Updates to the Alberta Human Services Drug Benefit Supplement

Effective July 1, 2014

Alberta Human Services

Inquiries should be directed to:

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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
FENTANYL CITRATE 0.05 MG / ML (BASE) INJECTION	FENTANYL CITRATE	00002240434	SDZ
KALYDECO 150 MG TABLET	IVACAFTOR	00002397412	VER

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-VORICONAZOLE 50 MG TABLET	VORICONAZOLE	00002409674	APX
APO-VORICONAZOLE 200 MG TABLET	VORICONAZOLE	00002409682	APX
ARANESP (0.5 ML SYRINGE) 50 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002391759	AMG
ARANESP (0.4 ML SYRINGE) 200 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002391805	AMG
JAMP-PIP/TAZ 4 G / VIAL (BASE) / 500 MG / VIAL (BASE) INJECTION	PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM	00002420430	JPC
SANDOZ VORICONAZOLE 50 MG TABLET	VORICONAZOLE	00002399245	SDZ
SANDOZ VORICONAZOLE 200 MG TABLET	VORICONAZOLE	00002399253	SDZ

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP-CLOPIDOGREL 75 MG (BASE) TABLET	CLOPIDOGREL BISULFATE	00002415550	JPC

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP-ZOLMITRIPTAN 2.5 MG TABLET	ZOLMITRIPTAN	00002421623	JPC
MAR-ZOLMITRIPTAN 2.5 MG TABLET	ZOLMITRIPTAN	00002399458	MAR
MINT-ZOLMITRIPTAN 2.5 MG TABLET	ZOLMITRIPTAN	00002419521	MPI

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
MINT-ZOLMITRIPTAN ODT 2.5 MG ORAL DISPERSIBLE TABLET	ZOLMITRIPTAN	00002419513	MPI

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
ARANESP (0.4 ML SYRINGE) 10 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002246354	AMG
ARANESP (0.4 ML SYRINGE) 10 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002392313	AMG
ARANESP (0.5 ML SYRINGE) 20 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002246355	AMG
ARANESP (0.5 ML SYRINGE) 20 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002392321	AMG
ARANESP (0.3 ML SYRINGE) 30 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002392348	AMG
ARANESP (0.4 ML SYRINGE) 40 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002391740	AMG
ARANESP (0.4 ML SYRINGE) 80 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002391767	AMG
ARANESP (0.3/ 0.4/ 0.5 ML SYR) 100 MCG / ML INJECTION	DARBEPOETIN	00002246357	AMG
ARANESP (0.5 ML SYRINGE) 100 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002391775	AMG
ARANESP (0.65 ML SYRINGE) 130 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002391783	AMG
ARANESP (0.3/ 0.4/ 0.5/ 0.65 ML SYR) 200 MCG / ML INJECTION	DARBEPOETIN	00002246358	AMG
ARANESP (0.6 ML SYRINGE) 300 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002391821	AMG
ARANESP (0.3/ 0.4/ 0.6/ 1.0 ML SYR) 500 MCG / ML INJECTION	DARBEPOETIN	00002246360	AMG
ARANESP (1.0 ML SYR) 500 MCG / SYR INJECTION SYRINGE	DARBEPOETIN	00002392364	AMG
EPREX (0.5 ML SYRINGE) 1,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002231583	JAI

Drug Product(s) with Changes to Criteria for Coverage, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
EPREX (0.5 ML SYRINGE) 2,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002231584	JAI
EPREX (0.3 ML SYRINGE) 3,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002231585	JAI
EPREX (0.4 ML SYRINGE) 4,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002231586	JAI
EPREX (0.5 ML SYRINGE) 5,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002243400	JAI
EPREX (0.6 ML SYRINGE) 6,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002243401	JAI
EPREX (0.8 ML SYRINGE) 8,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002243403	JAI
EPREX (1 ML SYRINGE) 10,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002231587	JAI
EPREX (0.5 ML SYRINGE) 20,000 UNIT / SYR INJECTION SYRINGE	EPOETIN ALFA	00002243239	JAI

New Established Interchangeable (IC) Grouping(s)

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

Generic Description	Strength / Form	New LCA Price
VORICONAZOLE	50 MG ORAL TABLET	3.2147
VORICONAZOLE	200 MG ORAL TABLET	12.8537

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 August 1, 2014. Groupings affected by a price increase, will be effective July 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
CLOPIDOGREL BISULFATE	75 MG (BASE) ORAL TABLET	0.6575

PART 3

Special Authorization

CLOPIDOGREL BISULFATE

(Refer to 20:12.18 of the Alberta Drug Benefit List for one month of coverage, following the first intravascular stent placement, when prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery.)

"For the prevention of thrombosis, for one month, when prescribed following intravascular bare metal stent placement. Patients who have received one month of coverage via the Limited Restricted Benefit will not be eligible for additional coverage under this criterion."*

"For the prevention of thrombosis, for up to 12 months, when prescribed following intravascular drug eluting stent (DES) placement. Patients who have received one month of coverage via the Limited Restricted Benefit may be eligible for an additional 11 months of coverage (i.e., up to 12 months of coverage) following the submission of a special authorization request."*

"For the prevention of ischemic events (cerebrovascular (e.g. stroke, TIA) or noncerebrovascular) in patients who have experienced an ischemic event while on ASA, or who have a contraindication to ASA. Special authorization for this criterion may be granted for 6 months."**

"Coverage will not be considered when clopidogrel and dipyridamole/ASA are intended for use in combination."

* Special Authorization for post-stent coverage is required when the prescriber prescribing the medication is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery; for treatment after repeat stents; or for continued coverage of up to 12 months following intravascular drug eluting stent (DES) placement.

In order to comply with the first and second criteria, information is required regarding the date, type of stent, and stenting procedure. In order to comply with the third criterion, information is required regarding the type of ischemic event experienced while on ASA and, if applicable, information is required as to why ASA cannot be used.

All requests for clopidogrel bisulfate must be completed using the Clopidogrel Special Authorization Request Form (ABC 30786).

** The following product(s) are eligible for auto-renewal for the third criterion only.

75 MG (BASE) ORAL TABLET

00002351536	**MYLAN-CLOPIDOGREL**	**MYP**	$	**0.6575**
00002412942	ABBOTT-CLOPIDOGREL	ABB	$	0.6576
00002252767	APO-CLOPIDOGREL	APX	$	0.6576
00002416387	AURO-CLOPIDOGREL	AUR	$	0.6576
00002385813	CLOPIDOGREL	SIV	$	0.6576
00002400553	CLOPIDOGREL	SNS	$	0.6576
00002303027	CO CLOPIDOGREL	APH	$	0.6576
00002415550	JAMP-CLOPIDOGREL	JPC	$	0.6576
00002422255	MAR-CLOPIDOGREL	MAR	$	0.6576
00002408910	MINT-CLOPIDOGREL	MPI	$	0.6576
00002348004	PMS-CLOPIDOGREL	PMS	$	0.6576
00002379813	RAN-CLOPIDOGREL	RAN	$	0.6576
00002359316	SANDOZ CLOPIDOGREL	SDZ	$	0.6576
00002293161	TEVA-CLOPIDOGREL	TEV	$	0.6576
00002238682	PLAVIX	SAV	$	2.7125

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% or serum ferritin >200 mcg/L. 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 or serum ferritin.

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 / ML INJECTION

00002246357	ARANESP (0.3/ 0.4/ 0.5 ML SYR)	AMG	$ 268.0000

For this product - pricing has been established on a per millilitre basis.

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% or serum ferritin >200 mcg/L. 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 or serum ferritin.

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

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% or serum ferritin >200 mcg/L. 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 or serum ferritin.

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).

200 MCG / ML INJECTION

00002246358	ARANESP (0.3/ 0.4/ 0.5/ 0.65 ML SYR)	AMG	$ 536.0000

For this product - pricing has been established on a per millilitre basis.

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% or serum ferritin >200 mcg/L. 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 or serum ferritin.

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).

500 MCG / ML INJECTION

00002246360	ARANESP (0.3/ 0.4/ 0.6/ 1.0 ML SYR)	AMG	$ 1465.8500

For this product - pricing has been established on a per millilitre basis.

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% or serum ferritin >200 mcg/L. 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 or serum ferritin.

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).

10 MCG / SYR INJECTION SYRINGE				
☒	00002246354	ARANESP (0.4 ML SYRINGE)	AMG	$ 26.8000
☒	00002392313	ARANESP (0.4 ML SYRINGE)	AMG	$ 26.8000
20 MCG / SYR INJECTION SYRINGE				
☒	00002246355	ARANESP (0.5 ML SYRINGE)	AMG	$ 53.6000
☒	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
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
200 MCG / SYR INJECTION SYRINGE				
	00002391805	ARANESP (0.4 ML SYRINGE)	AMG	$ 586.3400
300 MCG / SYR INJECTION SYRINGE				
	00002391821	ARANESP (0.6 ML SYRINGE)	AMG	$ 879.5100
500 MCG / SYR INJECTION SYRINGE				
	00002392364	ARANESP (1.0 ML SYR)	AMG	$ 1465.8500

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% or serum ferritin >200 mcg/L. 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 or serum ferritin.

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
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	$ 283.1400

FENTANYL CITRATE

"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.)

This product is eligible for auto-renewal.

0.05 MG / ML (BASE)	**INJECTION**			
00002240434	FENTANYL CITRATE	SDZ	$	1.9650

IVACAFTOR

Special authorization coverage may be provided for the treatment of cystic fibrosis (CF) in patients age 6 years and older who have a G551D mutation in the Cystic Fibrosis Transmembrane conductance Regulator (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 150mg 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/litre; 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/litre, 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 150mg 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 problems 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

PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM

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."

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.

4 G / VIAL (BASE) * 500 MG / VIAL (BASE) INJECTION

00002420430	**JAMP-PIP/TAZ**	**JPC**	$	**12.1100**
00002308460	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**12.1100**
00002362635	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**12.1100**
00002299658	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**12.1100**
00002370174	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**12.1100**
00002391546	**PIPERACILLIN/TAZOBACTAM**	**MYP**	$	**12.1100**
00002170809	TAZOCIN	PFI	$	23.8450

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**	$	**3.2147**
00002399245	SANDOZ VORICONAZOLE	SDZ	$	3.2148
00002256460	VFEND	PFI	$	12.7830

200 MG ORAL TABLET

00002409682	**APO-VORICONAZOLE**	**APX**	$	**12.8537**
00002399253	**SANDOZ VORICONAZOLE**	**SDZ**	$	**12.8537**
00002256479	VFEND	PFI	$	51.1109

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 TABLET

00002380951	**APO-ZOLMITRIPTAN**	**APX**	$	**4.6050**
00002421623	**JAMP-ZOLMITRIPTAN**	**JPC**	$	**4.6050**
00002399458	**MAR-ZOLMITRIPTAN**	**MAR**	$	**4.6050**
00002419521	**MINT-ZOLMITRIPTAN**	**MPI**	$	**4.6050**
00002369036	**MYLAN-ZOLMITRIPTAN**	**MYP**	$	**4.6050**
00002324229	**PMS-ZOLMITRIPTAN**	**PMS**	$	**4.6050**
00002362988	**SANDOZ ZOLMITRIPTAN**	**SDZ**	$	**4.6050**
00002313960	**TEVA-ZOLMITRIPTAN**	**TEV**	$	**4.6050**
00002238660	ZOMIG	AZC	$	13.9733

2.5 MG ORAL DISPERSIBLE TABLET

00002381575	**APO-ZOLMITRIPTAN RAPID**	**APX**	$	**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**
00002342545	**TEVA-ZOLMITRIPTAN OD**	**TEV**	$	**4.6050**
00002243045	ZOMIG RAPIMELT	AZC	$	14.1350