Updates to the Alberta Drug Benefit List

Effective May 1, 2020

Alberta Government

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: 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.

Copies of the *Alberta Drug Benefit List* 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) will be considered for coverage by Special Authorization for patients covered under Alberta government-sponsored drug programs.

New Drug Product(s) Available by Special Authorization

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACTEMRA (0.9 ML AUTO INJECTOR) 162 MG / SYRINGE INJECTION	TOCILIZUMAB	00002483327	HLR

Additional Brand(s) and/or Strength(s) Drug Product(s) Available by Step Therapy / Special Authorization

Trade Name / Strength / Form	Generic Description	DIN	MFR
PMS-FLUTICASONE / SALMETEROL DPI 50 MCG / DOSE / 100 MCG / DOSE METERED INHALATION POWDER	SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	00002494507	PMS
PMS-FLUTICASONE / SALMETEROL DPI 50 MCG / DOSE / 250 MCG / DOSE METERED INHALATION POWDER	SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	00002494515	PMS
PMS-FLUTICASONE / SALMETEROL DPI 50 MCG / DOSE / 500 MCG / DOSE METERED INHALATION POWDER	SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	00002494523	PMS
WIXELA INHUB 50 MCG / DOSE / 100 MCG / DOSE METERED INHALATION POWDER	SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	00002495597	MYP
WIXELA INHUB 50 MCG / DOSE / 250 MCG / DOSE METERED INHALATION POWDER	SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	00002495600	MYP
WIXELA INHUB 50 MCG / DOSE / 500 MCG / DOSE METERED INHALATION POWDER	SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	00002495619	MYP

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP ZOLMITRIPTAN 2.5 MG TABLET	ZOLMITRIPTAN	00002477106	JPC

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP-FEBUXOSTAT 80 MG TABLET	FEBUXOSTAT	00002490870	JPC
JAMP-LACOSAMIDE 50 MG TABLET	LACOSAMIDE	00002488388	JPC
JAMP-LACOSAMIDE 100 MG TABLET	LACOSAMIDE	00002488396	JPC

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP-LACOSAMIDE 150 MG TABLET	LACOSAMIDE	00002488418	JPC
JAMP-LACOSAMIDE 200 MG TABLET	LACOSAMIDE	00002488426	JPC

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACTEMRA (4 ML) 80 MG / VIAL INJECTION	TOCILIZUMAB	00002350092	HLR
ACTEMRA (0.9 ML SYRINGE) 162 MG / SYRINGE INJECTION	TOCILIZUMAB	00002424770	HLR
ACTEMRA (10 ML) 200 MG / VIAL INJECTION	TOCILIZUMAB	00002350106	HLR
ACTEMRA (20 ML) 400 MG / VIAL INJECTION	TOCILIZUMAB	00002350114	HLR

Restricted Benefit(s)

New Drug Product(s) Available by Restricted Benefit

Trade Name / Strength / Form	Generic Description	DIN	MFR
TRIAMCINOLONE HEXACETONIDE 20 MG / ML SUSPENSION INJECTION	TRIAMCINOLONE HEXACETONIDE	00002470632	MDX

Additional Brand(s) and/or Strength(s) of Drug Product(s) Available by Restricted Benefit

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACCEL-ENTECAVIR 0.5 MG TABLET	ENTECAVIR	00002479907	ACP
MINT-ENTECAVIR 0.5 MG TABLET	ENTECAVIR	00002485907	MPI

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACH-PRAVASTATIN 10 MG TABLET	PRAVASTATIN SODIUM	00002440644	AHI
ACH-PRAVASTATIN 20 MG TABLET	PRAVASTATIN SODIUM	00002440652	AHI
ACH-PRAVASTATIN 40 MG TABLET	PRAVASTATIN SODIUM	00002440660	AHI
ACT VENLAFAXINE XR 37.5 MG EXTENDED-RELEASE CAP	VENLAFAXINE HYDROCHLORIDE	00002304317	TEV
ACT VENLAFAXINE XR 150 MG EXTENDED-RELEASE CAPSULE	VENLAFAXINE HYDROCHLORIDE	00002304333	TEV
HYDROMORPHONE HP 50 MG / ML INJECTION	HYDROMORPHONE HYDROCHLORIDE	00002146126	SDZ

Added Product(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP HYDROXYCHLOROQUINE SULFATE 200 MG TABLET	HYDROXYCHLOROQUINE SULFATE	00002491427	JPC
JAMP-LATANOPROST 0.005% OPHTHALMIC SOLUTION	LATANOPROST	00002453355	JPC
JAMP-LATANOPROST / TIMOLOL 0.005% / 0.5% OPHTHALMIC SOLUTION	LATANOPROST/ TIMOLOL MALEATE	00002453770	JPC
KETOROLAC TROMETHAMINE 30 MG / ML INJECTION	KETOROLAC TROMETHAMINE	00002239944	SDZ
MAR-ACARBOSE 100 MG TABLET	ACARBOSE	00002494086	MAR
MAR-ACARBOSE 50 MG TABLET	ACARBOSE	00002494078	MAR
MINT-ATORVASTATIN 10 MG TABLET	ATORVASTATIN CALCIUM	00002479508	MPI
MINT-ATORVASTATIN 20 MG TABLET	ATORVASTATIN CALCIUM	00002479516	MPI
MINT-ATORVASTATIN 40 MG TABLET	ATORVASTATIN CALCIUM	00002479524	MPI
MINT-ONDANSETRON ODT 4 MG ORAL DISINT. TABLET	ONDANSETRON	00002487330	MPI
MINT-ONDANSETRON ODT 8 MG ORAL DISINT. TABLET	ONDANSETRON	00002487349	MPI
RAN-CLARITHROMYCIN 500 MG TABLET	CLARITHROMYCIN	00002361434	RAN
TRI-JORDYNA (28 DAY) 0.18 MG / 0.035 MG / 0.215 MG / 0.035 MG / 0.25 MG / 0.035 MG TABLET	NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL	00002486318	GLM

New Established Interchangeable (IC) Grouping(s)

The following IC Grouping(s) have been established and LCA pricing will be applied effective June 1, 2020.

Generic Description	Strength / Form	New LCA Price
ACARBOSE	50 MG TABLET	0.2021
ACARBOSE	100 MG TABLET	0.2799
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 TABLET	0.7709
SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	50 MCG / DOSE / 100 MCG / DOSE METERED INHALATION POWDER	0.7068
SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	50 MCG / DOSE / 250 MCG / DOSE METERED INHALATION POWDER	0.8460

New Established Interchangeable (IC) Grouping(s), continued

Generic Description	Strength / Form	New LCA Price
SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE	50 MCG / DOSE / 500 MCG / DOSE METERED INHALATION POWDER	1.2010

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 increase, will be effective June 1, 2020.

*Please review the online **Interactive Drug Benefit List** for further information.*

Generic Description	Strength / Form	New LCA Price
CLARITHROMYCIN	500 MG TABLET	0.8318
FEBUXOSTAT	80 MG TABLET	0.7950
HYDROXYCHLOROQUINE SULFATE	200 MG TABLET	0.1576
METHYLPHENIDATE HCL	20 MG TABLET	0.2735

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until May 31, 2020. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACCUPRIL 5 MG TABLET	QUINAPRIL	00001947664	PFI
ACCUPRIL 10 MG TABLET	QUINAPRIL	00001947672	PFI
ACCUPRIL 20 MG TABLET	QUINAPRIL	00001947680	PFI
ACCUPRIL 40 MG TABLET	QUINAPRIL	00001947699	PFI
ACCURETIC 10 / 12.5 MG TABLET	QUINAPRIL/ HYDROCHLOROTHIAZIDE	00002237367	PFI
ACCURETIC 20 / 12.5 MG TABLET	QUINAPRIL/ HYDROCHLOROTHIAZIDE	00002237368	PFI
ACCURETIC 20 / 25 MG TABLET	QUINAPRIL/ HYDROCHLOROTHIAZIDE	00002237369	PFI
ACLASTA 5 MG / 100 ML INJECTION	ZOLEDRONIC ACID	00002269198	NOV
ALESSE (21 DAY) 100 MCG / 20 MCG TABLET	LEVONORGESTREL/ ETHINYL ESTRADIOL	00002236974	PFI
ALESSE (28 DAY) 100 MCG / 20 MCG TABLET	LEVONORGESTREL/ ETHINYL ESTRADIOL	00002236975	PFI
APO-HYDROXYQUINE 200 MG TABLET	HYDROXYCHLOROQUINE SULFATE	00002246691	APX

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
ARTHROTEC-50 50 MCG / 200 MCG ENTERIC-COATED TABLET	DICLOFENAC SODIUM/ MISOPROSTOL	00001917056	PFI
ARTHROTEC-75 75 MCG / 200 MCG ENTERIC-COATED TABLET	DICLOFENAC SODIUM/ MISOPROSTOL	00002229837	PFI
ATIVAN 0.5 MG SUBLINGUAL TABLET	LORAZEPAM	00002041456	PFI
ATIVAN 0.5 MG TABLET	LORAZEPAM	00002041413	PFI
ATIVAN 1 MG SUBLINGUAL TABLET	LORAZEPAM	00002041464	PFI
ATIVAN 1 MG TABLET	LORAZEPAM	00002041421	PFI
ATIVAN 2 MG SUBLINGUAL TABLET	LORAZEPAM	00002041472	PFI
ATIVAN 2 MG TABLET	LORAZEPAM	00002041448	PFI
AUBAGIO 14 MG TABLET	TERIFLUNOMIDE	00002416328	GZM
BASAGLAR CARTRIDGE 100 UNIT / ML INJECTION	INSULIN GLARGINE	00002444844	LIL
BASAGLAR KWIKPEN (80 UNIT) 100 UNIT / INJECTION	INSULIN GLARGINE	00002461528	LIL
CALCIMAR 200 IU / ML INJECTION	SYNTHETIC CALCITONIN SALMON (SALCATONIN)	00001926691	SAV
CELEBREX 100 MG CAPSULE	CELECOXIB	00002239941	PFI
CELEBREX 200 MG CAPSULE	CELECOXIB	00002239942	PFI
CHAMPIX 0.5 MG TABLET	VARENICLINE TARTRATE	00002291177	PFI
CHAMPIX (STARTER PACK) 0.5 MG / 1 MG TABLET	VARENICLINE TARTRATE/ VARENICLINE TARTRATE	00002298309	PFI
CHAMPIX 1 MG TABLET	VARENICLINE TARTRATE	00002291185	PFI
COLESTID 1 G TABLET	COLESTIPOL HCL	00002132680	PFI
COMTAN 200 MG TABLET	ENTACAPONE	00002243763	NOV
CORTEF 10 MG TABLET	HYDROCORTISONE	00000030910	PFI
CORTEF 20 MG TABLET	HYDROCORTISONE	00000030929	PFI
COSENTYX 150 MG / ML INJECTION	SECUKINUMAB	00002438070	NOV
CYCLOMEN 50 MG CAPSULE	DANAZOL	00002018144	SAV
CYCLOMEN 100 MG CAPSULE	DANAZOL	00002018152	SAV
CYCLOMEN 200 MG CAPSULE	DANAZOL	00002018160	SAV
DALACIN C PALMITATE 15 MG / ML ORAL SOLUTION	CLINDAMYCIN PALMITATE HCL	00000225851	PFI
DEFEROXAMINE MESYLATE 500 MG / VIAL INJECTION	DEFEROXAMINE MESYLATE	00002241600	PFI

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
DEFEROXAMINE MESYLATE 2 G / VIAL INJECTION	DEFEROXAMINE MESYLATE	00002247022	PFI
DEPO-PROVERA 150 MG / ML INJECTION	MEDROXYPROGESTERONE ACETATE	00000585092	PFI
DEPO-TESTOSTERONE CYPIONATE 100 MG / ML INJECTION	TESTOSTERONE CYPIONATE	00000030783	PFI
DESFERAL 500 MG / VIAL INJECTION	DEFEROXAMINE MESYLATE	00001981242	NOV
DETROL LA 2 MG EXTENDED-RELEASE CAPSULE	TOLTERODINE L-TARTRATE	00002244612	PFI
DETROL LA 4 MG EXTENDED-RELEASE CAPSULE	TOLTERODINE L-TARTRATE	00002244613	PFI
DILANTIN 30 MG CAPSULE	PHENYTOIN SODIUM	00000022772	PFI
DILANTIN 100 MG CAPSULE	PHENYTOIN SODIUM	00000022780	PFI
DILANTIN INFATABS 50 MG CHEWABLE TABLET	PHENYTOIN	00000023698	PFI
DILANTIN-30 6 MG / ML ORAL SUSPENSION	PHENYTOIN	00000023442	PFI
DILANTIN-125 25 MG / ML ORAL SUSPENSION	PHENYTOIN	00000023450	PFI
DIOVAN 80 MG TABLET	VALSARTAN	00002244781	NOV
DIOVAN 160 MG TABLET	VALSARTAN	00002244782	NOV
DIOVAN 320 MG TABLET	VALSARTAN	00002289504	NOV
DIOVAN-HCT 80 MG / 12.5 MG TABLET	VALSARTAN/ HYDROCHLOROTHIAZIDE	00002241900	NOV
DIOVAN-HCT 160 MG / 12.5 MG TABLET	VALSARTAN/ HYDROCHLOROTHIAZIDE	00002241901	NOV
DIOVAN-HCT 160 MG / 25 MG TABLET	VALSARTAN/ HYDROCHLOROTHIAZIDE	00002246955	NOV
DIOVAN-HCT 320 MG / 12.5 MG TABLET	VALSARTAN/ HYDROCHLOROTHIAZIDE	00002308908	NOV
DIOVAN-HCT 320 MG / 25 MG TABLET	VALSARTAN/ HYDROCHLOROTHIAZIDE	00002308916	NOV
EFFEXOR XR 37.5 MG EXTENDED-RELEASE CAPSULE	VENLAFAXINE HCL	00002237279	PFI
EFFEXOR XR 75 MG EXTENDED-RELEASE CAPSULE	VENLAFAXINE HCL	00002237280	PFI
EFFEXOR XR 150 MG EXTENDED-RELEASE CAPSULE	VENLAFAXINE HCL	00002237282	PFI
ENTRESTO 24.3 MG / 25.7 MG TABLET	SACUBITRIL/ VALSARTAN	00002446928	NOV
ENTRESTO 48.6 MG / 51.4 MG TABLET	SACUBITRIL/ VALSARTAN	00002446936	NOV

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
ENTRESTO 97.2 MG / 102.8 MG TABLET	SACUBITRIL/ VALSARTAN	00002446944	NOV
ERYC 333 MG CAPSULE (ENTERIC-COATED PELLET)	ERYTHROMYCIN	00000873454	PFI
ESTALIS (2.7 /.62 MG / PTH) 140 MCG / DAY / 50 MCG / DAY TRANSDERMAL PATCH	NORETHINDRONE ACETATE/ ESTRADIOL-17B	00002241835	NOV
ESTALIS (4.8 / .51 MG / PTH) 250 MCG / DAY / 50 MCG / DAY TRANSDERMAL PATCH	NORETHINDRONE ACETATE/ ESTRADIOL-17B	00002241837	NOV
ESTRADOT 25 (0.39 MG / PTH) 25 MCG / DAY TRANSDERMAL PATCH	ESTRADIOL-17B	00002245676	NOV
ESTRADOT 37.5 (0.585 MG / PTH) 37.5 MCG / DAY TRANSDERMAL PATCH	ESTRADIOL-17B	00002243999	NOV
ESTRADOT 50 (0.78 MG / PTH) 50 MCG / DAY TRANSDERMAL PATCH	ESTRADIOL-17B	00002244000	NOV
ESTRADOT 75 (1.17 MG / PTH) 75 MCG / DAY TRANSDERMAL PATCH	ESTRADIOL-17B	00002244001	NOV
ESTRADOT 100 (1.56 MG / PTH) 100 MCG / DAY TRANSDERMAL PATCH	ESTRADIOL-17B	00002244002	NOV
EXELON 1.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242115	NOV
EXELON 2 MG / ML ORAL SOLUTION	RIVASTIGMINE HYDROGEN TARTRATE	00002245240	NOV
EXELON 3 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242116	NOV
EXELON 4.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242117	NOV
EXELON 6 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242118	NOV
EXJADE 125 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002287420	NOV
EXJADE 250 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002287439	NOV
EXJADE 500 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002287447	NOV
FLAGYL 10% VAGINAL CREAM	METRONIDAZOLE	00001926861	SAV
FLAGYSTATIN500 MG / 100, 000 UNIT VAGINAL OVULE	METRONIDAZOLE/ NYSTATIN	00001926829	SAV
FLURBIPROFEN 50 MG TABLET	FLURBIPROFEN	00001912046	AAP
FORADIL 12 MCG INHALATION CAPSULE	FORMOTEROL FUMARATE	00002230898	NOV
FRAGMIN (0.2 ML SYRINGE) 2,500 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002132621	PFI
FRAGMIN (0.28 ML SYRINGE) 3,500 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002430789	PFI

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
FRAGMIN (0.2 ML SYRINGE) 5,000 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002132648	PFI
FRAGMIN (0.3 ML SYRINGE) 7,500 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002352648	PFI
FRAGMIN (0.4 ML SYRINGE) 10,000 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002352656	PFI
FRAGMIN 10,000 IU / ML INJECTION	DALTEPARIN SODIUM	00002132664	PFI
FRAGMIN (0.5 ML SYRINGE) 12,500 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002352664	PFI
FRAGMIN (0.6 ML SYRINGE) 15,000 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002352672	PFI
FRAGMIN (0.72 ML SYRINGE) 18,000 IU / SYRINGE INJECTION	DALTEPARIN SODIUM	00002352680	PFI
FRAGMIN 25,000 IU / ML INJECTION	DALTEPARIN SODIUM	00002231171	PFI
HUMALOG 100 UNIT / ML INJECTION	INSULIN LISPRO	00002229704	LIL
HUMALOG CARTRIDGE 100 UNIT / ML INJECTION	INSULIN LISPRO	00002229705	LIL
HUMALOG KWIKPEN 100 UNIT / ML INJECTION	INSULIN LISPRO	00002403412	LIL
HUMALOG KWIKPEN 200 UNIT / ML INJECTION	INSULIN LISPRO	00002439611	LIL
HUMALOG MIX 25 CARTRIDGE 25% / 75% INJECTION	INSULIN LISPRO/ INSULIN LISPRO PROTAMINE	00002240294	LIL
HUMALOG MIX 25 KWIKPEN 25% / 75% INJECTION	INSULIN LISPRO/ INSULIN LISPRO PROTAMINE	00002403420	LIL
HUMALOG MIX 50 CARTRIDGE 50% / 50% INJECTION	INSULIN LISPRO/ INSULIN LISPRO PROTAMINE	00002240297	LIL
HUMALOG MIX 50 KWIKPEN 50% / 50% INJECTION	INSULIN LISPRO/ INSULIN LISPRO PROTAMINE	00002403439	LIL
HUMULIN 30 / 70 30 UNIT / ML / 70 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00000795879	LIL
HUMULIN 30 / 70 CARTRIDGE 30 UNIT / ML / 70 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00001959212	LIL
HUMULIN N 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00000587737	LIL
HUMULIN N CARTRIDGE 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00001959239	LIL
HUMULIN N KWIKPEN 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00002403447	LIL

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
HUMULIN R 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)	00000586714	LIL
HUMULIN R CARTRIDGE 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)	00001959220	LIL
IMOVANE 5 MG TABLET	ZOPICLONE	00002216167	SAV
IMOVANE 7.5 MG TABLET	ZOPICLONE	00001926799	SAV
INSPRA 25 MG TABLET	EPLERENONE	00002323052	PFI
INSPRA 50 MG TABLET	EPLERENONE	00002323060	PFI
IOPIDINE 0.5% OPH SOLUTION	APRACLONIDINE HCL	00002076306	NOV
ISOPTO CARPINE 2% OPHTHALMIC SOLUTION	PILOCARPINE HCL	00000000868	NOV
ISOPTO CARPINE 4% OPHTHALMIC SOLUTION	PILOCARPINE HCL	00000000884	NOV
JADENU 90 MG TABLET	DEFERASIROX	00002452219	NOV
JADENU 180 MG TABLET	DEFERASIROX	00002452227	NOV
JADENU 360 MG TABLET	DEFERASIROX	00002452235	NOV
KEVZARA (PRE-FILLED PEN) 150 MG / SYRINGE INJECTION	SARILUMAB	00002472961	SAV
KEVZARA 150 MG / SYRINGE INJECTION	SARILUMAB	00002460521	SAV
KEVZARA (PRE-FILLED PEN) 200 MG / SYRINGE INJECTION	SARILUMAB	00002472988	SAV
KEVZARA 200 MG / SYRINGE INJECTION	SARILUMAB	00002460548	SAV
LAMISIL 1% TOPICAL CREAM	TERBINAFINE HCL	00002031094	NOV
LAMISIL 1% TOPICAL SPRAY SOLUTION	TERBINAFINE HCL	00002238703	NOV
LAMISIL 250 MG TABLET	TERBINAFINE HCL	00002031116	NOV
LASIX 10 MG / ML ORAL SOLUTION	FUROSEMIDE	00002224720	SAV
LASIX SPECIAL 500 MG TABLET	FUROSEMIDE	00002224755	SAV
LESCOL XL 80 MG EXTENDED-RELEASE TABLET	FLUVASTATIN SODIUM	00002250527	NOV
LEVEMIR CARTRIDGE 100 UNIT / ML INJECTION	INSULIN DETEMIR	00002271842	NNA
LEVEMIR FLEXTOUCH 100 UNIT / ML INJECTION	INSULIN DETEMIR	00002412829	NNA
LIORESAL INTRATHECAL 0.05 MG / ML INJECTION	BACLOFEN	00002131048	NOV
LIORESAL INTRATHECAL 0.5 MG / ML INJECTION	BACLOFEN	00002131056	NOV

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
LIORESAL INTRATHECAL 2 MG / ML INJECTION	BACLOFEN	00002131064	NOV
LIPITOR 10 MG TABLET	ATORVASTATIN CALCIUM	00002230711	PFI
LIPITOR 20 MG TABLET	ATORVASTATIN CALCIUM	00002230713	PFI
LIPITOR 40 MG TABLET	ATORVASTATIN CALCIUM	00002230714	PFI
LIPITOR 80 MG TABLET	ATORVASTATIN CALCIUM	00002243097	PFI
LOMOTIL TABLET	DIPHENOXYLATE HCL/ ATROPINE SULFATE	00000036323	PFI
LONITEN 2.5 MG TABLET	MINOXIDIL	00000514497	PFI
LONITEN 10 MG TABLET	MINOXIDIL	00000514500	PFI
LOPRESOR SR 100 MG SUSTAINED-RELEASE TABLET	METOPROLOL TARTRATE	00000658855	NOV
LOPRESOR SR 200 MG SUSTAINED-RELEASE TABLET	METOPROLOL TARTRATE	00000534560	NOV
MAR-FEBUXOSTAT 80 MG TABLET	FEBUXOSTAT	00002473607	MAR
MINT-HYDROXYCHLOROQUINE 200 MG TABLET	HYDROXYCHLOROQUINE SULFATE	00002424991	MYP
NALCROM 100 MG CAPSULE	SODIUM CROMOGLYCATE	00000500895	SAV
NEO-MEDROL ACNE TOPICAL LOTION	METHYLPREDNISOLONE ACETATE/ NEOMYCIN SULFATE/ ALUMINUM CHLORHYDROXIDE COMPLEX/ SULFUR	00000195057	PFI
NEORAL 10 MG CAPSULE	CYCLOSPORINE	00002237671	NOV
NEORAL 25 MG CAPSULE	CYCLOSPORINE	00002150689	NOV
NEORAL 50 MG CAPSULE	CYCLOSPORINE	00002150662	NOV
NEORAL 100 MG CAPSULE	CYCLOSPORINE	00002150670	NOV
NEORAL 100 MG / ML ORAL SOLUTION	CYCLOSPORINE	00002150697	NOV
NEURONTIN 100 MG CAPSULE	GABAPENTIN	00002084260	PFI
NEURONTIN 300 MG CAPSULE	GABAPENTIN	00002084279	PFI
NEURONTIN 400 MG CAPSULE	GABAPENTIN	00002084287	PFI
NITROSTAT 0.3 MG SUBLINGUAL TABLET	NITROGLYCERIN	00000037613	PFI
NITROSTAT 0.6 MG SUBLINGUAL TABLET	NITROGLYCERIN	00000037621	PFI
NORVASC 5 MG TABLET	AMLODIPINE BESYLATE	00000878928	PFI
NORVASC 10 MG TABLET	AMLODIPINE BESYLATE	00000878936	PFI

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
NOVOLIN GE 30 / 70 30 UNIT / ML / 70 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00002024217	NNA
NOVOLIN GE 30 / 70 CARTRIDGE 30 UNIT / ML / 70 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00002025248	NNA
NOVOLIN GE 40 / 60 40 UNIT / ML / 60 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00002024314	NNA
NOVOLIN GE 50 / 50 CARTRIDGE 50 UNIT / ML / 50 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00002024322	NNA
NOVOLIN GE NPH 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00002024225	NNA
NOVOLIN GE NPH CARTRIDGE 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)	00002024268	NNA
NOVOLIN GE TORONTO 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)	00002024233	NNA
NOVOLIN GE TORONTO CARTRIDGE 100 UNIT / ML INJECTION	INSULIN HUMAN BIOSYNTHETIC (REGULAR)	00002024284	NNA
NOVORAPID 100 UNIT / ML INJECTION	INSULIN ASPART	00002245397	NNA
NOVORAPID CARTRIDGE 100 UNIT / ML INJECTION	INSULIN ASPART	00002244353	NNA
NOVORAPID FLEXTOUCH 100 UNIT / ML INJECTION	INSULIN ASPART	00002377209	NNA
NOZINAN 25 MG / ML INJECTION	METHOTRIMEPRAZINE HCL	00001927698	SAV
PEDIAPRED 1 MG / ML ORAL LIQUID	PREDNISOLONE SODIUM PHOSPHATE	00002230619	SAV
PMS-CLARITHROMYCIN 500 MG TABLET	CLARITHROMYCIN	00002247574	PMS
PREMARIN 0.3 MG SUSTAINED-RELEASE TABLET	CONJUGATED ESTROGENS	00002414678	PFI
PREMARIN 0.625 MG SUSTAINED-RELEASE TABLET	CONJUGATED ESTROGENS	00002414686	PFI
PREMARIN 0.625 MG / G VAGINAL CREAM	CONJUGATED ESTROGENS	00002043440	PFI
PREMARIN 1.25 MG SUSTAINED-RELEASE TABLET	CONJUGATED ESTROGENS	00002414694	PFI
PRIMAQUINE PHOSPHATE 15 MG TABLET	PRIMAQUINE PHOSPHATE	00002017776	SAV
RESONIUM CALCIUM 300 G ORAL POWDER	CALCIUM POLYSTYRENE SULPHONATE	00002017741	SAV

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
RITALIN 10 MG TABLET	METHYLPHENIDATE HCL	00000005606	NOV
RITALIN SR 20 MG EXTENDED-RELEASE TABLET	METHYLPHENIDATE HCL	00000632775	NOV
RYTHMODAN 100 MG CAPSULE	DISOPYRAMIDE	00002224801	SAV
SALAGEN 5 MG TABLET	PILOCARPINE HCL	00002216345	PFI
SANDOZ CLARITHROMYCIN 500 MG TABLET	CLARITHROMYCIN	00002266547	SDZ
SODIUM CHLORIDE 9 MG / ML INJECTION	SODIUM CHLORIDE	00000037796	PFI
SOFRACORT OTIC OPH SOLUTION	DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN	00002224623	SAV
SOLU-CORTEF 100 MG / VIAL INJECTION	HYDROCORTISONE SODIUM SUCCINATE	00000030600	PFI
SOLU-CORTEF 250 MG / VIAL INJECTION	HYDROCORTISONE SODIUM SUCCINATE	00000030619	PFI
SOLU-CORTEF 500 MG / VIAL INJECTION	HYDROCORTISONE SODIUM SUCCINATE	00000030627	PFI
SOLU-MEDROL 1 G / VIAL INJECTION	METHYLPREDNISOLONE SODIUM SUCCINATE	00000036137	PFI
SOLU-MEDROL 500 MG / VIAL INJECTION	METHYLPREDNISOLONE SODIUM SUCCINATE	00000030678	PFI
SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE-FREE) 40 MG / VIAL INJ	METHYLPREDNISOLONE SODIUM SUCCINATE	00002367947	PFI
SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE-FREE) 125 MG / VIAL INJECTION	METHYLPREDNISOLONE SODIUM SUCCINATE	00002367955	PFI
SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE-FREE) 500 MG / VIAL INJECTION	METHYLPREDNISOLONE SODIUM SUCCINATE	00002367963	PFI
SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE-FREE) 1 G / VIAL INJECTION	METHYLPREDNISOLONE SODIUM SUCCINATE	00002367971	PFI
SYNAREL 2 MG / ML NASAL SOLUTION	NAFARELIN ACETATE	00002188783	PFI
SYNPHASIC (21 DAY) 0.5 MG / 0.035 MG / 1 MG / 0.035 MG TABLET	NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL	00002187108	PFI
SYNPHASIC (28 DAY) 0.5 MG / 0.035 MG / 1 MG / 0.035 MG TABLET	NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL	00002187116	PFI
TALWIN 50 MG TABLET	PENTAZOCINE HCL	00002137984	SAV
TEGRETOL 20 MG / ML ORAL SUSPENSION	CARBAMAZEPINE	00002194333	NOV
TEGRETOL 200 MG TABLET	CARBAMAZEPINE	00000010405	NOV

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
TEGRETOL CR 200 MG SUSTAINED-RELEASE TABLET	CARBAMAZEPINE	00000773611	NOV
TEGRETOL CR 400 MG SUSTAINED-RELEASE TABLET	CARBAMAZEPINE	00000755583	NOV
TEVA-CLARITHROMYCIN 500 MG TABLET	CLARITHROMYCIN	00002248805	TEV
THYROGEN 0.9 MG / VIAL INJECTION	THYROTROPIN ALFA	00002246016	GZM
TRANSDERM-NITRO 0.2 MG / HR TRANSDERMAL PATCH	NITROGLYCERIN	00000584223	NOV
TRANSDERM-NITRO 0.4 MG / HR TRANSDERMAL PATCH	NITROGLYCERIN	00000852384	NOV
TEGRETOL CR 200 MG SUSTAINED-RELEASE TABLET	CARBAMAZEPINE	00000773611	NOV
TRANSDERM-NITRO 0.6 MG / HR TRANSDERMAL PATCH	NITROGLYCERIN	00002046156	NOV
TRESIBA FLEXTOUCH PEN 100 UNIT / ML INJECTION	INSULIN DEGLUDEC	00002467879	NNA
TRESIBA FLEXTOUCH PEN 200 UNIT / ML INJECTION	INSULIN DEGLUDEC	00002467887	NNA
VOLTAREN 50 MG RECTAL SUPPOSITORY	DICLOFENAC SODIUM	00000632724	NOV
XALACOM 0.005% / 0.5% OPHTHALMIC SOLUTION	LATANOPROST/ TIMOLOL MALEATE	00002246619	PFI
XALATAN 0.005% OPHTHALMIC SOLUTION	LATANOPROST	00002231493	PFI
XELJANZ 5 MG TABLET	TOFACITINIB CITRATE	00002423898	PFI
XELJANZ XR 11 MG EXTENDED-RELEASE TABLET	TOFACITINIB CITRATE	00002470608	PFI
XOLAIR 150 MG VIAL INJECTION	OMALIZUMAB	00002260565	NOV
ZAROXOLYN 2.5 MG TABLET	METOLAZONE	00000888400	SAV
ZELDOX 20 MG CAPSULE	ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE	00002298597	PFI
ZELDOX 40 MG CAPSULE	ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE	00002298600	PFI
ZELDOX 60 MG CAPSULE	ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE	00002298619	PFI
ZELDOX 80 MG CAPSULE	ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE	00002298627	PFI
ZOFRAN 0.8 MG / ML ORAL SOLUTION	ONDANSETRON HCL DIHYDRATE	00002229639	NOV
ZOFRAN 2 MG / ML INJECTION	ONDANSETRON HCL DIHYDRATE	00002213745	NOV
ZOFRAN 4 MG TABLET	ONDANSETRON HCL DIHYDRATE	00002213567	NOV

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
ZOFRAN 8 MG TABLET	ONDANSETRON HCL DIHYDRATE	00002213575	NOV
ZOFRAN ODT 4 MG ORAL DISINTEGRATING TABLET / FILM	ONDANSETRON	00002239372	NOV
ZOFRAN ODT 8 MG ORAL DISINTEGRATING TABLET / FILM	ONDANSETRON	00002239373	NOV
ZOMETA CONCENTRATE 0.8 MG / ML INJECTION	ZOLEDRONIC ACID	00002248296	NOV

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 May 1, 2020, 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 June 1, 2020 claims will no longer pay for these product(s).

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACCEL-CITALOPRAM 10 MG TABLET	CITALOPRAM HYDROBROMIDE	00002355248	ACP
ACCEL-CITALOPRAM 20 MG TABLET	CITALOPRAM HYDROBROMIDE	00002355256	ACP
ACCEL-CITALOPRAM 40 MG TABLET	CITALOPRAM HYDROBROMIDE	00002355264	ACP
ACT ATENOLOL 100 MG TABLET	ATENOLOL	00002255553	APH
ACT ATENOLOL 50 MG TABLET	ATENOLOL	00002255545	APH
AGGRENOX 200 MG / 25 MG CAPSULE	DIPYRIDAMOLE/ ASA	00002242119	BOE
APO-ALENDRONATE 10 MG TABLET	ALENDRONATE SODIUM	00002248728	APX
APO-BRIMONIDINE 0.2 % OPHTHALMIC SOLUTION	BRIMONIDINE TARTRATE	00002260077	APX
CORTIFOAM 10 % RECTAL FOAM	HYDROCORTISONE ACETATE	00000579335	PAL
GD-AZITHROMYCIN 40 MG / ML ORAL SUSPENSION	AZITHROMYCIN	00002274574	GMD
MINT-METFORMIN 850 MG TABLET	METFORMIN HCL	00002388774	MPI
NITROL 2 % TOPICAL OINTMENT	NITROGLYCERIN	00001926454	PAL
PREVEX HC 1 % TOPICAL OCCLUSIVE CREAM	HYDROCORTISONE	00000804533	GSK
PROPYL-THYRACIL 100 MG TABLET	PROPYLTHIOURACIL	00000010219	PAL
TARO-DEFERASIROX 500 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002463547	TAR
TEVA-PAROXETINE 30 MG TABLET	PAROXETINE HCL	00002248558	TEV

Discontinued Listing(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
TEVA-RABEPRAZOLE 10 MG ENTERIC-COATED TABLET	RABEPRAZOLE SODIUM	00002296632	TEV
TEVA-RABEPRAZOLE 20 MG ENTERIC-COATED TABLET	RABEPRAZOLE SODIUM	00002296640	TEV
TEVA-TRANDOLAPRIL 0.5 MG CAPSULE	TRANDOLAPRIL	00002415429	TEV
TEVA-TRANDOLAPRIL 1 MG CAPSULE	TRANDOLAPRIL	00002415437	TEV
TEVA-TRANDOLAPRIL 2 MG CAPSULE	TRANDOLAPRIL	00002415445	TEV
TEVA-TRANDOLAPRIL 4 MG CAPSULE	TRANDOLAPRIL	00002415453	TEV
TEVA-VENLAFAXINE XR 75 MG EXTENDED-RELEASE CAPSULE	VENLAFAXINE HCL	00002275031	TEV
TIMOPTIC-XE 0.25 % OPHTHALMIC LONG ACTING GELLAN SOLUTION	TIMOLOL MALEATE	00002171880	PUR

PART 2

Drug Additions

ACARBOSE

50 MG ORAL TABLET

00002494078	**MAR-ACARBOSE**	**MAR**	$	**0.2021**
00002190885	GLUCOBAY	BAI	$	0.2695

100 MG ORAL TABLET

00002494086	**MAR-ACARBOSE**	**MAR**	$	**0.2799**
00002190893	GLUCOBAY	BAI	$	0.3733

AMLODIPINE BESYLATE

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**
00002469030	**PHARMA-AMLODIPINE**	**PMS**	$	**0.1343**
00002321858	**RAN-AMLODIPINE**	**RAN**	$	**0.1343**
00002284383	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.1343**
00002357712	**SEPTA-AMLODIPINE**	**SEP**	$	**0.1343**
00002250497	**TEVA-AMLODIPINE**	**TEV**	$	**0.1343**
00000878928	NORVASC	PFI	$	1.4064

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**
00002469049	**PHARMA-AMLODIPINE**	**PMS**	$	**0.1993**
00002321866	**RAN-AMLODIPINE**	**RAN**	$	**0.1993**
00002284391	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.1993**
00002357720	**SEPTA-AMLODIPINE**	**SEP**	$	**0.1993**
00002250500	**TEVA-AMLODIPINE**	**TEV**	$	**0.1993**
00000878936	NORVASC	PFI	$	2.0528

APRACLONIDINE HCL

0.5 % OPHTHALMIC SOLUTION

00002076306	IOPIDINE	NOV	$	4.9880

ATORVASTATIN CALCIUM

10 MG (BASE) ORAL TABLET				
00002457741	**ACH-ATORVASTATIN**	**AHI**	$	**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**
00002399377	**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	PFI	$	1.8223
20 MG (BASE) ORAL TABLET				
00002457768	**ACH-ATORVASTATIN**	**AHI**	$	**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**
00002399385	**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	PFI	$	2.2779
40 MG (BASE) ORAL TABLET				
00002457776	**ACH-ATORVASTATIN**	**AHI**	$	**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**
00002399393	**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	PFI	$	2.4483
80 MG (BASE) ORAL TABLET				
00002457784	**ACH-ATORVASTATIN**	**AHI**	$	**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**
00002399407	**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	PFI	$	2.4483

BACLOFEN

0.05 MG / ML INJECTION

00002457059	**BACLOFEN INJECTION**	**TGT**	$	**7.5160**
00002413620	**BACLOFEN INTRATHECAL**	**STM**	$	**7.5160**
00002131048	LIORESAL INTRATHECAL	NOV	$	15.2660

0.5 MG / ML INJECTION

00002457067	**BACLOFEN INJECTION**	**TGT**	$	**5.6328**
00002413639	**BACLOFEN INTRATHECAL**	**STM**	$	**5.6328**
00002131056	LIORESAL INTRATHECAL	NOV	$	11.4385

2 MG / ML INJECTION

00002457075	**BACLOFEN INJECTION**	**TGT**	$	**22.5334**
00002413647	**BACLOFEN INTRATHECAL**	**STM**	$	**22.5334**
00002131064	LIORESAL INTRATHECAL	NOV	$	45.7608

CALCIUM POLYSTYRENE SULPHONATE

ORAL POWDER

00002017741	RESONIUM CALCIUM	SAV	$	0.3865

CARBAMAZEPINE

200 MG ORAL TABLET

00002407515	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.2432**
00000782718	**TEVA-CARBAMAZ**	**TEV**	$	**0.2432**
00000010405	TEGRETOL	NOV	$	0.4267

200 MG ORAL SUSTAINED-RELEASE TABLET

00002231543	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.0930**
00002261839	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.0930**
00000773611	TEGRETOL CR	NOV	$	0.4302

400 MG ORAL SUSTAINED-RELEASE TABLET

00002231544	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.1859**
00002261847	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.1859**
00000755583	TEGRETOL CR	NOV	$	0.8605

20 MG / ML ORAL SUSPENSION

00002367394	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.0728**
00002194333	TEGRETOL	NOV	$	0.0826

CLARITHROMYCIN

500 MG ORAL TABLET

00002247574	**PMS-CLARITHROMYCIN**	**PMS**	$	**0.8318**
00002361434	**RAN-CLARITHROMYCIN**	**RAN**	$	**0.8318**
00002266547	**SANDOZ CLARITHROMYCIN**	**SDZ**	$	**0.8318**
00002248805	**TEVA-CLARITHROMYCIN**	**TEV**	$	**0.8318**
00002126710	BIAXIN BID	BGP	$	3.3271

CLINDAMYCIN PALMITATE HCL

15 MG / ML (BASE) ORAL SOLUTION

00000225851	DALACIN C PALMITATE	PFI	$	0.1893

COLESTIPOL HCL

1 G ORAL TABLET

00002132680	COLESTID	PFI	$	0.2844

CONJUGATED ESTROGENS

0.3 MG ORAL SUSTAINED-RELEASE TABLET

00002414678	PREMARIN	PFI	$	0.3382

0.625 MG ORAL SUSTAINED-RELEASE TABLET

00002414686	PREMARIN	PFI	$	0.3382

1.25 MG ORAL SUSTAINED-RELEASE TABLET

00002414694	PREMARIN	PFI	$	0.3382

0.625 MG / G VAGINAL CREAM

00002043440	PREMARIN	PFI	$	0.7154

DALTEPARIN SODIUM

10,000 IU / ML INJECTION

00002132664	FRAGMIN	PFI	$	17.2610

25,000 IU / ML INJECTION

00002231171	FRAGMIN	PFI	$	43.1494

2,500 IU / SYR INJECTION SYRINGE

00002132621	FRAGMIN (0.2 ML SYRINGE)	PFI	$	5.4656

3,500 IU / SYR INJECTION SYRINGE

00002430789	FRAGMIN (0.28 ML SYRINGE)	PFI	$	7.6514

5,000 IU / SYR INJECTION SYRINGE

00002132648	FRAGMIN (0.2 ML SYRINGE)	PFI	$	10.9309

7,500 IU / SYR INJECTION SYRINGE

00002352648	FRAGMIN (0.3 ML SYRINGE)	PFI	$	16.3960

10,000 IU / SYR INJECTION SYRINGE

00002352656	FRAGMIN (0.4 ML SYRINGE)	PFI	$	21.8619

12,500 IU / SYR INJECTION SYRINGE

00002352664	FRAGMIN (0.5 ML SYRINGE)	PFI	$	27.3281

15,000 IU / SYR INJECTION SYRINGE

00002352672	FRAGMIN (0.6 ML SYRINGE)	PFI	$	32.7941

18,000 IU / SYR INJECTION SYRINGE

00002352680	FRAGMIN (0.72 ML SYRINGE)	PFI	$	39.3518

DANAZOL

50 MG ORAL CAPSULE

00002018144	CYCLOMEN	SAV	$	0.9983

100 MG ORAL CAPSULE

00002018152	CYCLOMEN	SAV	$	1.4816

200 MG ORAL CAPSULE

00002018160	CYCLOMEN	SAV	$	2.3676

DEFEROXAMINE MESYLATE

500 MG / VIAL INJECTION

00002241600	**DEFEROXAMINE MESYLATE**	**PFI**	$	**14.6690**
00001981242	DESFERAL	NOV	$	15.4390

2 G / VIAL INJECTION

00002247022	DEFEROXAMINE MESYLATE	PFI	$	20.8896

DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN

0.5 MG / ML * 5 MG / ML * 0.05 MG / ML OTIC/OPHTHALMIC SOLUTION

00002224623	SOFRACORT	SAV	$	2.0575

DICLOFENAC SODIUM

50 MG RECTAL SUPPOSITORY

00002231506	**PMS-DICLOFENAC**	**PMS**	$	**0.4339**
00002261928	**SANDOZ DICLOFENAC**	**SDZ**	$	**0.4339**
00000632724	VOLTAREN	NOV	$	1.4350

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	$	0.6822

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	$	0.9285

DIPHENOXYLATE HCL/ ATROPINE SULFATE

2.5 MG * 0.025 MG ORAL TABLET

00000036323	LOMOTIL	PFI	$	0.5113

DISOPYRAMIDE

100 MG ORAL CAPSULE

00002224801	RYTHMODAN	SAV	$	0.2950

ENTACAPONE

200 MG ORAL TABLET

00002380005	**SANDOZ ENTACAPONE**	**SDZ**	$	**0.4010**
00002375559	**TEVA-ENTACAPONE**	**TEV**	$	**0.4010**
00002243763	COMTAN	NOV	$	1.6685

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**	$	**5.5000**
00002396955	**APO-ENTECAVIR**	**APX**	$	**5.5000**
00002448777	**AURO-ENTECAVIR**	**AUR**	$	**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

ERYTHROMYCIN

333 MG ORAL CAPSULE (ENTERIC-COATED PELLET)

00000873454	ERYC	PFI	$	0.7361

ESTRADIOL-17B

25 MCG/DAY TRANSDERMAL PATCH

☒ 00002245676	ESTRADOT 25 (0.39 MG/PTH)	NOV	$	2.8562
☒ 00002243722	OESCLIM 25 (5 MG/PTH)	SLP	$	2.9053
☒ 00002247499	CLIMARA 25 (2 MG/PTH)	BAI	$	5.1600

37.5 MCG/DAY TRANSDERMAL PATCH

00002243999	ESTRADOT 37.5 (0.585 MG/PTH)	NOV	$	2.8750

ESTRADIOL-17B

50 MCG/DAY TRANSDERMAL PATCH

	00002246967	**SANDOZ ESTRADIOL DERM 50 (4 MG/PTH)**	**SDZ**	$	**2.5331**
⊠	00002243724	OESCLIM 50 (10 MG/PTH)	SLP	$	2.9145
	00002244000	ESTRADOT 50 (0.78 MG/PTH)	NOV	$	3.0662
⊠	00002231509	CLIMARA 50 (3.9 MG/PTH)	BAI	$	5.5118

75 MCG/DAY TRANSDERMAL PATCH

	00002246968	**SANDOZ ESTRADIOL DERM 75 (6 MG/PTH)**	**SDZ**	$	**2.7169**
	00002244001	ESTRADOT 75 (1.17 MG/PTH)	NOV	$	3.2875
⊠	00002247500	CLIMARA 75 (5.7 MG/PTH)	BAI	$	5.8764

100 MCG/DAY TRANSDERMAL PATCH

	00002246969	**SANDOZ ESTRADIOL DERM 100 (8 MG/PTH)**	**SDZ**	$	**2.8744**
	00002244002	ESTRADOT 100 (1.56 MG/PTH)	NOV	$	3.4737

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.

FORMOTEROL FUMARATE

12 MCG INHALATION CAPSULE

00002230898	FORADIL	NOV	$	0.8520

FUROSEMIDE

500 MG ORAL TABLET

00002224755	LASIX SPECIAL	SAV	$	3.3270

10 MG / ML ORAL SOLUTION

00002224720	LASIX	SAV	$	0.3229

GABAPENTIN

100 MG ORAL CAPSULE

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	PFI	$	0.4652

300 MG ORAL CAPSULE

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	PFI	$	1.1127

GABAPENTIN

400 MG ORAL CAPSULE

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	PFI	$	1.3261

HYDROCORTISONE

10 MG ORAL TABLET

00000030910	CORTEF	PFI	$	0.2077

20 MG ORAL TABLET

00000030929	CORTEF	PFI	$	0.3747

HYDROCORTISONE SODIUM SUCCINATE

100 MG / VIAL (BASE) INJECTION

00000030600	SOLU-CORTEF	PFI	$	4.1472

250 MG / VIAL (BASE) INJECTION

00000030619	SOLU-CORTEF	PFI	$	7.1975

500 MG / VIAL (BASE) INJECTION

00000030627	SOLU-CORTEF	PFI	$	10.8794

HYDROMORPHONE HCL

50 MG / ML INJECTION

00002146126	HYDROMORPHONE HP 50	SDZ	$	21.1271

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

INSULIN ASPART

100 UNIT / ML INJECTION

☒ 00002245397	NOVORAPID	NNA	$	3.0190
☒ 00002244353	NOVORAPID CARTRIDGE	NNA	$	4.0820
☒ 00002377209	NOVORAPID FLEXTOUCH	NNA	$	4.2500

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
☒ 00002245689	LANTUS	SAV	$	6.1690
☒ 00002251930	LANTUS CARTRIDGE	SAV	$	6.1900
☒ 00002294338	LANTUS PEN	SAV	$	6.1900

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

KETOROLAC TROMETHAMINE

30 MG / ML INJECTION

00002239944	KETOROLAC TROMETHAMINE	SDZ	$	4.4100

LATANOPROST

0.005 % OPHTHALMIC SOLUTION

00002296527	**APO-LATANOPROST**	**APX**	$	**3.6320**
00002373041	**GD-LATANOPROST**	**GMD**	$	**3.6320**
00002453355	**JAMP-LATANOPROST**	**JPC**	$	**3.6320**
00002426935	**MED-LATANOPROST**	**GMP**	$	**3.6320**
00002367335	**SANDOZ LATANOPROST**	**SDZ**	$	**3.6320**
00002254786	**TEVA-LATANOPROST**	**TEV**	$	**3.6320**
00002231493	XALATAN	PFI	$	12.1528

LATANOPROST/ TIMOLOL MALEATE

0.005 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002436256	**ACT LATANOPROST/TIMOLOL**	**APH**	$	**4.4268**
00002373068	**GD-LATANOPROST/TIMOLOL**	**GMD**	$	**4.4268**
00002453770	**JAMP-LATANOPROST/TIMOLOL**	**JPC**	$	**4.4268**
00002454505	**MED-LATANOPROST-TIMOLOL**	**GMP**	$	**4.4268**
00002246619	XALACOM	PFI	$	13.7543

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

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

LORAZEPAM

0.5 MG ORAL TABLET

00000655740	**APO-LORAZEPAM**	**APX**	$	**0.0359**
00000728187	**PMS-LORAZEPAM**	**PMS**	$	**0.0359**
00000711101	**TEVA-LORAZEPAM**	**TEV**	$	**0.0359**
00002041413	ATIVAN	PFI	$	0.0401

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	$	0.0499

LORAZEPAM

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	$	0.0782

0.5 MG ORAL SUBLINGUAL TABLET

00002410745	**LORAZEPAM**	**AAP**	$	**0.0914**
00002041456	ATIVAN	PFI	$	0.1218

1 MG ORAL SUBLINGUAL TABLET

00002410753	**LORAZEPAM**	**AAP**	$	**0.1151**
00002041464	ATIVAN	PFI	$	0.1534

2 MG ORAL SUBLINGUAL TABLET

00002410761	**LORAZEPAM**	**AAP**	$	**0.1787**
00002041472	ATIVAN	PFI	$	0.2383

MEDROXYPROGESTERONE ACETATE

150 MG / ML INJECTION

00000585092	DEPO-PROVERA	PFI	$	30.4800

METHOTRIMEPRAZINE HCL

25 MG / ML (BASE) INJECTION

00001927698	NOZINAN	SAV	$	3.6810

METHYLPHENIDATE HCL

10 MG ORAL TABLET

00002249324	**APO-METHYLPHENIDATE**	**APX**	$	**0.2216**
00000584991	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.2216**
00000005606	RITALIN	NOV	$	0.3876

20 MG ORAL EXTENDED-RELEASE TABLET

00002266687	**APO-METHYLPHENIDATE SR**	**APX**	$	**0.2820**
00002320312	**SANDOZ METHYLPHENIDATE**	**SDZ**	$	**0.2820**
00000632775	RITALIN SR	NOV	$	0.6801

METHYLPREDNISOLONE SODIUM SUCCINATE

40 MG / VIAL (BASE) INJECTION

00002231893	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**4.7801**
00002367947	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	7.0167

125 MG / VIAL (BASE) INJECTION

00002231894	**METHYLPREDNISOLONE SOD SUCCINATE**	**TEV**	$	**10.4010**
00002367955	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	16.6594

500 MG / VIAL (BASE) INJECTION

00002231895	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**24.6960**
00000030678	SOLU-MEDROL	PFI	$	40.9317
00002367963	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	41.7511

1 G / VIAL (BASE) INJECTION

00002241229	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**37.9336**
00000036137	SOLU-MEDROL	PFI	$	62.7302
00002367971	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	63.9987

METOLAZONE

2.5 MG ORAL TABLET

00000888400	ZAROXOLYN	SAV	$	0.2136

METOPROLOL TARTRATE

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

METRONIDAZOLE

10 % VAGINAL CREAM

00001926861	FLAGYL	SAV	$	0.2558

METRONIDAZOLE/ NYSTATIN

500 MG * 100,000 UNIT VAGINAL OVULE

00001926829	FLAGYSTATIN	SAV	$	3.4440

MINOXIDIL

2.5 MG ORAL TABLET

00000514497	LONITEN	PFI	$	0.4694

10 MG ORAL TABLET

00000514500	LONITEN	PFI	$	1.0346

NAFARELIN ACETATE

2 MG / ML (BASE) NASAL SOLUTION

00002188783	SYNAREL	PFI	$	48.8851

NITROGLYCERIN

0.3 MG ORAL SUBLINGUAL TABLET

00000037613	NITROSTAT	PFI	$	0.1537

0.6 MG ORAL SUBLINGUAL TABLET

00000037621	NITROSTAT	PFI	$	0.1537

0.2 MG/HR TRANSDERMAL PATCH

00002407442	**MYLAN-NITRO PATCH**	**MYP**	$	**0.4463**
00001911910	**NITRO-DUR 0.2**	**DRL**	$	**0.4463**
⊠ 00002230732	TRINIPATCH 0.2	PAL	$	0.6465
⊠ 00002162806	MINITRAN 0.2	VCL	$	0.6573
⊠ 00000584223	TRANSDERM-NITRO 0.2	NOV	$	0.7300

0.4 MG/HR TRANSDERMAL PATCH

00002407450	**MYLAN-NITRO PATCH**	**MYP**	$	**0.4937**
00001911902	**NITRO-DUR 0.4**	**DRL**	$	**0.4937**
⊠ 00002230733	TRINIPATCH 0.4	PAL	$	0.7301
⊠ 00002163527	MINITRAN 0.4	VCL	$	0.7427
⊠ 00000852384	TRANSDERM-NITRO 0.4	NOV	$	0.8240

0.6 MG/HR TRANSDERMAL PATCH

00002407469	**MYLAN-NITRO PATCH**	**MYP**	$	**0.4937**
00001911929	**NITRO-DUR 0.6**	**DRL**	$	**0.4937**
⊠ 00002230734	TRINIPATCH 0.6	PAL	$	0.7301
⊠ 00002163535	MINITRAN 0.6	VCL	$	0.7431
⊠ 00002046156	TRANSDERM-NITRO 0.6	NOV	$	0.8240

NORETHINDRONE ACETATE/ ESTRADIOL-17B

140 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH

00002241835	ESTALIS (2.7*.62 MG/PTH)	NOV	$	3.4012

250 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH

00002241837	ESTALIS (4.8*.51 MG/PTH)	NOV	$	3.4012

NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

00002187108	SYNPHASIC (21 DAY)	PFI	$	0.5946

0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

00002187116	SYNPHASIC (28 DAY)	PFI	$	0.4460

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

00002486318	**TRI-JORDYNA 28 (28 DAY)**	**GLM**	$	**0.7709**
00002029421	TRI-CYCLEN (28 DAY)	JAI	$	0.9536

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**
00002444674	**VPI-ONDANSETRON ODT**	**VPI**	$	**3.2720**
00002239372	ZOFRAN ODT	NOV	$	14.0040

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**
00002444682	**VPI-ONDANSETRON ODT**	**VPI**	$	**4.9930**
00002239373	ZOFRAN ODT	NOV	$	21.3690

ONDANSETRON HCL DIHYDRATE

4 MG (BASE) ORAL TABLET				
00002478927	**ACCEL-ONDANSETRON**	**ACP**	$	**2.6790**
00002288184	APO-ONDANSETRON	APX	$	3.2720
00002458810	CCP-ONDANSETRON	CEL	$	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
00002297868	MYLAN-ONDANSETRON	MYP	$	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
00002376091	SEPTA-ONDANSETRON	SEP	$	3.2720
00002213567	ZOFRAN	NOV	$	14.5480
8 MG (BASE) ORAL TABLET				
00002478935	**ACCEL-ONDANSETRON**	**ACP**	$	**4.0880**
00002288192	APO-ONDANSETRON	APX	$	4.9930
00002458802	CCP-ONDANSETRON	CEL	$	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
00002297876	MYLAN-ONDANSETRON	MYP	$	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
00002376105	SEPTA-ONDANSETRON	SEP	$	4.9930
00002213575	ZOFRAN	NOV	$	22.2030
0.8 MG / ML (BASE) ORAL SOLUTION				
00002291967	**ONDANSETRON**	**AAP**	$	**1.6641**
00002229639	ZOFRAN	NOV	$	2.1872
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	$	10.7200

PENTAZOCINE HCL

50 MG (BASE) ORAL TABLET				
00002137984	TALWIN	SAV	$	0.4790

PHENYTOIN

50 MG ORAL CHEWABLE TABLET				
00000023698	DILANTIN INFATABS	PFI	$	0.0879
6 MG / ML ORAL SUSPENSION				
00000023442	DILANTIN-30	PFI	$	0.0484
25 MG / ML ORAL SUSPENSION				
00002250896	**TARO-PHENYTOIN**	**TAR**	$	**0.0448**
00000023450	DILANTIN-125	PFI	$	0.0571

PHENYTOIN SODIUM

30 MG ORAL CAPSULE

00000022772	DILANTIN	PFI	$	0.1388

100 MG ORAL CAPSULE

00002460912	**APO-PHENYTOIN SODIUM**	**APX**	$	**0.0665**
00000022780	DILANTIN	PFI	$	0.0913

PILOCARPINE HCL

5 MG ORAL TABLET

00002216345	SALAGEN	PFI	$	1.4641

2 % OPHTHALMIC SOLUTION

00000000868	ISOPTO CARPINE	NOV	$	0.2720

PRAVASTATIN SODIUM

10 MG ORAL TABLET

00002440644	ACH-PRAVASTATIN	AHI	***$ 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
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
00000893757	PRAVACHOL	BMS	***$ 0.1354***	$	1.1243

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

40 MG ORAL TABLET

00002440660	ACH-PRAVASTATIN	AHI	***$ 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
00002222051	PRAVACHOL	BMS	***$ 0.1354***	$	1.3543

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.

PREDNISOLONE SODIUM PHOSPHATE

1 MG / ML (BASE) ORAL LIQUID

00002245532	**PMS-PREDNISOLONE**	**PMS**	$	**0.1248**
00002230619	PEDIAPRED	SAV	$	0.1399

PRIMAQUINE PHOSPHATE

15 MG (BASE) ORAL TABLET

00002017776	PRIMAQUINE PHOSPHATE	SAV	$	0.4397

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***	$	0.9742

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***	$	0.9742

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***	$	0.9742

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***	$	0.9742

MAC pricing will be applied based on the LCA Price for Lisinopril 1 x 20 mg tablet.

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***	$	0.9840

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***	$	0.9840

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***	$	0.9423

MAC pricing will be applied based on the LCA Price for Lisinopril/ Hydrochlorothiazide 1 x 20 mg/25 mg tablet.

SODIUM CROMOGLYCATE

100 MG ORAL CAPSULE

00000500895	NALCROM	SAV	$	1.5755

SYNTHETIC CALCITONIN SALMON (SALCATONIN)

200 IU / ML INJECTION

00001926691	CALCIMAR	SAV	$	30.4800

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	$	4.3032

1 % TOPICAL CREAM

00002031094	LAMISIL	NOV	$	0.5480

1 % TOPICAL SOLUTION

00002238703	LAMISIL	NOV	$	0.5560

TESTOSTERONE CYPIONATE

100 MG / ML INJECTION

00000030783	DEPO-TESTOSTERONE CYPIONATE	PFI	$	4.4681

THYROTROPIN ALFA

0.9 MG / VIAL INJECTION

00002246016	THYROGEN	GZM	$	871.2950

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	PFI	$	2.0433
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	PFI	$	2.0433

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

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**
00002244781	DIOVAN	NOV	$	1.2832
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**
00002244782	DIOVAN	NOV	$	1.2825
320 MG ORAL TABLET				
00002414244	**AURO-VALSARTAN**	**AUR**	$	**0.2098**
00002356775	**SANDOZ VALSARTAN**	**SDZ**	$	**0.2098**
00002356686	**TEVA-VALSARTAN**	**TEV**	$	**0.2098**
00002289504	DIOVAN	NOV	$	1.2357

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	$	1.2757
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	$	1.2807

VALSARTAN/ HYDROCHLOROTHIAZIDE

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	$	1.2850
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	$	1.2650
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	$	1.2657

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

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	PFI	$	0.9864
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	PFI	$	2.0010
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	PFI	$	2.1124

ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE

20 MG (BASE) ORAL CAPSULE				
00002449544	**AURO-ZIPRASIDONE**	**AUR**	$	**1.3784**
00002298597	ZELDOX	PFI	$	1.8579
40 MG (BASE) ORAL CAPSULE				
00002449552	**AURO-ZIPRASIDONE**	**AUR**	$	**1.5786**
00002298600	ZELDOX	PFI	$	2.1282
60 MG (BASE) ORAL CAPSULE				
00002449560	**AURO-ZIPRASIDONE**	**AUR**	$	**1.5786**
00002298619	ZELDOX	PFI	$	2.1282
80 MG (BASE) ORAL CAPSULE				
00002449579	**AURO-ZIPRASIDONE**	**AUR**	$	**1.5786**
00002298627	ZELDOX	PFI	$	2.1282

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

ZOPICLONE

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	$	1.0589

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	$	1.3370

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 60032).

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

100 MG ORAL CAPSULE

00002420155	**ACT CELECOXIB**	**APH**	$	**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**
00002355442	**PMS-CELECOXIB**	**PMS**	$	**0.1279**
00002412373	**RAN-CELECOXIB**	**RAN**	$	**0.1279**
00002442639	**SDZ CELECOXIB**	**SDZ**	$	**0.1279**
00002239941	CELEBREX	PFI	$	0.6992

200 MG ORAL CAPSULE

00002420163	**ACT CELECOXIB**	**APH**	$	**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**
00002355450	**PMS-CELECOXIB**	**PMS**	$	**0.2558**
00002412381	**RAN-CELECOXIB**	**RAN**	$	**0.2558**
00002442647	**SDZ CELECOXIB**	**SDZ**	$	**0.2558**
00002239942	CELEBREX	PFI	$	1.3988

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	$	0.6495
25 MG ORAL CAPSULE				
00002247073	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**1.3050**
00002150689	NEORAL	NOV	$	1.5100
50 MG ORAL CAPSULE				
00002247074	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**2.5450**
00002150662	NEORAL	NOV	$	2.9450
100 MG ORAL CAPSULE				
00002242821	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**5.0900**
00002150670	NEORAL	NOV	$	5.8920
100 MG / ML ORAL SOLUTION				
00002150697	NEORAL	NOV	$	5.2386

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**
00002463520	**TARO-DEFERASIROX**	**TAR**	$	**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**
00002463539	**TARO-DEFERASIROX**	**TAR**	$	**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

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	PFI	$	2.7815

50 MG ORAL TABLET

00002471450	**MINT-EPLERENONE**	**MPI**	$	**2.0595**
00002323060	INSPRA	PFI	$	2.7815

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

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.)

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
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

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	$	0.2906

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	$	628.8400

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	$	2.7725

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	$	2.7725

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	$	2.7725

RIVASTIGMINE HYDROGEN TARTRATE

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	$	2.7725
2 MG / ML (BASE) ORAL SOLUTION				
00002245240	EXELON	NOV	$	1.4575

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).

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	$	1.4478

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	$	1.7331

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	$	2.4604

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

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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	$	721.0000
200 MG / SYR INJECTION				
00002472988	KEVZARA (PREFILLED PEN)	SAV	$	721.0000
150 MG / SYR INJECTION SYRINGE				
00002460521	KEVZARA	SAV	$	721.0000
200 MG / SYR INJECTION SYRINGE				
00002460548	KEVZARA	SAV	$	721.0000

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.

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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;

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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

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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	$	831.1100

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 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	$	57.7432

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

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- 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

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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).

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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

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- 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

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
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal

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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).

☒ 00002424770 ACTEMRA (0.9 ML SYRINGE) HLR $ 358.9050

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.

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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).

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.
*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).

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"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,
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

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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).

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 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."

TOFACITINIB CITRATE

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).

5 MG (BASE)	ORAL	TABLET			
00002423898	XELJANZ		PFI	$	23.9589

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

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

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**	**MDA**	$	**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	$	115.7940

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