Updates to the Alberta Human Services Drug Benefit Supplement

Effective August 1, 2014

Alberta Human Services

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Administered by Alberta Blue Cross
on behalf of Alberta Health.

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

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

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

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

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Special Authorization

The following drug product(s) may be considered for coverage by special authorization for Alberta Human Services.

New Drug Product(s) Available by Special Authorization

Trade Name / Strength / Form	Generic Description	DIN	MFR
TECFIDERA 120 MG DELAYED-RELEASE CAPSULE	DIMETHYL FUMARATE	00002404508	BIO

Additionl Brand(s) and/or Strength(s) of Drug Products Available by Special Authorization

Trade Name / Strength / Form	Generic Description	DIN	MFR
AURO-GALANTAMINE ER 8 MG (BASE) EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002425157	AUR
AURO-GALANTAMINE ER 16 MG (BASE) EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002425165	AUR
AURO-GALANTAMINE ER 24 MG (BASE) EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002425173	AUR
OCPHYL 50 MCG / ML (BASE) INJECTION	OCTREOTIDE ACETATE	00002413191	PPH
OCPHYL 100 MCG / ML (BASE) INJECTION	OCTREOTIDE ACETATE	00002413205	PPH
OCPHYL 500 MCG / ML (BASE) INJECTION	OCTREOTIDE ACETATE	00002413213	PPH
ZOLEDRONIC ACID 0.05 MG / ML INJECTION	ZOLEDRONIC ACID	00002422433	DRL
ZOLEDRONIC ACID CONCENTRATE 0.8 MG / ML INJECTION	ZOLEDRONIC ACID	00002413701	OMG
ZOLEDRONIC ACID CONCENTRATE 0.8 MG / ML INJECTION	ZOLEDRONIC ACID	00002422425	DRL

Optional Special Authorization

The following drug product(s) may be considered for coverage by optional special authorization for Alberta Human Services clients.

Please refer to Section 3A of the online Alberta Human Services Drug Benefit Supplement at https://www.ab.bluecross.ca/dbl/pdfs/hsdbs.pdf for further information regarding the Optional Special Authorization of Select Drug Products criteria and related forms.

Additional Brand(s) and/or Strength(s) of Drug Product(s) Available by Optional Special Authorization

Trade Name / Strength / Form	Generic Description	DIN	MFR
MINT-CIPROFLOX 250 MG (BASE) TABLET	CIPROFLOXACIN HCL	00002423553	MPI
MINT-CIPROFLOX 500 MG (BASE) TABLET	CIPROFLOXACIN HCL	00002423561	MPI
MINT-CIPROFLOX 750 MG (BASE) TABLET	CIPROFLOXACIN HCL	00002423588	MPI

New Established Interchangeable (IC) Grouping(s)

The following IC Grouping(s) have been established and LCA pricing will be applied effective September 1, 2014.

Generic Description	Strength / Form	New LCA Price
OCTREOTIDE ACETATE	50 MCG / ML (BASE) INJECTION	1.7500
OCTREOTIDE ACETATE	100 MCG / ML (BASE) INJECTION	3.3000
OCTREOTIDE ACETATE	500 MCG / ML (BASE) INJECTION	15.5000

Least Cost Alternative (LCA) Price Change(s)

The following established IC Grouping(s) are affected and a revised LCA price has been established. Groupings affected by a price decrease, will be effective September 1, 2014.

Please review the online Alberta Drug Benefit List at https://www.ab.bluecross.ca/dbl/idbl_main1.html for further information.

Generic Description	Strength / Form	New LCA Price
CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE	32 MG / 12.5 MG ORAL TABLET	0.3008
CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE	32 MG / 25 MG ORAL TABLET	0.3008

Product(s) Removed from the ADBL at the Request of the Manufacturer

The Alberta government-sponsored drug programs previously covered the following drug product(s). Effective August 1, 2014 the listed product(s) will no longer be a benefit and will not be considered for coverage by special authorization. A transition period will be applied, and as of August 31, 2014, claims will no longer pay for these products.

Trade Name / Strength / Form	Generic Description	DIN	MFR
CEFPROZIL 50 MG / ML ORAL SUSPENSION	CEFPROZIL	00002332027	RAN

Discontinued Listing(s)

Notification of discontinuation has been received from the manufacturers. The Alberta government-sponsored drug programs previously covered the following drug product(s). Effective August 1, 2014, the listed product(s) will no longer be a benefit and will not be considered for coverage by special authorization. A transition period will be applied and, as of August 31, 2014 claims will no longer pay for these products. Please note, for products that were covered by Special Authorization, no transition period will be applied, and as of July 31, 2014, claims will no longer pay for these products.

Trade Name / Strength / Form	Generic Description	DIN	MFR
RESOURCE KID ESSENTIALS ORAL LIQUID	NUTRITIONAL PRODUCTS	0000999551	NHN

PART 3

Special Authorization

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 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/ Interferon Beta-1b Special Authorization Request Form (ABC 60001).

120 MG ORAL DELAYED-RELEASE CAPSULE

00002404508	TECFIDERA	BIO	$	16.1925

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 30776).

8 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002425157	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2465**
00002420821	**MAR-GALANTAMINE ER**	**MAR**	$	**1.2465**
00002339439	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2465**
00002316943	**PAT-GALANTAMINE ER**	**PAT**	$	**1.2465**
00002398370	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2465**
00002377950	**TEVA-GALANTAMINE ER**	**TEV**	$	**1.2465**
00002266717	REMINYL ER	JAI	$	5.0249

16 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002425165	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2465**
00002420848	**MAR-GALANTAMINE ER**	**MAR**	$	**1.2465**
00002339447	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2465**
00002316951	**PAT-GALANTAMINE ER**	**PAT**	$	**1.2465**
00002398389	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2465**
00002377969	**TEVA-GALANTAMINE ER**	**TEV**	$	**1.2465**
00002266725	REMINYL ER	JAI	$	5.0249

GALANTAMINE HYDROBROMIDE

24 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002425173	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2465**
00002420856	**MAR-GALANTAMINE ER**	**MAR**	$	**1.2465**
00002339455	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2465**
00002316978	**PAT-GALANTAMINE ER**	**PAT**	$	**1.2465**
00002398397	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2465**
00002377977	**TEVA-GALANTAMINE ER**	**TEV**	$	**1.2465**
00002266733	REMINYL ER	JAI	$	5.0249

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				
00002413191	**OCPHYL**	**PPH**	$	**1.7500**
00000839191	SANDOSTATIN	NOV	$	5.1460
100 MCG / ML (BASE) INJECTION				
00002413205	**OCPHYL**	**PPH**	$	**3.3000**
00000839205	SANDOSTATIN	NOV	$	9.7135
500 MCG / ML (BASE) INJECTION				
00002413213	**OCPHYL**	**PPH**	$	**15.5000**
00000839213	SANDOSTATIN	NOV	$	45.6526

ZOLEDRONIC ACID

Osteoporosis:

For the treatment of postmenopausal osteoporosis in women who have a high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture, as demonstrated by at least two of the following:

- Age greater than or equal to 75 years

- A prior fragility fracture

- A bone mineral density (BMD) T-score of less than or equal to -2.5

AND at least one of the following:

1) For whom oral bisphosphonates are contraindicated due to an untreatable abnormality of the esophagus which delays esophageal emptying (e.g., stricture or achalasia);

OR

2) Who have demonstrated severe gastrointestinal intolerance to a course of therapy with either alendronate or risedronate. Severe gastrointestinal intolerance is defined as manifested by weight loss or vomiting directly attributable to the oral bisphosphonates.

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, etidronate, 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 31377).

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 Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

ZOLEDRONIC ACID

0.05 MG / ML INJECTION

00002415100	**TARO-ZOLEDRONIC ACID**	**TAR**	$	**3.3540**
00002408082	**ZOLEDRONIC ACID**	**TEV**	$	**3.3540**
00002422433	**ZOLEDRONIC ACID**	**DRL**	$	**3.3540**
00002269198	ACLASTA	NOV	$	6.7683

"For the treatment of tumor-induced hypercalcemia in patients with documented evidence of intolerance or lack of response to clodronate or pamidronate. Special authorization may be granted for 6 months."

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

0.8 MG / ML INJECTION

00002415186	**TARO-ZOLEDRONIC ACID CONCENTRATE**	**TAR**	$	**58.1520**
00002407639	**ZOLEDRONIC ACID**	**TEV**	$	**58.1520**
00002401606	**ZOLEDRONIC ACID - Z**	**SDZ**	$	**58.1520**
00002413701	**ZOLEDRONIC ACID CONCENTRATE**	**OMG**	$	**58.1520**
00002422425	**ZOLEDRONIC ACID CONCENTRATE**	**DRL**	$	**58.1520**
00002248296	ZOMETA CONCENTRATE	NOV	$	110.8160

PART 3A

Optional Special Authorization

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 HCL

"For the treatment of

1) Respiratory Tract Infections:
- end stage COPD with or without bronchiectasis, where there has been documentation of previous Pseudomonas aeruginosa colonization/infection; or
- pneumonic illness in cystic fibrosis; or

2) Genitourinary Tract Infections:
- urinary tract infections; or
- prostatitis; or
- prophylaxis of urinary tract surgical procedures; or
- gonococcal infections; or

3) Skin and Soft Tissue/Bone and Joint Infections:
- malignant/invasive otitis externa; or
- bone/joint infections due to gram negative organisms; or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. diabetic foot infection, decubitus ulcers; or

4) Gastrointestinal Tract Infections:
- bacterial gastroenteritis where antimicrobial therapy is indicated; or
- typhoid fever (enteric fever); or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. intra-abdominal infections; or

5) Other:
- prophylaxis of adult contacts of cases of invasive meningococcal disease; or
- therapy/step-down therapy of hospital acquired gram negative infections; or
- empiric therapy of febrile neutropenia in combination with other appropriate agents; or
- exceptional case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references i.e. AMA CPGs or Bugs and Drugs; or
- for use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for Ciprofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

CIPROFLOXACIN HCL

250 MG (BASE) ORAL TABLET

00002229521	**APO-CIPROFLOX**	**APX**	$	**0.6186**
00002381907	**AURO-CIPROFLOXACIN**	**AUR**	$	**0.6186**
00002332132	**CIPROFLOXACIN**	**RAN**	$	**0.6186**
00002353318	**CIPROFLOXACIN**	**SNS**	$	**0.6186**
00002386119	**CIPROFLOXACIN**	**SIV**	$	**0.6186**
00002247339	**CO CIPROFLOXACIN**	**APH**	$	**0.6186**
00002380358	**JAMP-CIPROFLOXACIN**	**JPC**	$	**0.6186**
00002379686	**MAR-CIPROFLOXACIN**	**MAR**	$	**0.6186**
00002423553	**MINT-CIPROFLOX**	**MPI**	$	**0.6186**
00002317427	**MINT-CIPROFLOXACIN**	**MPI**	$	**0.6186**
00002245647	**MYLAN-CIPROFLOXACIN**	**MYP**	$	**0.6186**
00002161737	**NOVO-CIPROFLOXACIN**	**TEV**	$	**0.6186**
00002248437	**PMS-CIPROFLOXACIN**	**PMS**	$	**0.6186**
00002303728	**RAN-CIPROFLOX**	**RAN**	$	**0.6186**
00002246825	**RATIO-CIPROFLOXACIN**	**RPH**	$	**0.6186**
00002248756	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**0.6186**
00002379627	**SEPTA-CIPROFLOXACIN**	**SEP**	$	**0.6186**
00002155958	CIPRO	BAI	$	2.4964

500 MG (BASE) ORAL TABLET

00002229522	**APO-CIPROFLOX**	**APX**	$	**0.6979**
00002381923	**AURO-CIPROFLOXACIN**	**AUR**	$	**0.6979**
00002332140	**CIPROFLOXACIN**	**RAN**	$	**0.6979**
00002353326	**CIPROFLOXACIN**	**SNS**	$	**0.6979**
00002386127	**CIPROFLOXACIN**	**SIV**	$	**0.6979**
00002247340	**CO CIPROFLOXACIN**	**APH**	$	**0.6979**
00002380366	**JAMP-CIPROFLOXACIN**	**JPC**	$	**0.6979**
00002379694	**MAR-CIPROFLOXACIN**	**MAR**	$	**0.6979**
00002423561	**MINT-CIPROFLOX**	**MPI**	$	**0.6979**
00002317435	**MINT-CIPROFLOXACIN**	**MPI**	$	**0.6979**
00002245648	**MYLAN-CIPROFLOXACIN**	**MYP**	$	**0.6979**
00002161745	**NOVO-CIPROFLOXACIN**	**TEV**	$	**0.6979**
00002248438	**PMS-CIPROFLOXACIN**	**PMS**	$	**0.6979**
00002303736	**RAN-CIPROFLOX**	**RAN**	$	**0.6979**
00002246826	**RATIO-CIPROFLOXACIN**	**RPH**	$	**0.6979**
00002248757	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**0.6979**
00002379635	**SEPTA-CIPROFLOXACIN**	**SEP**	$	**0.6979**
00002155966	CIPRO	BAI	$	2.8166

750 MG (BASE) ORAL TABLET

00002229523	**APO-CIPROFLOX**	**APX**	$	**1.2780**
00002381931	**AURO-CIPROFLOXACIN**	**AUR**	$	**1.2780**
00002332159	**CIPROFLOXACIN**	**RAN**	$	**1.2780**
00002353334	**CIPROFLOXACIN**	**SNS**	$	**1.2780**
00002247341	**CO CIPROFLOXACIN**	**APH**	$	**1.2780**
00002380374	**JAMP-CIPROFLOXACIN**	**JPC**	$	**1.2780**
00002379708	**MAR-CIPROFLOXACIN**	**MAR**	$	**1.2780**
00002423588	**MINT-CIPROFLOX**	**MPI**	$	**1.2780**
00002317443	**MINT-CIPROFLOXACIN**	**MPI**	$	**1.2780**
00002245649	**MYLAN-CIPROFLOXACIN**	**MYP**	$	**1.2780**
00002161753	**NOVO-CIPROFLOXACIN**	**TEV**	$	**1.2780**
00002248439	**PMS-CIPROFLOXACIN**	**PMS**	$	**1.2780**
00002303744	**RAN-CIPROFLOX**	**RAN**	$	**1.2780**
00002246827	**RATIO-CIPROFLOXACIN**	**RPH**	$	**1.2780**
00002248758	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**1.2780**
00002379643	**SEPTA-CIPROFLOXACIN**	**SEP**	$	**1.2780**
00002155974	CIPRO	BAI	$	5.1578