Updates to the Alberta Human Services Drug Benefit Supplement

Effective February 1, 2015

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
MOZOBIL 20 MG / ML INJECTION	PLERIXAFOR	00002377225	SAV

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACH-EZETIMIBE 10 MG TABLET	EZETIMIBE	00002425610	AHI
APO-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002418932	APX
APO-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002418940	APX
CO CELECOXIB 100 MG CAPSULE	CELECOXIB	00002420155	APH
CO CELECOXIB 200 MG CAPSULE	CELECOXIB	00002420163	APH
GD-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002291975	GMD
GD-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002291983	GMD
JAMP-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002424533	JPC
JAMP-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002424541	JPC
JAMP-ZOLMITRIPTAN ODT 2.5 MG ORAL DISPERSIBLE TABLET	ZOLMITRIPTAN	00002428237	JPC
MAR-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002420058	MAR
MAR-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002420066	MAR
MINT-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002412497	MPI
MINT-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002412500	MPI
MYLAN-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002423278	MYP
MYLAN-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002399881	MYP
PMS-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002355442	PMS
PMS-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002355450	PMS
PMS-ZOLEDRONIC ACID 0.8 MG / ML INJECTION	ZOLEDRONIC ACID	00002403056	PMS
RAN-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002412373	RAN
RAN-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002412381	RAN
SANDOZ CELECOXIB 100 MG CAPSULE	CELECOXIB	00002321246	SDZ

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
SANDOZ CELECOXIB 200 MG CAPSULE	CELECOXIB	00002321254	SDZ
SANDOZ LINEZOLID 600 MG TABLET	LINEZOLID	00002422689	SDZ
SANDOZ VORICONAZOLE 50 MG TABLET	VORICONAZOLE	00002399245	SDZ
SANDOZ VORICONAZOLE 200 MG TABLET	VORICONAZOLE	00002399253	SDZ
TEVA-CELECOXIB 100 MG CAPSULE	CELECOXIB	00002288915	TEV
TEVA-CELECOXIB 200 MG CAPSULE	CELECOXIB	00002288923	TEV
TEVA-VALGANCICLOVIR 450 MG TABLET	VALGANCICLOVIR HCL	00002413825	TEV
TEVA-VORICONAZOLE 50 MG TABLET	VORICONAZOLE	00002396866	TEV
TEVA-VORICONAZOLE 200 MG TABLET	VORICONAZOLE	00002396874	TEV

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-VALGANCICLOVIR 450 MG TABLET	VALGANCICLOVIR HCL	00002393824	APX
RITUXAN 10 MG / ML INJECTION	RITUXIMAB	00002241927	HLR
VALCYTE 450 MG TABLET	VALGANCICLOVIR HCL	00002245777	HLR
VALCYTE 50 MG / ML ORAL SUSPENSION	VALGANCICLOVIR HCL	00002306085	HLR

Restricted Benefit(s)

Drug Product(s) Added as Restricted Benefit(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
DIPHENHYDRAMINE 2.5 MG / ML ORAL ELIXIR	DIPHENHYDRAMINE HCL	00002298503	JPC

New Established Interchangeable (IC) Grouping(s)

The following IC Grouping(s) have been established and LCA pricing will be applied effective March 1, 2015.

Generic Description	Strength / Form	New LCA Price
CELECOXIB	100 MG CAPSULE	0.1748
CELECOXIB	200 MG CAPSULE	0.3497
LINEZOLID	600 MG TABLET	37.0500

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 March 1, 2015.

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
MODAFINIL	100 MG TABLET	0.9293
VALGANCICLOVIR HCL	450 MG TABLET	11.6062
ZOLEDRONIC ACID	0.8 MG / ML INJECTION	38.7856

Product(s) With A Price Change

The following product(s) had a Price Decrease. The previous higher price will be recognized until February 28, 2015. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-MODAFINIL 100 MG TABLET	MODAFINIL	00002285398	APX
ZOLEDRONIC ACID - Z 0.8 MG / ML INJECTION	ZOLEDRONIC ACID	00002401606	SDZ
ZOLEDRONIC ACID CONCENTRATE 0.8 MG / ML INJECTION	ZOLEDRONIC ACID	00002413701	OMG
ZOLEDRONIC ACID CONCENTRATE 0.8 MG / ML INJECTION	ZOLEDRONIC ACID	00002422425	DRL

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 February 1, 2015, 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 February 28, 2015 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 January 31, 2015, claims will no longer pay for these products.

Trade Name / Strength / Form	Generic Description	DIN	MFR
LEVAQUIN 250 MG TABLET	LEVOFLOXACIN	00002236841	JAI
MYLAN-TIZANIDINE 4 MG TABLET	TIZANIDINE HCL	00002272059	MYP
OPTIMENTAL ORAL LIQUID	NUTRITIONAL PRODUCTS	00000999420	ABN
PERATIVE ORAL LIQUID	NUTRITIONAL PRODUCTS	00000999423	ABN
POLYCOSE ORAL POWDER	NUTRITIONAL PRODUCTS	00000999928	ABN
PULMOCARE ORAL LIQUID	NUTRITIONAL PRODUCTS	00000999412	ABN

PART 2

Drug Additions

DIPHENHYDRAMINE HCL

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

2.5 MG / ML ORAL ELIXIR

☒ 00002298503	DIPHENHYDRAMINE	JPC	$	0.0303
☒ 00000792705	PMS-DIPHENHYDRAMINE	PPH	$	0.0303

PART 3

Special Authorization

CELECOXIB

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

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

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

All requests for celecoxib must be completed using the Celecoxib Special Authorization Request Form (ABC 31140).

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

100 MG ORAL CAPSULE

00002418932	**APO-CELECOXIB**	**APX**	$	**0.1748**
00002420155	**CO CELECOXIB**	**APH**	$	**0.1748**
00002291975	**GD-CELECOXIB**	**GMD**	$	**0.1748**
00002424533	**JAMP-CELECOXIB**	**JPC**	$	**0.1748**
00002420058	**MAR-CELECOXIB**	**MAR**	$	**0.1748**
00002412497	**MINT-CELECOXIB**	**MPI**	$	**0.1748**
00002423278	**MYLAN-CELECOXIB**	**MYP**	$	**0.1748**
00002355442	**PMS-CELECOXIB**	**PMS**	$	**0.1748**
00002412373	**RAN-CELECOXIB**	**RAN**	$	**0.1748**
00002321246	**SANDOZ CELECOXIB**	**SDZ**	$	**0.1748**
00002288915	**TEVA-CELECOXIB**	**TEV**	$	**0.1748**
00002239941	CELEBREX	PFI	$	0.6992

200 MG ORAL CAPSULE

00002418940	**APO-CELECOXIB**	**APX**	$	**0.3497**
00002420163	**CO CELECOXIB**	**APH**	$	**0.3497**
00002291983	**GD-CELECOXIB**	**GMD**	$	**0.3497**
00002424541	**JAMP-CELECOXIB**	**JPC**	$	**0.3497**
00002420066	**MAR-CELECOXIB**	**MAR**	$	**0.3497**
00002412500	**MINT-CELECOXIB**	**MPI**	$	**0.3497**
00002399881	**MYLAN-CELECOXIB**	**MYP**	$	**0.3497**
00002355450	**PMS-CELECOXIB**	**PMS**	$	**0.3497**
00002412381	**RAN-CELECOXIB**	**RAN**	$	**0.3497**
00002321254	**SANDOZ CELECOXIB**	**SDZ**	$	**0.3497**
00002288923	**TEVA-CELECOXIB**	**TEV**	$	**0.3497**
00002239942	CELEBREX	PFI	$	1.3988

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

00002425610	**ACH-EZETIMIBE**	**AHI**	$	**0.4549**
00002414716	**ACT EZETIMIBE**	**APH**	$	**0.4549**
00002427826	**APO-EZETIMIBE**	**APX**	$	**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

LINEZOLID

"For the treatment of:

1) Vancomycin-resistant enterococcus infections or

2) Methicillin-resistant Staphylococcus aureus (MRSA)/methicillin-resistant coagulase-negative Staphylococcus infections in patients who are unresponsive to or intolerant of vancomycin or

3) Susceptible organisms in patients severely intolerant or allergic to all other appropriate alternatives (e.g. beta-lactam antibiotics, clindamycin, trimethoprim/sulfamethoxazole and vancomycin) or to facilitate patient discharge from hospital where it otherwise would not be possible.

This product must be prescribed in consultation with a specialist in Infectious Diseases in all instances."

In order to comply with the above criteria, information is required regarding the type of infection and organisms involved. Information is also required regarding previous antibiotic therapy that has been utilized and the patient's response to therapy and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. The specialist in Infectious Diseases that recommended this drug is also required.

600 MG ORAL TABLET

00002422689	**SANDOZ LINEZOLID**	**SDZ**	$	**37.0500**
00002243684	ZYVOXAM	PFI	$	74.1000

MODAFINIL

"For the treatment of documented narcolepsy. This drug product must be prescribed by a specialist in Neurology or Psychiatry, or a sleep specialist affiliated with a recognized level 1 lab.

Special authorization may be granted for 6 months."

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

100 MG ORAL TABLET

00002285398	**APO-MODAFINIL**	**APX**	$	**0.9293**
00002239665	ALERTEC	SHB	$	1.3490

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 / ML INJECTION

00002377225	MOZOBIL	SAV	$	6295.8333

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 (e.g., etanercept, infliximab or adalimumab) (minimum 12 week trial).

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.
'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist").

- Initial coverage may be approved for 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 experienced a subsequent loss of effect as defined by a worsening greater than or equal to 0.6 in the DAS28 score AND possess a DAS28 score of greater than or equal to 3.2.

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 31205).

RITUXIMAB

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 one dose of 375 mg per square metre of body surface area administered once weekly for 4 weeks.
- Patients will be limited to receiving one dose 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 Rituxan for Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA) must be completed using the Rituxan for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form (ABC 60018).

10 MG / ML INJECTION				
00002241927	RITUXAN	HLR	$	45.3100

VALGANCICLOVIR HCL

"For the treatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS)."
"Special authorization may be granted for 12 months."

"For the prevention of CMV disease in solid organ transplant patients at risk (i.e. risk is defined as donor +ve/recipient -ve for CMV, or recipient +ve for CMV, or recipient +ve in patients receiving antilymphocyte antibody [ALA]).

For the purpose of administering this criterion, islet transplant recipients are at similar risk of CMV disease to patients undergoing a solid organ transplant and qualify for drug coverage."
"Special authorization may be granted for 100 days."

"For the prevention of CMV disease in kidney transplant patients at risk (i.e. risk is defined as donor +ve/recipient -ve for CMV, or recipient +ve for CMV, or recipient +ve in patients receiving antilymphocyte antibody [ALA])."

"Special authorization may be granted for 200 days."

All requests for valganciclovir must be completed using the Valganciclovir Special Authorization Request Form (ABC 60017).

450 MG (BASE) ORAL TABLET				
00002413825	**TEVA-VALGANCICLOVIR**	**TEV**	$	**11.6062**
00002393824	APO-VALGANCICLOVIR	APX	$	17.4093
00002245777	VALCYTE	HLR	$	23.2123
50 MG / ML ORAL SUSPENSION				
00002306085	VALCYTE	HLR	$	2.5791

VORICONAZOLE

"For the treatment of invasive aspergillosis for post-hospital discharge only."

"For treatment of culture proven invasive candidiasis with documented resistance to fluconazole."

"This medication must be prescribed in consultation with a specialist in Infectious Diseases."

50 MG ORAL TABLET				
00002409674	**APO-VORICONAZOLE**	**APX**	$	**3.1958**
00002399245	**SANDOZ VORICONAZOLE**	**SDZ**	$	**3.1958**
00002396866	**TEVA-VORICONAZOLE**	**TEV**	$	**3.1958**
00002256460	VFEND	PFI	$	12.7830
200 MG ORAL TABLET				
00002409682	**APO-VORICONAZOLE**	**APX**	$	**12.7777**
00002399253	**SANDOZ VORICONAZOLE**	**SDZ**	$	**12.7777**
00002396874	**TEVA-VORICONAZOLE**	**TEV**	$	**12.7777**
00002256479	VFEND	PFI	$	51.1109

ZOLEDRONIC ACID

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

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

0.8 MG / ML INJECTION

00002403056	**PMS-ZOLEDRONIC ACID**	**PMS**	$	**38.7856**
00002401606	**ZOLEDRONIC ACID - Z**	**SDZ**	$	**38.7856**
00002413701	**ZOLEDRONIC ACID CONCENTRATE**	**OMG**	$	**38.7856**
00002422425	**ZOLEDRONIC ACID CONCENTRATE**	**DRL**	$	**38.7856**
00002415186	TARO-ZOLEDRONIC ACID CONCENTRATE	TAR	$	58.1520
00002407639	ZOLEDRONIC ACID	TEV	$	58.1520
00002248296	ZOMETA CONCENTRATE	NOV	$	110.8160

ZOLMITRIPTAN

"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.

2.5 MG ORAL DISPERSIBLE TABLET

00002381575	**APO-ZOLMITRIPTAN RAPID**	**APX**	$	**4.6050**
00002428237	**JAMP-ZOLMITRIPTAN ODT**	**JPC**	$	**4.6050**
00002419513	**MINT-ZOLMITRIPTAN ODT**	**MPI**	$	**4.6050**
00002387158	**MYLAN-ZOLMITRIPTAN ODT**	**MYP**	$	**4.6050**
00002324768	**PMS-ZOLMITRIPTAN ODT**	**PMS**	$	**4.6050**
00002362996	**SANDOZ ZOLMITRIPTAN ODT**	**SDZ**	$	**4.6050**
00002428474	**SEPTA-ZOLMITRIPTAN-ODT**	**SEP**	$	**4.6050**
00002342545	**TEVA-ZOLMITRIPTAN OD**	**TEV**	$	**4.6050**
00002243045	ZOMIG RAPIMELT	AZC	$	14.1350