Updates to the Alberta Human Services Drug Benefit Supplement

Effective December 1, 2014

Alberta Human Services

Inquiries should be directed to:

Pharmacy Services
Alberta Blue Cross
10009 108 Street NW
Edmonton AB T5J 3C5

Telephone Number: (780) 498-8370 (Edmonton)
(403) 294-4041 (Calgary)
1-800-361-9632 (Toll Free)

FAX Number: (780) 498-8406
1-877-305-9911 (Toll Free)

Website: http://www.employment.alberta.ca/FCH/2086.html

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
AUBAGIO 14 MG TABLET	TERIFLUNOMIDE	00002416328	GZM

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-EZETIMIBE 10 MG TABLET	EZETIMIBE	00002427826	APX
EZETIMIBE 10 MG TABLET	EZETIMIBE	00002429659	SIV
EZETIMIBE 10 MG TABLET	EZETIMIBE	00002431300	SNS
JAMP-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002416948	JPC
JAMP-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002416956	JPC
JAMP-RIZATRIPTAN IR 5 MG TABLET	RIZATRIPTAN BENZOATE	00002429233	JPC
JAMP-RIZATRIPTAN IR 10 MG TABLET	RIZATRIPTAN BENZOATE	00002429241	JPC
MED-DUTASTERIDE 0.5 MG CAPSULE	DUTASTERIDE	00002416298	GMP

New Drug Product(s) Available by Step Therapy / Special Authorization

Trade Name / Strength / Form	Generic Description	DIN	MFR
JENTADUETO 2.5 MG / 500 MG TABLET	LINAGLIPTIN/ METFORMIN HCL	00002403250	BOE
JENTADUETO 2.5 MG / 850 MG TABLET	LINAGLIPTIN/ METFORMIN HCL	00002403269	BOE
JENTADUETO 2.5 MG / 1,000 MG TABLET	LINAGLIPTIN/ METFORMIN HCL	00002403277	BOE

Product(s) With A Price Change

The following product(s) had a Price Decrease. The previous higher price will be recognized until December 31, 2014.

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP-RIZATRIPTAN 5 MG TABLET	RIZATRIPTAN BENZOATE	00002380455	JPC

Discontinued Listing(s)

Notification of discontinuation has been received from the manufacturer(s). The Alberta government-sponsored drug programs previously covered the following drug product(s). Effective December 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 December 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 November 30, 2014, claims will no longer pay for these products.

Trade Name / Strength / Form	Generic Description	DIN	MFR
TEVA-FLUTAMIDE 250 MG TABLET	FLUTAMIDE	00002230089	TEV

PART 3

Special Authorization

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 HCl must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 30776).

5 MG ORAL TABLET

00002362260	**APO-DONEPEZIL**	**APX**	$	**1.1806**
00002400561	**AURO-DONEPEZIL**	**AUR**	$	**1.1806**
00002397595	**CO DONEPEZIL**	**APH**	$	**1.1806**
00002420597	**DONEPEZIL**	**SIV**	$	**1.1806**
00002402645	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**1.1806**
00002404419	**JAMP-DONEPEZIL**	**JPC**	$	**1.1806**
00002416948	**JAMP-DONEPEZIL**	**JPC**	$	**1.1806**
00002402092	**MAR-DONEPEZIL**	**MAR**	$	**1.1806**
00002359472	**MYLAN-DONEPEZIL**	**MYP**	$	**1.1806**
00002322331	**PMS-DONEPEZIL**	**PMS**	$	**1.1806**
00002381508	**RAN-DONEPEZIL**	**RAN**	$	**1.1806**
00002328666	**SANDOZ DONEPEZIL**	**SDZ**	$	**1.1806**
00002428482	**SEPTA DONEPEZIL**	**SEP**	$	**1.1806**
00002340607	**TEVA-DONEPEZIL**	**TEV**	$	**1.1806**
00002232043	ARICEPT	PFI	$	4.8620

10 MG ORAL TABLET

00002362279	**APO-DONEPEZIL**	**APX**	$	**1.1806**
00002400588	**AURO-DONEPEZIL**	**AUR**	$	**1.1806**
00002397609	**CO DONEPEZIL**	**APH**	$	**1.1806**
00002420600	**DONEPEZIL**	**SIV**	$	**1.1806**
00002402653	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**1.1806**
00002404427	**JAMP-DONEPEZIL**	**JPC**	$	**1.1806**
00002416956	**JAMP-DONEPEZIL**	**JPC**	$	**1.1806**
00002402106	**MAR-DONEPEZIL**	**MAR**	$	**1.1806**
00002359480	**MYLAN-DONEPEZIL**	**MYP**	$	**1.1806**
00002322358	**PMS-DONEPEZIL**	**PMS**	$	**1.1806**
00002381516	**RAN-DONEPEZIL**	**RAN**	$	**1.1806**
00002328682	**SANDOZ DONEPEZIL**	**SDZ**	$	**1.1806**
00002428490	**SEPTA DONEPEZIL**	**SEP**	$	**1.1806**
00002340615	**TEVA-DONEPEZIL**	**TEV**	$	**1.1806**
00002232044	ARICEPT	PFI	$	4.8620

DUTASTERIDE

"For the treatment of benign prostatic hyperplasia in patients who are poor surgical risks or who have enlarged prostates and have moderate to severe symptoms suggestive of obstruction.

Special authorization may be granted for 6 months"

Information is required regarding the medical condition(s) or circumstances by which this patient would be deemed a poor surgical risk.

All requests (including renewal requests) for dutasteride must be completed using the Dutasteride/Finasteride Special Authorization Request Form (ABC 31257).

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

0.5 MG ORAL CAPSULE

00002412691	**ACT DUTASTERIDE**	**APH**	$	**0.4205**
00002404206	**APO-DUTASTERIDE**	**APX**	$	**0.4205**
00002416298	**MED-DUTASTERIDE**	**GMP**	$	**0.4205**
00002428873	**MINT-DUTASTERIDE**	**MPI**	$	**0.4205**
00002393220	**PMS-DUTASTERIDE**	**PMS**	$	**0.4205**
00002424444	**SANDOZ DUTASTERIDE**	**SDZ**	$	**0.4205**
00002408287	**TEVA-DUTASTERIDE**	**TEV**	$	**0.4205**
00002247813	AVODART	GSK	$	1.6819

EZETIMIBE

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

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

* High cardiovascular risk is defined as possessing one of the following:
1) Pre-existing cardiovascular disease and/or cerebrovascular disease, or
2) Diabetes, or
3) Familial hypercholesterolemia, or
4) Greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool, or
5) Three or more of the following risk factors:
- Family history of premature cardiovascular disease
- Smoking
- Hypertension
- Obesity
- Glucose intolerance
- Renal disease.

Special authorization for these criteria may be granted for 6 months."

All requests for ezetimibe must be completed using the Ezetimibe Special Authorization Request Form (ABC 30925).

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

10 MG ORAL TABLET

00002414716	**ACT EZETIMIBE**	**APH**	$	**0.4549**
00002427826	**APO-EZETIMIBE**	**APX**	$	**0.4549**
00002429659	**EZETIMIBE**	**SIV**	$	**0.4549**
00002431300	**EZETIMIBE**	**SNS**	$	**0.4549**
00002378035	**MYLAN-EZETIMIBE**	**MYP**	$	**0.4549**
00002419548	**RAN-EZETIMIBE**	**RAN**	$	**0.4549**
00002416778	**SANDOZ EZETIMIBE**	**SDZ**	$	**0.4549**
00002354101	**TEVA-EZETIMIBE**	**TEV**	$	**0.4549**
00002247521	EZETROL	MFC	$	1.8196

LINAGLIPTIN/ METFORMIN HCL

SPECIAL AUTHORIZATION

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 Inhibitors Special Authorization Request Form (ABC 60012).

2.5 MG * 500 MG ORAL TABLET				
00002403250	JENTADUETO	BOE	$	1.3337
2.5 MG * 850 MG ORAL TABLET				
00002403269	JENTADUETO	BOE	$	1.3337
2.5 MG * 1,000 MG ORAL TABLET				
00002403277	JENTADUETO	BOE	$	1.3337

RIZATRIPTAN BENZOATE

"For the treatment of acute migraine attacks in patients where other standard therapy has failed. Special authorization may be granted for 24 months."

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				
00002393476	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002381702	**CO RIZATRIPTAN**	**APH**	$	**3.7050**
00002380463	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429241	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
00002379678	**MAR-RIZATRIPTAN**	**MAR**	$	**3.7050**
00002240521	MAXALT	MFC	$	15.5874

TERIFLUNOMIDE

SPECIAL AUTHORIZATION

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 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.

TERIFLUNOMIDE

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 teriflunomide must be completed using the Dimethyl Fumarate/Glatiramer Acetate/ Interferon Beta-1a/Interferon Beta-1b/Teriflunomide Special Authorization Request Form (ABC 60001).

14 MG ORAL TABLET				
00002416328	AUBAGIO	GZM	$	53.9696