MAR-PAROXETINE**	**MAR**	$	**0.3453**
00002421399	**MINT-PAROXETINE**	**MPI**	$	**0.3453**
00002479788	**NRA-PAROXETINE**	**NRA**	$	**0.3453**
00002282860	**PAROXETINE**	**SNS**	$	**0.3453**
00002388243	**PAROXETINE**	**SIV**	$	**0.3453**
00002247752	**PMS-PAROXETINE**	**PMS**	$	**0.3453**
00001940473	PAXIL	GSK	$	2.0562

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

SERTRALINE HCL

25 MG (BASE) ORAL CAPSULE				
00002477882	**AG-SERTRALINE**	**AGP**	$	**0.1516**
00002238280	**APO-SERTRALINE**	**APX**	$	**0.1516**
00002390906	**AURO-SERTRALINE**	**AUR**	$	**0.1516**
00002357143	**JAMP-SERTRALINE**	**JPC**	$	**0.1516**
00002399415	**MAR-SERTRALINE**	**MAR**	$	**0.1516**
00002402378	**MINT-SERTRALINE**	**MPI**	$	**0.1516**
00002244838	**PMS-SERTRALINE**	**PMS**	$	**0.1516**
00002245159	**SANDOZ SERTRALINE**	**SDZ**	$	**0.1516**
00002353520	**SERTRALINE**	**SNS**	$	**0.1516**
00002386070	**SERTRALINE**	**SIV**	$	**0.1516**
00002469626	**SERTRALINE**	**JPC**	$	**0.1516**
00002240485	**TEVA-SERTRALINE**	**TEV**	$	**0.1516**
00002132702	ZOLOFT	UJC	$	0.8937
50 MG (BASE) ORAL CAPSULE				
00002477890	**AG-SERTRALINE**	**AGP**	$	**0.3032**
00002238281	**APO-SERTRALINE**	**APX**	$	**0.3032**
00002390914	**AURO-SERTRALINE**	**AUR**	$	**0.3032**
00002357151	**JAMP-SERTRALINE**	**JPC**	$	**0.3032**
00002399423	**MAR-SERTRALINE**	**MAR**	$	**0.3032**
00002402394	**MINT-SERTRALINE**	**MPI**	$	**0.3032**
00002244839	**PMS-SERTRALINE**	**PMS**	$	**0.3032**
00002245160	**SANDOZ SERTRALINE**	**SDZ**	$	**0.3032**
00002353539	**SERTRALINE**	**SNS**	$	**0.3032**
00002386089	**SERTRALINE**	**SIV**	$	**0.3032**
00002469634	**SERTRALINE**	**JPC**	$	**0.3032**
00002240484	**TEVA-SERTRALINE**	**TEV**	$	**0.3032**
00001962817	ZOLOFT	UJC	$	1.7872
100 MG (BASE) ORAL CAPSULE				
00002477904	**AG-SERTRALINE**	**AGP**	$	**0.3303**
00002238282	**APO-SERTRALINE**	**APX**	$	**0.3303**
00002390922	**AURO-SERTRALINE**	**AUR**	$	**0.3303**
00002357178	**JAMP-SERTRALINE**	**JPC**	$	**0.3303**
00002399431	**MAR-SERTRALINE**	**MAR**	$	**0.3303**
00002402408	**MINT-SERTRALINE**	**MPI**	$	**0.3303**
00002244840	**PMS-SERTRALINE**	**PMS**	$	**0.3303**
00002245161	**SANDOZ SERTRALINE**	**SDZ**	$	**0.3303**
00002353547	**SERTRALINE**	**SNS**	$	**0.3303**
00002386097	**SERTRALINE**	**SIV**	$	**0.3303**
00002469642	**SERTRALINE**	**JPC**	$	**0.3303**
00002240481	**TEVA-SERTRALINE**	**TEV**	$	**0.3303**
00001962779	ZOLOFT	UJC	$	1.9010

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**	$	**0.0554**
00001937227	**PMS-TRAZODONE**	**PMS**	$	**0.0554**
00002144263	**TEVA-TRAZODONE**	**TEV**	$	**0.0554**
00002348772	**TRAZODONE**	**SNS**	$	**0.0554**
75 MG ORAL TABLET				
00002237339	PMS-TRAZODONE	PMS	$	0.4422
100 MG ORAL TABLET				
00002147645	**APO-TRAZODONE**	**APX**	$	**0.0989**
00001937235	**PMS-TRAZODONE**	**PMS**	$	**0.0989**
00002144271	**TEVA-TRAZODONE**	**TEV**	$	**0.0989**
00002348780	**TRAZODONE**	**SNS**	$	**0.0989**
150 MG ORAL TABLET				
00002147653	**APO-TRAZODONE D**	**APX**	$	**0.1453**
00002144298	**TEVA-TRAZODONE**	**TEV**	$	**0.1453**
00002348799	**TRAZODONE**	**SNS**	$	**0.1453**

VORTIOXETINE HYDROBROMIDE

5 MG ORAL TABLET				
00002432919	TRINTELLIX	LBC	$	2.8824
10 MG ORAL TABLET				
00002432927	TRINTELLIX	LBC	$	3.0192
20 MG ORAL TABLET				
00002432943	TRINTELLIX	LBC	$	3.2779

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				
00002403137	**APO-AMITRIPTYLINE**	**APX**	$	**0.0664**
00000335053	**ELAVIL**	**AAP**	$	**0.0664**
25 MG ORAL TABLET				
00002403145	**APO-AMITRIPTYLINE**	**APX**	$	**0.1211**
00000335061	**ELAVIL**	**AAP**	$	**0.1211**
50 MG ORAL TABLET				
00002403153	**APO-AMITRIPTYLINE**	**APX**	$	**0.2347**
00000335088	**ELAVIL**	**AAP**	$	**0.2347**
75 MG ORAL TABLET				
00002403161	**APO-AMITRIPTYLINE**	**APX**	$	**0.3634**
00000754129	**ELAVIL**	**AAP**	$	**0.3634**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.28 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(TRICYCLICS AND OTHER NOREPINEPHRINE-REUPTAKE INHIBITORS)

CLOMIPRAMINE HCL

10 MG ORAL TABLET				
00000330566	ANAFRANIL	APX	$	0.3191
25 MG ORAL TABLET				
00000324019	ANAFRANIL	APX	$	0.4349
50 MG ORAL TABLET				
00000402591	ANAFRANIL	APX	$	0.8008
25 MG ORAL CAPSULE				
00002497506	TARO-CLOMIPRAMINE	TAR	$	0.3417
50 MG ORAL CAPSULE				
00002497514	TARO-CLOMIPRAMINE	TAR	$	0.6291

DESIPRAMINE HCL

10 MG ORAL TABLET				
00002216248	DESIPRAMINE	AAP	$	0.4345
25 MG ORAL TABLET				
00002216256	DESIPRAMINE	AAP	$	0.4345
50 MG ORAL TABLET				
00002216264	DESIPRAMINE	AAP	$	0.7659
75 MG ORAL TABLET				
00002216272	DESIPRAMINE	AAP	$	1.0184

IMIPRAMINE HCL

10 MG ORAL TABLET				
00000360201	IMIPRAMINE	AAP	$	0.1564
25 MG ORAL TABLET				
00000312797	IMIPRAMINE	AAP	$	0.2822
50 MG ORAL TABLET				
00000326852	IMIPRAMINE	AAP	$	0.5508
75 MG ORAL TABLET				
00000644579	IMIPRAMINE	AAP	$	0.7206

NORTRIPTYLINE HCL

10 MG (BASE) ORAL CAPSULE				
00000015229	AVENTYL	AAP	$	0.2819
25 MG (BASE) ORAL CAPSULE				
00000015237	AVENTYL	AAP	$	0.5697

TRIMIPRAMINE MALEATE

12.5 MG (BASE) ORAL TABLET				
00000740799	TRIMIPRAMINE	AAP	$	0.2462
25 MG (BASE) ORAL TABLET				
00000740802	TRIMIPRAMINE	AAP	$	0.3171
50 MG (BASE) ORAL TABLET				
00000740810	TRIMIPRAMINE	AAP	$	0.6208
100 MG (BASE) ORAL TABLET				
00000740829	TRIMIPRAMINE	AAP	$	1.0593
75 MG (BASE) ORAL CAPSULE				
00002070987	TRIMIPRAMINE	AAP	$	0.8356

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.92 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MISCELLANEOUS ANTIDEPRESSANTS)

BUPROPION HCL

100 MG ORAL SUSTAINED-RELEASE TABLET				
00002391562	**BUPROPION SR**	**SNS**	$	**0.1547**
00002275074	**SANDOZ BUPROPION SR**	**SDZ**	$	**0.1547**
150 MG ORAL SUSTAINED-RELEASE TABLET				
00002391570	**BUPROPION SR**	**SNS**	$	**0.2297**
00002275082	**SANDOZ BUPROPION SR**	**SDZ**	$	**0.2297**
150 MG ORAL EXTENDED-RELEASE TABLET				
00002439654	**ACT BUPROPION XL**	**APH**	$	**0.1463**
00002382075	**MYLAN-BUPROPION XL**	**MYP**	$	**0.1463**
00002475804	**RAN-BUPROPION XL**	**RAN**	$	**0.1463**
00002275090	WELLBUTRIN XL	VCL	$	0.5883
300 MG ORAL EXTENDED-RELEASE TABLET				
00002439662	**ACT BUPROPION XL**	**APH**	$	**0.2927**
00002382083	**MYLAN-BUPROPION XL**	**MYP**	$	**0.2927**
00002475812	**RAN-BUPROPION XL**	**RAN**	$	**0.2927**
00002275104	WELLBUTRIN XL	VCL	$	1.1769

L-TRYPTOPHAN

250 MG ORAL TABLET				
00002239326	TRYPTAN	VCL	$	0.4070
500 MG ORAL TABLET				
00002248538	**APO-TRYPTOPHAN**	**APX**	$	**0.3563**
00002240333	**TEVA-TRYPTOPHAN**	**TEV**	$	**0.3563**
00002029456	TRYPTAN	VCL	$	0.8143
750 MG ORAL TABLET				
00002458721	**APO-TRYPTOPHAN**	**APX**	$	**0.9889**
00002239327	TRYPTAN	VCL	$	1.1999
1 G ORAL TABLET				
00002248539	**APO-TRYPTOPHAN**	**APX**	$	**0.7126**
00002237250	**TEVA-TRYPTOPHAN**	**TEV**	$	**0.7126**
00000654531	TRYPTAN	VCL	$	1.6363
500 MG ORAL CAPSULE				
00002248540	**APO-TRYPTOPHAN**	**APX**	$	**0.3955**
00002240334	**TEVA-TRYPTOPHAN**	**TEV**	$	**0.3955**
00000718149	TRYPTAN	VCL	$	0.8143

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.92 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MISCELLANEOUS ANTIDEPRESSANTS)

MIRTAZAPINE

15 MG ORAL TABLET				
00002411695	**AURO-MIRTAZAPINE**	**AUR**	$	**0.0974**
00002496666	**MIRTAZAPINE**	**SIV**	$	**0.0974**
00002256096	**MYLAN-MIRTAZAPINE**	**MYP**	$	**0.0974**
00002273942	**PMS-MIRTAZAPINE**	**PMS**	$	**0.0974**
30 MG ORAL TABLET				
00002286629	**APO-MIRTAZAPINE**	**APX**	$	**0.1950**
00002411709	**AURO-MIRTAZAPINE**	**AUR**	$	**0.1950**
00002370689	**MIRTAZAPINE**	**SNS**	$	**0.1950**
00002496674	**MIRTAZAPINE**	**SIV**	$	**0.1950**
00002256118	**MYLAN-MIRTAZAPINE**	**MYP**	$	**0.1950**
00002248762	**PMS-MIRTAZAPINE**	**PMS**	$	**0.1950**
00002250608	**SANDOZ MIRTAZAPINE**	**SDZ**	$	**0.1950**
00002259354	**TEVA-MIRTAZAPINE**	**TEV**	$	**0.1950**
00002243910	REMERON	MFC	$	1.4662
45 MG ORAL TABLET				
00002256126	MYLAN-MIRTAZAPINE	MYP	$	1.1576

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

ARIPIPRAZOLE

2 MG ORAL TABLET				
00002471086	**APO-ARIPIPRAZOLE**	**APX**	$	**0.8092**
00002460025	**AURO-ARIPIPRAZOLE**	**AUR**	$	**0.8092**
00002483556	**MINT-ARIPIPRAZOLE**	**MPI**	$	**0.8092**
00002466635	**PMS-ARIPIPRAZOLE**	**PMS**	$	**0.8092**
00002473658	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**0.8092**
00002322374	ABILIFY	OTS	$	3.1618

ALBERTA HEALTH RESTRICTED BENEFIT

This Drug Product is a benefit for patients 13 to 17 years of age inclusive.

5 MG ORAL TABLET				
00002471094	**APO-ARIPIPRAZOLE**	**APX**	$	**0.9046**
00002460033	**AURO-ARIPIPRAZOLE**	**AUR**	$	**0.9046**
00002483564	**MINT-ARIPIPRAZOLE**	**MPI**	$	**0.9046**
00002466643	**PMS-ARIPIPRAZOLE**	**PMS**	$	**0.9046**
00002473666	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**0.9046**
00002322382	ABILIFY	OTS	$	3.5591

ALBERTA HEALTH RESTRICTED BENEFIT

This Drug Product is a benefit for patients 13 to 17 years of age inclusive.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

ARIPIPRAZOLE

10 MG ORAL TABLET				
00002471108	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0754**
00002460041	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0754**
00002483572	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.0754**
00002466651	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0754**
00002473674	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0754**
00002322390	ABILIFY	OTS	$	4.1016
15 MG ORAL TABLET				
00002471116	**APO-ARIPIPRAZOLE**	**APX**	$	**1.2692**
00002460068	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.2692**
00002483580	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.2692**
00002466678	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.2692**
00002473682	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.2692**
00002322404	ABILIFY	OTS	$	4.1016
20 MG ORAL TABLET				
00002471124	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0017**
00002460076	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0017**
00002483599	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.0017**
00002466686	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0017**
00002473690	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0017**
00002322412	ABILIFY	OTS	$	4.1016
30 MG ORAL TABLET				
00002471132	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0017**
00002460084	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0017**
00002483602	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.0017**
00002466694	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0017**
00002473704	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0017**
00002322455	ABILIFY	OTS	$	4.1016

BREXPIPRAZOLE

0.25 MG ORAL TABLET				
00002461749	REXULTI	OTS	$	3.5000
0.5 MG ORAL TABLET				
00002461757	REXULTI	OTS	$	3.5000
1 MG ORAL TABLET				
00002461765	REXULTI	OTS	$	3.5000
2 MG ORAL TABLET				
00002461773	REXULTI	OTS	$	3.5000
3 MG ORAL TABLET				
00002461781	REXULTI	OTS	$	3.5000
4 MG ORAL TABLET				
00002461803	REXULTI	OTS	$	3.5000

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

CLOZAPINE

25 MG ORAL TABLET

00002248034	**AA-CLOZAPINE**	**AAP**	$	**0.6594**
00002247243	**GEN-CLOZAPINE**	**MYP**	$	**0.6594**
00000894737	CLOZARIL	HLS	$	0.9420

50 MG ORAL TABLET

00002458748	**AA-CLOZAPINE**	**AAP**	$	**1.3188**
00002305003	**GEN-CLOZAPINE**	**MYP**	$	**1.3188**
00002490668	CLOZARIL	HLS	$	1.8840

100 MG ORAL TABLET

00002248035	**AA-CLOZAPINE**	**AAP**	$	**2.6446**
00002247244	**GEN-CLOZAPINE**	**MYP**	$	**2.6446**
00000894745	CLOZARIL	HLS	$	3.7780

200 MG ORAL TABLET

00002458756	**AA-CLOZAPINE**	**AAP**	$	**5.2892**
00002305011	**GEN-CLOZAPINE**	**MYP**	$	**5.2892**
00002490676	CLOZARIL	HLS	$	7.5560

LURASIDONE HCL

20 MG ORAL TABLET

00002422050	LATUDA	SUN	$	4.2500

40 MG ORAL TABLET

00002387751	LATUDA	SUN	$	4.2500

60 MG ORAL TABLET

00002413361	LATUDA	SUN	$	4.2500

80 MG ORAL TABLET

00002387778	LATUDA	SUN	$	4.2500

120 MG ORAL TABLET

00002387786	LATUDA	SUN	$	4.2500

OLANZAPINE

2.5 MG ORAL TABLET

00002281791	**APO-OLANZAPINE**	**APX**	$	**0.1772**
00002417243	**JAMP OLANZAPINE FC**	**JPC**	$	**0.1772**
00002410141	**MINT-OLANZAPINE**	**MPI**	$	**0.1772**
00002372819	**OLANZAPINE**	**SNS**	$	**0.1772**
00002385864	**OLANZAPINE**	**SIV**	$	**0.1772**
00002303116	**PMS-OLANZAPINE**	**PMS**	$	**0.1772**
00002310341	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.1772**
00002276712	**TEVA-OLANZAPINE**	**TEV**	$	**0.1772**
00002229250	ZYPREXA	LIL	$	1.9361

5 MG ORAL TABLET

00002281805	**APO-OLANZAPINE**	**APX**	$	**0.3544**
00002417251	**JAMP OLANZAPINE FC**	**JPC**	$	**0.3544**
00002410168	**MINT-OLANZAPINE**	**MPI**	$	**0.3544**
00002372827	**OLANZAPINE**	**SNS**	$	**0.3544**
00002385872	**OLANZAPINE**	**SIV**	$	**0.3544**
00002303159	**PMS-OLANZAPINE**	**PMS**	$	**0.3544**
00002310368	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.3544**
00002276720	**TEVA-OLANZAPINE**	**TEV**	$	**0.3544**
00002229269	ZYPREXA	LIL	$	3.8081

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**	$	**0.5316**
00002417278	**JAMP OLANZAPINE FC**	**JPC**	$	**0.5316**
00002410176	**MINT-OLANZAPINE**	**MPI**	$	**0.5316**
00002372835	**OLANZAPINE**	**SNS**	$	**0.5316**
00002385880	**OLANZAPINE**	**SIV**	$	**0.5316**
00002303167	**PMS-OLANZAPINE**	**PMS**	$	**0.5316**
00002310376	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.5316**
00002276739	**TEVA-OLANZAPINE**	**TEV**	$	**0.5316**
00002229277	ZYPREXA	LIL	$	5.7120

10 MG (BASE) ORAL TABLET

00002281821	**APO-OLANZAPINE**	**APX**	$	**0.7088**
00002417286	**JAMP OLANZAPINE FC**	**JPC**	$	**0.7088**
00002410184	**MINT-OLANZAPINE**	**MPI**	$	**0.7088**
00002372843	**OLANZAPINE**	**SNS**	$	**0.7088**
00002385899	**OLANZAPINE**	**SIV**	$	**0.7088**
00002303175	**PMS-OLANZAPINE**	**PMS**	$	**0.7088**
00002310384	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.7088**
00002276747	**TEVA-OLANZAPINE**	**TEV**	$	**0.7088**
00002229285	ZYPREXA	LIL	$	7.6163

15 MG ORAL TABLET

00002281848	**APO-OLANZAPINE**	**APX**	$	**1.0631**
00002417294	**JAMP OLANZAPINE FC**	**JPC**	$	**1.0631**
00002410192	**MINT-OLANZAPINE**	**MPI**	$	**1.0631**
00002372851	**OLANZAPINE**	**SNS**	$	**1.0631**
00002385902	**OLANZAPINE**	**SIV**	$	**1.0631**
00002303183	**PMS-OLANZAPINE**	**PMS**	$	**1.0631**
00002310392	**SANDOZ OLANZAPINE**	**SDZ**	$	**1.0631**
00002276755	**TEVA-OLANZAPINE**	**TEV**	$	**1.0631**
00002238850	ZYPREXA	LIL	$	11.6186

5 MG ORAL DISINTEGRATING TABLET

00002360616	**APO-OLANZAPINE ODT**	**APX**	$	**0.3574**
00002448726	**AURO-OLANZAPINE ODT**	**AUR**	$	**0.3574**
00002406624	**JAMP-OLANZAPINE ODT**	**JPC**	$	**0.3574**
00002436965	**MINT-OLANZAPINE ODT**	**MPI**	$	**0.3574**
00002343665	**OLANZAPINE ODT**	**SIV**	$	**0.3574**
00002303191	**PMS-OLANZAPINE ODT**	**PMS**	$	**0.3574**
00002327775	**SANDOZ OLANZAPINE ODT**	**SDZ**	$	**0.3574**
00002243086	ZYPREXA ZYDIS	LIL	$	3.7871

10 MG (BASE) ORAL DISINTEGRATING TABLET

00002360624	**APO-OLANZAPINE ODT**	**APX**	$	**0.7143**
00002448734	**AURO-OLANZAPINE ODT**	**AUR**	$	**0.7143**
00002406632	**JAMP-OLANZAPINE ODT**	**JPC**	$	**0.7143**
00002389096	**MAR-OLANZAPINE ODT**	**MAR**	$	**0.7143**
00002436973	**MINT-OLANZAPINE ODT**	**MPI**	$	**0.7143**
00002343673	**OLANZAPINE ODT**	**SIV**	$	**0.7143**
00002303205	**PMS-OLANZAPINE ODT**	**PMS**	$	**0.7143**
00002414104	**RAN-OLANZAPINE ODT**	**RAN**	$	**0.7143**
00002327783	**SANDOZ OLANZAPINE ODT**	**SDZ**	$	**0.7143**
00002243087	ZYPREXA ZYDIS	LIL	$	7.5675

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

PALIPERIDONE

3 MG ORAL EXTENDED-RELEASE TABLET				
00002300273	INVEGA	JAI	$	3.9820
6 MG ORAL EXTENDED-RELEASE TABLET				
00002300281	INVEGA	JAI	$	5.9560
9 MG ORAL EXTENDED-RELEASE TABLET				
00002300303	INVEGA	JAI	$	7.9390

QUETIAPINE FUMARATE

25 MG (BASE) ORAL TABLET				
00002316080	**ACT QUETIAPINE**	**APH**	$	**0.0494**
00002475979	**AG-QUETIAPINE**	**AGP**	$	**0.0494**
00002313901	**APO-QUETIAPINE**	**APX**	$	**0.0494**
00002390205	**AURO-QUETIAPINE**	**AUR**	$	**0.0494**
00002447193	**BIO-QUETIAPINE**	**BMD**	$	**0.0494**
00002330415	**JAMP-QUETIAPINE**	**JPC**	$	**0.0494**
00002399822	**MAR-QUETIAPINE**	**MAR**	$	**0.0494**
00002438003	**MINT-QUETIAPINE**	**MPI**	$	**0.0494**
00002439158	**NAT-QUETIAPINE**	**NTP**	$	**0.0494**
00002296551	**PMS-QUETIAPINE**	**PMS**	$	**0.0494**
00002317893	**QUETIAPINE**	**SIV**	$	**0.0494**
00002353164	**QUETIAPINE**	**SNS**	$	**0.0494**
00002387794	**QUETIAPINE**	**AHI**	$	**0.0494**
00002397099	**RAN-QUETIAPINE**	**RAN**	$	**0.0494**
00002236951	SEROQUEL	AZC	$	0.5195
50 MG (BASE) ORAL TABLET				
00002361892	PMS-QUETIAPINE	PMS	$	0.5778
100 MG (BASE) ORAL TABLET				
00002316099	**ACT QUETIAPINE**	**APH**	$	**0.1318**
00002313928	**APO-QUETIAPINE**	**APX**	$	**0.1318**
00002390213	**AURO-QUETIAPINE**	**AUR**	$	**0.1318**
00002447207	**BIO-QUETIAPINE**	**BMD**	$	**0.1318**
00002330423	**JAMP-QUETIAPINE**	**JPC**	$	**0.1318**
00002399830	**MAR-QUETIAPINE**	**MAR**	$	**0.1318**
00002438011	**MINT-QUETIAPINE**	**MPI**	$	**0.1318**
00002439166	**NAT-QUETIAPINE**	**NTP**	$	**0.1318**
00002296578	**PMS-QUETIAPINE**	**PMS**	$	**0.1318**
00002317907	**QUETIAPINE**	**SIV**	$	**0.1318**
00002353172	**QUETIAPINE**	**SNS**	$	**0.1318**
00002387808	**QUETIAPINE**	**AHI**	$	**0.1318**
00002397102	**RAN-QUETIAPINE**	**RAN**	$	**0.1318**
00002236952	SEROQUEL	AZC	$	1.3860
150 MG (BASE) ORAL TABLET				
00002439174	NAT-QUETIAPINE	NTP	$	1.0195

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

QUETIAPINE FUMARATE

200 MG (BASE) ORAL TABLET

00002316110	**ACT QUETIAPINE**	**APH**	$	**0.2647**
00002313936	**APO-QUETIAPINE**	**APX**	$	**0.2647**
00002390248	**AURO-QUETIAPINE**	**AUR**	$	**0.2647**
00002447223	**BIO-QUETIAPINE**	**BMD**	$	**0.2647**
00002330458	**JAMP-QUETIAPINE**	**JPC**	$	**0.2647**
00002399849	**MAR-QUETIAPINE**	**MAR**	$	**0.2647**
00002438046	**MINT-QUETIAPINE**	**MPI**	$	**0.2647**
00002439182	**NAT-QUETIAPINE**	**NTP**	$	**0.2647**
00002296594	**PMS-QUETIAPINE**	**PMS**	$	**0.2647**
00002317923	**QUETIAPINE**	**SIV**	$	**0.2647**
00002353199	**QUETIAPINE**	**SNS**	$	**0.2647**
00002387824	**QUETIAPINE**	**AHI**	$	**0.2647**
00002397110	**RAN-QUETIAPINE**	**RAN**	$	**0.2647**
00002236953	SEROQUEL	AZC	$	2.7830

300 MG (BASE) ORAL TABLET

00002316129	**ACT QUETIAPINE**	**APH**	$	**0.3863**
00002313944	**APO-QUETIAPINE**	**APX**	$	**0.3863**
00002390256	**AURO-QUETIAPINE**	**AUR**	$	**0.3863**
00002447258	**BIO-QUETIAPINE**	**BMD**	$	**0.3863**
00002330466	**JAMP-QUETIAPINE**	**JPC**	$	**0.3863**
00002399857	**MAR-QUETIAPINE**	**MAR**	$	**0.3863**
00002438054	**MINT-QUETIAPINE**	**MPI**	$	**0.3863**
00002439190	**NAT-QUETIAPINE**	**NTP**	$	**0.3863**
00002296608	**PMS-QUETIAPINE**	**PMS**	$	**0.3863**
00002317931	**QUETIAPINE**	**SIV**	$	**0.3863**
00002353202	**QUETIAPINE**	**SNS**	$	**0.3863**
00002387832	**QUETIAPINE**	**AHI**	$	**0.3863**
00002397129	**RAN-QUETIAPINE**	**RAN**	$	**0.3863**
00002244107	SEROQUEL	AZC	$	4.0610

50 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002450860	**ACH-QUETIAPINE FUMARATE XR**	**AHI**	$	**0.2501**
00002457229	**APO-QUETIAPINE XR**	**APX**	$	**0.2501**
00002417359	**QUETIAPINE XR**	**SIV**	$	**0.2501**
00002407671	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.2501**
00002395444	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.2501**
00002300184	SEROQUEL XR	AZC	$	1.0003

150 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002450879	**ACH-QUETIAPINE FUMARATE XR**	**AHI**	$	**0.4926**
00002457237	**APO-QUETIAPINE XR**	**APX**	$	**0.4926**
00002417367	**QUETIAPINE XR**	**SIV**	$	**0.4926**
00002407698	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.4926**
00002395452	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.4926**
00002321513	SEROQUEL XR	AZC	$	1.9701

200 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002450887	**ACH-QUETIAPINE FUMARATE XR**	**AHI**	$	**0.6661**
00002457245	**APO-QUETIAPINE XR**	**APX**	$	**0.6661**
00002417375	**QUETIAPINE XR**	**SIV**	$	**0.6661**
00002407701	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.6661**
00002395460	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.6661**
00002300192	SEROQUEL XR	AZC	$	2.6641

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

QUETIAPINE FUMARATE

300 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002450895	**ACH-QUETIAPINE FUMARATE XR**	**AHI**	$	**0.9776**
00002457253	**APO-QUETIAPINE XR**	**APX**	$	**0.9776**
00002417383	**QUETIAPINE XR**	**SIV**	$	**0.9776**
00002407728	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.9776**
00002395479	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.9776**
00002300206	SEROQUEL XR	AZC	$	3.9101

400 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002450909	**ACH-QUETIAPINE FUMARATE XR**	**AHI**	$	**1.3270**
00002457261	**APO-QUETIAPINE XR**	**APX**	$	**1.3270**
00002417391	**QUETIAPINE XR**	**SIV**	$	**1.3270**
00002407736	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**1.3270**
00002395487	**TEVA-QUETIAPINE XR**	**TEV**	$	**1.3270**
00002300214	SEROQUEL XR	AZC	$	5.3080

RISPERIDONE

0.25 MG ORAL TABLET

00002282119	**APO-RISPERIDONE**	**APX**	$	**0.1036**
00002359529	**JAMP-RISPERIDONE**	**JPC**	$	**0.1036**
00002371766	**MAR-RISPERIDONE**	**MAR**	$	**0.1036**
00002359790	**MINT-RISPERIDONE**	**MPI**	$	**0.1036**
00002252007	**PMS-RISPERIDONE**	**PMS**	$	**0.1036**
00002328305	**RAN-RISPERIDONE**	**RAN**	$	**0.1036**
00002356880	**RISPERIDONE**	**SNS**	$	**0.1036**
00002303655	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.1036**
00002282690	**TEVA-RISPERIDONE**	**TEV**	$	**0.1036**

0.5 MG ORAL TABLET

00002282127	**APO-RISPERIDONE**	**APX**	$	**0.1735**
00002359537	**JAMP-RISPERIDONE**	**JPC**	$	**0.1735**
00002371774	**MAR-RISPERIDONE**	**MAR**	$	**0.1735**
00002359804	**MINT-RISPERIDONE**	**MPI**	$	**0.1735**
00002252015	**PMS-RISPERIDONE**	**PMS**	$	**0.1735**
00002328313	**RAN-RISPERIDONE**	**RAN**	$	**0.1735**
00002356899	**RISPERIDONE**	**SNS**	$	**0.1735**
00002303663	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.1735**

1 MG ORAL TABLET

00002282135	**APO-RISPERIDONE**	**APX**	$	**0.2397**
00002359545	**JAMP-RISPERIDONE**	**JPC**	$	**0.2397**
00002371782	**MAR-RISPERIDONE**	**MAR**	$	**0.2397**
00002359812	**MINT-RISPERIDON**	**MPI**	$	**0.2397**
00002252023	**PMS-RISPERIDONE**	**PMS**	$	**0.2397**
00002328321	**RAN-RISPERIDONE**	**RAN**	$	**0.2397**
00002356902	**RISPERIDONE**	**SNS**	$	**0.2397**
00002279800	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.2397**
00002264196	**TEVA-RISPERIDONE**	**TEV**	$	**0.2397**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

RISPERIDONE

2 MG ORAL TABLET				
00002282143	**APO-RISPERIDONE**	**APX**	$	**0.4795**
00002359553	**JAMP-RISPERIDONE**	**JPC**	$	**0.4795**
00002371790	**MAR-RISPERIDONE**	**MAR**	$	**0.4795**
00002359820	**MINT-RISPERIDON**	**MPI**	$	**0.4795**
00002252031	**PMS-RISPERIDONE**	**PMS**	$	**0.4795**
00002328348	**RAN-RISPERIDONE**	**RAN**	$	**0.4795**
00002356910	**RISPERIDONE**	**SNS**	$	**0.4795**
00002279819	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.4795**
00002264218	**TEVA-RISPERIDONE**	**TEV**	$	**0.4795**
3 MG ORAL TABLET				
00002282151	**APO-RISPERIDONE**	**APX**	$	**0.7180**
00002359561	**JAMP-RISPERIDONE**	**JPC**	$	**0.7180**
00002371804	**MAR-RISPERIDONE**	**MAR**	$	**0.7180**
00002359839	**MINT-RISPERIDON**	**MPI**	$	**0.7180**
00002252058	**PMS-RISPERIDONE**	**PMS**	$	**0.7180**
00002328364	**RAN-RISPERIDONE**	**RAN**	$	**0.7180**
00002356929	**RISPERIDONE**	**SNS**	$	**0.7180**
00002279827	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.7180**
00002264226	**TEVA-RISPERIDONE**	**TEV**	$	**0.7180**
4 MG ORAL TABLET				
00002282178	**APO-RISPERIDONE**	**APX**	$	**0.9574**
00002359588	**JAMP-RISPERIDONE**	**JPC**	$	**0.9574**
00002371812	**MAR-RISPERIDONE**	**MAR**	$	**0.9574**
00002359847	**MINT-RISPERIDON**	**MPI**	$	**0.9574**
00002252066	**PMS-RISPERIDONE**	**PMS**	$	**0.9574**
00002328372	**RAN-RISPERIDONE**	**RAN**	$	**0.9574**
00002356937	**RISPERIDONE**	**SNS**	$	**0.9574**
00002279835	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.9574**
00002264234	**TEVA-RISPERIDONE**	**TEV**	$	**0.9574**
0.5 MG ORAL DISINTEGRATING TABLET				
00002413485	MYLAN-RISPERIDONE ODT	MYP	$	0.5588
1 MG ORAL DISINTEGRATING TABLET				
00002413493	MYLAN-RISPERIDONE ODT	MYP	$	0.5150
2 MG ORAL DISINTEGRATING TABLET				
00002413507	MYLAN-RISPERIDONE ODT	MYP	$	1.0187
3 MG ORAL DISINTEGRATING TABLET				
00002413515	MYLAN-RISPERIDONE ODT	MYP	$	1.5275
4 MG ORAL DISINTEGRATING TABLET				
00002413523	MYLAN-RISPERIDONE ODT	MYP	$	2.0425

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				
00002454319	**JAMP-RISPERIDONE**	**JPC**	$	**0.4895**
00002279266	**PMS-RISPERIDONE**	**PMS**	$	**0.4895**
00002236950	RISPERDAL	JAI	$	1.4118

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE

20 MG (BASE) ORAL CAPSULE				
00002449544	**AURO-ZIPRASIDONE**	**AUR**	$	**1.3784**
00002298597	ZELDOX	UJC	$	1.8950
40 MG (BASE) ORAL CAPSULE				
00002449552	**AURO-ZIPRASIDONE**	**AUR**	$	**1.5786**
00002298600	ZELDOX	UJC	$	2.1707
60 MG (BASE) ORAL CAPSULE				
00002449560	**AURO-ZIPRASIDONE**	**AUR**	$	**1.5786**
00002298619	ZELDOX	UJC	$	2.1707
80 MG (BASE) ORAL CAPSULE				
00002449579	**AURO-ZIPRASIDONE**	**AUR**	$	**1.5786**
00002298627	ZELDOX	UJC	$	2.1707

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.08 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(BUTYROPHENONES)

HALOPERIDOL

0.5 MG ORAL TABLET				
00000363685	TEVA-HALOPERIDOL	TEV	$	0.1430
1 MG ORAL TABLET				
00000363677	TEVA-HALOPERIDOL	TEV	$	0.2148
2 MG ORAL TABLET				
00000363669	TEVA-HALOPERIDOL	TEV	$	0.3211
5 MG ORAL TABLET				
00000363650	TEVA-HALOPERIDOL	TEV	$	0.5121
10 MG ORAL TABLET				
00000713449	TEVA-HALOPERIDOL	TEV	$	0.7450
5 MG / ML INJECTION				
00000808652	HALOPERIDOL	SDZ	$	5.0715

HALOPERIDOL DECANOATE

100 MG / ML (BASE) INJECTION				
00002130300	HALOPERIDOL LA	SDZ	$	19.5447

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.24 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(PHENOTHIAZINES)

CHLORPROMAZINE HCL

25 MG (BASE) ORAL TABLET				
00000232823	TEVA-CHLORPROMAZINE	TEV	$	0.2577
50 MG (BASE) ORAL TABLET				
00000232807	TEVA-CHLORPROMAZINE	TEV	$	0.2948

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.24 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (PHENOTHIAZINES)

CHLORPROMAZINE HCL

100 MG (BASE) ORAL TABLET

00000232831	TEVA-CHLORPROMAZINE	TEV	$	0.7849

FLUPHENAZINE HCL

1 MG ORAL TABLET

00000405345	FLUPHENAZINE	AAP	$	0.2001

2 MG ORAL TABLET

00000410632	FLUPHENAZINE	AAP	$	0.2572

5 MG ORAL TABLET

00000405361	FLUPHENAZINE	AAP	$	0.4203

METHOTRIMEPRAZINE HCL

25 MG / ML (BASE) INJECTION

00001927698	NOZINAN	SAV	$	3.7650

METHOTRIMEPRAZINE MALEATE

2 MG (BASE) ORAL TABLET

00002238403	METHOPRAZINE	AAP	$	0.0783

5 MG (BASE) ORAL TABLET

00002238404	METHOPRAZINE	AAP	$	0.1132

25 MG (BASE) ORAL TABLET

00002238405	METHOPRAZINE	AAP	$	0.2911

50 MG (BASE) ORAL TABLET

00002238406	METHOPRAZINE	AAP	$	0.4406

PERICIAZINE

5 MG ORAL CAPSULE

00001926780	NEULEPTIL	ERF	$	0.2170

10 MG ORAL CAPSULE

00001926772	NEULEPTIL	ERF	$	0.3535

10 MG / ML ORAL DROPS

00001926756	NEULEPTIL	ERF	$	0.4283

PERPHENAZINE

2 MG ORAL TABLET

00000335134	PERPHENAZINE	AAP	$	0.0715

4 MG ORAL TABLET

00000335126	PERPHENAZINE	AAP	$	0.0865

8 MG ORAL TABLET

00000335118	PERPHENAZINE	AAP	$	0.0951

16 MG ORAL TABLET

00000335096	PERPHENAZINE	AAP	$	0.1456

TRIFLUOPERAZINE HCL

1 MG (BASE) ORAL TABLET

00000345539	TRIFLUOPERAZINE	AAP	$	0.1532

2 MG (BASE) ORAL TABLET

00000312754	TRIFLUOPERAZINE	AAP	$	0.2009

5 MG (BASE) ORAL TABLET

00000312746	TRIFLUOPERAZINE	AAP	$	0.2660

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.24 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (PHENOTHIAZINES)

TRIFLUOPERAZINE HCL

10 MG (BASE) ORAL TABLET				
00000326836	TRIFLUOPERAZINE	AAP	$	0.3188
20 MG (BASE) ORAL TABLET				
00000595942	TRIFLUOPERAZINE	AAP	$	0.6375

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.32 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (THIOXANTHENES)

FLUPENTIXOL DECANOATE

20 MG / ML INJECTION				
00002156032	FLUANXOL DEPOT	LBC	$	7.8744
100 MG / ML INJECTION				
00002156040	FLUANXOL DEPOT	LBC	$	39.3729

FLUPENTIXOL DIHYDROCHLORIDE

0.5 MG ORAL TABLET				
00002156008	FLUANXOL	LBC	$	0.2721
3 MG ORAL TABLET				
00002156016	FLUANXOL	LBC	$	0.5876

ZUCLOPENTHIXOL ACETATE

50 MG / ML INJECTION				
00002230405	CLOPIXOL ACUPHASE	LBC	$	16.3428

ZUCLOPENTHIXOL DECANOATE

200 MG / ML INJECTION				
00002230406	CLOPIXOL DEPOT	LBC	$	16.3428

ZUCLOPENTHIXOL DIHYDROCHLORIDE

10 MG (BASE) ORAL TABLET				
00002230402	CLOPIXOL	LBC	$	0.4203
25 MG (BASE) ORAL TABLET				
00002230403	CLOPIXOL	LBC	$	1.0506

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.92 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (MISCELLANEOUS ANTIPSYCHOTICS)

LOXAPINE SUCCINATE

2.5 MG (BASE) ORAL TABLET				
00002242868	XYLAC	PPH	$	0.2395
10 MG (BASE) ORAL TABLET				
00002230838	XYLAC	PPH	$	0.3740

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.92 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(MISCELLANEOUS ANTIPSYCHOTICS)

LOXAPINE SUCCINATE

25 MG (BASE) ORAL TABLET				
00002230839	XYLAC	PPH	$	0.5685

PIMOZIDE

2 MG ORAL TABLET				
00002245432	PIMOZIDE	AAP	$	0.3531
4 MG ORAL TABLET				
00002245433	PIMOZIDE	AAP	$	0.5380

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:20.04 ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS
(AMPHETAMINES)

DEXTROAMPHETAMINE SULFATE

5 MG ORAL TABLET				
00002443236	**DEXTROAMPHETAMINE**	**AAP**	$	**0.5081**
00001924516	DEXEDRINE	PAL	$	0.6564
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002448319	**ACT DEXTROAMPHETAMINE SR**	**APH**	$	**0.8096**
00001924559	DEXEDRINE	PAL	$	0.9415
15 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002448327	**ACT DEXTROAMPHETAMINE SR**	**APH**	$	**0.9898**
00001924567	DEXEDRINE	PAL	$	1.1510

LISDEXAMFETAMINE DIMESYLATE

RESTRICTED BENEFIT - For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older.

20 MG ORAL CAPSULE				
00002347156	VYVANSE	TAK	$	2.8058
30 MG ORAL CAPSULE				
00002322951	VYVANSE	TAK	$	3.3560
40 MG ORAL CAPSULE				
00002347164	VYVANSE	TAK	$	3.9060
50 MG ORAL CAPSULE				
00002322978	VYVANSE	TAK	$	4.4562
60 MG ORAL CAPSULE				
00002347172	VYVANSE	TAK	$	5.0063

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				
☒ 00002273950	APO-METHYLPHENIDATE	APX	$	0.0947
☒ 00002234749	PMS-METHYLPHENIDATE	PMS	$	0.0947
10 MG ORAL TABLET				
00002249324	**APO-METHYLPHENIDATE**	**APX**	$	**0.2216**
00000584991	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.2216**
00000005606	RITALIN	NOV	$	0.3974
20 MG ORAL TABLET				
00002249332	**APO-METHYLPHENIDATE**	**APX**	$	**0.3387**
00000585009	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.3387**
20 MG ORAL EXTENDED-RELEASE TABLET				
00002266687	**APO-METHYLPHENIDATE SR**	**APX**	$	**0.2820**
00002320312	**SANDOZ METHYLPHENIDATE**	**SDZ**	$	**0.2820**
00000632775	RITALIN SR	NOV	$	0.6973
10 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002277166	BIPHENTIN	ELV	$	0.7710

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

15 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002277131	BIPHENTIN	ELV	$	1.1035

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

20 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002277158	BIPHENTIN	ELV	$	1.4260

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

30 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002277174	BIPHENTIN	ELV	$	1.9570

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

40 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002277182	BIPHENTIN	ELV	$	2.4935

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

50 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002277190	BIPHENTIN	ELV	$	3.0240

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

60 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002277204	BIPHENTIN	ELV	$	3.5195

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:20.92 ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS
(MISCELLANEOUS ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS)

METHYLPHENIDATE HCL

80 MG ORAL CONTROLLED-RELEASE CAPSULE

00002277212	BIPHENTIN	ELV	$	4.6440

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.04 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS
(BARBITURATES)

PHENOBARBITAL

15 MG ORAL TABLET

00000178799	PHENOBARB	PPH	$	0.1529

30 MG ORAL TABLET

00000178802	PHENOBARB	PPH	$	0.1580

60 MG ORAL TABLET

00000178810	PHENOBARB	PPH	$	0.2361

100 MG ORAL TABLET

00000178829	PHENOBARB	PPH	$	0.3394

5 MG / ML ORAL ELIXIR

00000645575	PHENOBARB	PPH	$	0.1489

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS
(BENZODIAZEPINES)

ALPRAZOLAM

0.25 MG ORAL TABLET

00002349191	**ALPRAZOLAM**	**SNS**	$	**0.0609**
00000865397	**APO-ALPRAZ**	**APX**	$	**0.0609**
00001913484	**TEVA-ALPRAZOL**	**TEV**	$	**0.0609**

0.5 MG ORAL TABLET

00002349205	**ALPRAZOLAM**	**SNS**	$	**0.0728**
00000865400	**APO-ALPRAZ**	**APX**	$	**0.0728**
00001913492	**TEVA-ALPRAZOL**	**TEV**	$	**0.0728**

BROMAZEPAM

3 MG ORAL TABLET

00002177161	**APO-BROMAZEPAM**	**APX**	$	**0.0776**
00002230584	**TEVA-BROMAZEPAM**	**TEV**	$	**0.0776**

6 MG ORAL TABLET

00002177188	**APO-BROMAZEPAM**	**APX**	$	**0.1134**
00002230585	**TEVA-BROMAZEPAM**	**TEV**	$	**0.1134**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BENZODIAZEPINES)

CHLORDIAZEPOXIDE HCL

5 MG ORAL CAPSULE				
00000522724	CHLORDIAZEPOXIDE	AAP	$	0.0776
10 MG ORAL CAPSULE				
00000522988	CHLORDIAZEPOXIDE	AAP	$	0.1222
25 MG ORAL CAPSULE				
00000522996	CHLORDIAZEPOXIDE	AAP	$	0.1895

CHLORDIAZEPOXIDE HCL/ CLIDINIUM BROMIDE

5 MG * 2.5 MG ORAL CAPSULE				
00000618454	**CHLORAX**	**AAP**	$	**0.2554**
00000115630	LIBRAX	VCL	$	0.3468

CLORAZEPATE DIPOTASSIUM

3.75 MG ORAL CAPSULE				
00000860689	CLORAZEPATE	AAP	$	0.1687
7.5 MG ORAL CAPSULE				
00000860700	CLORAZEPATE	AAP	$	0.2200
15 MG ORAL CAPSULE				
00000860697	CLORAZEPATE	AAP	$	0.4405

DIAZEPAM

2 MG ORAL TABLET				
00000405329	DIAZEPAM	AAP	$	0.0551
5 MG ORAL TABLET				
00000362158	DIAZEPAM	AAP	$	0.1466
10 MG ORAL TABLET				
00000405337	DIAZEPAM	AAP	$	0.0867
5 MG / ML INJECTION				
00000399728	DIAZEPAM	SDZ	$	1.7582

FLURAZEPAM HCL

15 MG ORAL CAPSULE				
00000521698	FLURAZEPAM	AAP	$	0.1306
30 MG ORAL CAPSULE				
00000521701	FLURAZEPAM	AAP	$	0.1528

LORAZEPAM

0.5 MG ORAL TABLET				
00000655740	**APO-LORAZEPAM**	**APX**	$	**0.0359**
00000728187	**PMS-LORAZEPAM**	**PMS**	$	**0.0359**
00000711101	**TEVA-LORAZEPAM**	**TEV**	$	**0.0359**
1 MG ORAL TABLET				
00000655759	**APO-LORAZEPAM**	**APX**	$	**0.0447**
00002351080	**LORAZEPAM**	**SNS**	$	**0.0447**
00000728195	**PMS-LORAZEPAM**	**PMS**	$	**0.0447**
00000637742	**TEVA-LORAZEPAM**	**TEV**	$	**0.0447**
00002041421	ATIVAN	PFI	$	0.0512
2 MG ORAL TABLET				
00000655767	**APO-LORAZEPAM**	**APX**	$	**0.0699**
00002351099	**LORAZEPAM**	**SNS**	$	**0.0699**
00000728209	**PMS-LORAZEPAM**	**PMS**	$	**0.0699**
00000637750	**TEVA-LORAZEPAM**	**TEV**	$	**0.0699**
00002041448	ATIVAN	PFI	$	0.0816

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BENZODIAZEPINES)

LORAZEPAM

0.5 MG ORAL SUBLINGUAL TABLET

00002410745	**LORAZEPAM**	**AAP**	$	**0.0914**
00002041456	ATIVAN	PFI	$	0.1250

1 MG ORAL SUBLINGUAL TABLET

00002410753	**LORAZEPAM**	**AAP**	$	**0.1151**
00002041464	ATIVAN	PFI	$	0.1573

2 MG ORAL SUBLINGUAL TABLET

00002410761	**LORAZEPAM**	**AAP**	$	**0.1787**
00002041472	ATIVAN	PFI	$	0.2444

MIDAZOLAM HCL

5 MG / ML (BASE) INJECTION

00002240286	MIDAZOLAM	SDZ	$	4.1000

NITRAZEPAM

5 MG ORAL TABLET

00000511528	MOGADON	AAP	$	0.1718

10 MG ORAL TABLET

00000511536	MOGADON	AAP	$	0.2571

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

00000604453	RESTORIL	AAP	$	0.2317

30 MG ORAL CAPSULE

00000604461	RESTORIL	AAP	$	0.2804

TRIAZOLAM

0.25 MG ORAL TABLET

00000808571	TRIAZO	AAP	$	0.2858

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**	$	**0.3517**
00002231492	**NOVO-BUSPIRONE**	**TEV**	$	**0.3517**
00002230942	**PMS-BUSPIRONE**	**PMS**	$	**0.3517**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.92 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS

(MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS)

HYDROXYZINE HCL

10 MG ORAL CAPSULE				
00000646059	HYDROXYZINE	AAP	$	0.1224
25 MG ORAL CAPSULE				
00000738832	**NOVO-HYDROXYZIN**	**TEV**	$	**0.1425**
00000646024	HYDROXYZINE	AAP	$	0.1563
50 MG ORAL CAPSULE				
00000738840	**NOVO-HYDROXYZIN**	**TEV**	$	**0.2068**
00000646016	HYDROXYZINE	AAP	$	0.2269
2 MG / ML ORAL SYRUP				
00000024694	ATARAX	ERF	$	0.0592

ZOPICLONE

3.75 MG ORAL TABLET				
00002458543	PMS-ZOPICLONE	PMS	$	0.0743
5 MG ORAL TABLET				
00002245077	**APO-ZOPICLONE**	**APX**	$	**0.0990**
00002406969	**JAMP-ZOPICLONE**	**JPC**	$	**0.0990**
00002386771	**MAR-ZOPICLONE**	**MAR**	$	**0.0990**
00002391716	**MINT-ZOPICLONE**	**MPI**	$	**0.0990**
00002243426	**PMS-ZOPICLONE**	**PMS**	$	**0.0990**
00002267918	**RAN-ZOPICLONE**	**RAN**	$	**0.0990**
00002246534	**RATIO-ZOPICLONE**	**TEV**	$	**0.0990**
00002344122	**ZOPICLONE**	**SNS**	$	**0.0990**
00002385821	**ZOPICLONE**	**SIV**	$	**0.0990**
00002216167	IMOVANE	SAV	$	1.0832
7.5 MG ORAL TABLET				
00002218313	**APO-ZOPICLONE**	**APX**	$	**0.1250**
00002406977	**JAMP-ZOPICLONE**	**JPC**	$	**0.1250**
00002386798	**MAR-ZOPICLONE**	**MAR**	$	**0.1250**
00002391724	**MINT-ZOPICLONE**	**MPI**	$	**0.1250**
00002240606	**PMS-ZOPICLONE**	**PMS**	$	**0.1250**
00002267926	**RAN-ZOPICLONE**	**RAN**	$	**0.1250**
00002242481	**RATIO-ZOPICLONE**	**TEV**	$	**0.1250**
00002008203	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.1250**
00002282445	**ZOPICLONE**	**SNS**	$	**0.1250**
00002385848	**ZOPICLONE**	**SIV**	$	**0.1250**
00001926799	IMOVANE	SAV	$	1.3677

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:28 ANTIMANIC AGENTS

LITHIUM CARBONATE

150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0667**
00002216132	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0667**
00000461733	CARBOLITH	VCL	$	0.1302
150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0667**
00002013231	LITHANE	ERF	$	0.1173

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:28 ANTIMANIC AGENTS

LITHIUM CARBONATE

300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0657**
00002216140	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0657**
00000236683	CARBOLITH	VCL	$	0.1012
300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0657**
00000406775	LITHANE	ERF	$	0.1169
600 MG ORAL CAPSULE				
00002216159	PMS-LITHIUM CARBONATE	PMS	$	0.1988

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 Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

6.25 MG (BASE) ORAL TABLET				
00002398435	MYLAN-ALMOTRIPTAN	MYP	$	7.0433
12.5 MG (BASE) ORAL TABLET				
00002466821	**ALMOTRIPTAN**	**SNS**	$	**2.3478**
00002398443	**MYLAN-ALMOTRIPTAN**	**MYP**	$	**2.3478**
00002405334	**SANDOZ ALMOTRIPTAN**	**SDZ**	$	**2.3478**
00002434849	**TEVA-ALMOTRIPTAN**	**TEV**	$	**2.3478**

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 Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

1 MG (BASE) ORAL TABLET				
00002314290	**TEVA-NARATRIPTAN**	**TEV**	$	**12.4993**
00002237820	AMERGE	GSK	$	15.4403
2.5 MG (BASE) ORAL TABLET				
00002322323	**SANDOZ NARATRIPTAN**	**SDZ**	$	**6.1436**
00002314304	**TEVA-NARATRIPTAN**	**TEV**	$	**6.1436**
00002237821	AMERGE	GSK	$	16.2768

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 Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

5 MG (BASE) ORAL TABLET				
00002393468	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002380455	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429233	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
10 MG (BASE) ORAL TABLET				
00002381702	**ACT RIZATRIPTAN**	**APH**	$	**3.7050**
00002393476	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002441144	**AURO-RIZATRIPTAN**	**AUR**	$	**3.7050**
00002380463	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429241	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
00002379678	**MAR-RIZATRIPTAN**	**MAR**	$	**3.7050**
00002240521	MAXALT	MFC	$	16.5163
5 MG (BASE) ORAL DISINTEGRATING TABLET				
00002483270	**ACCEL-RIZATRIPTAN ODT**	**ACP**	$	**2.9633**
00002458764	**CCP-RIZATRIPTAN ODT**	**CEL**	$	**2.9633**
00002379198	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**2.9633**
00002465086	JAMP-RIZATRIPTAN ODT	JPC	$	3.7050
00002462788	MAR-RIZATRIPTAN ODT	MAR	$	3.7050
00002436604	NAT-RIZATRIPTAN ODT	NTP	$	3.7050
00002393360	PMS-RIZATRIPTAN RDT	PMS	$	3.7050
00002442906	RIZATRIPTAN ODT	SNS	$	3.7050
00002446111	RIZATRIPTAN ODT	SIV	$	3.7050
00002351870	SANDOZ RIZATRIPTAN ODT	SDZ	$	3.7050
00002396661	TEVA-RIZATRIPTAN ODT	TEV	$	3.7050
00002240518	MAXALT RPD	MFC	$	16.5163
10 MG (BASE) ORAL DISINTEGRATING TABLET				
00002483289	**ACCEL-RIZATRIPTAN ODT**	**ACP**	$	**2.9633**
00002458772	**CCP-RIZATRIPTAN ODT**	**CEL**	$	**2.9633**
00002379201	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**2.9633**
00002465094	JAMP-RIZATRIPTAN ODT	JPC	$	3.7050
00002462796	MAR-RIZATRIPTAN ODT	MAR	$	3.7050
00002436612	NAT-RIZATRIPTAN ODT	NTP	$	3.7050
00002393379	PMS-RIZATRIPTAN RDT	PMS	$	3.7050
00002442914	RIZATRIPTAN ODT	SNS	$	3.7050
00002446138	RIZATRIPTAN ODT	SIV	$	3.7050
00002351889	SANDOZ RIZATRIPTAN ODT	SDZ	$	3.7050
00002396688	TEVA-RIZATRIPTAN ODT	TEV	$	3.7050
00002240519	MAXALT RPD	MFC	$	16.5163

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS

(SELECTIVE SEROTONIN AGONISTS)

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 Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

5 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230418	IMITREX	GSK	$	16.0217
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230420	IMITREX	GSK	$	16.4842

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 Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

50 MG (BASE) ORAL TABLET				
00002268388	**APO-SUMATRIPTAN**	**APX**	$	**2.7732**
00002268914	**MYLAN-SUMATRIPTAN**	**MYP**	$	**2.7732**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**2.7732**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**2.7732**
00002286521	**SUMATRIPTAN**	**SNS**	$	**2.7732**
00002385570	**SUMATRIPTAN DF**	**SIV**	$	**2.7732**
00002286823	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**2.7732**
00002212153	IMITREX DF	GSK	$	16.5165
100 MG (BASE) ORAL TABLET				
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**3.0549**
00002268922	**MYLAN-SUMATRIPTAN**	**MYP**	$	**3.0549**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**3.0549**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**3.0549**
00002286548	**SUMATRIPTAN**	**SNS**	$	**3.0549**
00002385589	**SUMATRIPTAN DF**	**SIV**	$	**3.0549**
00002239367	**TEVA-SUMATRIPTAN**	**TEV**	$	**3.0549**
00002286831	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**3.0549**
00002212161	IMITREX DF	GSK	$	18.1947
6 MG / SYR (BASE) INJECTION SYRINGE				
00002361698	**TARO-SUMATRIPTAN (0.5 ML)**	**TAR**	$	**37.9982**
00002212188	IMITREX (0.5 ML)	GSK	$	48.3778

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS

(SELECTIVE SEROTONIN AGONISTS)

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 Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

2.5 MG ORAL TABLET				
00002458780	**CCP-ZOLMITRIPTAN**	**CEL**	$	**3.5375**
00002477106	**JAMP ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002421623	**JAMP-ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002419521	**MINT-ZOLMITRIPTAN**	**MPI**	$	**3.5375**
00002421534	**NAT-ZOLMITRIPTAN**	**NTP**	$	**3.5375**
00002324229	**PMS-ZOLMITRIPTAN**	**PMS**	$	**3.5375**
00002362988	**SANDOZ ZOLMITRIPTAN**	**SDZ**	$	**3.5375**
00002313960	**TEVA-ZOLMITRIPTAN**	**TEV**	$	**3.5375**
00002238660	ZOMIG	AZC	$	14.9600
2.5 MG ORAL DISPERSIBLE TABLET				
00002428237	**JAMP-ZOLMITRIPTAN ODT**	**JPC**	$	**1.7532**
00002428474	**SEPTA-ZOLMITRIPTAN-ODT**	**SEP**	$	**1.7532**
00002243045	ZOMIG RAPIMELT	AZC	$	14.9600
5 MG / DOSE NASAL UNIT DOSE SPRAY				
00002248993	ZOMIG	AZC	$	14.9600

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	$	0.4232
1 MG (BASE) ORAL TABLET				
00000511552	SANDOMIGRAN DS	PAL	$	0.7347

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.04 ANTIPARKINSONIAN AGENTS

(ADAMANTANES)

AMANTADINE HCL

100 MG ORAL CAPSULE				
00001990403	PDP-AMANTADINE HYDROCHLORIDE	PPH	$	0.6120
10 MG / ML ORAL SYRUP				
00002022826	PDP-AMANTADINE HYDROCHLORIDE	PPH	$	0.1348

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.08 ANTIPARKINSONIAN AGENTS (ANTICHOLINERGIC AGENTS)

BENZTROPINE MESYLATE

1 MG ORAL TABLET				
00000706531	PDP-BENZTROPINE	PPH	$	0.0522
1 MG / ML INJECTION				
00002238903	BENZTROPINE OMEGA	OMG	$	10.5000

ETHOPROPAZINE HCL

50 MG (BASE) ORAL TABLET				
00001927744	PARSITAN	ERF	$	0.2398

TRIHEXYPHENIDYL HCL

2 MG ORAL TABLET				
00000545058	TRIHEXYPHENIDYL	AAP	$	0.0411
5 MG ORAL TABLET				
00000545074	TRIHEXYPHENIDYL	AAP	$	0.0744

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.12 ANTIPARKINSONIAN AGENTS (CATECHOL-O-METHYLTRANSFERASE (COMT) INHIBITORS)

ENTACAPONE

200 MG ORAL TABLET				
00002380005	**SANDOZ ENTACAPONE**	**SDZ**	$	**0.4010**
00002375559	**TEVA-ENTACAPONE**	**TEV**	$	**0.4010**
00002243763	COMTAN	SDZ	$	1.6685

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	$	0.3197
100 MG * 25 MG (BASE) ORAL CAPSULE				
00000386464	PROLOPA 100-25	HLR	$	0.5265
200 MG * 50 MG (BASE) ORAL CAPSULE				
00000386472	PROLOPA 200-50	HLR	$	0.8839

LEVODOPA/ CARBIDOPA

100 MG * 10 MG ORAL TABLET				
00002195933	**APO-LEVOCARB**	**APX**	$	**0.1479**
00002457954	**MINT-LEVOCARB**	**MPI**	$	**0.1479**
00002244494	**TEVA-LEVOCARBIDOPA**	**TEV**	$	**0.1479**
100 MG * 25 MG ORAL TABLET				
00002195941	**APO-LEVOCARB**	**APX**	$	**0.2209**
00002457962	**MINT-LEVOCARB**	**MPI**	$	**0.2209**
00002244495	**TEVA-LEVOCARBIDOPA**	**TEV**	$	**0.2209**
00000513997	SINEMET 100/25	MFC	$	0.7491

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.16 ANTIPARKINSONIAN AGENTS (DOPAMINE PRECURSORS)

LEVODOPA/ CARBIDOPA

250 MG * 25 MG ORAL TABLET				
00002195968	**APO-LEVOCARB**	**APX**	$	**0.2466**
00002457970	**MINT-LEVOCARB**	**MPI**	$	**0.2466**
00002244496	**TEVA-LEVOCARBIDOPA**	**TEV**	$	**0.2466**
00000328219	SINEMET 250/25	MFC	$	0.8363
100 MG * 25 MG ORAL SUSTAINED-RELEASE TABLET				
00002272873	AA-LEVOCARB CR	AAP	$	0.3857
200 MG * 50 MG ORAL SUSTAINED-RELEASE TABLET				
00002245211	AA-LEVOCARB CR	AAP	$	0.7115

LEVODOPA/ CARBIDOPA/ ENTACAPONE

50 MG * 12.5 MG * 200 MG ORAL TABLET				
00002305933	STALEVO	SDZ	$	1.7061
75 MG * 18.75 MG * 200 MG ORAL TABLET				
00002337827	STALEVO	SDZ	$	1.7061
100 MG * 25 MG * 200 MG ORAL TABLET				
00002305941	STALEVO	SDZ	$	1.7061
125 MG * 31.25 MG * 200 MG ORAL TABLET				
00002337835	STALEVO	SDZ	$	1.7061
150 MG * 37.5 MG * 200 MG ORAL TABLET				
00002305968	STALEVO	SDZ	$	1.7061

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	BROMOCRIPTINE	AAP	$	1.1176
5 MG (BASE) ORAL CAPSULE				
00002230454	BROMOCRIPTINE	AAP	$	1.6730

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				
00002297302	**ACT PRAMIPEXOLE**	**APH**	$	**0.1950**
00002292378	**APO-PRAMIPEXOLE**	**APX**	$	**0.1950**
00002424061	**AURO-PRAMIPEXOLE**	**AUR**	$	**0.1950**
00002309122	**PRAMIPEXOLE**	**SIV**	$	**0.1950**
00002315262	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**0.1950**
00002237145	MIRAPEX	BOE	$	1.1594
1 MG ORAL TABLET				
00002297329	**ACT PRAMIPEXOLE**	**APH**	$	**0.3901**
00002292394	**APO-PRAMIPEXOLE**	**APX**	$	**0.3901**
00002424096	**AURO-PRAMIPEXOLE**	**AUR**	$	**0.3901**
00002309149	**PRAMIPEXOLE**	**SIV**	$	**0.3901**
00002315289	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**0.3901**
1.5 MG ORAL TABLET				
00002297337	**ACT PRAMIPEXOLE**	**APH**	$	**0.3901**
00002292408	**APO-PRAMIPEXOLE**	**APX**	$	**0.3901**
00002424118	**AURO-PRAMIPEXOLE**	**AUR**	$	**0.3901**
00002309157	**PRAMIPEXOLE**	**SIV**	$	**0.3901**
00002315297	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**0.3901**

ROPINIROLE HCL

0.25 MG (BASE) ORAL TABLET				
00002316846	**ACT ROPINIROLE**	**APH**	$	**0.0709**
00002352338	**JAMP-ROPINIROLE**	**JPC**	$	**0.0709**
00002314037	**RAN-ROPINIROLE**	**RAN**	$	**0.0709**
00002353040	**ROPINIROLE**	**SNS**	$	**0.0709**
1 MG (BASE) ORAL TABLET				
00002316854	**ACT ROPINIROLE**	**APH**	$	**0.2838**
00002352346	**JAMP-ROPINIROLE**	**JPC**	$	**0.2838**
00002314053	**RAN-ROPINIROLE**	**RAN**	$	**0.2838**
00002353059	**ROPINIROLE**	**SNS**	$	**0.2838**
2 MG (BASE) ORAL TABLET				
00002316862	**ACT ROPINIROLE**	**APH**	$	**0.3122**
00002352354	**JAMP-ROPINIROLE**	**JPC**	$	**0.3122**
00002314061	**RAN-ROPINIROLE**	**RAN**	$	**0.3122**
5 MG (BASE) ORAL TABLET				
00002316870	**ACT ROPINIROLE**	**APH**	$	**0.8596**
00002352362	**JAMP-ROPINIROLE**	**JPC**	$	**0.8596**
00002314088	**RAN-ROPINIROLE**	**RAN**	$	**0.8596**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.32 ANTIPARKINSONIAN AGENTS
(MONOAMINE OXIDASE B INHIBITORS)

SELEGILINE HCL

5 MG ORAL TABLET				
00002230641	**APO-SELEGILINE**	**APX**	$	**0.5021**
00002068087	**NOVO-SELEGILINE**	**TEV**	$	**0.5021**

34:00

Dental Agents

34:00 DENTAL AGENTS

34:00

SODIUM FLUORIDE

2.21 MG ORAL CHEWABLE TABLET

00000575569	FLUOR-A-DAY	PMS	$	0.0880

36:00

Diagnostic Agents

36:00 DIAGNOSTIC AGENTS

36:60 THYROID FUNCTION

THYROTROPIN ALFA

0.9 MG / VIAL INJECTION

00002246016	THYROGEN	GZM	$	878.8000

40:00

Electrolytic, Caloric, and Water Balance

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:10 AMMONIA DETOXICANTS

LACTULOSE

667 MG / ML ORAL SYRUP

00002295881	**JAMP-LACTULOSE**	**JPC**	$	**0.0145**
00002412268	**LACTULOSE**	**SNS**	$	**0.0145**
00000703486	**PMS-LACTULOSE**	**PMS**	$	**0.0145**
00002469391	**PMS-LACTULOSE-PHARMA**	**PMS**	$	**0.0145**
00000854409	**RATIO-LACTULOSE**	**TEV**	$	**0.0145**
00002331551	**TEVA-LACTULOSE**	**TEV**	$	**0.0145**

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:12 REPLACEMENT PREPARATIONS

MAGNESIUM GLUCOHEPTONATE

100 MG / ML ORAL SOLUTION

☒ 00080004109	MAGNESIUM-ODAN	ODN	$	0.0199
☒ 00000026697	ROUGIER MAGNESIUM	TEV	$	0.0200

MAGNESIUM GLUCONATE

500 MG ORAL TABLET

☒ 00080009539	JAMP MAGNESIUM GLUCONATE	JPC	$	0.1088
☒ 00000555126	MAGLUCATE	PPH	$	0.1183

POTASSIUM BICARBONATE

975 MG (BASE) ORAL EFFERVESCENT TABLET

00080033602	JAMP-K EFFERVESCENT (25 MEQ)	JPC	$	0.4760

POTASSIUM CHLORIDE (K+)

8 MEQ ORAL SUSTAINED-RELEASE TABLET

☒ 00080013005	JAMP-K 8	JPC	***$ 0.0450***	$	0.0450
☒ 00002246734	SANDOZ K	SDZ	***$ 0.0450***	$	0.0450

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release tablet.

8 MEQ ORAL EXTENDED-RELEASE CAPSULE

00080062704	JAMP-POTASSIUM CHLORIDE ER	JPC	***$ 0.0822***	$	0.0822

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release capsules.

8 MEQ ORAL SUSTAINED-RELEASE CAPSULE

00002042304	MICRO-K EXTENCAPS	PAL	***$ 0.0822***	$	0.1021

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release capsules.

20 MEQ ORAL TABLET/SUSTAINED-RELEASE TABLET

☒ 00080013007	JAMP-K 20	JPC	***$ 0.1995***	$	0.1995
☒ 00080004415	ODAN K-20	ODN	***$ 0.1995***	$	0.1995
☒ 00002242261	SANDOZ K 20	SDZ	***$ 0.1995***	$	0.1995

MAC pricing has been applied based on the lowest unit cost for an 20 mEq (K+) oral tablet and / or sustained-release tablet.

POTASSIUM CHLORIDE (K+)(CL-)

1.33 MEQ / ML ORAL LIQUID

00080024835	JAMP POTASSIUM CHLORIDE	JPC	$	0.0360

POTASSIUM CITRATE (K+)

25 MEQ ORAL EFFERVESCENT TABLET

00002085992	K-LYTE	WSP	$	0.5600

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:12 REPLACEMENT PREPARATIONS

SODIUM ACID PHOSPHATE/ SODIUM BICARBONATE/ POTASSIUM BICARBONATE

500 MG (BASE) * 469 MG (BASE) * 123 MG (BASE) ORAL EFFERVESCENT TABLET

00080047562	JAMP-SODIUM PHOSPHATE	JPC	$	1.4010

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	$	0.3954

SODIUM POLYSTYRENE SULFONATE

250 MG / ML ORAL SUSPENSION

00000769541	SOLYSTAT	PPH	$	0.1566

ORAL POWDER

00000755338	**SOLYSTAT**	**PPH**	$	**0.0926**
00002026961	KAYEXALATE	SAV	$	0.1851

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.16 DIURETICS (POTASSIUM-SPARING DIURETICS)

AMILORIDE HCL

5 MG ORAL TABLET

00002249510	MIDAMOR	AAP	$	0.3103

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.20 DIURETICS (THIAZIDE DIURETICS)

HYDROCHLOROTHIAZIDE

12.5 MG ORAL TABLET

☒ 00002327856	APO-HYDRO	APX	$	0.0322
☒ 00002274086	PMS-HYDROCHLOROTHIAZIDE	PMS	$	0.0322

25 MG ORAL TABLET

00000326844	**APO-HYDRO**	**APX**	$	**0.0157**
00002360594	**HYDROCHLOROTHIAZIDE**	**SNS**	$	**0.0157**
00000021474	**TEVA-HYDRAZIDE**	**TEV**	$	**0.0157**

50 MG ORAL TABLET

00000312800	**APO-HYDRO**	**APX**	$	**0.0217**
00002360608	**HYDROCHLOROTHIAZIDE**	**SNS**	$	**0.0217**
00000021482	**TEVA-HYDRAZIDE**	**TEV**	$	**0.0217**

HYDROCHLOROTHIAZIDE/ AMILORIDE HCL

50 MG * 5 MG ORAL TABLET

00000784400	AA-AMILZIDE	AAP	$	0.0838

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.20 DIURETICS

(THIAZIDE DIURETICS)

HYDROCHLOROTHIAZIDE/ TRIAMTERENE

25 MG * 50 MG ORAL TABLET				
00000441775	**APO-TRIAZIDE**	**APX**	$	**0.0608**
00000532657	**TEVA-TRIAMTERENE/HCTZ**	**TEV**	$	**0.0608**

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.24 DIURETICS

(THIAZIDE-LIKE DIURETICS)

CHLORTHALIDONE

50 MG ORAL TABLET				
00000360279	CHLORTHALIDONE	AAP	$	0.1419

INDAPAMIDE HEMIHYDRATE

1.25 MG (BASE) ORAL TABLET				
00002245246	**APO-INDAPAMIDE**	**APX**	$	**0.1490**
00002240067	**MYLAN-INDAPAMIDE**	**MYP**	$	**0.1490**
2.5 MG (BASE) ORAL TABLET				
00002223678	**APO-INDAPAMIDE**	**APX**	$	**0.2364**
00002153483	**MYLAN-INDAPAMIDE**	**MYP**	$	**0.2364**

METOLAZONE

2.5 MG ORAL TABLET				
00000888400	ZAROXOLYN	SAV	$	0.2185

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

00002374609	**APO-MONTELUKAST**	**APX**	$	**0.4231**
00002401274	**AURO-MONTELUKAST**	**AUR**	$	**0.4231**
00002391422	**JAMP-MONTELUKAST**	**JPC**	$	**0.4231**
00002399997	**MAR-MONTELUKAST**	**MAR**	$	**0.4231**
00002408643	**MINT-MONTELUKAST**	**MPI**	$	**0.4231**
00002379333	**MONTELUKAST**	**SNS**	$	**0.4231**
00002382474	**MONTELUKAST**	**SIV**	$	**0.4231**
00002379236	**MONTELUKAST SODIUM**	**AHI**	$	**0.4231**
00002489821	**NRA-MONTELUKAST**	**NRA**	$	**0.4231**
00002373947	**PMS-MONTELUKAST FC**	**PMS**	$	**0.4231**
00002389517	**RAN-MONTELUKAST**	**RAN**	$	**0.4231**
00002328593	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.4231**
00002355523	**TEVA-MONTELUKAST**	**TEV**	$	**0.4231**
00002238217	SINGULAIR	MFC	$	2.4823

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 Human Services Drug Benefit Supplement for eligibility for Alberta Human Services clients.)

4 MG (BASE) ORAL CHEWABLE TABLET

00002377608	**APO-MONTELUKAST**	**APX**	$	**0.2758**
00002442353	**JAMP-MONTELUKAST**	**JPC**	$	**0.2758**
00002399865	**MAR-MONTELUKAST**	**MAR**	$	**0.2758**
00002408627	**MINT-MONTELUKAST**	**MPI**	$	**0.2758**
00002382458	**MONTELUKAST**	**SIV**	$	**0.2758**
00002354977	**PMS-MONTELUKAST**	**PMS**	$	**0.2758**
00002330385	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.2758**
00002355507	**TEVA-MONTELUKAST**	**TEV**	$	**0.2758**
00002243602	SINGULAIR	MFC	$	1.5264

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

00002377616	**APO-MONTELUKAST**	**APX**	$	**0.3082**
00002442361	**JAMP-MONTELUKAST**	**JPC**	$	**0.3082**
00002399873	**MAR-MONTELUKAST**	**MAR**	$	**0.3082**
00002408635	**MINT-MONTELUKAST**	**MPI**	$	**0.3082**
00002382466	**MONTELUKAST**	**SIV**	$	**0.3082**
00002354985	**PMS-MONTELUKAST**	**PMS**	$	**0.3082**
00002330393	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.3082**
00002355515	**TEVA-MONTELUKAST**	**TEV**	$	**0.3082**
00002238216	SINGULAIR	MFC	$	1.6902

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 Human Services Drug Benefit Supplement for eligibility for Alberta Human Services clients.)

48:00 RESPIRATORY TRACT AGENTS

48:10.24 ANTI-INFLAMMATORY AGENTS (LEUKOTRIENE MODIFIERS)

MONTELUKAST SODIUM

4 MG (BASE) ORAL GRANULE

00002358611	**SANDOZ MONTELUKAST**	**SDZ**	$	**1.3139**
00002247997	SINGULAIR	MFC	$	1.5722

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

48:00 RESPIRATORY TRACT AGENTS

48:10.32 ANTI-INFLAMMATORY AGENTS (MAST-CELL STABILIZERS)

SODIUM CROMOGLYCATE

100 MG ORAL CAPSULE

00000500895	NALCROM	SAV	$	1.6117

1 % INHALATION SOLUTION

00002046113	PMS-SODIUM CROMOGLYCATE	PMS	$	1.0640

48:00 RESPIRATORY TRACT AGENTS

48:12.08 BRONCHODILATORS (ANTICHOLINERGIC AGENTS)

GLYCOPYRRONIUM BROMIDE

50 MCG INHALATION CAPSULE

00002394936	SEEBRI BREEZHALER	NOV	$	1.7700

48:00 RESPIRATORY TRACT AGENTS

48:24 MUCOLYTIC AGENTS

ACETYLCYSTEINE

20 % INHALATION SOLUTION

☒ 00002243098	ACETYLCYSTEINE	SDZ	$	0.7000

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

00002387131	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**1.7600**
00001945270	CILOXAN	NOV	$	2.2240

ERYTHROMYCIN

0.5 % OPHTHALMIC OINTMENT

00001912755	PDP-ERYTHROMYCIN	PPH	$	6.0000

OFLOXACIN

0.3 % OPHTHALMIC SOLUTION

00002143291	OCUFLOX	ALL	$	2.6949

TOBRAMYCIN

0.3 % OPHTHALMIC SOLUTION

00002241755	**SANDOZ TOBRAMYCIN**	**SDZ**	$	**1.3620**
00000513962	TOBREX	NOV	$	1.8580

0.3 % OPHTHALMIC OINTMENT

00000614254	TOBREX	NOV	$	2.6343

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**

BUDESONIDE

100 MCG / DOSE NASAL METERED DOSE SPRAY

00002230648	MYLAN-BUDESONIDE AQ	MYP	$	0.1006

CIPROFLOXACIN HCL/ DEXAMETHASONE

0.3 % * 0.1 % OTIC SUSPENSION

00002481901	**TARO-CIPROFLOXACIN/DEXAMETHASONE**	**TAR**	$	**2.8840**
00002252716	CIPRODEX	NOV	$	3.8720

DEXAMETHASONE

0.1 % OPHTHALMIC SUSPENSION

00000042560	MAXIDEX	NOV	$	1.7180

0.1 % OPHTHALMIC OINTMENT

00000042579	MAXIDEX	NOV	$	2.6600

FLUOROMETHOLONE

0.1 % OPHTHALMIC SUSPENSION

00000432814	SANDOZ FLUOROMETHOLONE	SDZ	$	1.8774

FLUOROMETHOLONE ACETATE

0.1 % OPHTHALMIC SUSPENSION

00000756784	FLAREX	NOV	$	1.9920

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08 ANTI-INFLAMMATORY AGENTS (CORTICOSTEROIDS)

FLUTICASONE FUROATE

100 MCG / DOSE INHALATION METERED INHALATION POWDER

00002446561	ARNUITY ELLIPTA	GSK	$	1.3504

200 MCG / DOSE INHALATION METERED INHALATION POWDER

00002446588	ARNUITY ELLIPTA	GSK	$	2.7007

MOMETASONE FUROATE

50 MCG / DOSE NASAL METERED DOSE SPRAY

00002403587	**APO-MOMETASONE**	**APX**	$	**0.0752**
00002449811	**SANDOZ MOMETASONE**	**SDZ**	$	**0.0752**
00002475863	**TEVA-MOMETASONE**	**TEV**	$	**0.0752**
00002238465	NASONEX	MFC	$	0.2125

PREDNISOLONE ACETATE

0.12 % OPHTHALMIC SUSPENSION

00000299405	PRED MILD	ALL	$	1.8881

1 % OPHTHALMIC SUSPENSION

00001916203	**SANDOZ PREDNISOLONE ACETATE**	**SDZ**	$	**1.9400**
00000700401	**TEVA-PREDNISOLONE**	**TEV**	$	**1.9400**
00000301175	PRED FORTE	ALL	$	5.2880

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08.00 ANTI-INFLAMMATORY AGENTS CORTICOSTEROIDS (COMBINATION ANTI-INFECTIVE/CORTICOSTEROID AGENTS)

DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN

0.5 MG / ML * 5 MG / ML * 0.05 MG / ML OTIC/OPHTHALMIC SOLUTION

00002224623	SOFRACORT	SAV	$	2.1038

DEXAMETHASONE/ NEOMYCIN SULFATE/ POLYMYXIN B SULFATE

1 MG / ML * 3.5 MG / ML (BASE) * 6,000 UNIT / ML OPHTHALMIC SUSPENSION

00000042676	MAXITROL	NOV	$	2.1800

1 MG / G * 3.5 MG / G (BASE) * 6,000 UNIT / G OPHTHALMIC OINTMENT

00000358177	MAXITROL	NOV	$	3.0400

DEXAMETHASONE/ TOBRAMYCIN

0.1 % * 0.3 % OPHTHALMIC SUSPENSION

00000778907	TOBRADEX	NOV	$	2.1720

0.1 % * 0.3 % OPHTHALMIC OINTMENT

00000778915	TOBRADEX	NOV	$	3.2057

FLUMETHASONE PIVALATE/ CLIOQUINOL

0.02 % * 1 % OTIC SOLUTION

00000074454	LOCACORTEN VIOFORM	PAL	$	1.6887

PREDNISOLONE ACETATE/ SULFACETAMIDE SODIUM

0.2 % * 10 % OPHTHALMIC SUSPENSION

00000807788	BLEPHAMIDE	ALL	$	2.8599

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				
00002441020	**APO-DICLOFENAC OPHTHALMIC**	**APX**	$	**1.2397**
00002475065	**DICLOFENAC**	**PSL**	$	**1.2397**
00002475197	**MINT-DICLOFENAC**	**MPI**	$	**1.2397**
00002454807	**SANDOZ DICLOFENAC OPHTHA**	**SDZ**	$	**1.2397**
00001940414	VOLTAREN OPHTHA	NOV	$	2.7600

KETOROLAC TROMETHAMINE

0.45 % OPHTHALMIC SOLUTION				
00002369362	ACUVAIL	ALL	$	0.6466
0.5 % OPHTHALMIC SOLUTION				
00002245821	**KETOROLAC**	**AAP**	$	**2.7585**
00001968300	ACULAR	ALL	$	3.6490

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:16 LOCAL ANESTHETICS

LIDOCAINE HCL

2 % ORAL LIQUID				
00000001686	**XYLOCAINE VISCOUS**	**APC**	$	**0.1130**
00001968823	LIDODAN VISCOUS	ODN	$	0.1850

PROPARACAINE HCL

0.5 % OPHTHALMIC SOLUTION				
00000035076	ALCAINE	ALC	$	0.8880

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:24 MYDRIATICS

ATROPINE SULFATE

1 % OPHTHALMIC SOLUTION				
00000035017	ISOPTO ATROPINE	ALC	$	0.7640

CYCLOPENTOLATE HCL

1 % OPHTHALMIC SOLUTION				
00000252506	CYCLOGYL	ALC	$	1.0500

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:28 MOUTHWASHES AND GARGLES

BENZYDAMINE HCL

0.15 % ORAL RINSE				
00002463105	**ODAN-BENZYDAMINE**	**ODN**	$	**0.0384**
00002239537	**PMS-BENZYDAMINE**	**PMS**	$	**0.0384**

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:28 MOUTHWASHES AND GARGLES

COMPOUND PRESCRIPTION

ORAL

00000999209	COMPD-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT 0.12%)	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

ORAL

00000999109	COMPD-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT .12%)	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared 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	$	0.6389

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:32 VASOCONSTRICTORS

PHENYLEPHRINE HCL

2.5 % OPHTHALMIC SOLUTION

	00000465763	MYDFRIN	ALC	$	1.2640

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.04 ANTIGLAUCOMA AGENTS (ALPHA-ADRENERGIC AGONISTS)

BRIMONIDINE TARTRATE

0.2 % OPHTHALMIC SOLUTION

	00002305429	**SANDOZ BRIMONIDINE**	**SDZ**	$	**1.1550**
	00002236876	ALPHAGAN	ALL	$	3.6899

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.08 ANTIGLAUCOMA AGENTS (BETA-ADRENERGIC AGENTS)

BETAXOLOL HCL

0.25 % (BASE) OPHTHALMIC SUSPENSION

	00001908448	BETOPTIC S	NOV	$	2.4520

TIMOLOL MALEATE

0.25 % (BASE) OPHTHALMIC SOLUTION

	00002166712	SANDOZ TIMOLOL MALEATE	SDZ	$	0.9678

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	ELV	$	4.1390

0.5 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION

	00002171899	TIMOPTIC-XE	ELV	$	5.2830

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.12 ANTIGLAUCOMA AGENTS (CARBONIC ANHYDRASE INHIBITORS)

ACETAZOLAMIDE

250 MG ORAL TABLET

	00000545015	ACETAZOLAMIDE	AAP	$	0.1414

BRINZOLAMIDE

1 % OPHTHALMIC SUSPENSION

	00002238873	AZOPT	NOV	$	3.5460

DORZOLAMIDE HCL

2 % (BASE) OPHTHALMIC SOLUTION

	00002453347	**JAMP-DORZOLAMIDE**	**JPC**	$	**2.1081**
	00002316307	**SANDOZ DORZOLAMIDE**	**SDZ**	$	**2.1081**
	00002216205	TRUSOPT	ELV	$	4.3930
☒	00002269090	TRUSOPT (PRESERVATIVE-FREE)	ELV	$	4.3935

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.12 ANTIGLAUCOMA AGENTS (CARBONIC ANHYDRASE INHIBITORS)

METHAZOLAMIDE

50 MG ORAL TABLET

00002245882	METHAZOLAMIDE	AAP	$	0.5502

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.20 ANTIGLAUCOMA AGENTS (MIOTICS)

PILOCARPINE HCL

2 % OPHTHALMIC SOLUTION

00000000868	ISOPTO CARPINE	NOV	$	0.2780

4 % OPHTHALMIC SOLUTION

00000000884	ISOPTO CARPINE	NOV	$	0.3160

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.28 ANTIGLAUCOMA AGENTS (PROSTAGLANDIN ANALOGS)

BIMATOPROST

OPHTHALMIC SOLUTION

00002429063	**VISTITAN 0.03%**	**SDZ**	$	**9.1936**
00002324997	LUMIGAN RC 0.01%	ALL	$	11.8871

LATANOPROST

0.005 % OPHTHALMIC SOLUTION

00002296527	**APO-LATANOPROST**	**APX**	$	**3.6320**
00002373041	**GD-LATANOPROST**	**UJC**	$	**3.6320**
00002453355	**JAMP-LATANOPROST**	**JPC**	$	**3.6320**
00002489570	**LATANOPROST**	**TGT**	$	**3.6320**
00002426935	**MED-LATANOPROST**	**GMP**	$	**3.6320**
00002367335	**SANDOZ LATANOPROST**	**SDZ**	$	**3.6320**
00002254786	**TEVA-LATANOPROST**	**TEV**	$	**3.6320**
00002231493	XALATAN	UJC	$	12.3960

LATANOPROSTENE BUNOD

0.024 % OPHTHALMIC SOLUTION

00002484218	VYZULTA	VCL	$	5.2500

TRAVOPROST

0.003 % OPHTHALMIC SOLUTION

00002457997	IZBA	NOV	$	3.9400

0.004 % OPHTHALMIC SOLUTION

00002415739	**APO-TRAVOPROST Z**	**APX**	$	**4.0264**
00002413167	**SANDOZ TRAVOPROST**	**SDZ**	$	**4.0264**
00002318008	TRAVATAN Z	NOV	$	11.6960

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	$	4.4799

BRINZOLAMIDE/ BRIMONIDINE TARTRATE

1 % * 0.2 % OPHTHALMIC SUSPENSION

00002435411	SIMBRINZA	NOV	$	4.7180

BRINZOLAMIDE/ TIMOLOL MALEATE

1 % * 0.5 % (BASE) OPHTHALMIC SUSPENSION

00002331624	AZARGA	NOV	$	4.0800

DORZOLAMIDE HCL/ TIMOLOL MALEATE

2 % (BASE) * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002299615	**APO-DORZO-TIMOP**	**APX**	$	**1.9887**
00002489635	**DORZOLAMIDE AND TIMOLOL**	**TGT**	$	**1.9887**
00002457539	**JAMP DORZOLAMIDE-TIMOLOL**	**JPC**	$	**1.9887**
00002437686	**MED-DORZOLAMIDE-TIMOLOL**	**GMP**	$	**1.9887**
00002344351	**SANDOZ DORZOLAMIDE/ TIMOLOL**	**SDZ**	$	**1.9887**
☒ 00002258692	COSOPT PRESERVATIVE-FREE	ELV	$	2.6930
00002240113	COSOPT	ELV	$	6.6560

LATANOPROST/ TIMOLOL MALEATE

0.005 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002436256	**ACT LATANOPROST/TIMOLOL**	**APH**	$	**4.4268**
00002373068	**GD-LATANOPROST/TIMOLOL**	**UJC**	$	**4.4268**
00002453770	**JAMP-LATANOPROST/TIMOLOL**	**JPC**	$	**4.4268**
00002489368	**LATANOPROST AND TIMOLOL**	**TGT**	$	**4.4268**
00002454505	**MED-LATANOPROST-TIMOLOL**	**GMP**	$	**4.4268**
00002246619	XALACOM	UJC	$	14.0320

TRAVOPROST/ TIMOLOL MALEATE

0.004 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002415305	**APO-TRAVOPROST-TIMOP PQ**	**APX**	$	**8.8425**
00002278251	DUOTRAV PQ	NOV	$	11.3400

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

AFLIBERCEPT

RESTRICTED BENEFIT

This Drug Product is a benefit to a member of an Alberta Government Sponsored Drug Plan when the Drug Product is prescribed by a registered prescriber and pursuant to the following criteria:

"For the treatment of neovascular (wet) age-related macular degeneration (AMD) if all of the following apply to the eye to be treated:

- The best corrected visual acuity (BCVA) is between 6/12 (20/40) and 6/96 (20/320); and
- There is active disease activity (choroidal neovascularization) and no permanent structural damage to the central fovea; and
- There is evidence of recent (< three (3) months) presumed disease progression (blood vessel growth, as indicated by fluoroscein angiography, optical coherence tomography (OCT) or recent visual acuity changes); and
- No concurrent verteporfin PDT treatment; and
- The injection will be administered by a qualified ophthalmologist with experience in intravitreal injections.

Treatment with anti-VEGF agents should be continued only in patients who maintain adequate response to therapy.

The anti-VEGF agent should be discontinued if any of the following occur:
- Reduction in BCVA in the treated eye to less than fifteen (15) letters (absolute) on two (2) consecutive visits in the treated eye, attributed to AMD in the absence of other pathology; or
- Reduction in BCVA of thirty (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; or
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three (3) consecutive visits.

The interval between the doses should be no less than 1 month.

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent."

"For the treatment of diabetic macular edema (DME), in patients with severe visual impairment as defined by:

Best-Corrected Visual Acuity (using the Early Treatment Diabetic Retinopathy Study visual acuity test) of seventy-eight (78) to twenty-four (24) letters and a central retinal thickness greater than or equal to three hundred (300) micrometres meeting all of the following criteria:
- clinically significant diabetic macular edema for whom laser photocoagulation is also indicated, and
- a hemoglobin A1c of less than or equal to 12%.

Coverage will not be provided to patients who have failed to respond to a previous anti-VEGF agent."

"For the treatment of visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (BRVO).

Aflibercept is administered by intravitreal injection once every month. The interval between doses should not be shorter than one month. The treatment interval may be extended up to 3 months based on visual and anatomic outcomes. Prescribers are advised to periodically assess the need for continued therapy.

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

AFLIBERCEPT

Clinical trial experience of a monthly dosing regimen of 2 mg aflibercept beyond 6 months in the CRVO and BRVO indications is limited. The dosing regimen of once every 4 weeks changed, at 24 weeks, to a regimen that allowed for extension of the treatment based on visual and anatomic outcomes in the CRVO clinical trials and to once every 8 weeks in the BRVO clinical trial.

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent."

2 MG / VIAL INJECTION			
00002415992	EYLEA	BAI	$ 1418.0000

APRACLONIDINE HCL

0.5 % OPHTHALMIC SOLUTION			
00002076306	IOPIDINE	NOV	$ 5.1140

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

RANIBIZUMAB

This Drug Product is a benefit to a member of an Alberta Government Sponsored Drug Plan when the Drug Product is prescribed by a registered prescriber and pursuant to the following criteria:

"For the treatment of visual impairment due to macular edema secondary to retinal vein occlusion (RVO).

Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on ranibizumab treatment. Thereafter patients should be monitored monthly for visual acuity.

Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to macular edema secondary to RVO and continued until stable visual acuity is reached again for three consecutive monthly assessments."

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent.

"For the treatment of diabetic macular edema (DME), in patients with severe visual impairment as defined by:

Best-Corrected Visual Acuity (using the Early Treatment Diabetic Retinopathy Study visual acuity test) of seventy-eight (78) to twenty-four (24) letters and a central retinal thickness greater than or equal to three hundred (300) micrometres meeting all of the following criteria:
- clinically significant diabetic macular edema for whom laser photocoagulation is also indicated, and
- a hemoglobin A1c of less than or equal to 11%."

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent.

"For the treatment of neovascular (wet) age-related macular degeneration (AMD) in anti-vascular endothelial growth factor (anti-VEGF) treatment naive patients if all of the following apply to the eye to be treated:

- The best corrected visual acuity (BCVA) is between 6/12 (20/40) and 6/96 (20/320); and
- There is active disease activity (choroidal neovascularization) and no permanent structural damage to the central fovea; and
- There is evidence of recent (< three (3) months) presumed disease progression (blood vessel growth, as indicated by fluoroscein angiography, optical coherence tomography (OCT) or recent visual acuity changes); and
- No concurrent verteporfin PDT treatment; and
- The injection will be administered by a qualified ophthalmologist with experience in intravitreal injections.

Treatment with anti-VEGF agents should be continued only in patients who maintain adequate response to therapy.

The anti-VEGF agent should be discontinued if any of the following occur:
- Reduction in BCVA in the treated eye to less than fifteen (15) letters (absolute) on two (2) consecutive visits in the treated eye, attributed to AMD in the absence of other pathology; or
- Reduction in BCVA of thirty (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; or
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three (3) consecutive visits."

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

RANIBIZUMAB

The interval between the doses should be no less than 1 month.

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent.

2.3 MG / VIAL INJECTION

00002296810	LUCENTIS	NOV	$ 1616.5500

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	$	0.5317

56:00 GASTROINTESTINAL DRUGS

56:14 CHOLELITHOLYTIC AGENTS

URSODIOL

250 MG ORAL TABLET

00002472392	**JAMP-URSODIOL**	**JPC**	$	**0.3818**
00002273497	**PMS-URSODIOL C**	**PMS**	$	**0.3818**
00002426900	**URSODIOL TABLETS USP**	**GLM**	$	**0.3818**
00002238984	URSO	AXC	$	1.5469

500 MG ORAL TABLET

00002472406	**JAMP-URSODIOL**	**JPC**	$	**0.7242**
00002273500	**PMS-URSODIOL C**	**PMS**	$	**0.7242**
00002426919	**URSODIOL TABLETS USP**	**GLM**	$	**0.7242**
00002245894	URSO DS	AXC	$	2.9345

56:00 GASTROINTESTINAL DRUGS

56:16 DIGESTANTS

LIPASE/ AMYLASE/ PROTEASE

10,440 UNIT * 56,400 UNIT * 57,100 UNIT ORAL TABLET

00002230019	VIOKACE	NHN	$	0.2650

20,880 UNIT * 113,400 UNIT * 112,500 UNIT ORAL TABLET

00002241933	VIOKACE	NHN	$	0.4068

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE

00000263818	COTAZYM	MFC	$	0.2083

4,000 UNIT * 12,000 UNIT * 12,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789445	PANCREASE MT 4	VPL	$	0.6250

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000502790	COTAZYM ECS 8	MFC	$	0.3759

10,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789437	PANCREASE MT 10	VPL	$	1.5625

10,000 UNIT * 33,200 UNIT * 37,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00002200104	CREON 10 MINIMICROSPHERES	BGP	$	0.2723

16,000 UNIT * 48,000 UNIT * 48,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789429	PANCREASE MT 16	VPL	$	2.4997

20,000 UNIT * 55,000 UNIT * 55,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000821373	COTAZYM ECS 20	MFC	$	0.9855

25,000 UNIT * 74,000 UNIT * 62,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00001985205	CREON 25 MINIMICROSPHERES	BGP	$	0.8507

56:00 GASTROINTESTINAL DRUGS

56:22.08 ANTIEMETICS (ANTIHISTAMINES)

DIMENHYDRINATE

10 MG / ML INJECTION				
00000392731	DIMENHYDRINATE I.V.	SDZ	$	1.0297
50 MG / ML INJECTION				
00000392537	DIMENHYDRINATE I.M.	SDZ	$	1.4490

PROCHLORPERAZINE

5 MG ORAL TABLET				
00000886440	PROCHLORAZINE	AAP	$	0.1895
10 MG ORAL TABLET				
00000886432	PROCHLORAZINE	AAP	$	0.2314
10 MG RECTAL SUPPOSITORY				
00000789720	SANDOZ PROCHLORPERAZINE	SDZ	$	2.0055

56:00 GASTROINTESTINAL DRUGS

56:22.20 ANTIEMETICS (5-HT3 RECEPTOR ANTAGONISTS)

GRANISETRON HCL

1 MG (BASE) ORAL TABLET				
00002308894	**APO-GRANISETRON**	**APX**	$	**4.5000**
00002452359	**NAT-GRANISETRON**	**NTP**	$	**4.5000**

ONDANSETRON

4 MG ORAL DISINTEGRATING TABLET/FILM				
00002487330	**MINT-ONDANSETRON ODT**	**MPI**	$	**3.2720**
00002481723	**ONDANSETRON ODT**	**SDZ**	$	**3.2720**
00002389983	**ONDISSOLVE ODF**	**TAK**	$	**3.2720**
00002239372	ZOFRAN ODT	NOV	$	14.3590
8 MG ORAL DISINTEGRATING TABLET/FILM				
00002487349	**MINT-ONDANSETRON ODT**	**MPI**	$	**4.9930**
00002481731	**ONDANSETRON ODT**	**SDZ**	$	**4.9930**
00002389991	**ONDISSOLVE ODF**	**TAK**	$	**4.9930**
00002239373	ZOFRAN ODT	NOV	$	21.9110

56:00 GASTROINTESTINAL DRUGS

56:22.20 ANTIEMETICS

(5-HT3 RECEPTOR ANTAGONISTS)

ONDANSETRON HCL DIHYDRATE

4 MG (BASE) ORAL TABLET				
00002478927	**ACCEL-ONDANSETRON**	**ACP**	$	**2.6790**
00002458810	**CCP-ONDANSETRON**	**CEL**	$	**2.6790**
00002297868	**MYLAN-ONDANSETRON**	**MYP**	$	**2.6790**
00002288184	APO-ONDANSETRON	APX	$	3.2720
00002296349	CO ONDANSETRON	APH	$	3.2720
00002313685	JAMP-ONDANSETRON	JPC	$	3.2720
00002371731	MAR-ONDANSETRON	MAR	$	3.2720
00002305259	MINT-ONDANSETRON	MPI	$	3.2720
00002417839	NAT-ONDANSETRON	NTP	$	3.2720
00002421402	ONDANSETRON	SNS	$	3.2720
00002258188	PMS-ONDANSETRON	PMS	$	3.2720
00002274310	SANDOZ ONDANSETRON	SDZ	$	3.2720
00002213567	ZOFRAN	NOV	$	14.9180
8 MG (BASE) ORAL TABLET				
00002478935	**ACCEL-ONDANSETRON**	**ACP**	$	**4.0880**
00002458802	**CCP-ONDANSETRON**	**CEL**	$	**4.0880**
00002297876	**MYLAN-ONDANSETRON**	**MYP**	$	**4.0880**
00002288192	APO-ONDANSETRON	APX	$	4.9930
00002296357	CO ONDANSETRON	APH	$	4.9930
00002313693	JAMP-ONDANSETRON	JPC	$	4.9930
00002371758	MAR-ONDANSETRON	MAR	$	4.9930
00002305267	MINT-ONDANSETRON	MPI	$	4.9930
00002417847	NAT-ONDANSETRON	NTP	$	4.9930
00002421410	ONDANSETRON	SNS	$	4.9930
00002258196	PMS-ONDANSETRON	PMS	$	4.9930
00002274329	SANDOZ ONDANSETRON	SDZ	$	4.9930
00002213575	ZOFRAN	NOV	$	22.7660
0.8 MG / ML (BASE) ORAL SOLUTION				
00002291967	**APO-ONDANSETRON**	**APX**	$	**1.1360**
00002490617	**JAMP ONDANSETRON**	**JPC**	$	**1.1360**
00002229639	ZOFRAN	NOV	$	2.2426
2 MG / ML (BASE) INJECTION				
00002420414	**JAMP-ONDANSETRON (PRESERVATIVE FREE)**	**JPC**	$	**3.4552**
00002390019	**ONDANSETRON (PRESERVATIVE FREE)**	**MYP**	$	**3.4552**
00002279428	**ONDANSETRON (UNPRESERVED)**	**SDZ**	$	**3.4552**
00002464578	**ONDANSETRON INJECTION USP**	**STM**	$	**3.4552**
00002213745	ZOFRAN	NOV	$	10.9930
2 MG / ML (BASE) INJECTION				
00002420422	**JAMP-ONDANSETRON (WITH PRESERVATIVE)**	**JPC**	$	**3.4552**
00002279436	**ONDANSETRON (PRESERVED)**	**SDZ**	$	**3.4552**
00002274418	**ONDANSETRON HYDROCHLORIDE DIHYDRATE (PRESERVED)**	**SDZ**	$	**3.4552**

56:00 GASTROINTESTINAL DRUGS

56:22.92 ANTIEMETICS

(MISCELLANEOUS ANTIEMETICS)

APREPITANT

RESTRICTED BENEFIT - This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates).

80 MG ORAL CAPSULE

00002298791	EMEND	MFC	$	34.2387

APREPITANT/ APREPITANT

RESTRICTED BENEFIT - This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates).

80 MG * 125 MG ORAL CAPSULE

00002298813	EMEND TRI-PACK	MFC	$	34.2387

DOXYLAMINE SUCCINATE/ PYRIDOXINE HCL

10 MG * 10 MG ORAL SUSTAINED-RELEASE TABLET

00002413248	**APO-DOXYLAMINE/B6**	**APX**	$	**0.6402**
00002406187	**PMS-DOXYLAMINE-PYRIDOXINE**	**PMS**	$	**0.6402**
00000609129	DICLECTIN	DUI	$	1.2803

NABILONE

0.5 MG ORAL CAPSULE

00002393581	**ACT NABILONE**	**APH**	$	**0.7756**
00002380900	**PMS-NABILONE**	**PMS**	$	**0.7756**
00002384884	**TEVA-NABILONE**	**TEV**	$	**0.7756**
00002256193	CESAMET	VCL	$	3.4871

1 MG ORAL CAPSULE

00002380919	**PMS-NABILONE**	**PMS**	$	**1.5513**
00002384892	**TEVA-NABILONE**	**TEV**	$	**1.5513**
00000548375	CESAMET	VCL	$	6.9739

56:00 GASTROINTESTINAL DRUGS

56:28.12 ANTIULCER AGENTS AND ACID SUPPRESSANTS

(HISTAMINE H2-ANTAGONISTS)

CIMETIDINE

200 MG ORAL TABLET

00000584215	CIMETIDINE	AAP	$	0.3518

300 MG ORAL TABLET

00000487872	CIMETIDINE	AAP	$	0.3543

FAMOTIDINE

20 MG ORAL TABLET

00002351102	**FAMOTIDINE**	**SNS**	$	**0.2657**
00002022133	**TEVA-FAMOTIDINE**	**TEV**	$	**0.2657**

40 MG ORAL TABLET

00002351110	**FAMOTIDINE**	**SNS**	$	**0.4833**
00002022141	**TEVA-FAMOTIDINE**	**TEV**	$	**0.4833**

NIZATIDINE

150 MG ORAL CAPSULE

00000778338	AXID	PPH	$	1.2347

56:00 GASTROINTESTINAL DRUGS

56:28.12 ANTIULCER AGENTS AND ACID SUPPRESSANTS (HISTAMINE H2-ANTAGONISTS)

RANITIDINE HCL

150 MG (BASE) ORAL TABLET				
00000733059	**APO-RANITIDINE**	**APX**	$	**0.1197**
00002463717	**JAMP-RANITIDINE**	**JPC**	$	**0.1197**
00002443708	**MAR-RANITIDINE**	**MAR**	$	**0.1197**
00002242453	**PMS-RANITIDINE**	**PMS**	$	**0.1197**
00002336480	**RAN-RANITIDINE**	**RAN**	$	**0.1197**
00002353016	**RANITIDINE**	**SNS**	$	**0.1197**
00002385953	**RANITIDINE**	**SIV**	$	**0.1197**
300 MG (BASE) ORAL TABLET				
00000733067	**APO-RANITIDINE**	**APX**	$	**0.2253**
00002463725	**JAMP-RANITIDINE**	**JPC**	$	**0.2253**
00002443716	**MAR-RANITIDINE**	**MAR**	$	**0.2253**
00002242454	**PMS-RANITIDINE**	**PMS**	$	**0.2253**
00002336502	**RAN-RANITIDINE**	**RAN**	$	**0.2253**
00002353024	**RANITIDINE**	**SNS**	$	**0.2253**
00002385961	**RANITIDINE**	**SIV**	$	**0.2253**
15 MG / ML (BASE) ORAL SOLUTION				
00002280833	APO-RANITIDINE	APX	$	0.1480

56:00 GASTROINTESTINAL DRUGS

56:28.28 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROSTAGLANDINS)

MISOPROSTOL

100 MCG ORAL TABLET				
00002244022	MISOPROSTOL	AAP	$	0.2952
200 MCG ORAL TABLET				
00002244023	MISOPROSTOL	AAP	$	0.4916

56:00 GASTROINTESTINAL DRUGS

56:28.32 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTECTANTS)

SUCRALFATE

1 G ORAL TABLET				
00002125250	**APO-SUCRALFATE**	**APX**	$	**0.3089**
00002045702	**TEVA-SUCRALFATE**	**TEV**	$	**0.3089**
00002100622	SULCRATE	AXC	$	0.6399
200 MG / ML ORAL SUSPENSION				
00002103567	SULCRATE SUSPENSION PLUS	AXC	$	0.1146

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

LANSOPRAZOLE

15 MG ORAL DELAYED-RELEASE CAPSULE

00002293811	APO-LANSOPRAZOLE	APX	***$ 0.0669***	$ 0.5000
00002357682	LANSOPRAZOLE	SNS	***$ 0.0669***	$ 0.5000
00002385767	LANSOPRAZOLE	SIV	***$ 0.0669***	$ 0.5000
00002433001	LANSOPRAZOLE	PMS	***$ 0.0669***	$ 0.5000
00002353830	MYLAN-LANSOPRAZOLE	MYP	***$ 0.0669***	$ 0.5000
00002402610	RAN-LANSOPRAZOLE	RAN	***$ 0.0669***	$ 0.5000
00002385643	SANDOZ LANSOPRAZOLE	SDZ	***$ 0.0669***	$ 0.5000
00002280515	TEVA-LANSOPRAZOLE	TEV	***$ 0.0669***	$ 0.5000
00002165503	PREVACID	BGP	***$ 0.0669***	$ 2.1418

MAC pricing will be applied based on the LCA Price for Rabeprazole Sodium 1 X 10 mg enteric-coated tablet.

30 MG ORAL DELAYED-RELEASE CAPSULE

00002293838	APO-LANSOPRAZOLE	APX	***$ 0.1875***	$ 0.5000
00002357690	LANSOPRAZOLE	SNS	***$ 0.1875***	$ 0.5000
00002410389	LANSOPRAZOLE	SIV	***$ 0.1875***	$ 0.5000
00002433028	LANSOPRAZOLE	PMS	***$ 0.1875***	$ 0.5000
00002353849	MYLAN-LANSOPRAZOLE	MYP	***$ 0.1875***	$ 0.5000
00002402629	RAN-LANSOPRAZOLE	RAN	***$ 0.1875***	$ 0.5000
00002385651	SANDOZ LANSOPRAZOLE	SDZ	***$ 0.1875***	$ 0.5000
00002280523	TEVA-LANSOPRAZOLE	TEV	***$ 0.1875***	$ 0.5000
00002165511	PREVACID	BGP	***$ 0.1875***	$ 2.1418

MAC pricing will be applied based on the LCA Price for Pantoprazole Magnesium 1 X 40 mg enteric-coated tablet.

LANSOPRAZOLE/ AMOXICILLIN TRIHYDRATE/ CLARITHROMYCIN

30 MG * 500 MG (BASE) * 500 MG ORAL TABLET/CAPSULE

00002470780	**APO-LANSOPRAZOLE-AMOXICILLIN-CLARITHROMYCIN**	**APX**		**$ 67.9100**
00002238525	**HP-PAC (KIT)**	**BGP**		**$ 67.9100**

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

OMEPRAZOLE

10 MG ORAL CAPSULE/SUSTAINED-RELEASE TABLET

00002296438	SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAPSULE)	SDZ	***$ 0.0669***	$	0.9470
00002295407	TEVA-OMEPRAZOLE (DELAYED-RELEASE TABLET)	TEV	***$ 0.0669***	$	0.9470

MAC pricing will be applied based on the LCA Price for Rabeprazole Sodium 1 X 10 mg enteric-coated tablet.

20 MG ORAL CAPSULE/SUSTAINED-RELEASE TABLET

00002245058	APO-OMEPRAZOLE (DELAYED-RELEASE CAPSULE)	APX	***$ 0.1875***	$	0.2287
00002420198	JAMP-OMEPRAZOLE DR (DELAYED-RELEASE TABLET)	JPC	***$ 0.1875***	$	0.2287
00002439549	NAT-OMEPRAZOLE DR (DELAYED-RELEASE TABLET)	NTP	***$ 0.1875***	$	0.2287
00002501880	NRA-OMEPRAZOLE (SUSTAINED-RELEASE TABLET)	NRA	***$ 0.1875***	$	0.2287
00002348691	OMEPRAZOLE (DELAYED-RELEASE CAPSULE)	SNS	***$ 0.1875***	$	0.2287
00002416549	OMEPRAZOLE (DELAYED-RELEASE TABLET)	AHI	***$ 0.1875***	$	0.2287
00002411857	OMEPRAZOLE-20 (DELAYED-RELEASE CAPSULE)	SIV	***$ 0.1875***	$	0.2287
00002320851	PMS-OMEPRAZOLE (SUSTAINED-RELEASE CAP)	PMS	***$ 0.1875***	$	0.2287
00002296446	SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAP)	SDZ	***$ 0.1875***	$	0.2287
00002295415	TEVA-OMEPRAZOLE (DELAYED-RELEASE TABLET)	TEV	***$ 0.1875***	$	0.2287
00000846503	LOSEC (SUSTAINED-RELEASE CAPSULE)	CAG	***$ 0.1875***	$	1.1320
00002190915	LOSEC (SUSTAINED-RELEASE TABLET)	CAG	***$ 0.1875***	$	2.3820

MAC pricing will be applied based on the LCA Price for Pantoprazole Magnesium 1 X 40 mg enteric-coated tablet.

PANTOPRAZOLE MAGNESIUM

40 MG ORAL ENTERIC-COATED TABLET

00002408570	**MYLAN-PANTOPRAZOLE T**	**MYP**	$	**0.1875**
00002441853	**PANTOPRAZOLE MAGNESIUM**	**ALH**	$	**0.1875**
00002466147	**PANTOPRAZOLE T**	**SNS**	$	**0.1875**
00002440628	**TEVA-PANTOPRAZOLE MAGNESIUM**	**TEV**	$	**0.1875**
00002267233	TECTA	TAK	$	0.7500

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

PANTOPRAZOLE SODIUM

40 MG ORAL ENTERIC-COATED TABLET

00002481588	AG-PANTOPRAZOLE SODIUM	AGP	***$ 0.1875***	$ 0.2016
00002292920	APO-PANTOPRAZOLE	APX	***$ 0.1875***	$ 0.2016
00002415208	AURO-PANTOPRAZOLE	AUR	***$ 0.1875***	$ 0.2016
00002357054	JAMP-PANTOPRAZOLE	JPC	***$ 0.1875***	$ 0.2016
00002467372	M-PANTOPRAZOLE	MTR	***$ 0.1875***	$ 0.2016
00002416565	MAR-PANTOPRAZOLE	MAR	***$ 0.1875***	$ 0.2016
00002417448	MINT-PANTOPRAZOLE	MPI	***$ 0.1875***	$ 0.2016
00002471825	NRA-PANTOPRAZOLE	NRA	***$ 0.1875***	$ 0.2016
00002370808	PANTOPRAZOLE	SNS	***$ 0.1875***	$ 0.2016
00002437945	PANTOPRAZOLE	PMS	***$ 0.1875***	$ 0.2016
00002428180	PANTOPRAZOLE-40	SIV	***$ 0.1875***	$ 0.2016
00002307871	PMS-PANTOPRAZOLE	PMS	***$ 0.1875***	$ 0.2016
00002305046	RAN-PANTOPRAZOLE	RAN	***$ 0.1875***	$ 0.2016
00002301083	SANDOZ PANTOPRAZOLE	SDZ	***$ 0.1875***	$ 0.2016
00002285487	TEVA-PANTOPRAZOLE	TEV	***$ 0.1875***	$ 0.2016
00002229453	PANTOLOC	TAK	***$ 0.1875***	$ 2.0803

MAC pricing will be applied based on the LCA Price for Pantoprazole Magnesium 1 X 40 mg enteric-coated tablet.

RABEPRAZOLE SODIUM

10 MG ORAL ENTERIC-COATED TABLET

00002310805	**PMS-RABEPRAZOLE EC**	**PMS**	$	**0.0669**
00002385449	**RABEPRAZOLE**	**SIV**	$	**0.0669**
00002356511	**RABEPRAZOLE EC**	**SNS**	$	**0.0669**
00002298074	**RAN-RABEPRAZOLE**	**RAN**	$	**0.0669**
00002314177	**SANDOZ RABEPRAZOLE**	**SDZ**	$	**0.0669**
00002243796	PARIET	JAI	$	0.9410

20 MG ORAL ENTERIC-COATED TABLET

00002310813	**PMS-RABEPRAZOLE EC**	**PMS**	$	**0.1338**
00002385457	**RABEPRAZOLE**	**SIV**	$	**0.1338**
00002356538	**RABEPRAZOLE EC**	**SNS**	$	**0.1338**
00002298082	**RAN-RABEPRAZOLE**	**RAN**	$	**0.1338**
00002314185	**SANDOZ RABEPRAZOLE**	**SDZ**	$	**0.1338**
00002243797	PARIET	JAI	$	1.8822

56:00 GASTROINTESTINAL DRUGS

56:32 PROKINETIC AGENTS

DOMPERIDONE MALEATE

10 MG (BASE) ORAL TABLET

00002103613	**APO-DOMPERIDONE**	**APX**	$	**0.0428**
00002238341	**DOMPERIDONE**	**SIV**	$	**0.0428**
00002350440	**DOMPERIDONE**	**SNS**	$	**0.0428**
00002369206	**JAMP-DOMPERIDONE**	**JPC**	$	**0.0428**
00002403870	**MAR-DOMPERIDONE**	**MAR**	$	**0.0428**
00002236466	**PMS-DOMPERIDONE**	**PMS**	$	**0.0428**
00002462834	**PRZ-DOMPERIDONE**	**PCI**	$	**0.0428**
00002268078	**RAN-DOMPERIDONE**	**RAN**	$	**0.0428**
00001912070	**TEVA-DOMPERIDONE**	**TEV**	$	**0.0428**

56:00 GASTROINTESTINAL DRUGS

56:32 PROKINETIC AGENTS

METOCLOPRAMIDE HCL

5 MG ORAL TABLET				
00002230431	METONIA	PPH	$	0.0676
1 MG / ML ORAL LIQUID				
00002230433	METONIA	PPH	$	0.0625
5 MG / ML INJECTION				
☒ 00002185431	METOCLOPRAMIDE HYDROCHLORIDE	SDZ	$	3.3925

56:00 GASTROINTESTINAL DRUGS

56:36 ANTI-INFLAMMATORY AGENTS

MESALAZINE

1.2 G ORAL DELAYED AND EXTENDED-RELEASE TABLET				
00002297558	MEZAVANT	TAK	$	1.6911
500 MG ORAL EXTENDED-RELEASE TABLET				
00002099683	PENTASA	FEI	$	0.6090
1 G ORAL EXTENDED-RELEASE TABLET				
00002399466	PENTASA	FEI	$	1.2162
400 MG ORAL ENTERIC-COATED TABLET				
☒ 00002171929	NOVO-5 ASA	TEV	$	0.4996
☒ 00001997580	ASACOL	ALL	$	0.5780
500 MG ORAL ENTERIC-COATED TABLET				
00002112787	SALOFALK	AXC	$	0.6115
800 MG ORAL ENTERIC-COATED TABLET				
00002267217	ASACOL 800	ALL	$	1.1400
500 MG RECTAL SUPPOSITORY				
00002112760	SALOFALK	AXC	$	1.3612
1 G RECTAL SUPPOSITORY				
☒ 00002474018	MEZERA	AVP	$	1.8000
☒ 00002153564	PENTASA	FEI	$	1.8004
☒ 00002242146	SALOFALK	AXC	$	1.9926
1 G / ENM RECTAL ENEMA				
00002153521	PENTASA (1G/100ML)	FEI	$	4.1629
2 G / ENM RECTAL ENEMA				
00002112795	SALOFALK (2G/60G)	AXC	$	4.3571
4 G / ENM RECTAL ENEMA				
☒ 00002153556	PENTASA (4G/100 ML)	FEI	$	5.0146
☒ 00002112809	SALOFALK (4G/60G)	AXC	$	7.3998

OLSALAZINE SODIUM

250 MG ORAL CAPSULE				
00002063808	DIPENTUM	ATH	$	0.6025

56:00 GASTROINTESTINAL DRUGS

56:92 MISCELLANEOUS GI DRUGS

PINAVERIUM BROMIDE

50 MG ORAL TABLET

00002469677	**PINAVERIUM**	**AAP**	$	**0.3066**
00001950592	DICETEL	BGP	$	0.3784

100 MG ORAL TABLET

00002469685	**PINAVERIUM**	**AAP**	$	**0.5346**
00002230684	DICETEL	BGP	$	0.6597

TRIMEBUTINE MALEATE

100 MG ORAL TABLET

00002245663	TRIMEBUTINE	AAP	$	0.3073

200 MG ORAL TABLET

00002245664	TRIMEBUTINE	AAP	$	0.6722

60:00

Gold Compounds

60:00 GOLD COMPOUNDS

60:00

AURANOFIN

3 MG ORAL CAPSULE

00001916823	RIDAURA	XPI	$	6.2138

64:00

Heavy Metal Antagonists

64:00 HEAVY METAL ANTAGONISTS

64:00

DEFEROXAMINE MESYLATE

500 MG / VIAL INJECTION

00002241600	**DEFEROXAMINE MESYLATE**	**PFI**	$	**14.6690**
00001981242	DESFERAL	NOV	$	15.8710

2 G / VIAL INJECTION

00002247022	DEFEROXAMINE MESYLATE	PFI	$	58.6800

PENICILLAMINE

250 MG ORAL CAPSULE

00000016055	CUPRIMINE	VCL	$	3.7790

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 determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

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 determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

BECLOMETHASONE DIPROPIONATE

50 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002242029	QVAR CFC-FREE	VCL	$	0.1671
100 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002242030	QVAR CFC-FREE	VCL	$	0.3226

BETAMETHASONE SODIUM PHOSPHATE/ BETAMETHASONE ACETATE

3 MG / ML (BASE) * 3 MG / ML INJECTION				
00000028096	CELESTONE SOLUSPAN	MFC	$	13.9567

BUDESONIDE

100 MCG / DOSE INHALATION METERED INHALATION POWDER				
00000852074	PULMICORT TURBUHALER	AZC	$	0.1636
200 MCG / DOSE INHALATION METERED INHALATION POWDER				
00000851752	PULMICORT TURBUHALER	AZC	$	0.3345
400 MCG / DOSE INHALATION METERED INHALATION POWDER				
00000851760	PULMICORT TURBUHALER	AZC	$	0.4883
0.125 MG / ML INHALATION SUSPENSION				
00002465949	**TEVA-BUDESONIDE**	**TEV**	$	**0.1714**
00002229099	PULMICORT NEBUAMP	AZC	$	0.2375
0.25 MG / ML INHALATION SUSPENSION				
00001978918	PULMICORT NEBUAMP	AZC	$	0.4750
0.5 MG / ML INHALATION SUSPENSION				
00002465957	**TEVA-BUDESONIDE**	**TEV**	$	**0.6839**
00001978926	PULMICORT NEBUAMP	AZC	$	0.9473

CICLESONIDE

100 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002285606	ALVESCO	COV	$	0.3963
200 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002285614	ALVESCO	COV	$	0.6553

CORTISONE ACETATE

25 MG ORAL TABLET				
00000280437	CORTISONE ACETATE	VCL	$	0.3611

DEXAMETHASONE

0.5 MG ORAL TABLET				
00002261081	**APO-DEXAMETHASONE**	**APX**	$	**0.1564**
00001964976	**PMS-DEXAMETHASONE**	**PMS**	$	**0.1564**
0.75 MG ORAL TABLET				
00001964968	PMS-DEXAMETHASONE	PMS	$	0.6783
2 MG ORAL TABLET				
00002279363	PMS-DEXAMETHASONE	PMS	$	0.5530
4 MG ORAL TABLET				
00002250055	**APO-DEXAMETHASONE**	**APX**	$	**0.3046**
00001964070	**PMS-DEXAMETHASONE**	**PMS**	$	**0.3046**

DEXAMETHASONE SODIUM PHOSPHATE

4 MG / ML (BASE) INJECTION				
00000664227	**DEXAMETHASONE SODIUM PHOSPHATE**	**SDZ**	$	**1.6900**
00001977547	**DEXAMETHASONE SODIUM PHOSPHATE**	**STM**	$	**1.6900**
10 MG / ML (BASE) INJECTION				
00000783900	PMS-DEXAMETHASONE SODIUM PHOSP	PMS	$	1.2830
00000874582	DEXAMETHASONE SODIUM PHOSPHATE	SDZ	$	4.5600

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

FLUDROCORTISONE ACETATE

0.1 MG ORAL TABLET				
00002086026	FLORINEF	PAL	$	0.2818

FLUTICASONE PROPIONATE

50 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002244291	FLOVENT HFA	GSK	$	0.2172
125 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002244292	FLOVENT HFA	GSK	$	0.3746
250 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002503131	**PMS-FLUTICASONE HFA**	**PMS**	$	**0.5628**
00002244293	FLOVENT HFA	GSK	$	0.7494
55 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002467895	AERMONY RESPICLICK	TEV	$	0.2826
113 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002467909	AERMONY RESPICLICK	TEV	$	0.5160
232 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002467917	AERMONY RESPICLICK	TEV	$	0.8025
250 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002237246	FLOVENT DISKUS	GSK	$	0.7494
500 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002237247	FLOVENT DISKUS	GSK	$	1.1469

HYDROCORTISONE

10 MG ORAL TABLET				
00000030910	CORTEF	PFI	$	0.2181
20 MG ORAL TABLET				
00000030929	CORTEF	PFI	$	0.3944

HYDROCORTISONE SODIUM SUCCINATE

100 MG / VIAL (BASE) INJECTION				
00000030600	SOLU-CORTEF	PFI	$	4.4500
250 MG / VIAL (BASE) INJECTION				
00000030619	SOLU-CORTEF	PFI	$	7.5300
500 MG / VIAL (BASE) INJECTION				
00000030627	SOLU-CORTEF	PFI	$	15.5660

METHYLPREDNISOLONE

4 MG ORAL TABLET				
00000030988	MEDROL	PFI	$	0.5060
16 MG ORAL TABLET				
00000036129	MEDROL	PFI	$	1.4589

METHYLPREDNISOLONE ACETATE

20 MG / ML INJECTION				
00001934325	DEPO-MEDROL	PFI	$	2.8480
40 MG / ML INJECTION				
00000030759	DEPO-MEDROL	PFI	$	6.3600
80 MG / ML INJECTION				
00000030767	DEPO-MEDROL	PFI	$	12.1919
40 MG / ML INJECTION				
00001934333	DEPO-MEDROL (PRESERVED)	PFI	$	6.2920
80 MG / ML INJECTION				
00001934341	DEPO-MEDROL (PRESERVED)	PFI	$	9.4246

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

METHYLPREDNISOLONE ACETATE/ LIDOCAINE HCL

40 MG / ML * 10 MG / ML INJECTION

00000260428	DEPO-MEDROL WITH LIDOCAINE	PFI	$	7.0900

METHYLPREDNISOLONE SODIUM SUCCINATE

40 MG / VIAL (BASE) INJECTION

00002231893	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**4.7801**
00002367947	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	7.3000

125 MG / VIAL (BASE) INJECTION

00002231894	**METHYLPREDNISOLONE SOD SUCCINATE**	**TEV**	$	**10.4010**
00002367955	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	17.7470

500 MG / VIAL (BASE) INJECTION

00002231895	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**24.6960**
00002367963	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	42.8112
00000030678	SOLU-MEDROL	PFI	$	43.6000

1 G / VIAL (BASE) INJECTION

00002241229	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**37.9336**
00002367971	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	66.5700
00000036137	SOLU-MEDROL	PFI	$	66.8300

MOMETASONE FUROATE

100 MCG / DOSE INHALATION METERED INHALATION POWDER

00002438690	ASMANEX TWISTHALER	MFC	$	1.2561

RESTRICTED BENEFIT - This Drug Product is a benefit for patients up to 11 years of age inclusive.

200 MCG / DOSE INHALATION METERED INHALATION POWDER

00002243595	ASMANEX TWISTHALER	MFC	$	0.6437

400 MCG / DOSE INHALATION METERED INHALATION POWDER

00002243596	ASMANEX TWISTHALER	MFC	$	1.2876

PREDNISOLONE SODIUM PHOSPHATE

1 MG / ML (BASE) ORAL LIQUID

00002245532	**PMS-PREDNISOLONE**	**PMS**	$	**0.1259**
00002230619	PEDIAPRED	SAV	$	0.1430

PREDNISONE

1 MG ORAL TABLET

00000271373	WINPRED	AAP	$	0.1201

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

00001999761	KENALOG-10	WSD	$	3.5800

40 MG / ML INJECTION

00001977563	**TRIAMCINOLONE ACETONIDE USP**	**STM**	$	**5.7750**
00001999869	KENALOG-40	WSD	$	8.3166

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

TRIAMCINOLONE HEXACETONIDE

RESTRICTED BENEFIT - "This product is a benefit for patients up to 17 years of age inclusive for the treatment of Juvenile Idiopathic Arthritis."

20 MG / ML INJECTION				
00002470632	TRIAMCINOLONE HEXACETONIDE INJECTABLE SUSPENSION	MDX	$	18.0000

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:08 ANDROGENS

DANAZOL

50 MG ORAL CAPSULE				
00002018144	CYCLOMEN	SAV	$	1.0212
100 MG ORAL CAPSULE				
00002018152	CYCLOMEN	SAV	$	1.5156
200 MG ORAL CAPSULE				
00002018160	CYCLOMEN	SAV	$	2.4220

TESTOSTERONE CYPIONATE

100 MG / ML INJECTION				
00002496003	**TARO-TESTOSTERONE CYPIONATE**	**TAR**	$	**3.4878**
00000030783	DEPO-TESTOSTERONE CYPIONATE	PFI	$	4.8130

TESTOSTERONE ENANTHATE

200 MG / ML INJECTION				
00000029246	DELATESTRYL	VCL	$	10.6092

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

DESOGESTREL/ ETHINYL ESTRADIOL

0.15 MG * 0.03 MG ORAL TABLET				
00002317192	**APRI 21**	**TEV**	$	**0.3700**
00002396491	**FREYA 21**	**MYP**	$	**0.3700**
00002410249	**MIRVALA 21**	**APX**	$	**0.3700**
00002042487	MARVELON (21 DAY)	MFC	$	0.6942
0.15 MG * 0.03 MG ORAL TABLET				
00002317206	**APRI 28**	**TEV**	$	**0.2775**
00002396610	**FREYA 28**	**MYP**	$	**0.2775**
00002410257	**MIRVALA 28**	**APX**	$	**0.2775**
00002042479	MARVELON (28 DAY)	MFC	$	0.5207

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				
00002272903	LINESSA 21	APC	$	0.7429
0.1 MG * 0.025 MG * 0.125 MG * 0.025 MG * 0.15 MG * 0.025 MG ORAL TABLET				
00002257238	LINESSA 28	APC	$	0.5571

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

DROSPIRENONE/ ETHINYL ESTRADIOL

3 MG * 0.03 MG ORAL TABLET				
00002410788	**ZAMINE 21**	**APX**	$	**0.4442**
00002261723	YASMIN 21	BAI	$	0.5924
3 MG * 0.03 MG ORAL TABLET				
00002410796	**ZAMINE 28**	**APX**	$	**0.3332**
00002261731	YASMIN 28	BAI	$	0.4443

LEVONORGESTREL

1.5 MG ORAL TABLET				
00002433532	**BACKUP PLAN ONESTEP**	**APX**	$	**8.6000**
00002425009	**CONTINGENCY ONE**	**MYP**	$	**8.6000**
00002293854	PLAN B	TEP	$	17.2000
19.5 MG INTRAUTERINE INSERT				
00002459523	KYLEENA	BAI	$	326.0600
52 MG INTRAUTERINE INSERT				
00002243005	MIRENA SYSTEM	BAI	$	348.4500

LEVONORGESTREL/ ETHINYL ESTRADIOL

100 MCG * 20 MCG ORAL TABLET				
00002387875	**ALYSENA 21**	**APX**	$	**0.3629**
00002298538	**AVIANE 21**	**TEV**	$	**0.3629**
00002236974	ALESSE (21 DAY)	PFI	$	0.7470
150 MCG * 30 MCG ORAL TABLET				
00002387085	**OVIMA 21**	**APX**	$	**0.3467**
00002295946	**PORTIA 21**	**TEV**	$	**0.3467**
100 MCG * 20 MCG ORAL TABLET				
00002387883	**ALYSENA 28**	**APX**	$	**0.2721**
00002298546	**AVIANE 28**	**TEV**	$	**0.2721**
00002236975	ALESSE (28 DAY)	PFI	$	0.5604
150 MCG * 30 MCG ORAL TABLET				
00002387093	**OVIMA 28**	**APX**	$	**0.2600**
00002295954	**PORTIA 28**	**TEV**	$	**0.2600**

LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL

50 MCG * 30 MCG * 75 MCG * 40 MCG * 125 MCG * 30 MCG ORAL TABLET				
00000707600	TRIQUILAR (21 DAY)	BAI	$	0.7500
50 MCG * 30 MCG * 75 MCG * 40 MCG * 125 MCG * 30 MCG ORAL TABLET				
00000707503	TRIQUILAR (28 DAY)	BAI	$	0.5625

NORETHINDRONE

0.35 MG ORAL TABLET				
00002441306	**JENCYCLA (28 DAY)**	**LPC**	$	**0.3925**
00002410303	**MOVISSE (28 DAY)**	**MYP**	$	**0.3925**

NORETHINDRONE ACETATE/ ETHINYL ESTRADIOL

1 MG * 20 MCG ORAL TABLET				
00000315966	MINESTRIN 1/20 (21 DAY)	ALL	$	0.6686
1.5 MG * 0.03 MG ORAL TABLET				
00000297143	LOESTRIN 1.5/30 (21 DAY)	ALL	$	0.6686
1 MG * 20 MCG ORAL TABLET				
00000343838	MINESTRIN 1/20 (28 DAY)	ALL	$	0.5015
1.5 MG * 0.03 MG ORAL TABLET				
00000353027	LOESTRIN 1.5/30 (28 DAY)	ALL	$	0.5015

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

00002187108	SYNPHASIC (21 DAY)	PFI	$	0.6185

0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

00002187116	SYNPHASIC (28 DAY)	PFI	$	0.4638

NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL

0.18 MG * 0.035 MG * 0.215 MG * 0.035 MG * 0.25 MG * 0.035 MG ORAL TABLET

00002486296	TRI-JORDYNA (21 DAY)	GLM	$	1.0279

0.18 MG * 0.035 MG * 0.215 MG * 0.035 MG * 0.25 MG * 0.035 MG ORAL TABLET

00002486318	TRI-JORDYNA 28 (28 DAY)	GLM	$	0.7709

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.04 ESTROGENS AND ANTIESTROGENS (ESTROGENS)

CONJUGATED ESTROGENS

0.3 MG ORAL SUSTAINED-RELEASE TABLET

00002414678	PREMARIN	PFI	$	0.3532

0.625 MG ORAL SUSTAINED-RELEASE TABLET

00002414686	PREMARIN	PFI	$	0.3382

1.25 MG ORAL SUSTAINED-RELEASE TABLET

00002414694	PREMARIN	PFI	$	0.3864

0.625 MG / G VAGINAL CREAM

00002043440	PREMARIN	PFI	$	0.7510

ESTRADIOL-17B

0.5 MG ORAL TABLET

00002449048	**LUPIN-ESTRADIOL**	**LPC**	$	**0.1199**
00002225190	ESTRACE	ACE	$	0.1401

1 MG ORAL TABLET

00002449056	**LUPIN-ESTRADIOL**	**LPC**	$	**0.2313**
00002148587	ESTRACE	ACE	$	0.2709

2 MG ORAL TABLET

00002449064	**LUPIN-ESTRADIOL**	**LPC**	$	**0.4083**
00002148595	ESTRACE	ACE	$	0.4782

0.06 % TRANSDERMAL GEL

00002238704	ESTROGEL	MFC	$	0.3401

0.1 % TRANSDERMAL GEL

☒ 00002424924	DIVIGEL (0.25 MG PACK)	SLP	$	0.8190
☒ 00002424835	DIVIGEL (0.5 MG PACK)	SLP	$	0.8190
☒ 00002424843	DIVIGEL (1 MG PACK)	SLP	$	0.8190

25 MCG/DAY TRANSDERMAL PATCH

☒ 00002245676	ESTRADOT 25 (0.39 MG/PTH)	NOV	$	2.9275
☒ 00002243722	OESCLIM 25 (5 MG/PTH)	SLP	$	2.9890
☒ 00002247499	CLIMARA 25 (2 MG/PTH)	BAI	$	5.1600

37.5 MCG/DAY TRANSDERMAL PATCH

00002243999	ESTRADOT 37.5 (0.585 MG/PTH)	NOV	$	2.9475

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.04 ESTROGENS AND ANTIESTROGENS (ESTROGENS)

ESTRADIOL-17B

50 MCG/DAY TRANSDERMAL PATCH					
	00002246967	**SANDOZ ESTRADIOL DERM 50 (4 MG/PTH)**	**SDZ**	$	**2.6598**
☒	00002243724	OESCLIM 50 (10 MG/PTH)	SLP	$	3.0019
	00002244000	ESTRADOT 50 (0.78 MG/PTH)	NOV	$	3.1425
☒	00002231509	CLIMARA 50 (3.9 MG/PTH)	BAI	$	5.5118
75 MCG/DAY TRANSDERMAL PATCH					
	00002246968	**SANDOZ ESTRADIOL DERM 75 (6 MG/PTH)**	**SDZ**	$	**2.8527**
	00002244001	ESTRADOT 75 (1.17 MG/PTH)	NOV	$	3.3700
☒	00002247500	CLIMARA 75 (5.7 MG/PTH)	BAI	$	5.8764
100 MCG/DAY TRANSDERMAL PATCH					
	00002246969	**SANDOZ ESTRADIOL DERM 100 (8 MG/PTH)**	**SDZ**	$	**3.0181**
	00002244002	ESTRADOT 100 (1.56 MG/PTH)	NOV	$	3.5600
10 MCG VAGINAL TABLET					
	00002325462	VAGIFEM	NNA	$	4.3089
2 MG VAGINAL SLOW-RELEASE RING					
	00002168898	ESTRING	PAL	$	74.6655

NORETHINDRONE ACETATE/ ESTRADIOL-17B

140 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH					
	00002241835	ESTALIS (2.7*.62 MG/PTH)	NOV	$	3.4950
250 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH					
	00002241837	ESTALIS (4.8*.51 MG/PTH)	NOV	$	3.4950

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.02 ANTIDIABETIC AGENTS (ALPHA-GLUCOSIDASE INHIBITORS)

ACARBOSE

50 MG ORAL TABLET					
	00002493780	**ACARBOSE**	**STR**	$	**0.1348**
	00002494078	**MAR-ACARBOSE**	**MAR**	$	**0.1348**
	00002190885	GLUCOBAY	BAI	$	0.2695
100 MG ORAL TABLET					
	00002493799	**ACARBOSE**	**STR**	$	**0.1866**
	00002494086	**MAR-ACARBOSE**	**MAR**	$	**0.1866**
	00002190893	GLUCOBAY	BAI	$	0.3733

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.04 ANTIDIABETIC AGENTS (BIGUANIDES)

METFORMIN HCL

500 MG ORAL TABLET

00002257726	**ACT METFORMIN**	**APH**	$	**0.0247**
00002438275	**AURO-METFORMIN**	**AUR**	$	**0.0247**
00002380196	**JAMP-METFORMIN**	**JPC**	$	**0.0247**
00002353377	**METFORMIN**	**SNS**	$	**0.0247**
00002385341	**METFORMIN FC**	**SIV**	$	**0.0247**
00002223562	**PMS-METFORMIN**	**PMS**	$	**0.0247**
00002246820	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.0247**
00002099233	GLUCOPHAGE	SAV	$	0.2716

850 MG ORAL TABLET

00002257734	**ACT METFORMIN**	**APH**	$	**0.0339**
00002438283	**AURO-METFORMIN**	**AUR**	$	**0.0339**
00002380218	**JAMP-METFORMIN**	**JPC**	$	**0.0339**
00002353385	**METFORMIN**	**SNS**	$	**0.0339**
00002385368	**METFORMIN FC**	**SIV**	$	**0.0339**
00002242589	**PMS-METFORMIN**	**PMS**	$	**0.0339**
00002246821	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.0339**
00002162849	GLUCOPHAGE	SAV	$	0.3673

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN ASPART

100 UNIT / ML INJECTION

☒ 00002245397	NOVORAPID	NNA	$	3.0190
☒ 00002244353	NOVORAPID CARTRIDGE	NNA	$	4.0820
☒ 00002377209	NOVORAPID FLEXTOUCH	NNA	$	4.3307

INSULIN DEGLUDEC

100 UNIT / ML INJECTION

00002467879	TRESIBA FLEXTOUCH PEN	NNA	$	7.4333

200 UNIT / ML INJECTION

00002467887	TRESIBA FLEXTOUCH PEN	NNA	$	14.8666

INSULIN DETEMIR

100 UNIT / ML INJECTION

☒ 00002271842	LEVEMIR CARTRIDGE	NNA	$	7.2006
☒ 00002412829	LEVEMIR FLEXTOUCH	NNA	$	7.4333

INSULIN GLARGINE

100 UNIT / ML INJECTION

☒ 00002444844	BASAGLAR CARTRIDGE	LIL	$	4.6425
☒ 00002461528	BASAGLAR KWIKPEN (80 UNIT)	LIL	$	4.6425

INSULIN GLULISINE (RDNA ORIGIN)

100 UNIT / ML INJECTION

☒ 00002279460	APIDRA	SAV	$	2.6580
☒ 00002279479	APIDRA CARTRIDGE	SAV	$	3.5100
☒ 00002294346	APIDRA PEN	SAV	$	3.5433

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

100 UNIT / ML INJECTION

☒ 00000587737	HUMULIN N	LIL	$	2.3800
☒ 00002024225	NOVOLIN GE NPH	NNA	$	2.4360
☒ 00001959239	HUMULIN N CARTRIDGE	LIL	$	3.1146
☒ 00002403447	HUMULIN N KWIKPEN	LIL	$	3.1146
☒ 00002024268	NOVOLIN GE NPH CARTRIDGE	NNA	$	3.1926

INSULIN HUMAN BIOSYNTHETIC (REGULAR)

100 UNIT / ML INJECTION

☒ 00000586714	HUMULIN R	LIL	$	2.3800
☒ 00002024233	NOVOLIN GE TORONTO	NNA	$	2.3820
☒ 00001959220	HUMULIN R CARTRIDGE	LIL	$	3.1146
☒ 00002024284	NOVOLIN GE TORONTO CARTRIDGE	NNA	$	3.1180

INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

30 UNIT / ML * 70 UNIT / ML INJECTION

☒ 00000795879	HUMULIN 30/70	LIL	$	2.3800
☒ 00002024217	NOVOLIN GE 30/70	NNA	$	2.4480
☒ 00002025248	NOVOLIN GE 30/70 CARTRIDGE	NNA	$	3.0853
☒ 00001959212	HUMULIN 30/70 CARTRIDGE	LIL	$	3.1146

40 UNIT / ML * 60 UNIT / ML INJECTION

00002024314	NOVOLIN GE 40/60 CARTRIDGE	NNA	$	3.1073

50 UNIT / ML * 50 UNIT / ML INJECTION

00002024322	NOVOLIN GE 50/50 CARTRIDGE	NNA	$	3.1073

INSULIN LISPRO

100 UNIT / ML INJECTION

☒ 00002229704	HUMALOG	LIL	$	2.9155
☒ 00002403412	HUMALOG KWIKPEN	LIL	$	3.8394
☒ 00002229705	HUMALOG CARTRIDGE	LIL	$	3.8912

200 UNIT / ML INJECTION

00002439611	HUMALOG KWIKPEN	LIL	$	7.1467

INSULIN LISPRO/ INSULIN LISPRO PROTAMINE

25 % * 75 % INJECTION

☒ 00002403420	HUMALOG MIX 25 KWIKPEN	LIL	$	3.8846
☒ 00002240294	HUMALOG MIX 25 CARTRIDGE	LIL	$	3.9353

50 % * 50 % INJECTION

☒ 00002403439	HUMALOG MIX 50 KWIKPEN	LIL	$	3.8200
☒ 00002240297	HUMALOG MIX 50 CARTRIDGE	LIL	$	3.8540

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.16 ANTIDIABETIC AGENTS (MEGLITINIDES)

REPAGLINIDE

0.5 MG ORAL TABLET				
00002321475	**ACT REPAGLINIDE**	**APH**	$	**0.0808**
00002424258	**AURO-REPAGLINIDE**	**AUR**	$	**0.0808**
00002357453	**SANDOZ REPAGLINIDE**	**SDZ**	$	**0.0808**
00002239924	GLUCONORM	NNA	$	0.3365
1 MG ORAL TABLET				
00002321483	**ACT REPAGLINIDE**	**APH**	$	**0.0840**
00002424266	**AURO-REPAGLINIDE**	**AUR**	$	**0.0840**
00002357461	**SANDOZ REPAGLINIDE**	**SDZ**	$	**0.0840**
00002239925	GLUCONORM	NNA	$	0.3498
2 MG ORAL TABLET				
00002321491	**ACT REPAGLINIDE**	**APH**	$	**0.0873**
00002424274	**AURO-REPAGLINIDE**	**AUR**	$	**0.0873**
00002357488	**SANDOZ REPAGLINIDE**	**SDZ**	$	**0.0873**
00002239926	GLUCONORM	NNA	$	0.3634

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.20 ANTIDIABETIC AGENTS (SULFONYLUREAS)

GLICLAZIDE

80 MG ORAL TABLET				
00002245247	**APO-GLICLAZIDE**	**APX**	$	**0.0931**
00002287072	**GLICLAZIDE**	**SNS**	$	**0.0931**
00002238103	**TEVA-GLICLAZIDE**	**TEV**	$	**0.0931**
00000765996	DIAMICRON	SEV	$	0.3911
30 MG ORAL SUSTAINED-RELEASE TABLET				
00002297795	**APO-GLICLAZIDE MR**	**APX**	$	**0.0931**
00002423286	**MINT-GLICLAZIDE MR**	**MPI**	$	**0.0931**
00002438658	**MYLAN-GLICLAZIDE MR**	**MYP**	$	**0.0931**
00002463571	**RAN-GLICLAZIDE MR**	**RAN**	$	**0.0931**
00002461323	**SANDOZ GLICLAZIDE MR**	**SDZ**	$	**0.0931**
00002242987	DIAMICRON MR	SEV	$	0.1475
60 MG ORAL SUSTAINED-RELEASE TABLET				
00002407124	**APO-GLICLAZIDE MR**	**APX**	$	**0.0632**
00002423294	**MINT-GLICLAZIDE MR**	**MPI**	$	**0.0632**
00002439328	**RAN-GLICLAZIDE MR**	**RAN**	$	**0.0632**
00002461331	**SANDOZ GLICLAZIDE MR**	**SDZ**	$	**0.0632**
00002356422	DIAMICRON MR	SEV	$	0.2652

GLYBURIDE

2.5 MG ORAL TABLET				
00001913654	**APO-GLYBURIDE**	**APX**	$	**0.0321**
00002350459	**GLYBURIDE**	**SNS**	$	**0.0321**
00001913670	**TEVA-GLYBURIDE**	**TEV**	$	**0.0321**
5 MG ORAL TABLET				
00001913662	**APO-GLYBURIDE**	**APX**	$	**0.0573**
00002350467	**GLYBURIDE**	**SNS**	$	**0.0573**
00001913689	**TEVA-GLYBURIDE**	**TEV**	$	**0.0573**

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:22.12 ANTIHYPOGLYCEMIC AGENTS (GLYCOGENOLYTIC AGENTS)

GLUCAGON, RDNA ORIGIN

1 MG / VIAL INJECTION

☒ 00002333619	GLUCAGEN	NPA	$	86.5518
☒ 00002333627	GLUCAGEN HYPOKIT	NPA	$	86.5518
☒ 00002243297	GLUCAGON	LIL	$	92.5680

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:24 PARATHYROID

SYNTHETIC CALCITONIN SALMON (SALCATONIN)

200 IU / ML INJECTION

00001926691	CALCIMAR	SAV	$	31.1800

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:28 PITUITARY

DESMOPRESSIN ACETATE

0.1 MG ORAL TABLET

00002284030	**DESMOPRESSIN**	**AAP**	$	**0.6609**
00000824305	DDAVP	FEI	$	1.3336

0.2 MG ORAL TABLET

00002284049	**DESMOPRESSIN**	**AAP**	$	**1.3217**
00000824143	DDAVP	FEI	$	2.6670

10 MCG / DOSE NASAL METERED DOSE SPRAY

00002242465	DESMOPRESSIN	AAP	$	1.6048

4 MCG / ML INJECTION

00000873993	DDAVP	FEI	$	10.9781

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:32 PROGESTINS

MEDROXYPROGESTERONE ACETATE

2.5 MG ORAL TABLET

00002244726	**APO-MEDROXY**	**APX**	$	**0.0416**
00002221284	**TEVA-MEDROXYPROGESTERONE**	**TEV**	$	**0.0416**

5 MG ORAL TABLET

00002244727	**APO-MEDROXY**	**APX**	$	**0.0823**
00002221292	**TEVA-MEDROXYPROGESTERONE**	**TEV**	$	**0.0823**

10 MG ORAL TABLET

00002277298	**APO-MEDROXY**	**APX**	$	**0.1670**
00002221306	**TEVA-MEDROXYPROGESTERONE**	**TEV**	$	**0.1670**

100 MG ORAL TABLET

00002267640	APO-MEDROXY	APX	$	1.2057

150 MG / ML INJECTION

00000585092	DEPO-PROVERA	PFI	$	31.6900

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:32 PROGESTINS

PROGESTERONE

"Due to the high prevalence of peanut allergies within the population, Alberta Health has chosen to highlight the fact that Teva-Progesterone 100 mg capsules contain peanut oil, while the Brand Name drug product Prometrium does not. Please note that the Expert Committee does not regularly review possible allergens within drug products listed in the Alberta Drug Benefit List (ADBL) and it remains the responsibility of the prescribing physician and dispensing pharmacist to review all patient allergies."

100 MG ORAL CAPSULE				
00002439913	**TEVA-PROGESTERONE (PEANUT OIL)**	**TEV**	$	**0.3762**
00002166704	PROMETRIUM	MFC	$	1.1330

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.04 THYROID AND ANTITHYROID AGENTS (THYROID AGENTS)

DESICCATED THYROID

30 MG ORAL TABLET				
00000023949	THYROID	ERF	$	0.3500
60 MG ORAL TABLET				
00000023957	THYROID	ERF	$	0.6000
125 MG ORAL TABLET				
00000023965	THYROID	ERF	$	1.0800

LEVOTHYROXINE SODIUM

0.025 MG ORAL TABLET				
00002172062	SYNTHROID	BGP	$	0.0990
0.05 MG ORAL TABLET				
00002213192	**ELTROXIN**	**APC**	$	**0.0338**
00002172070	SYNTHROID	BGP	$	0.0680
0.075 MG ORAL TABLET				
00002172089	SYNTHROID	BGP	$	0.1071
0.088 MG ORAL TABLET				
00002172097	SYNTHROID	BGP	$	0.1071
0.1 MG ORAL TABLET				
00002213206	**ELTROXIN**	**APC**	$	**0.0416**
00002172100	SYNTHROID	BGP	$	0.0838
0.112 MG ORAL TABLET				
00002171228	SYNTHROID	BGP	$	0.1129
0.125 MG ORAL TABLET				
00002172119	SYNTHROID	BGP	$	0.1142
0.137 MG ORAL TABLET				
00002233852	SYNTHROID	BGP	$	0.1930
0.15 MG ORAL TABLET				
00002213214	**ELTROXIN**	**APC**	$	**0.0458**
00002172127	SYNTHROID	BGP	$	0.0898
0.175 MG ORAL TABLET				
00002172135	SYNTHROID	BGP	$	0.1226
0.2 MG ORAL TABLET				
00002213222	**ELTROXIN**	**APC**	$	**0.0486**
00002172143	SYNTHROID	BGP	$	0.0958
0.3 MG ORAL TABLET				
00002172151	SYNTHROID	BGP	$	0.1321

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.04 THYROID AND ANTITHYROID AGENTS (THYROID AGENTS)

LIOTHYRONINE SODIUM

5 MCG (BASE) ORAL TABLET				
00002494337	**TEVA-LIOTHYRONINE**	**TEV**	$	**1.1587**
00001919458	CYTOMEL	PFI	$	1.3979
25 MCG (BASE) ORAL TABLET				
00002494345	**TEVA-LIOTHYRONINE**	**TEV**	$	**1.2595**
00001919466	CYTOMEL	PFI	$	1.5195

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.08 THYROID AND ANTITHYROID AGENTS (ANTITHYROID AGENTS)

PROPYLTHIOURACIL

50 MG ORAL TABLET				
☒ 00000010200	PROPYL-THYRACIL	PAL	$	0.2465

THIAMAZOLE

5 MG ORAL TABLET				
00002490625	**JAMP METHIMAZOLE**	**JPC**	$	**0.1531**
00002480107	**MAR-METHIMAZOLE**	**MAR**	$	**0.1531**
00000015741	TAPAZOLE	PAL	$	0.2858

80:00

Serums, Toxoids and Vaccines

80:00 SERUMS, TOXOIDS, AND VACCINES

80:04 SERUMS

ALLERGY SERUM

INJECTION

00000999981	ALLERGY SERUM	XXX	$	0.0000

84:00

Skin and Mucous Membrane Agents

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:00

COMPOUND PRESCRIPTION

TOPICAL

00000999119	COMPOUND - RETINOIC ACID (TRETINOIN) (TOPICAL)	XXX	$	0.0000
00000999112	MISCELLANEOUS TOPICAL COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999219	COMPOUND - RETINOIC ACID (TRETINOIN) (TOPICAL)	XXX	$	0.0000
00000999213	MISCELLANEOUS TOPICAL COMPOUND	XXX	$	0.0000

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- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04 ANTI-INFECTIVES

COMPOUND PRESCRIPTION

TOPICAL

00000999103 COMPOUND-ANTI-INFECTIVE (TOPICAL) XXX $ 0.0000

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In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999203 COMPOUND-ANTI-INFECTIVE (TOPICAL) XXX $ 0.0000

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- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound 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	$	0.6954

METRONIDAZOLE

1 % TOPICAL CREAM				
00002156091	NORITATE	VCL	$	0.6265
1 % TOPICAL GEL				
00002297809	METROGEL	GAL	$	0.7062
10 % VAGINAL CREAM				
00001926861	FLAGYL	SAV	$	0.2617

METRONIDAZOLE/ NYSTATIN

500 MG * 100,000 UNIT VAGINAL OVULE				
00001926829	FLAGYSTATIN	SAV	$	3.5230

MUPIROCIN

2 % TOPICAL OINTMENT				
00002279983	TARO-MUPIROCIN	TAR	$	0.4970

SODIUM FUSIDATE

2 % TOPICAL OINTMENT				
00000586676	FUCIDIN	LEO	$	0.6954

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.04 ANTI-INFECTIVES ANTIFUNGALS (ALLYLAMINES)

TERBINAFINE HCL

1 % TOPICAL CREAM				
00002031094	LAMISIL	NOV	$	0.5630
1 % TOPICAL SOLUTION				
00002238703	LAMISIL	NOV	$	0.5710

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.08 ANTI-INFECTIVES ANTIFUNGALS (AZOLES)

KETOCONAZOLE

2 % TOPICAL CREAM				
00002245662	KETODERM	TPT	$	0.4044

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.20 ANTI-INFECTIVES
ANTIFUNGALS
(HYDROXYPYRIDONES)

CICLOPIROX OLAMINE

1 % TOPICAL CREAM

00002221802	LOPROX	VCL	$	0.3220

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.92 ANTI-INFECTIVES
(MISCELLANEOUS LOCAL ANTI-INFECTIVES)

SILVER SULFADIAZINE

1 % TOPICAL CREAM

00000323098	FLAMAZINE	SNE	$	0.2150

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

AMCINONIDE

0.1 % TOPICAL CREAM

00002246714	TARO-AMCINONIDE	TAR	$	0.2484

BECLOMETHASONE DIPROPIONATE

250 MCG / G TOPICAL CREAM

00002089602	PROPADERM	VCL	$	0.4710

BETAMETHASONE DIPROPIONATE

0.05 % (BASE) TOPICAL CREAM

00000804991	**TEVA-TOPISONE**	**TEV**	$	**0.2046**
00000323071	DIPROSONE	MFC	$	0.2091

0.05 % (BASE) TOPICAL GLYCOL CREAM

00000849650	TEVA-TOPILENE	TEV	$	0.5186

0.05 % (BASE) TOPICAL OINTMENT

00000805009	**TEVA-TOPISONE**	**TEV**	$	**0.2186**
00000344923	DIPROSONE	MFC	$	0.2197

0.05 % (BASE) TOPICAL GLYCOL OINTMENT

00000629367	**DIPROLENE GLYCOL**	**MFC**	$	**0.5186**
00000849669	**TEVA-TOPILENE**	**TEV**	$	**0.5186**

0.05 % (BASE) TOPICAL LOTION

00000417246	**DIPROSONE**	**MFC**	$	**0.2022**
00000809187	**TEVA-TOPISONE**	**TEV**	$	**0.2022**

0.05 % (BASE) TOPICAL GLYCOL LOTION

00001927914	TEVA-TOPILENE	TEV	$	0.2832

BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID

0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT

00000578436	DIPROSALIC	MFC	$	0.9084

0.5 MG / ML (BASE) * 20 MG / ML TOPICAL LOTION

00002245688	RATIO-TOPISALIC	TEV	$	0.4512

BETAMETHASONE SODIUM PHOSPHATE

5 MG / ENM (BASE) RECTAL ENEMA

00002060884	BETNESOL (5MG/100ML)	PAL	$	10.8991

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

BETAMETHASONE VALERATE

0.05 % (BASE) TOPICAL CREAM				
00000716618	**BETADERM MILD**	**TAR**	$	**0.0596**
00000535427	**TEVA-ECTOSONE MILD**	**TEV**	$	**0.0596**
0.1 % (BASE) TOPICAL CREAM				
00000716626	**BETADERM REGULAR**	**TAR**	$	**0.0889**
00000535435	**TEVA-ECTOSONE REGULAR**	**TEV**	$	**0.0889**
0.05 % (BASE) TOPICAL OINTMENT				
00000716642	BETADERM MILD	TAR	$	0.0722
0.1 % (BASE) TOPICAL OINTMENT				
00000716650	BETADERM REGULAR	TAR	$	0.1076
0.05 % (BASE) TOPICAL LOTION				
00000653209	TEVA-ECTOSONE MILD	TEV	$	0.2846
0.1 % (BASE) TOPICAL LOTION				
00000750050	TEVA-ECTOSONE REGULAR	TEV	$	0.3529
0.1 % (BASE) SCALP LOTION				
00000653217	TEVA-ECTOSONE SCALP	TEV	$	0.0853

BUDESONIDE

2.3 MG / ENM RECTAL ENEMA				
00002052431	ENTOCORT (115 ML)	TPG	$	9.6145

CALCIPOTRIOL MONOHYDRATE/ BETAMETHASONE DIPROPIONATE

50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL OINTMENT				
00002244126	DOVOBET	LEO	$	1.5923

CLOBETASOL 17-PROPIONATE

0.05 % TOPICAL CREAM				
00002024187	**MYLAN-CLOBETASOL**	**MYP**	$	**0.2279**
00002245523	**TARO-CLOBETASOL**	**TAR**	$	**0.2279**
00001910272	**TEVA-CLOBETASOL**	**TEV**	$	**0.2279**
00002213265	DERMOVATE	TPT	$	0.9484
0.05 % TOPICAL OINTMENT				
00002026767	**MYLAN-CLOBETASOL**	**MYP**	$	**0.2279**
00002245524	**TARO-CLOBETASOL**	**TAR**	$	**0.2279**
00001910280	**TEVA-CLOBETASOL**	**TEV**	$	**0.2279**
00002213273	DERMOVATE	TPT	$	0.9484
0.05 % SCALP LOTION				
00002216213	**MYLAN-CLOBETASOL**	**MYP**	$	**0.1990**
00002245522	**TARO-CLOBETASOL**	**TAR**	$	**0.1990**
00001910299	**TEVA-CLOBETASOL**	**TEV**	$	**0.1990**
00002213281	DERMOVATE	TPT	$	0.7607

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

COMPOUND PRESCRIPTION

TOPICAL

00000999107 COMPOUND-CORTICOSTEROIDS - TOPICAL XXX $ 0.0000

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To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999207 COMPOUND-CORTICOSTEROIDS - TOPICAL XXX $ 0.0000

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DESONIDE

0.05 % TOPICAL CREAM

00002229315 PDP-DESONIDE PPH $ 0.4142

0.05 % TOPICAL OINTMENT

00002229323 PDP-DESONIDE PPH $ 0.4125

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

DESOXIMETASONE

0.05 % TOPICAL CREAM				
00002221918	TOPICORT MILD	VCL	$	0.5213
0.25 % TOPICAL CREAM				
00002221896	TOPICORT	VCL	$	0.7335

FLUOCINONIDE

0.05 % TOPICAL CREAM				
☒ 00000716863	LYDERM	TPT	$	0.2573
☒ 00002161923	LIDEX	VCL	$	0.2597
0.05 % TOPICAL EMOLLIENT CREAM				
☒ 00002163152	LIDEMOL	VCL	$	0.2162
☒ 00000598933	TIAMOL	TPT	$	0.2183
0.05 % TOPICAL OINTMENT				
☒ 00002236996	LYDERM	TPT	$	0.3216
☒ 00002161966	LIDEX	VCL	$	0.3278
0.05 % TOPICAL GEL				
☒ 00002161974	LIDEX	VCL	$	0.3360
☒ 00002236997	LYDERM	TPT	$	0.3360

HALOBETASOL PROPIONATE

0.05 % TOPICAL CREAM				
00001962701	ULTRAVATE	VCL	$	0.9948

HYDROCORTISONE

0.5 % TOPICAL OINTMENT				
00000716685	CORTODERM MILD	TAR	$	0.1896
1 % TOPICAL OINTMENT				
00000716693	CORTODERM REGULAR	TAR	$	0.0597
1 % TOPICAL LOTION				
00080057191	JAMP-HYDROCORTISONE	JPC	$	0.1191
100 MG / ENM RECTAL ENEMA				
00002112736	CORTENEMA (100MG/60ML)	AXC	$	7.6483

HYDROCORTISONE 17-VALERATE

0.2 % TOPICAL CREAM				
00002242984	HYDROVAL	TPT	$	0.1667
0.2 % TOPICAL OINTMENT				
00002242985	HYDROVAL	TPT	$	0.1734

HYDROCORTISONE ACETATE

0.5 % TOPICAL CREAM				
00000716820	HYDERM	TAR	$	0.1986
1 % TOPICAL CREAM				
00000716839	HYDERM	TAR	$	0.0533
1 % TOPICAL LOTION				
00000681997	DERMAFLEX HC	PAL	$	0.1057

HYDROCORTISONE ACETATE/ PRAMOXINE HCL

1 % * 1 % RECTAL FOAM				
00000363014	PROCTOFOAM-HC	DUI	$	1.3839

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

HYDROCORTISONE ACETATE/ PRAMOXINE HCL/ ZINC SULFATE

10 MG * 20 MG * 10 MG RECTAL SUPPOSITORY

00002240851	PROCTODAN-HC	ODN	$	1.3650

0.5 % * 1 % * 0.5 % RECTAL OINTMENT

00002234466	**PROCTODAN-HC**	**ODN**	$	**0.7314**
00000505781	ANUGESIC-HC	MCL	$	0.9100

HYDROCORTISONE ACETATE/ UREA

1 % * 10 % TOPICAL CREAM

00000681989	DERMAFLEX HC	PAL	$	0.1880

HYDROCORTISONE ACETATE/ ZINC SULFATE

10 MG * 10 MG RECTAL SUPPOSITORY

00002236399	**ANODAN-HC**	**ODN**	$	**0.9506**
00000476285	ANUSOL-HC	CHD	$	1.1183

0.5 % * 0.5 % RECTAL OINTMENT

00002128446	**ANODAN-HC**	**ODN**	$	**0.3850**
00002387239	**JAMPZINC-HC**	**JPC**	$	**0.3850**
00000505773	ANUSOL-HC	CHD	$	0.7827

MOMETASONE FUROATE

0.1 % TOPICAL CREAM

00002367157	**TARO-MOMETASONE**	**TAR**	$	**0.5993**
00000851744	ELOCOM	MFC	$	0.7446

0.1 % TOPICAL OINTMENT

00002248130	**TEVA-MOMETASONE**	**TEV**	$	**0.6013**
00000851736	ELOCOM	MFC	$	0.6698

0.1 % TOPICAL LOTION

00002266385	**TARO-MOMETASONE**	**TAR**	$	**0.3977**
00000871095	ELOCOM	MFC	$	0.4992

TRIAMCINOLONE ACETONIDE

0.1 % TOPICAL CREAM

00000716960	**TRIADERM REGULAR**	**TAR**	$	**0.1075**
00002194058	ARISTOCORT R	VCL	$	0.1420

0.5 % TOPICAL CREAM

00002194066	ARISTOCORT C	VCL	$	1.2560

0.1 % TOPICAL OINTMENT

00002194031	ARISTOCORT R	VCL	$	0.1435

0.1 % DENTAL PASTE

00001964054	ORACORT	TAR	$	1.5301

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

00002496410	**TARO-CLOTRIMAZOLE/BETAMETHASONE**	**TAR**	$	**0.6964**
00000611174	LOTRIDERM	MFC	$	0.8234

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06.00 ANTI-INFLAMMATORY AGENTS

(COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS)

COMPOUND PRESCRIPTION

00000999110	COMBINATION ANTI-INFECTIVE /CORTICOSTEROID	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

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- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

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To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999211	COMBINATION ANTI-INFECTIVE/CORTICOSTEROID	XXX	$	0.0000

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To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06.00 ANTI-INFLAMMATORY AGENTS

(COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS)

HYDROCORTISONE/ CINCHOCAINE HCL/ FRAMYCETIN SULFATE/ ESCULIN

5 MG * 5 MG * 10 MG * 10 MG RECTAL SUPPOSITORY

00002247882	**PROCTOL**	**ODN**	$	**0.6000**
00002242528	**SANDOZ PROCTOMYXIN HC**	**SDZ**	$	**0.6000**

5 MG / G * 5 MG / G * 10 MG / G * 10 MG / G RECTAL OINTMENT

00002247322	**PROCTOL**	**ODN**	$	**0.4000**
00002242527	**SANDOZ PROCTOMYXIN HC**	**SDZ**	$	**0.4000**
00002226383	**TEVA-PROCTOSONE**	**TEV**	$	**0.4000**
00002223252	PROCTOSEDYL	AXC	$	0.8873

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:08 ANTIPRURITICS AND LOCAL ANESTHETICS

LIDOCAINE

5 % TOPICAL OINTMENT

00002083795	**LIDODAN**	**ODN**	$	**0.2800**
00000001961	XYLOCAINE	APC	$	0.3457

LIDOCAINE HCL

2 % TOPICAL JELLY

☒ 00000001694	XYLOCAINE JELLY	APC	$	0.5833

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:28 KERATOLYTIC AGENTS

COMPOUND PRESCRIPTION

TOPICAL

00000999104	COMPOUND- SALICYLIC ACID (TOPICAL)	XXX	$	0.0000

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- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999204	COMPOUND- SALICYLIC ACID (TOPICAL)	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

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To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

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	$	0.9203

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:92 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ACITRETIN

10 MG ORAL CAPSULE

00002468840	**MINT-ACITRETIN**	**MPI**	$	**1.2965**
00002466074	**TARO-ACITRETIN**	**TAR**	$	**1.2965**
00002070847	SORIATANE	ALR	$	2.3654

25 MG ORAL CAPSULE

00002468859	**MINT-ACITRETIN**	**MPI**	$	**2.2770**
00002466082	**TARO-ACITRETIN**	**TAR**	$	**2.2770**
00002070863	SORIATANE	ALR	$	4.1539

AZELAIC ACID

15 % TOPICAL GEL

00002270811	FINACEA	LEO	$	0.6369

CALCIPOTRIOL

50 MCG / G TOPICAL OINTMENT

00001976133	DOVONEX	LEO	$	0.8063

CALCIPOTRIOL MONOHYDRATE/ BETAMETHASONE DIPROPIONATE

50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL GEL

00002319012	DOVOBET	LEO	$	1.5596

50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL FOAM

00002457393	ENSTILAR	LEO	$	1.6146

COLLAGENASE

250 UNIT / G TOPICAL OINTMENT

00002063670	SANTYL	SNE	$	3.1200

ISOTRETINOIN

10 MG ORAL CAPSULE

00002257955	**CLARUS**	**MYP**	$	**0.9313**
00000582344	ACCUTANE	HLR	$	0.9547

40 MG ORAL CAPSULE

00002257963	**CLARUS**	**MYP**	$	**1.9003**
00000582352	ACCUTANE	HLR	$	1.9480

TAZAROTENE

0.05 % TOPICAL GEL

00002230784	TAZORAC	ALL	$	1.4280

0.1 % TOPICAL GEL

00002230785	TAZORAC	ALL	$	1.4280

86:00

Smooth Muscle Relaxants

86:00 SMOOTH MUSCLE RELAXANTS

86:12 GENITOURINARY SMOOTH MUSCLE RELAXANTS

OXYBUTYNIN CHLORIDE

2.5 MG ORAL TABLET

00002240549	PMS-OXYBUTYNIN	PMS	$	0.1736

5 MG ORAL TABLET

00002163543	**APO-OXYBUTYNIN**	**APX**	$	**0.0986**
00002350238	**OXYBUTYNIN**	**SNS**	$	**0.0986**
00002240550	**PMS-OXYBUTYNIN**	**PMS**	$	**0.0986**
00002230394	**TEVA-OXYBUTYNIN**	**TEV**	$	**0.0986**

1 MG / ML ORAL SYRUP

00002223376	PMS-OXYBUTYNIN	PMS	$	0.1800

PROPIVERINE HYDROCHLORIDE

5 MG ORAL TABLET

00002460289	MICTORYL PEDIATRIC	DUI	$	0.3700

This Drug Product is a restricted benefit for symptomatic treatment of urinary incontinence and/or increased urinary frequency and urgency in pediatric patients from 5-18 years old with overactive bladder.

SOLIFENACIN SUCCINATE

5 MG ORAL TABLET

00002446375	**AURO-SOLIFENACIN**	**AUR**	$	**0.3041**
00002424339	**JAMP-SOLIFENACIN**	**JPC**	$	**0.3041**
00002417723	**PMS-SOLIFENACIN**	**PMS**	$	**0.3041**
00002493039	**PRZ-SOLIFENACIN**	**PCI**	$	**0.3041**
00002437988	**RAN-SOLIFENACIN**	**RAN**	$	**0.3041**
00002399032	**SANDOZ SOLIFENACIN**	**SDZ**	$	**0.3041**
00002458241	**SOLIFENACIN**	**SNS**	$	**0.3041**
00002397900	**TEVA-SOLIFENACIN**	**TEV**	$	**0.3041**
00002277263	VESICARE	ASP	$	1.5135

10 MG ORAL TABLET

00002446383	**AURO-SOLIFENACIN**	**AUR**	$	**0.3041**
00002424347	**JAMP-SOLIFENACIN**	**JPC**	$	**0.3041**
00002417731	**PMS-SOLIFENACIN**	**PMS**	$	**0.3041**
00002493047	**PRZ-SOLIFENACIN**	**PCI**	$	**0.3041**
00002437996	**RAN-SOLIFENACIN**	**RAN**	$	**0.3041**
00002399040	**SANDOZ SOLIFENACIN**	**SDZ**	$	**0.3041**
00002458268	**SOLIFENACIN**	**SNS**	$	**0.3041**
00002397919	**TEVA-SOLIFENACIN**	**TEV**	$	**0.3041**
00002277271	VESICARE	ASP	$	1.5135

TOLTERODINE L-TARTRATE

2 MG ORAL EXTENDED-RELEASE CAPSULE

00002404184	**MYLAN-TOLTERODINE ER**	**MYP**	$	**0.4911**
00002413140	**SANDOZ TOLTERODINE LA**	**SDZ**	$	**0.4911**
00002412195	**TEVA-TOLTERODINE LA**	**TEV**	$	**0.4911**
00002244612	DETROL LA	UJC	$	2.0841

4 MG ORAL EXTENDED-RELEASE CAPSULE

00002404192	**MYLAN-TOLTERODINE ER**	**MYP**	$	**0.4911**
00002413159	**SANDOZ TOLTERODINE LA**	**SDZ**	$	**0.4911**
00002412209	**TEVA-TOLTERODINE LA**	**TEV**	$	**0.4911**
00002244613	DETROL LA	UJC	$	2.0841

86:00 SMOOTH MUSCLE RELAXANTS

86:16 RESPIRATORY SMOOTH MUSCLE RELAXANTS

THEOPHYLLINE

100 MG ORAL SUSTAINED-RELEASE TABLET				
00000692689	AA-THEO LA	AAP	$	0.1681
200 MG ORAL SUSTAINED-RELEASE TABLET				
00000692697	AA-THEO LA	AAP	$	0.1868
300 MG ORAL SUSTAINED-RELEASE TABLET				
00000692700	AA-THEO LA	AAP	$	0.2263
600 MG ORAL SUSTAINED-RELEASE TABLET				
00002014181	UNIPHYL	ELV	$	0.6090

88:00

Vitamins

88:00 VITAMINS

88:08 VITAMIN B COMPLEX

CYANOCOBALAMIN

1,000 MCG / ML INJECTION

00001987003	**CYANOCOBALAMIN**	**STM**	$	**0.3063**
00002413795	**CYANOCOBALAMIN**	**MYP**	$	**0.3063**
00002420147	**JAMP-CYANOCOBALAMIN**	**JPC**	$	**0.3063**
00000521515	**VITAMIN B12**	**SDZ**	$	**0.3063**

FOLIC ACID

5 MG ORAL TABLET

☒ 00002285673	EURO FOLIC	SDZ	$	0.0198
☒ 00002366061	JAMP-FOLIC ACID	JPC	$	0.0198
☒ 00000426849	FOLIC ACID	AAP	$	0.0418

THIAMINE HCL

100 MG / ML INJECTION

☒ 00002193221	THIAMIJECT	OMG	$	1.1880

88:00 VITAMINS

88:16 VITAMIN D

ALFACALCIDOL

0.25 MCG ORAL CAPSULE

00000474517	ONE-ALPHA	LEO	$	0.4855

1 MCG ORAL CAPSULE

00000474525	ONE-ALPHA	LEO	$	1.4532

2 MCG / ML ORAL DROPS

00002240329	ONE-ALPHA	LEO	$	5.5521

2 MCG / ML INJECTION

00002242502	ONE-ALPHA	LEO	$	17.8048

CALCITRIOL

0.25 MCG ORAL CAPSULE

00002495899	**CALCITRIOL**	**STR**	$	**0.2341**
00002431637	**CALCITRIOL-ODAN**	**ODN**	$	**0.2341**
00002485710	**TARO-CALCITRIOL**	**TAR**	$	**0.2341**
00000481823	ROCALTROL	SLP	$	0.7283

0.5 MCG ORAL CAPSULE

00002495902	**CALCITRIOL**	**STR**	$	**0.3723**
00002431645	**CALCITRIOL-ODAN**	**ODN**	$	**0.3723**
00002485729	**TARO-CALCITRIOL**	**TAR**	$	**0.3723**
00000481815	ROCALTROL	SLP	$	1.1583

1 MCG / ML INJECTION

00002399334	CALCITRIOL	STM	$	9.4337

88:00 VITAMINS

88:24 VITAMIN K ACTIVITY

PHYTONADIONE

2 MG / ML INJECTION

00000781878	VITAMIN K1 PEDIATRIC	SDZ	$	11.3419

10 MG / ML INJECTION

00000804312	VITAMIN K1	SDZ	$	6.4260

92:00

Miscellaneous Therapeutic Agents

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

ALENDRONATE SODIUM

70 MG ORAL TABLET

00002485184	**AG-ALENDRONATE**	**AGP**	$	**2.1014**
00002299712	**ALENDRONATE**	**SIV**	$	**2.1014**
00002352966	**ALENDRONATE**	**SNS**	$	**2.1014**
00002381494	**ALENDRONATE SODIUM**	**AHI**	$	**2.1014**
00002248730	**APO-ALENDRONATE**	**APX**	$	**2.1014**
00002388553	**AURO-ALENDRONATE**	**AUR**	$	**2.1014**
00002385031	**JAMP-ALENDRONATE**	**JPC**	$	**2.1014**
00002394871	**MINT-ALENDRONATE**	**MPI**	$	**2.1014**
00002284006	**PMS-ALENDRONATE-FC**	**PMS**	$	**2.1014**
00002288109	**SANDOZ ALENDRONATE**	**SDZ**	$	**2.1014**
00002261715	**TEVA-ALENDRONATE**	**TEV**	$	**2.1014**
00002245329	FOSAMAX	MFC	$	11.0114

ALENDRONATE SODIUM/ VITAMIN D3

70 MG * 5,600 UNIT ORAL TABLET

00002454475	**APO-ALENDRONATE/VITAMIN D3**	**APX**	$	**1.2174**
00002403641	**TEVA-ALENDRONATE/CHOLECALCIFEROL**	**TEV**	$	**1.2174**
00002314940	FOSAVANCE	MFC	$	5.0366

ALLOPURINOL

100 MG ORAL TABLET

00002402769	**APO-ALLOPURINOL**	**APX**	$	**0.0780**
00002396327	**MAR-ALLOPURINOL**	**MAR**	$	**0.0780**
00000402818	**ZYLOPRIM**	**AAP**	$	**0.0780**

200 MG ORAL TABLET

00002402777	**APO-ALLOPURINOL**	**APX**	$	**0.1300**
00002396335	**MAR-ALLOPURINOL**	**MAR**	$	**0.1300**
00000479799	**ZYLOPRIM**	**AAP**	$	**0.1300**

300 MG ORAL TABLET

00002402785	**APO-ALLOPURINOL**	**APX**	$	**0.2125**
00002396343	**MAR-ALLOPURINOL**	**MAR**	$	**0.2125**
00000402796	**ZYLOPRIM**	**AAP**	$	**0.2125**

AZATHIOPRINE

50 MG ORAL TABLET

00002242907	**APO-AZATHIOPRINE**	**APX**	$	**0.2405**
00002236819	**TEVA-AZATHIOPRINE**	**TEV**	$	**0.2405**
00000004596	IMURAN	APC	$	1.1590

BETAHISTINE DIHYDROCHLORIDE

8 MG ORAL TABLET

00002449145	AURO-BETAHISTINE	AUR	$	0.1273

16 MG ORAL TABLET

00002449153	**AURO-BETAHISTINE**	**AUR**	$	**0.1106**
00002466449	**BETAHISTINE**	**SNS**	$	**0.1106**
00002330210	**PMS-BETAHISTINE**	**PMS**	$	**0.1106**
00002280191	**TEVA-BETAHISTINE**	**TEV**	$	**0.1106**
00002243878	SERC	BGP	$	0.4999

CLODRONATE DISODIUM

400 MG ORAL CAPSULE

00002245828	CLASTEON	SUN	$	1.2374

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

CLONIDINE HCL

0.025 MG ORAL TABLET

00002304163	TEVA-CLONIDINE	TEV	$	0.2849

COLCHICINE

0.6 MG ORAL TABLET

00000572349	**COLCHICINE**	**ODN**	$	**0.2565**
00002373823	**JAMP-COLCHICINE**	**JPC**	$	**0.2565**
00002402181	**PMS-COLCHICINE**	**PMS**	$	**0.2565**

COMPOUND PRESCRIPTION

INJECTION

00000999114	MISCELLANEOUS INJECTABLE COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

INJECTION

00000999215	MISCELLANEOUS INJECTABLE COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

COMPOUND PRESCRIPTION

00000999999	MISCELLANEOUS COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999216	MISCELLANEOUS COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

COMPOUND PRESCRIPTION

ORAL

00000999214 MISCELLANEOUS ORAL COMPOUND XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

ORAL

00000999113 MISCELLANEOUS ORAL COMPOUND XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

DIMETHYL SULFOXIDE

50 % BLADDER IRRIGATION SOLUTION

00000493392 RIMSO-50 MYP $ 1.7736

FLUNARIZINE HCL

5 MG (BASE) ORAL CAPSULE

00002246082 FLUNARIZINE AAP $ 0.8230

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

LEUCOVORIN CALCIUM

5 MG (BASE) ORAL TABLET

00002496828	**MINT-LEUCOVORIN**	**MPI**	$	**3.6776**
00002493357	**RIVA LEUCOVORIN**	**RIV**	$	**3.6776**
00002170493	LEDERLE LEUCOVORIN CALCIUM	PFI	$	7.2466

10 MG / ML INJECTION

00002087316	LEUCOVORIN CALCIUM	TEV	$	13.7886

NAFARELIN ACETATE

2 MG / ML (BASE) NASAL SOLUTION

00002188783	SYNAREL	PFI	$	50.8350

PAMIDRONATE DISODIUM

For the products within the following three groupings, pricing has been established on a per millilitre basis.

3 MG / ML INJECTION

00002244550	PAMIDRONATE DISODIUM	PFI	$	3.0317

6 MG / ML INJECTION

00002244551	PAMIDRONATE DISODIUM	PFI	$	9.0366

9 MG / ML INJECTION

00002244552	PAMIDRONATE DISODIUM	PFI	$	9.0953

PENTOSAN POLYSULFATE SODIUM

100 MG ORAL CAPSULE

00002029448	ELMIRON	JAI	$	2.3814

RISEDRONATE SODIUM

35 MG ORAL TABLET

00002353687	**APO-RISEDRONATE**	**APX**	$	**1.9787**
00002406306	**AURO-RISEDRONATE**	**AUR**	$	**1.9787**
00002368552	**JAMP-RISEDRONATE**	**JPC**	$	**1.9787**
00002302209	**PMS-RISEDRONATE**	**PMS**	$	**1.9787**
00002370255	**RISEDRONATE**	**SNS**	$	**1.9787**
00002411407	**RISEDRONATE-35**	**SIV**	$	**1.9787**
00002327295	**SANDOZ RISEDRONATE**	**SDZ**	$	**1.9787**
00002298392	**TEVA-RISEDRONATE**	**TEV**	$	**1.9787**
00002246896	ACTONEL	ALL	$	11.6009

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:08 5 ALFA REDUCTASE INHIBITORS

DUTASTERIDE

0.5 MG ORAL CAPSULE

00002404206	**APO-DUTASTERIDE**	**APX**	$	**0.3027**
00002469308	**AURO-DUTASTERIDE**	**AUR**	$	**0.3027**
00002429012	**DUTASTERIDE**	**SIV**	$	**0.3027**
00002443058	**DUTASTERIDE**	**SNS**	$	**0.3027**
00002484870	**JAMP DUTASTERIDE**	**JPC**	$	**0.3027**
00002416298	**MED-DUTASTERIDE**	**GMP**	$	**0.3027**
00002428873	**MINT-DUTASTERIDE**	**MPI**	$	**0.3027**
00002393220	**PMS-DUTASTERIDE**	**PMS**	$	**0.3027**
00002424444	**SANDOZ DUTASTERIDE**	**SDZ**	$	**0.3027**
00002408287	**TEVA-DUTASTERIDE**	**TEV**	$	**0.3027**
00002247813	AVODART	GSK	$	1.7660

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:08 5 ALFA REDUCTASE INHIBITORS

FINASTERIDE

5 MG ORAL TABLET

00002365383	**APO-FINASTERIDE**	**APX**	$	**0.4138**
00002405814	**AURO-FINASTERIDE**	**AUR**	$	**0.4138**
00002355043	**FINASTERIDE**	**AHI**	$	**0.4138**
00002445077	**FINASTERIDE**	**SNS**	$	**0.4138**
00002447541	**FINASTERIDE**	**SIV**	$	**0.4138**
00002357224	**JAMP-FINASTERIDE**	**JPC**	$	**0.4138**
00002389878	**MINT-FINASTERIDE**	**MPI**	$	**0.4138**
00002310112	**PMS-FINASTERIDE**	**PMS**	$	**0.4138**
00002322579	**SANDOZ FINASTERIDE**	**SDZ**	$	**0.4138**
00002348500	**TEVA-FINASTERIDE**	**TEV**	$	**0.4138**
00002010909	PROSCAR	MFC	$	2.0816

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 the initial prescription is prescribed by a Specialist in Rheumatology or Internal Medicine.

10 MG ORAL TABLET

00002478862	**ACCEL-LEFLUNOMIDE**	**ACP**	$	**2.0000**
00002256495	APO-LEFLUNOMIDE	APX	$	2.6433
00002351668	LEFLUNOMIDE	SNS	$	2.6433
00002283964	SANDOZ LEFLUNOMIDE	SDZ	$	2.6433
00002261251	TEVA-LEFLUNOMIDE	TEV	$	2.6433
00002241888	ARAVA	SAV	$	11.0677

20 MG ORAL TABLET

00002478870	**ACCEL-LEFLUNOMIDE**	**ACP**	$	**2.0000**
00002256509	APO-LEFLUNOMIDE	APX	$	2.6433
00002351676	LEFLUNOMIDE	SNS	$	2.6433
00002283972	SANDOZ LEFLUNOMIDE	SDZ	$	2.6433
00002261278	TEVA-LEFLUNOMIDE	TEV	$	2.6433
00002241889	ARAVA	SAV	$	11.0680

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:92 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

ABOBOTULINUMTOXINA

300 IU / VIAL INJECTION

00002460203	DYSPORT THERAPEUTIC	ISP	$	385.5600

500 IU / VIAL INJECTION

00002456117	DYSPORT THERAPEUTIC	ISP	$	642.6000

BOTULINUMTOXINA(150KD), FREE FROM COMPLEXING PROTEIN

50 UNIT / VIAL INJECTION

00002371081	XEOMIN	MPC	$	165.0000

100 UNIT / VIAL INJECTION

00002324032	XEOMIN	MPC	$	330.0000

ONABOTULINUMTOXINA

INJECTION

00001981501	BOTOX (50/100/200 UNITS/VIAL)	ALL	$	3.5700

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

00000999399	OPTICHAMBER DIAMOND (CHAMBER ONLY)	RNA	$	17.2000
00000990080	VORTEX	KGH	$	19.4977
00000990091	AEROCHAMBER PLUS FLOW-VU W/ MOUTHPIECE	TMI	$	23.5500
00000990100	AEROCHAMBER PLUS FLOW-VU YOUTH W/ MOUTHPIECE	TMI	$	23.5500
00000990101	INSPIRA CHAMBER WITH MOUTHPIECE	LPC	$	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

00000990015	VORTEX TODDLER/INFANT MASK DEVICE	KGH	$	13.0047
00000999398	OPTICHAMBER DIAMOND (WITH SMALL MASK)	RNA	$	29.4000
00000990092	AEROCHAMBER PLUS FLOW-VU W/ SMALL MASK	TMI	$	37.6700
00000990103	INSPIRA CHAMBER W/ SM INSPIRAMASK/SOOTHERMASK DEV	LPC	$	37.6700

PEDIATRIC DEVICE

00000990016	VORTEX CHILD/PEDIATRIC MASK DEVICE	KGH	$	13.0047
00000999397	OPTICHAMBER DIAMOND (WITH MEDIUM MASK)	RNA	$	29.4000
00000990093	AEROCHAMBER PLUS FLOW-VU W/ MEDIUM MASK	TMI	$	37.6700
00000990102	INSPIRA CHAMBER W/ MED INSPIRAMASK/SOOTHERMASK DEV	LPC	$	37.6700

ADULT DEVICE

00000999396	OPTICHAMBER DIAMOND (WITH LARGE MASK)	RNA	$	32.4000
00000990109	AEROCHAMBER PLUS FLOW-VU W/ ADULT SMALL MASK	TMI	$	39.8600
00000990094	AEROCHAMBER PLUS FLOW-VU W/ LARGE MASK	TMI	$	39.8600

Appendices

Abbreviations

Pharmaceutical Manufacturers

Appendix 1
Abbreviations

ASA ..... acetylsalicylic acid
COMPD ..... compound
DEV..... device
ENM..... enema
FC ..... film coated
G ..... gram(s)
HCL..... hydrochloride

HR..... per hour
IU ..... international unit(s)
MCG..... microgram
MED ..... medium
MEQ..... milliequivalent

MG ..... milligram
ML..... millilitre
PTH..... patch
SM..... small
SYR..... syringe

W..... with
%..... percent

Appendix 2
Pharmaceutical Manufacturers

A
AAP AA Pharma Inc.
ABV Abbvie Corporation
ACE Acerus Pharmaceuticals Corporation
ACP Accel Pharma Inc.
AHI Accord Healthcare Inc.
AKC Akcea Therapeutics Inc.
ALC Alcon Canada Inc.
ALH Altius Healthcare Inc.
ALL Allergan Inc.
ALR Allergan Inc./Aralez Pharmaceuticals Inc.
AMD Amdipharm Limited
AMG Amgen Inc.
AMP Atnahs Pharma/Methapharm Inc.
ANT Alnylam Netherlands B.V.
APC Aspen Pharmacare Canada Inc.
APG Alexion Pharma GMBH
APH Actavis Pharma Company
APP Apopharma Inc.
APX Apotex Inc.
ARA Aralez Pharmaceuticals Inc.
ASP Astellas Pharma Canada Inc.
ATH Atnahs Pharma UK Limited
AUR Auro Pharma Inc.
AVP Avir Pharma Inc.
AXC Aptalis Pharma Canada Inc.
AZC AstraZeneca Canada Inc.

B
BAI Bayer Inc.
BAX Baxter Corporation
BCF Biocodex SA
BGP BGP Pharma ULC
BIO Biogen Idec Canada Inc
BMD Biomed Pharma
BMS Bristol-Myers Squibb
BOE Boehringer Ingelheim (Canada) Ltd.
BVM SOBI Canada Inc.

C
CAG Cheplapharm Arzneimittel GMBH Germany
CCC Chiesi Canada Corp.
CEL Cellchem Pharmaceuticals Inc.
CHD Church & Dwight Canada
CHH Celltrion Healthcare/Hospira Healthcare
CIP Cipher Pharmaceuticals Inc.
COV Covis Pharma
CTC Celltrion Healthcare/Teva Canada Innovation
CUB Cubist Pharmaceuticals, Inc.
CYC Cycle Pharmaceuticals Ltd.

D
DRL Dr. Reddy's Laboratories Inc.
DUI Duchesnay Inc.

E
EIS Eisai Limited
ELV Elvium Life Sciences
ERF ERFA Canada 2012 Inc.
ETP Ethypharm Inc.

F
FEI Ferring Inc.
FKC Fresenius Kabi Canada

G
GAL Galderma Canada Inc.
GIL Gilead Sciences Inc.
GLM Glenmark Phamaceuticals Canada Inc.
GMD Genmed, a Division of Pfizer Canada Inc.
GMP Generic Medical Partners Inc.
GSK GlaxoSmithKline
GZM Genzyme, a Division of Sanofi-Aventis CA.

H
HLR Hoffmann-La Roche Limited
HLS HLS Therapeutics Inc.
HSP Hospira Healthcare Corporation

I
ICP Intercept Pharmaceuticals Inc.
ISP Ipsen Biopharm Limited
IUK Indivior UK Limited

J
JAI Janssen Inc.
JPC Jamp Pharma Corporation
JUN Juno Pharmaceuticals Corp.

K
KGH Kego Healthcare
KTI Knight Therapeutics Inc.

L
LBC Lundbeck Canada Inc.
LEO Leo Pharma Inc.
LIL Eli Lilly Canada Inc.
LPC Lupin Pharma Canada Limited
LUI Lundbeck Inc.

M
MAL Mallinckrodt Canada ULC.
MAR Marcan Pharmaceuticals Inc

Appendix 2
Pharmaceutical Manufacturers

M

MCL McNeil Consumer Healthcare
MDK Medunik Canada
MDX Medexus Inc.
MEN MendeliKabs Inc.
MFC Merck Canada Inc.
MIT Mitsubishi Tanabe Pharma Canada, Inc.
MJO Mead Johnson Nutrition (Canada) Co.
MPC Merz Pharma Canada Ltd.
MPI Mint Pharmaceuticals Inc.
MTR Mantra Pharma Inc.
MYP Mylan Pharmaceuticals ULC
MYS Mylan Specialty LP/Pfizer Canada Inc.

N

NHN Nestle Health Science
NNA Novo Nordisk Canada Inc.
NOV Novartis Pharmaceuticals Canada Inc.
NPA Novo Nordisk Canada/Paladin Labs
NRA Nora Pharma Inc.
NTI Jacobus Pharmaceuticals Company Inc.
NTP Natco Pharma (Canada) Inc.
NUN Nutricia North America

O

ODN Odan Laboratories Ltd.
OMG Omega Laboratories Limited
ORI Orimed Pharma Corporation
OTS Otsuka Pharmaceutical Co. Ltd.

P

PAL Paladin Labs Inc.
PCI Pharmaris Canada Inc.
PFI Pfizer Canada ULC.
PIE Pierre Fabre Dermo-Cosmetique Canada Inc.
PMS Pharmascience Inc.
PPH Pendopharm Inc.
PSL Pharma Stulln Inc.
PUR Purdue Pharma

R

RAN Ranbaxy Pharmaceuticals Canada Inc.
RAP HZNP Canada Limited
RIV Laboratoire Riva Inc.
RNA Respironics NJ Inc – Auto Control Med Inc.
RRD Recordati Rare Diseases Canada Inc.

S

SAV Sanofi-Aventis
SDZ Sandoz Canada Inc.
SEP Septa Pharmaceuticals Inc.
SEV Servier Canada Inc.
SGM Leadiant Biosciences, Inc.
SHB Shire Pharma Canada ULC
SIV Sivem Pharmaceuticals ULC
SLP Searchlight Pharma Inc.
SLX Salix Pharmaceuticals Inc.
SNE Smith & Nephew Inc.
SNS Sanis Health Inc.
SRO EMD Serono Canada Inc.
SSB Samsung Bioepis Co., Ltd
STM SteriMax Inc.
STR Strides Pharma Canada Inc.
SUN Sunovion Pharmaceutical Inc.

T

TAK Takeda Canada, Inc.
TAR Taro Pharmaceuticals Inc.
TEP Teva Branded Pharmaceutical Products / Paladin Labs Inc.
TEV Teva Canada Limited
TGT Teligent Canada, Inc.
TMI Trudell Medical International
TMP Teva Canada Ltd/Teva Canada Innovation G.P. S.E.N.C
TPG Tillotts Pharma GMBH
TPT Taropharma, a division of Taro Pharmaceuticals Inc.
TSA Tersera Canada Inc.

U

UCB UCB Pharma Canada Inc.
UJC Upjohn Canada ULC

V

VCL Bausch Health
VER Vertex Pharmaceuticals (Canada) Inc
VPI VPI Pharmaceuticals Inc.
VPL Vivus Pharmaceuticals Limited
VTC Bausch Health./Teva Canada Ltd.

W

WSD Westwood Squibb (Division of Bristol-Myers Squibb Canada)
WSP Wellspring Pharmaceutical Canada Corp.

X

XPI Xediton Pharmaceuticals Inc.
XXX Miscellaneous Manufacturers