Updates to the Alberta Drug Benefit List

Effective November 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.

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACH-PIOGLITAZONE 15 MG TABLET	PIOGLITAZONE HCL	00002391600	AHI
ACH-PIOGLITAZONE 30 MG TABLET	PIOGLITAZONE HCL	00002339587	AHI
ACH-PIOGLITAZONE 45 MG TABLET	PIOGLITAZONE HCL	00002339595	AHI
JAMP-PIOGLITAZONE 15 MG TABLET	PIOGLITAZONE HCL	00002397307	JPC
JAMP-PIOGLITAZONE 30 MG TABLET	PIOGLITAZONE HCL	00002365529	JPC
JAMP-PIOGLITAZONE 45 MG TABLET	PIOGLITAZONE HCL	00002365537	JPC

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
ENBREL 25 MG / VIAL INJECTION	ETANERCEPT	00002242903	AMG
ENBREL 50 MG / SYRINGE INJECTION	ETANERCEPT	00002274728	AMG
ERELZI 25 MG / 0.5 ML INJECTION SYRINGE	ETANERCEPT	00002462877	SDZ
ERELZI 50 MG / ML INJECTION SYRINGE	ETANERCEPT	00002462869	SDZ
ERELZI 50 MG / ML SENSOREADY AUTO INJECTOR SYRINGE	ETANERCEPT	00002462850	SDZ
STELARA (0.5 ML VIAL OR SYRINGE) 45 MG VIAL OR SYRINGE INJECTION	USTEKINUMAB	00002320673	JAI
STELARA (1.0 ML SYRINGE) 90 MG / SYRINGE INJECTION	USTEKINUMAB	00002320681	JAI

Optional Special Authorization

The following drug product(s) will be considered for coverage by Optional Special Authorization for patients covered under Alberta government-sponsored drug programs.

*Please refer to **Section 3A** of the online Alberta Drug Benefit List for further information regarding the Optional Special Authorization of Select Drug Products criteria and related forms.*

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
AG-MOXIFLOXACIN 400 MG TABLET	MOXIFLOXACIN HCL	00002478137	AGP

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACARBOSE 50 MG TABLET	ACARBOSE	00002493780	STR
ACARBOSE 100 MG TABLET	ACARBOSE	00002493799	STR
AG-ATENOLOL 50 MG TABLET	ATENOLOL	00002369184	AGP
AG-ATENOLOL 100 MG TABLET	ATENOLOL	00002369192	AGP
AG-ATORVASTATIN 10 MG TABLET	ATORVASTATIN CALCIUM	00002478145	AGP
AG-ATORVASTATIN 20 MG TABLET	ATORVASTATIN CALCIUM	00002478153	AGP
AG-ATORVASTATIN 40 MG TABLET	ATORVASTATIN CALCIUM	00002478161	AGP
AG-ATORVASTATIN 80 MG TABLET	ATORVASTATIN CALCIUM	00002478188	AGP
AG-PAROXETINE 20 MG TABLET	PAROXETINE HCL	00002475545	AGP
AG-PAROXETINE 30 MG TABLET	PAROXETINE HCL	00002475553	AGP
AG-PRAVASTATIN 10 MG TABLET	PRAVASTATIN SODIUM	00002476142	AGP
AG-PRAVASTATIN 20 MG TABLET	PRAVASTATIN SODIUM	00002476150	AGP
AG-PRAVASTATIN 40 MG TABLET	PRAVASTATIN SODIUM	00002476169	AGP
AG-PREGABALIN 25 MG CAPSULE	PREGABALIN	00002480727	AGP
AG-PREGABALIN 50 MG CAPSULE	PREGABALIN	00002480735	AGP
AG-PREGABALIN 75 MG CAPSULE	PREGABALIN	00002480743	AGP
AG-PREGABALIN 150 MG CAPSULE	PREGABALIN	00002480751	AGP
AG-QUETIAPINE 25 MG TABLET	QUETIAPINE FUMARATE	00002475979	AGP
AG-RAMIPRIL 2.5 MG CAPSULE	RAMIPRIL	00002477572	AGP
AG-RAMIPRIL 5 MG CAPSULE	RAMIPRIL	00002477580	AGP
AG-RAMIPRIL 10 MG CAPSULE	RAMIPRIL	00002477599	AGP
AG-SERTRALINE 25 MG CAPSULE	SERTRALINE HCL	00002477882	AGP
AG-SERTRALINE 50 MG CAPSULE	SERTRALINE HCL	00002477890	AGP
AG-SERTRALINE 100 MG CAPSULE	SERTRALINE HCL	00002477904	AGP
CALCITRIOL 0.25 MCG CAPSULE	CALCITRIOL	00002495899	STR
CALCITRIOL 0.5 MCG CAPSULE	CALCITRIOL	00002495902	STR
FRAGMIN 16500 IU/0.66 ML INJECTION SYRINGE	DALTEPARIN SODIUM	00002494582	PFI
JAMP METHIMAZOLE 5 MG TABLET	THIAMAZOLE	00002490625	JPC
NRA-AMLODIPINE 2.5 MG TABLET	AMLODIPINE BESYLATE	00002476452	NRA
NRA-AMLODIPINE 5 MG TABLET	AMLODIPINE BESYLATE	00002476460	NRA
NRA-AMLODIPINE 10 MG TABLET	AMLODIPINE BESYLATE	00002476479	NRA
RIVA-PYRIDOSTIGMINE 60 MG TABLET	PYRIDOSTIGMINE BROMIDE	00002495643	RIV

Added Product(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
TRI-JORDYNA (21 DAY) TABLET	NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL	00002486296	GLM
VALSARTAN 80 MG TABLET	VALSARTAN	00002366959	SNS
VALSARTAN 160 MG TABLET	VALSARTAN	00002366967	SNS
VALSARTAN 320 MG TABLET	VALSARTAN	00002366975	SNS
ZAMINE 21 TABLET	DROSPIRENONE/ ETHINYL ESTRADIOL	00002410788	APX
ZAMINE 28 TABLET	DROSPIRENONE/ ETHINYL ESTRADIOL	00002410796	APX

New Established Interchangeable (IC) Grouping(s)

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

Generic Description	Strength / Form	New LCA Price
DROSPIRENONE/ ETHINYL ESTRADIOL	(21 DAY) 3 MG / 0.03 MG TABLET	0.4442
DROSPIRENONE/ ETHINYL ESTRADIOL	(28 DAY) 3 MG / 0.03 MG TABLET	0.3332
NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL	(21 DAY) 0.18 MG / 0.035 MG / 0.215 MG / 0.035 MG / 0.25 MG / 0.035 MG TABLET	1.0279
PIOGLITAZONE HCL	45 MG TABLET	1.3113
PYRIDOSTIGMINE BROMIDE	60 MG TABLET	0.4009

Least Cost Alternative (LCA) Price Change(s)

The following established IC Grouping(s) are affected and a revised LCA price has been established. Groupings affected by a price decrease, will be effective December 1, 2020. Please review the online ***Interactive Drug Benefit List*** *for further information.*

Generic Description	Strength / Form	New LCA Price
ACARBOSE	50 MG TABLET	0.1348
ACARBOSE	100 MG TABLET	0.1866
CALCITRIOL	0.25 MCG CAPSULE	0.2341
CALCITRIOL	0.5 MCG CAPSULE	0.7446
METHIMAZOLE	5 MG TABLET	0.1531
METHOTREXATE SODIUM (UNPRESERVED)	25 MG / ML INJECTION	3.5101

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until November 30, 2020. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
CALCITRIOL-ODAN 0.25 MCG CAPSULE	CALCITRIOL	00002431637	ODN
CALCITRIOL-ODAN 0.5 MCG CAPSULE	CALCITRIOL	00002431645	ODN
MAR-ACARBOSE 100 MG TABLET	ACARBOSE	00002494086	MAR
MAR-ACARBOSE 50 MG TABLET	ACARBOSE	00002494078	MAR
MAR-METHIMAZOLE 5 MG TABLET	THIAMAZOLE	00002480107	MAR
METHOTREXATE SODIUM (UNPRESERVED) 25 MG / ML INJECTION	METHOTREXATE SODIUM	00002099705	TEV
METOJECT SUBCUTANEOUS 15 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454858	MDX
METOJECT SUBCUTANEOUS 17.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454769	MDX
METOJECT SUBCUTANEOUS 20 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454866	MDX
METOJECT SUBCUTANEOUS 22.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454777	MDX
METOJECT SUBCUTANEOUS 25 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454874	MDX
RUXIENCE 10 MG / ML INJECTION	RITUXIMAB	00002495724	PFI
SALAGEN 5 MG TABLET	PILOCARPINE HCL	00002216345	AMD
TARO-CALCITRIOL 0.25 MCG CAPSULE	CALCITRIOL	00002485710	TAR
TARO-CALCITRIOL 0.5 MCG CAPSULE	CALCITRIOL	00002485729	TAR
ZIEXTENZO (0.6 ML SYRINGE) 6 MG / SYRINGE INJECTION	PEGFILGRASTIM	00002497395	SDZ

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 November 1, 2020, the listed product(s) will no longer be a benefit and where applicable, will not be considered for coverage by Special Authorization. A transition period will be applied and as of December 1, 2020 claims will no longer pay for these product(s).

Trade Name / Strength / Form	Generic Description	DIN	MFR
ANUGESIC-HC RECTAL SUPPOSITORY	HYDROCORTISONE ACETATE/ PRAMOXINE HCL/ ZINC SULFATE	00000476242	MCL
DDAVP 10 MCG / DOSE NASAL METERED DOSE SPRAY	DESMOPRESSIN ACETATE	00000836362	FEI
FIBRISTAL 5 MG TABLET	ULIPRISTAL ACETATE	00002408163	ALL

Discontinued Listing(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
JAMP-ALPRAZOLAM 0.25 MG TABLET	ALPRAZOLAM	00002400111	JPC
JAMP-ALPRAZOLAM 0.5 MG TABLET	ALPRAZOLAM	00002400138	JPC
LIORESAL 10 MG TABLET	BACLOFEN	00000455881	NOV
LIORESAL D.S. 20 MG TABLET	BACLOFEN	00000636576	NOV
LOZIDE 2.5 MG TABLET	INDAPAMIDE HEMIHYDRATE	00000564966	SEV
OCTOSTIM 150 MCG / DOSE NASAL METERED DOSE SPRAY	DESMOPRESSIN ACETATE	00002237860	FEI
ORCIPRENALINE 2 MG / ML ORAL SYRUP	ORCIPRENALINE SULFATE	00002236783	AAP
PRINIVIL 10 MG TABLET	LISINOPRIL	00000839396	MFC
VOLTAREN 50 MG ENTERIC-COATED TABLET	DICLOFENAC SODIUM	00000514012	NOV

PART 2

Drug Additions

ACARBOSE

50 MG ORAL TABLET

00002493780	**ACARBOSE**	**STR**	$	**0.1348**
00002494078	**MAR-ACARBOSE**	**MAR**	$	**0.1348**
00002190885	GLUCOBAY	BAI	$	0.2695

100 MG ORAL TABLET

00002493799	**ACARBOSE**	**STR**	$	**0.1866**
00002494086	**MAR-ACARBOSE**	**MAR**	$	**0.1866**
00002190893	GLUCOBAY	BAI	$	0.3733

AMLODIPINE BESYLATE

2.5 MG (BASE) ORAL TABLET

00002385783	**AMLODIPINE**	**SIV**	$	**0.0767**
00002419556	**AMLODIPINE BESYLATE**	**AHI**	$	**0.0767**
00002371707	**MAR-AMLODIPINE**	**MAR**	$	**0.0767**
00002476452	**NRA-AMLODIPINE**	**NRA**	$	**0.0767**
00002469022	**PHARMA-AMLODIPINE**	**PMS**	$	**0.0767**
00002295148	**PMS-AMLODIPINE**	**PMS**	$	**0.0767**
00002330474	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.0767**

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**
00002476460	**NRA-AMLODIPINE**	**NRA**	$	**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**
00000878928	NORVASC	UJC	$	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**
00002476479	**NRA-AMLODIPINE**	**NRA**	$	**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**
00000878936	NORVASC	UJC	$	2.0528

ATENOLOL

50 MG ORAL TABLET

00002369184	**AG-ATENOLOL**	**AGP**	$	**0.1107**
00000773689	**APO-ATENOL**	**APX**	$	**0.1107**
00002238316	**ATENOLOL**	**SIV**	$	**0.1107**
00002466465	**ATENOLOL**	**SNS**	$	**0.1107**
00002367564	**JAMP-ATENOLOL**	**JPC**	$	**0.1107**
00002371987	**MAR-ATENOLOL**	**MAR**	$	**0.1107**
00002368021	**MINT-ATENOL**	**MPI**	$	**0.1107**
00002237600	**PMS-ATENOLOL**	**PMS**	$	**0.1107**
00002267985	**RAN-ATENOLOL**	**RAN**	$	**0.1107**
00002171791	**TEVA-ATENOLOL**	**TEV**	$	**0.1107**
00002039532	TENORMIN	AZC	$	0.6086

100 MG ORAL TABLET

00002369192	**AG-ATENOLOL**	**AGP**	$	**0.1821**
00000773697	**APO-ATENOL**	**APX**	$	**0.1821**
00002238318	**ATENOLOL**	**SIV**	$	**0.1821**
00002466473	**ATENOLOL**	**SNS**	$	**0.1821**
00002367572	**JAMP-ATENOLOL**	**JPC**	$	**0.1821**
00002371995	**MAR-ATENOLOL**	**MAR**	$	**0.1821**
00002368048	**MINT-ATENOL**	**MPI**	$	**0.1821**
00002237601	**PMS-ATENOLOL**	**PMS**	$	**0.1821**
00002267993	**RAN-ATENOLOL**	**RAN**	$	**0.1821**
00002171805	**TEVA-ATENOLOL**	**TEV**	$	**0.1821**
00002039540	TENORMIN	AZC	$	1.0006

ATORVASTATIN CALCIUM

10 MG (BASE) ORAL TABLET

00002457741	**ACH-ATORVASTATIN**	**AHI**	$	**0.1743**
00002478145	**AG-ATORVASTATIN**	**AGP**	$	**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**
00002477149	**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	UJC	$	1.8223

20 MG (BASE) ORAL TABLET

00002457768	**ACH-ATORVASTATIN**	**AHI**	$	**0.2179**
00002478153	**AG-ATORVASTATIN**	**AGP**	$	**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**
00002477157	**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	UJC	$	2.2779

ATORVASTATIN CALCIUM

40 MG (BASE) ORAL TABLET

00002457776	**ACH-ATORVASTATIN**	**AHI**	$	**0.2342**
00002478161	**AG-ATORVASTATIN**	**AGP**	$	**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**
00002477165	**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	UJC	$	2.4483

80 MG (BASE) ORAL TABLET

00002457784	**ACH-ATORVASTATIN**	**AHI**	$	**0.2342**
00002478188	**AG-ATORVASTATIN**	**AGP**	$	**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**
00002477173	**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	UJC	$	2.4483

CALCITRIOL

0.25 MCG ORAL CAPSULE

00002495899	**CALCITRIOL**	**STR**	$	**0.2341**
00002431637	**CALCITRIOL-ODAN**	**ODN**	$	**0.2341**
00002485710	**TARO-CALCITRIOL**	**TAR**	$	**0.2341**
00000481823	ROCALTROL	HLR	$	0.7071

0.5 MCG ORAL CAPSULE

00002495902	**CALCITRIOL**	**STR**	$	**0.3723**
00002431645	**CALCITRIOL-ODAN**	**ODN**	$	**0.3723**
00002485729	**TARO-CALCITRIOL**	**TAR**	$	**0.3723**
00000481815	ROCALTROL	HLR	$	1.1246

DALTEPARIN SODIUM

16,500 IU / SYR INJECTION SYRINGE

00002494582	FRAGMIN	PFI	$	36.0740

DROSPIRENONE/ ETHINYL ESTRADIOL

3 MG * 0.03 MG ORAL TABLET

00002410788	**ZAMINE 21**	**APX**	$	**0.4442**
00002261723	YASMIN 21	BAI	$	0.5924

3 MG * 0.03 MG ORAL TABLET

00002410796	**ZAMINE 28**	**APX**	$	**0.3332**
00002261731	YASMIN 28	BAI	$	0.4443

METHOTREXATE SODIUM

25 MG / ML (BASE) INJECTION				
00002099705	**METHOTREXATE SOD.(UNPRESERVED)**	**TEV**	$	**3.5101**
00002182955	METHOTREXATE SOD.(UNPRESERVED)	PFI	$	5.6250
15 MG / SYR (BASE) INJECTION SYRINGE				
00002454858	METOJECT SUBCUTANEOUS	MDX	$	24.5700
17.5 MG / SYR (BASE) INJECTION SYRINGE				
00002454769	METOJECT SUBCUTANEOUS	MDX	$	24.0000
20 MG / SYR (BASE) INJECTION SYRINGE				
00002454866	METOJECT SUBCUTANEOUS	MDX	$	26.2500
22.5 MG / SYR (BASE) INJECTION SYRINGE				
00002454777	METOJECT SUBCUTANEOUS	MDX	$	26.2500
25 MG / SYR (BASE) INJECTION SYRINGE				
00002454874	METOJECT SUBCUTANEOUS	MDX	$	29.2500

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				
00002486296	**TRI-JORDYNA (21 DAY)**	**GLM**	$	**1.0279**
00002028700	TRI-CYCLEN (21 DAY)	JAI	$	1.2715

PAROXETINE HCL

20 MG (BASE) ORAL TABLET				
00002475545	**AG-PAROXETINE**	**AGP**	$	**0.3250**
00002240908	**APO-PAROXETINE**	**APX**	$	**0.3250**
00002383284	**AURO-PAROXETINE**	**AUR**	$	**0.3250**
00002368870	**JAMP-PAROXETINE**	**JPC**	$	**0.3250**
00002411954	**MAR-PAROXETINE**	**MAR**	$	**0.3250**
00002421380	**MINT-PAROXETINE**	**MPI**	$	**0.3250**
00002282852	**PAROXETINE**	**SNS**	$	**0.3250**
00002388235	**PAROXETINE**	**SIV**	$	**0.3250**
00002247751	**PMS-PAROXETINE**	**PMS**	$	**0.3250**
00002248557	**TEVA-PAROXETINE**	**TEV**	$	**0.3250**
00001940481	PAXIL	GSK	$	1.8959
30 MG (BASE) ORAL TABLET				
00002475553	**AG-PAROXETINE**	**AGP**	$	**0.3453**
00002240909	**APO-PAROXETINE**	**APX**	$	**0.3453**
00002383292	**AURO-PAROXETINE**	**AUR**	$	**0.3453**
00002368889	**JAMP-PAROXETINE**	**JPC**	$	**0.3453**
00002411962	**MAR-PAROXETINE**	**MAR**	$	**0.3453**
00002421399	**MINT-PAROXETINE**	**MPI**	$	**0.3453**
00002282860	**PAROXETINE**	**SNS**	$	**0.3453**
00002388243	**PAROXETINE**	**SIV**	$	**0.3453**
00002247752	**PMS-PAROXETINE**	**PMS**	$	**0.3453**
00001940473	PAXIL	GSK	$	2.0140

PILOCARPINE HCL

5 MG ORAL TABLET				
00002496119	**ACCEL-PILOCARPINE**	**ACP**	$	**1.2445**
00002216345	**SALAGEN**	**AMD**	$	**1.2445**

PRAVASTATIN SODIUM

10 MG ORAL TABLET

00002440644	ACH-PRAVASTATIN	AHI	***$ 0.1354***	$	0.2916
00002476142	AG-PRAVASTATIN	AGP	***$ 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
00002476150	AG-PRAVASTATIN	AGP	***$ 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.

40 MG ORAL TABLET

00002440660	ACH-PRAVASTATIN	AHI	***$ 0.1354***	$	0.4143
00002476169	AG-PRAVASTATIN	AGP	***$ 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.

PREGABALIN

25 MG ORAL CAPSULE				
00002480727	**AG-PREGABALIN**	**AGP**	$	**0.1481**
00002394235	**APO-PREGABALIN**	**APX**	$	**0.1481**
00002433869	**AURO-PREGABALIN**	**AUR**	$	**0.1481**
00002435977	**JAMP-PREGABALIN**	**JPC**	$	**0.1481**
00002423804	**MINT-PREGABALIN**	**MPI**	$	**0.1481**
00002494841	**NAT-PREGABALIN**	**NTP**	$	**0.1481**
00002359596	**PMS-PREGABALIN**	**PMS**	$	**0.1481**
00002403692	**PREGABALIN**	**SIV**	$	**0.1481**
00002405539	**PREGABALIN**	**SNS**	$	**0.1481**
00002392801	**RAN-PREGABALIN**	**RAN**	$	**0.1481**
00002390817	**SANDOZ PREGABALIN**	**SDZ**	$	**0.1481**
00002361159	**TEVA-PREGABALIN**	**TEV**	$	**0.1481**
50 MG ORAL CAPSULE				
00002480735	**AG-PREGABALIN**	**AGP**	$	**0.2324**
00002394243	**APO-PREGABALIN**	**APX**	$	**0.2324**
00002433877	**AURO-PREGABALIN**	**AUR**	$	**0.2324**
00002435985	**JAMP-PREGABALIN**	**JPC**	$	**0.2324**
00002423812	**MINT-PREGABALIN**	**MPI**	$	**0.2324**
00002494868	**NAT-PREGABALIN**	**NTP**	$	**0.2324**
00002359618	**PMS-PREGABALIN**	**PMS**	$	**0.2324**
00002403706	**PREGABALIN**	**SIV**	$	**0.2324**
00002405547	**PREGABALIN**	**SNS**	$	**0.2324**
00002392828	**RAN-PREGABALIN**	**RAN**	$	**0.2324**
00002390825	**SANDOZ PREGABALIN**	**SDZ**	$	**0.2324**
00002361175	**TEVA-PREGABALIN**	**TEV**	$	**0.2324**
75 MG ORAL CAPSULE				
00002480743	**AG-PREGABALIN**	**AGP**	$	**0.3007**
00002394251	**APO-PREGABALIN**	**APX**	$	**0.3007**
00002433885	**AURO-PREGABALIN**	**AUR**	$	**0.3007**
00002435993	**JAMP-PREGABALIN**	**JPC**	$	**0.3007**
00002424185	**MINT-PREGABALIN**	**MPI**	$	**0.3007**
00002494876	**NAT-PREGABALIN**	**NTP**	$	**0.3007**
00002359626	**PMS-PREGABALIN**	**PMS**	$	**0.3007**
00002403714	**PREGABALIN**	**SIV**	$	**0.3007**
00002405555	**PREGABALIN**	**SNS**	$	**0.3007**
00002392836	**RAN-PREGABALIN**	**RAN**	$	**0.3007**
00002390833	**SANDOZ PREGABALIN**	**SDZ**	$	**0.3007**
00002361183	**TEVA-PREGABALIN**	**TEV**	$	**0.3007**
150 MG ORAL CAPSULE				
00002480751	**AG-PREGABALIN**	**AGP**	$	**0.4145**
00002394278	**APO-PREGABALIN**	**APX**	$	**0.4145**
00002433907	**AURO-PREGABALIN**	**AUR**	$	**0.4145**
00002436000	**JAMP-PREGABALIN**	**JPC**	$	**0.4145**
00002424207	**MINT-PREGABALIN**	**MPI**	$	**0.4145**
00002494884	**NAT-PREGABALIN**	**NTP**	$	**0.4145**
00002359634	**PMS-PREGABALIN**	**PMS**	$	**0.4145**
00002403722	**PREGABALIN**	**SIV**	$	**0.4145**
00002405563	**PREGABALIN**	**SNS**	$	**0.4145**
00002392844	**RAN-PREGABALIN**	**RAN**	$	**0.4145**
00002390841	**SANDOZ PREGABALIN**	**SDZ**	$	**0.4145**
00002361205	**TEVA-PREGABALIN**	**TEV**	$	**0.4145**

PYRIDOSTIGMINE BROMIDE

60 MG ORAL TABLET				
00002495643	**RIVA-PYRIDOSTIGMINE**	**RIV**	$	**0.4009**
00000869961	MESTINON	VCL	$	0.4986

QUETIAPINE FUMARATE

25 MG (BASE) ORAL TABLET

00002316080	**ACT QUETIAPINE**	**APH**	$	**0.0494**
00002475979	**AG-QUETIAPINE**	**AGP**	$	**0.0494**
00002313901	**APO-QUETIAPINE**	**APX**	$	**0.0494**
00002390205	**AURO-QUETIAPINE**	**AUR**	$	**0.0494**
00002447193	**BIO-QUETIAPINE**	**BMD**	$	**0.0494**
00002330415	**JAMP-QUETIAPINE**	**JPC**	$	**0.0494**
00002399822	**MAR-QUETIAPINE**	**MAR**	$	**0.0494**
00002438003	**MINT-QUETIAPINE**	**MPI**	$	**0.0494**
00002439158	**NAT-QUETIAPINE**	**NTP**	$	**0.0494**
00002296551	**PMS-QUETIAPINE**	**PMS**	$	**0.0494**
00002317893	**QUETIAPINE**	**SIV**	$	**0.0494**
00002353164	**QUETIAPINE**	**SNS**	$	**0.0494**
00002387794	**QUETIAPINE**	**AHI**	$	**0.0494**
00002397099	**RAN-QUETIAPINE**	**RAN**	$	**0.0494**
00002236951	SEROQUEL	AZC	$	0.5195

RAMIPRIL

2.5 MG ORAL CAPSULE/TABLET

00002477572	**AG-RAMIPRIL (CAPSULE)**	**AGP**	$	**0.0817**
00002251531	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.0817**
00002387395	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.0817**
00002331128	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.0817**
00002420465	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.0817**
00002421305	**MINT-RAMIPRIL (CAPSULE)**	**MPI**	$	**0.0817**
00002469065	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.0817**
00002287927	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.0817**
00002374846	**RAMIPRIL (CAPSULE)**	**SNS**	$	**0.0817**
00002310511	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.0817**
00002247945	**TEVA-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.0817**
00002221837	ALTACE (CAPSULE)	VCL	$	0.8726

5 MG ORAL CAPSULE/TABLET

00002477580	**AG-RAMIPRIL (CAPSULE)**	**AGP**	$	**0.0817**
00002251574	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.0817**
00002387409	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.0817**
00002331136	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.0817**
00002420473	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.0817**
00002421313	**MINT-RAMIPRIL (CAPSULE)**	**MPI**	$	**0.0817**
00002469073	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.0817**
00002287935	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.0817**
00002374854	**RAMIPRIL (CAPSULE)**	**SNS**	$	**0.0817**
00002310538	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.0817**
00002247946	**TEVA-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.0817**
00002221845	ALTACE (CAPSULE)	VCL	$	0.8954

10 MG ORAL CAPSULE/TABLET

00002477599	**AG-RAMIPRIL (CAPSULE)**	**AGP**	$	**0.1034**
00002251582	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.1034**
00002387417	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.1034**
00002331144	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.1034**
00002420481	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.1034**
00002421321	**MINT-RAMIPRIL (CAPSULE)**	**MPI**	$	**0.1034**
00002469081	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.1034**
00002287943	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.1034**
00002374862	**RAMIPRIL (CAPSULE)**	**SNS**	$	**0.1034**
00002310546	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.1034**
00002247947	**TEVA-RAMIPRIL (CAPSULE)**	**TEV**	$	**0.1034**
00002221853	ALTACE (CAPSULE)	VCL	$	1.1501

SERTRALINE HCL

25 MG (BASE) ORAL CAPSULE

00002477882	**AG-SERTRALINE**	**AGP**	$	**0.1516**
00002238280	**APO-SERTRALINE**	**APX**	$	**0.1516**
00002390906	**AURO-SERTRALINE**	**AUR**	$	**0.1516**
00002357143	**JAMP-SERTRALINE**	**JPC**	$	**0.1516**
00002399415	**MAR-SERTRALINE**	**MAR**	$	**0.1516**
00002402378	**MINT-SERTRALINE**	**MPI**	$	**0.1516**
00002244838	**PMS-SERTRALINE**	**PMS**	$	**0.1516**
00002245159	**SANDOZ SERTRALINE**	**SDZ**	$	**0.1516**
00002353520	**SERTRALINE**	**SNS**	$	**0.1516**
00002386070	**SERTRALINE**	**SIV**	$	**0.1516**
00002469626	**SERTRALINE**	**JPC**	$	**0.1516**
00002240485	**TEVA-SERTRALINE**	**TEV**	$	**0.1516**
00002132702	ZOLOFT	UJC	$	0.8762

50 MG (BASE) ORAL CAPSULE

00002477890	**AG-SERTRALINE**	**AGP**	$	**0.3032**
00002238281	**APO-SERTRALINE**	**APX**	$	**0.3032**
00002390914	**AURO-SERTRALINE**	**AUR**	$	**0.3032**
00002357151	**JAMP-SERTRALINE**	**JPC**	$	**0.3032**
00002399423	**MAR-SERTRALINE**	**MAR**	$	**0.3032**
00002402394	**MINT-SERTRALINE**	**MPI**	$	**0.3032**
00002244839	**PMS-SERTRALINE**	**PMS**	$	**0.3032**
00002245160	**SANDOZ SERTRALINE**	**SDZ**	$	**0.3032**
00002353539	**SERTRALINE**	**SNS**	$	**0.3032**
00002386089	**SERTRALINE**	**SIV**	$	**0.3032**
00002469634	**SERTRALINE**	**JPC**	$	**0.3032**
00002240484	**TEVA-SERTRALINE**	**TEV**	$	**0.3032**
00001962817	ZOLOFT	UJC	$	1.7522

100 MG (BASE) ORAL CAPSULE

00002477904	**AG-SERTRALINE**	**AGP**	$	**0.3303**
00002238282	**APO-SERTRALINE**	**APX**	$	**0.3303**
00002390922	**AURO-SERTRALINE**	**AUR**	$	**0.3303**
00002357178	**JAMP-SERTRALINE**	**JPC**	$	**0.3303**
00002399431	**MAR-SERTRALINE**	**MAR**	$	**0.3303**
00002402408	**MINT-SERTRALINE**	**MPI**	$	**0.3303**
00002244840	**PMS-SERTRALINE**	**PMS**	$	**0.3303**
00002245161	**SANDOZ SERTRALINE**	**SDZ**	$	**0.3303**
00002353547	**SERTRALINE**	**SNS**	$	**0.3303**
00002386097	**SERTRALINE**	**SIV**	$	**0.3303**
00002469642	**SERTRALINE**	**JPC**	$	**0.3303**
00002240481	**TEVA-SERTRALINE**	**TEV**	$	**0.3303**
00001962779	ZOLOFT	UJC	$	1.8637

THIAMAZOLE

5 MG ORAL TABLET

00002490625	**JAMP METHIMAZOLE**	**JPC**	$	**0.1531**
00002480107	**MAR-METHIMAZOLE**	**MAR**	$	**0.1531**
00000015741	TAPAZOLE	PAL	$	0.2799

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**
00002366959	**VALSARTAN**	**SNS**	$	**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**
00002366967	**VALSARTAN**	**SNS**	$	**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**
00002366975	**VALSARTAN**	**SNS**	$	**0.2098**
00002289504	DIOVAN	NOV	$	1.2357

PART 3

Special Authorization

ETANERCEPT

25 MG / VIAL INJECTION

00002242903	ENBREL	AMG	$	200.7100

Ankylosing Spondylitis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 50 mg per week for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed at week 12 by an RA Specialist after the initial twelve weeks of therapy 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 approved for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if 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 etanercept for Ankylosing Spondylitis must be

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completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 up to 100 mg per week for 12 weeks.
-Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 12 weeks of therapy to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:

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- 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 50 mg per week 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.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 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).

- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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.

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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 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of twelve months. 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 RA 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 etanercept for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Psoriatic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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.

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'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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, for a period of 12 months. Ongoing coverage may be considered 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 etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Rheumatoid Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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

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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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, 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."

All requests (including renewal requests) for etanercept 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).

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25 MG / SYR INJECTION SYRINGE

00002462877	ERELZI	SDZ	$	120.5000

Ankylosing Spondylitis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 50 mg per week for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed at week 12 by an RA Specialist after the initial twelve weeks of therapy 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 approved for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if 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 etanercept for Ankylosing Spondylitis must be

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completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 up to 100 mg per week for 12 weeks.
-Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 12 weeks of therapy to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:

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- 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 50 mg per week 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.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 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).

- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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.

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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 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of twelve months. 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 RA 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 etanercept for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Psoriatic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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.

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'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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, for a period of 12 months. Ongoing coverage may be considered 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 etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Rheumatoid Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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

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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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, 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."

All requests (including renewal requests) for etanercept 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).

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50 MG / SYR INJECTION SYRINGE

☒ 00002462869 ERELZI SDZ $ 241.0000

Ankylosing Spondylitis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 50 mg per week for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed at week 12 by an RA Specialist after the initial twelve weeks of therapy 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 approved for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if 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 etanercept for Ankylosing Spondylitis must be

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completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 up to 100 mg per week for 12 weeks.
-Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 12 weeks of therapy to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:

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- 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 50 mg per week 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.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 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).

- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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.

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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 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of twelve months. 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 RA 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 etanercept for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Psoriatic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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.

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'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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, for a period of 12 months. Ongoing coverage may be considered 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 etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Rheumatoid Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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

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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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, 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."

All requests (including renewal requests) for etanercept 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).

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Ankylosing Spondylitis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 50 mg per week for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed at week 12 by an RA Specialist after the initial twelve weeks of therapy 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 approved for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if 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 etanercept for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

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Plaque Psoriasis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 up to 100 mg per week for 12 weeks.
-Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 12 weeks of therapy 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

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Following this assessment, continued coverage may be considered for 50 mg per week 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.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 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).

- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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:

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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 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of twelve months. 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 RA 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 etanercept for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Psoriatic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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").

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- Initial coverage may be approved for 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, for a period of 12 months. Ongoing coverage may be considered 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 etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Rheumatoid Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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

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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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, 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."

All requests (including renewal requests) for etanercept 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).

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Ankylosing Spondylitis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with

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Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 50 mg per week for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed at week 12 by an RA Specialist after the initial twelve weeks of therapy 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 approved for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if 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 etanercept for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

ETANERCEPT

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 up to 100 mg per week for 12 weeks.
-Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 12 weeks, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 12 weeks of therapy 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 50 mg per week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology

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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.

All requests (including renewal requests) for etanercept for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 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).

- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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,

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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 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of twelve months. 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 RA 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 etanercept for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Psoriatic Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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 50 mg per week for 8 weeks.

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- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, for a period of 12 months. Ongoing coverage may be considered 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 etanercept for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Rheumatoid Arthritis

***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naive patients will be assessed for coverage with Brenzys or Erelzi. Effective June 1, 2019, all new Special Authorization requests for the treatment of Psoriatic Arthritis for etanercept-naive patients will be assessed for coverage with Erelzi. Effective November 1, 2020, all new Special Authorization requests for the treatment of adult Plaque Psoriasis for etanercept-naive patients will be assessed for coverage with Erelzi. Enbrel will not be approved for new etanercept starts for patients with the indications stated above; however, coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.

In addition, all new Special Authorization requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis or pediatric Plaque Psoriasis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi. Enbrel will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg, and coverage for Enbrel will continue for patients who are currently well maintained on Enbrel and are considered a 'responder' as defined in criteria.***

"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

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- 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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept 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 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 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 50 mg per week, 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."

All requests (including renewal requests) for etanercept 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).

PEGFILGRASTIM

Effective June 1, 2019, all Special Authorization requests for pegfilgrastim will be assessed for coverage with Fulphila, Lapelga or Ziextenzo. Neulasta will not be approved for new pegfilgrastim starts or repeat treatments (e.g., new course of chemotherapy).

"In patients with non-myeloid malignancies, receiving myelosuppresive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia."

All requests for pegfilgrastim must be completed using the Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form (ABC 60013).

Please note: Coverage cannot be considered for palliative patients.

6 MG / SYR INJECTION SYRINGE

☒ 00002484153	FULPHILA (0.6 ML SYRINGE)	BGP	$	1424.6300
☒ 00002474565	LAPELGA (0.6 ML SYRINGE)	APX	$	1424.6300
☒ 00002497395	ZIEXTENZO (0.6 ML SYRINGE)	SDZ	$	1424.6300
☒ 00002249790	NEULASTA (0.6 ML SYRINGE)	AMG	$	2555.0600

PIOGLITAZONE HCL

The drug product(s) listed below are eligible for coverage via the step therapy/special authorization process.

FIRST-LINE DRUG PRODUCT(S): METFORMIN

"For the treatment of Type 2 diabetes in patients who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of metformin or who are intolerant to metformin (e.g. dermatologic reactions) or for whom the product is contraindicated."

Special authorization may be granted for 24 months.

Note: If a claim for the Step therapy drug product is rejected, pharmacists can use their professional judgment to determine the appropriateness of using the intervention code(s) noted below to re-submit a claim. The pharmacist is responsible to document on the patient's record the rationale for using the second-line therapy drug.

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated

15 MG (BASE) ORAL TABLET

00002391600	**ACH-PIOGLITAZONE**	**AHI**	$	**0.6225**
00002302861	**ACT PIOGLITAZONE**	**TEV**	$	**0.6225**
00002302942	**APO-PIOGLITAZONE**	**APX**	$	**0.6225**
00002397307	**JAMP-PIOGLITAZONE**	**JPC**	$	**0.6225**

30 MG (BASE) ORAL TABLET

00002339587	**ACH-PIOGLITAZONE**	**AHI**	$	**0.8721**
00002302888	**ACT PIOGLITAZONE**	**TEV**	$	**0.8721**
00002302950	**APO-PIOGLITAZONE**	**APX**	$	**0.8721**
00002365529	**JAMP-PIOGLITAZONE**	**JPC**	$	**0.8721**

45 MG (BASE) ORAL TABLET

00002339595	**ACH-PIOGLITAZONE**	**AHI**	$	**1.3113**
00002302977	**APO-PIOGLITAZONE**	**APX**	$	**1.3113**
00002365537	**JAMP-PIOGLITAZONE**	**JPC**	$	**1.3113**

RITUXIMAB

10 MG / ML INJECTION

☒ 00002495724 RUXIENCE PFI $ 29.7000

Rheumatoid Arthritis

Effective June 1, 2020, all new Special Authorization requests for the treatment of Rheumatoid Arthritis for rituximab naive patients will be assessed for coverage with Riximyo, Ruxience or Truxima. Rituxan will not be approved for new rituximab starts for patients with Rheumatoid Arthritis; however, coverage for Rituxan will continue for patients who completed a previous two-dose course of therapy with Rituxan and are considered a 'responder' as defined in criteria.

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:

- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily); AND
- One anti-tumor necrosis factor (anti-TNF) therapy (minimum 12 week trial).

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

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

- Initial coverage may be approved for a dose of 1000 mg of rituximab administered at 0 and 2 weeks (total of 2 - 1000 mg doses).
- Patients will be limited to receiving one dose of rituximab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For coverage for an additional two-dose course of therapy, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after each course of therapy, between 16 and 24 weeks after receiving the initial dose of each course of therapy, to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- An improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place] following the initial course of rituximab; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places] following the initial course of rituximab.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above, AND
3) The patient must have residual disease or disease activity returning to a level above a DAS28 score of 2.6.

Subsequent courses of therapy cannot be considered prior to 24 weeks elapsing from the initial dose of the previous course of therapy."

All requests (including renewal requests) for rituximab for Rheumatoid Arthritis must be completed using the Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60046).

Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA)

RITUXIMAB

***Effective September 1, 2020, all new Special Authorization requests for the treatment of Granulomatosis with Polyangiitis or Microscopic Polyangiitis for rituximab naive patients will be assessed for coverage with Ruxience. Rituxan will not be approved for new rituximab starts for patients with Granulomatosis with Polyangiitis or Microscopic Polyangiitis; however, coverage for Rituxan will continue for patients who completed a previous 4 week course of therapy with Rituxan and achieved remission but subsequently relapsed.

Additionally, patients will not be permitted to switch between rituximab products, if the patient has been previously trialed on any rituximab product and deemed unresponsive to therapy.***

"For use in combination with glucocorticoids for the induction of remission of severely active granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis) or microscopic polyangiitis (MPA) in adult patients who have:
- Severe active disease that is life- or organ-threatening. The organ(s) and how the organ(s) is (are) threatened must be specified;
AND
- A positive serum assay for either proteinase 3-ANCA (anti-neutrophil cytoplasmic antibody) or myeloperoxidase-ANCA. A copy of the lab report must be provided; AND
- Cyclophosphamide cannot be used for ONE of the following reasons:
a) The patient has failed a minimum of six intravenous pulses of cyclophosphamide; OR
b) The patient has failed three months of oral cyclophosphamide therapy; OR
c) The patient has a severe intolerance or an allergy to cyclophosphamide; OR
d) Cyclophosphamide is contraindicated; OR
e) The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide.

- Coverage may be approved for a maximum of 375 mg per square metre of body surface area weekly for 4 weeks.
- Patients will be limited to receiving two doses of rituximab per prescription at their pharmacy.
- For relapse following a remission, coverage may be provided for patients who experience a flare of severe active disease that is life- or organ-threatening; or, who experience worsening symptoms in 2 or more organs even if not life-threatening. Note: For relapse following a rituximab-induced remission, additional coverage may be approved no sooner than 6 months after previous rituximab treatment."

All requests (including renewal requests) for rituximab for Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA) must be completed using the Rituximab for Granulomatosis with Polyangiitis/Microscopic Polyangiitis Special Authorization Request Form (ABC 60018).

USTEKINUMAB

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 to or intolerant to:

at least THREE of the following:
- Cosentyx (secukinumab)
- Erelzi (etanercept)
- Humira (adalimumab)
- Inflectra (infliximab)
- Renflexis (infliximab)
- Skyrizi (risankizumab)
- Taltz (ixekizumab)

AND

- 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 three doses of 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose per prescription at their pharmacy.
- 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, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 weeks of therapy 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.

USTEKINUMAB

Following this assessment, continued coverage may be considered for 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks 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.

All requests (including renewal requests) for ustekinumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Risankizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

45 MG INJECTION VIAL OR SYRINGE				
00002320673	STELARA (0.5 ML VIAL OR SYRINGE)	JAI	$	4465.5800
For this product - pricing has been established on a per vial or syringe basis.				
90 MG / SYR INJECTION SYRINGE				
00002320681	STELARA (1.0 ML SYRINGE)	JAI	$	4465.5800

PART 3A

Optional Special Authorization

Criteria For Optional Special Authorization Of Select Drug Products

Patient claims for select quinolone prescriptions written by a non-designated prescriber will be subject to a first forgiveness rule, meaning the first claim will be paid. Subsequent claims for the same product (irrespective of strength, route and form) within a 90-day period would require the prescriber to apply for special authorization for coverage on the patient' s behalf.

MOXIFLOXACIN HCL

"To be prescribed according to ONE of the following criteria:

For the treatment of

1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

2) Community acquired pneumonia in patients with co-morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking); or

3) Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

4) Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with beta-lactam (penicillin and cephalosporin) allergy; or

5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for Moxifloxacin HCl must be completed using the Select Quinolones Special Authorization Request Form (ABC 60042).

400 MG (BASE) ORAL TABLET

00002478137	**AG-MOXIFLOXACIN**	**AGP**	$	**1.5230**
00002404923	**APO-MOXIFLOXACIN**	**APX**	$	**1.5230**
00002432242	**AURO-MOXIFLOXACIN**	**AUR**	$	**1.5230**
00002443929	**JAMP-MOXIFLOXACIN**	**JPC**	$	**1.5230**
00002447061	**JAMP-MOXIFLOXACIN**	**JPC**	$	**1.5230**
00002447053	**MAR-MOXIFLOXACIN**	**MAR**	$	**1.5230**
00002457814	**MED-MOXIFLOXACIN**	**GMP**	$	**1.5230**
00002383381	**SANDOZ MOXIFLOXACIN**	**SDZ**	$	**1.5230**
00002375702	**TEVA-MOXIFLOXACIN**	**TEV**	$	**1.5230**