Alberta
Drug Benefit List

Effective April 1, 2019

Alberta
Government

Inquiries should be directed to:

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Alberta Blue Cross
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Edmonton AB T5J 3C5

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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.

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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PART 1

SECTION 1

Policies and Guidelines

INTRODUCTION

Acknowledgments

Alberta Health acknowledges the important role Alberta Blue Cross continues to play in the production of the List and in the development of an overall strategy and initiatives to better manage Alberta Health sponsored drug programs.

Eligibility

The Alberta Drug Benefit List *(*the *"*List*"* or *"*ADBL*")* defines the drugs and Drug Products that are covered by Alberta government-sponsored drug programs. These programs are for Albertans and their dependents who are covered by:

1. the Alberta Blue Cross *Non-Group Coverage (Group 1)* offered by the Alberta Health Care Insurance Plan, or
2. the Alberta Blue Cross *Coverage for Seniors (Group 66)* provided to all Alberta senior citizens, or
3. the drug coverage provided to individuals approved by Alberta Health for *Palliative Coverage.* (For these individuals the *Palliative Coverage Drug Benefit Supplement* must also be considered), or
4. the drug coverage provided to Alberta Human Services clients. (For these clients the *Alberta Human Services Drug Benefit Supplement* must also be considered.)

Additional Notes Regarding Application of the List

1. The List is not intended to be used as a scientific reference or prescribing guide.
2. Formularies used by hospitals and continuing care facilities are developed independently of the List*.*
3. Drugs are classified according to the Pharmacologic–Therapeutic Classification (PTC) developed by the American Society of Health-System Pharmacists for the purpose of the American Hospital Formulary Service.

   Permission to use this system has been granted by the American Society of Health-System Pharmacists. The Society is not responsible for the accuracy of transpositions or excerpts from the original content.

   Where necessary, additional PTCs may have been assigned by Alberta Health to facilitate product location in the List.
4. Where appropriate, the *Compendium of Pharmaceuticals and Specialties*, published by the Canadian Pharmacist's Association, was used as a reference source for the trade name, generic name, Manufacturer, strength and dosage form.

The Canadian Pharmacist's Association is not responsible for the accuracy of transpositions or excerpts from the original content.

5. Other reference sources used for the trade name, generic name, manufacturer, strength and dosage form are:
   - Completed Drug Notification Form (DNF)
   - Notice of Compliance (NOC)
   - Product Monograph

The DBL is not a prescribing or a diagnostic tool. Prescribers should refer to drug monographs and utilize professional judgment.

6. Drug Identification Numbers (DINs) listed reflect current Manufacturer information available as the date this was published.
7. Alberta Health reserves the right to make changes, without notice, to the List through the on-line Interactive List, and any such changes to the on-line Interactive List are effective on the date of the change (unless otherwise stated) and regardless of the date of publication of the pdf version or updates.

Legend

1. Pharmacologic–Therapeutic Classification.
2. Pharmacologic–Therapeutic sub-classification.
3. Nonproprietary or generic ingredient name of the drug.
4. Drug strength and dosage form.
5. The Drug Identification Number (DIN), assigned by the Therapeutic Products Directorate (TPD), Health Protection Branch, Health Canada.
6. A box containing an X ☒ to the left of the DIN indicates that the product is not interchangeable with other products or interchangeability has not been assessed within the category.
7. All active ingredients of combination products are listed.
8. Strengths of active ingredients are listed in the same order as the ingredients. This example indicates that the topical cream contains 0.5 mg/g hydrocortisone acetate and 30 mg/g salicylic acid.
9. Brand name of the drug.
10. Three letter identification code assigned to each manufacturer. The codes are listed in Appendix 2 at the end of the List.
11. For products which are marked as non-interchangeable, the price is indicated in regular type (not bold type). These prices are supplied by the manufacturer and are expressed in decimal dollars.
12. For those products which are single source, the price is indicated in regular type (not bold type). These prices are supplied by the manufacturer and are expressed in decimal dollars.
13. Interchangeable grouping where the Least Cost Alternative (LCA) Price Policy has not been applied. This example indicates these two products are deemed interchangeable. These prices are supplied by the manufacturer and are expressed in decimal dollars.
14. The LCA Price for the selected interchangeable category appears in bold type. The LCA price is the maximum price which will be paid. The prices listed are expressed as decimal dollars. An authorized health care provider may request special authorization if a particular brand is essential in the care of a patient where the LCA Price would otherwise apply. For further information refer to the Special Authorization Guidelines section of the ADBL or List.
15. Products or devices designated as restricted benefits and limited restricted benefits are identified by a comment after the generic name. The comment indicates “RESTRICTED BENEFIT” or “LIMITED RESTRICTED BENEFIT” along with an explanation of the limits and/or restrictions. In this example, coverage of Emend is restricted to the drug being prescribed by the Directors of Alberta Health Services – Cancer Care “Cancer Centres” (or their designates). For more information about products or devices designated as restricted benefits, refer to the restricted benefits section of the List.
16. A MAC Grouping means a grouping of Drug Products that have been listed on the ADBL or the List as being subject to a MAC Price; a MAC Grouping may include a grouping of IC Drugs, in which case the grouping shall be treated as an Established IC Grouping. Groupings subject to MAC Price will have the maximum amount established by the Minister which will be paid by the Government of Alberta.

Example of Drug Product Listings

08:00 ANTI-INFECTIVE AGENTS
08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM
250 MG (BASE) * 125 MG (BASE) ORAL TABLET

00002243350	APO-AMOXI CLAV	APX	$	0.9375	

28:00 CENTRAL NERVOUS SYSTEM AGENTS
28:08:08 ANALGESICS AND ANTIPYRETICS
(OPIATE AGONISTS)

OXYCODONE HCL
10 MG ORAL TABLET

00002319985	**PMS-OXYCODONE**	**PMS**	**$**	**0.2283**	
00000443948	**SUPEUDOL**	**SDZ**	**$**	**0.2283**	
00002240131	OXY-IR	PUR	$	0.4110	

28:00 CENTRAL NERVOUS SYSTEM AGENTS
28:08:04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM
100 MG ORAL SUSTAINED-RELEASE TABLET

00002091194	APO-DICLO SR	APX	***$***	***0.3124***	$	0.4048
00002231505	PMS-DICLOFENAC-SR	PMS	***$***	***0.3124***	$	0.4048
00002261944	SANDOZ DICLOFENAC SR	SDZ	***$***	***0.3124***	$	0.4048
00000590827	VOLTAREN SR	NOV	***$***	***0.3124***	$	1.7729

MAC pricing has been applied based on the LCA price for 4 x 25 mg oral enteric-coated tablets.

08:00 ANTI-INFECTIVE AGENTS
08:12.28.20 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(LINCOMYCINS)

CLINDAMYCIN PHOSPHATE
150 MG / ML (BASE) INJECTION

00002230535	CLINDAMYCIN (60 & 120 ML)	SDZ	$	3.6550
00002230540	CLINDAMYCIN	SDZ	$	3.6550
00000260436	DALACIN C PHOSPHATE	PFI	$	4.4469

84:00 SKIN AND MUCOUS MEMBRANE AGENTS
84:06 ANTI-INFLAMMATORY AGENTS

BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID
0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT

00000578436	DIPROSALIC	MFC	$	0.9084

FLUOCINONIDE
0.05 % TOPICAL EMOLLIENT CREAM

☒ 00000598933	TIAMOL	VCL	$	0.2079
☒ 00002163152	LIDEMOL	TPT	$	0.2122

48:00 RESPIRATORY TRACT AGENTS
48:10.24 ANTI-INFLAMMATORY AGENTS
(LEUKOTRIENE MODIFIERS)

APREPITANT
RESTRICTED BENEFIT - This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates).
80 MG ORAL CAPSULE

00002298791	EMEND 80 MG	MFC	$	33.0788

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DRUG REVIEWS

The Minister of Health makes the final decisions on changes to the ADBL (List) after considering the recommendations of the Expert Committee on Drug Evaluation and Therapeutics (Expert Committee), and/or the Canadian Drug Expert Committee (CDEC), and/or Alberta Health.

Drug Product Manufacturers wishing to have their Drug Product(s) listed on the List are required to make submissions in accordance with the procedures and criteria published in the List.

Common Drug Review

Alberta is a participant in the national Common Drug Review Procedure (CDR Procedure) and considers recommendations from CDEC. Alberta Health and Alberta Blue Cross are not involved in the administration process for CDR submissions and so any questions regarding CDR submissions should be directed to the CDR. Submissions relating to New Drugs, Drugs with a New Indication(s), New Combination Products, or Subsequent Entry Biologics that have received a Health Canada Notice of Compliance (NOC) or conditional NOC (NOC/c), or have a pending NOC or NOC/c for the indication(s) to be reviewed should be directed to the CDR for consideration. Submissions to the CDR must comply with the CDR Procedure and Submission Guideline requirements available on the CDR website at https://www.cadth.ca/about-cadth/what-we-do/products-services/cdr

Expert Committee on Drug Evaluation and Therapeutics Drug Reviews

The Minister of Health has established an Expert Committee on Drug Evaluation and Therapeutics to refine and maintain the List on an ongoing basis. All Drug Products not eligible for review under the CDR Procedure or the Interchangeable Expedited Review Procedure must be reviewed by the Expert Committee prior to their determination as benefits on the List.

The Expert Committee considers the scientific, therapeutic, clinical and socio-economic merits of Drug Products. The Committee receives advice and assistance from external consultants and agencies when needed. The Expert Committee makes recommendations on the List to Alberta Health through the Executive Director, Pharmaceuticals & Supplementary Health Benefits.

Interchangeable Reviews

Drug Products may be considered for listing in interchangeable groupings through Expedited Review or Full Review. Expedited Review Drug Products are not required to undergo a Full Review by the Expert Committee. Interchangeable Drug Product submissions will be screened by Alberta Blue Cross to determine eligibility for an Expedited Review and the results provided to Alberta Health. Interchangeable drug submissions requiring a Full Review will be reviewed by the Expert Committee under its usual Drug Product review procedure.

Referrals

Alberta Health at all times and in all circumstances reserves the right to refer any submission to the CDR Procedure and/or the Expert Committee for further advice or for a Full Review.

Deferrals

The Expert Committee and/or Alberta Health reserve the right to defer any submission it deems appropriate in order to ensure that it may complete a review in a manner that protects patient safety and maintains the integrity of the ADBL and the government-sponsored drug programs. Examples of reasons for deferrals include, but are not limited to:

1. To request additional information in order to conduct a review and prepare recommendations;
2. Where additional time, research and/or consultation is required before a review can be completed or a recommendation can be made;
3. Where new or novel issues are raised;
4. Where issues, questions or concerns relating to any of the listing criteria or factors arise, including but not limited to:
   (a) interchangeable safety issues,
   (b) whether the criteria requires expansion or clarification,
   (c) the Drug Product,
   (d) the listing,
   (e) the price,
   (f) any other relevant criteria or factor.

Alberta Health
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SUBMISSIONS FOR DRUG REVIEWS

Only submissions satisfying all of the submission requirements of the applicable category of Drug Product that are deemed complete by the applicable submission deadline date will be put forward for review.

1) In addition to the submission requirements, the Expert Committee and/or Alberta Health, at their sole discretion, reserve the right to request the Drug Product file from Health Canada's Therapeutic Products Directorate (TPD), or any additional information from the Manufacturer, CDEC, or any other entity that the Expert Committee and/or Alberta Health considers necessary, which may result in a delay in the listing recommendation for the Drug Product.
2) There is no obligation or guarantee that every completed submission will be reviewed, and/or a recommendation made, by a specific date or at the next scheduled meeting of the Expert Committee.
3) Pre-NOC submissions may be made; however, the submission will only be reviewed once it is complete.
4) Any request by a Manufacturer to hold a submission will result in a submission being deemed incomplete as of the date of the request. A submission on hold will only be considered complete once correspondence is received from a Manufacturer to proceed with the submission.
5) Only one (1) copy of a submission for a Drug Product is required. A determination by Alberta Blue Cross that a submission is complete is preliminary and made only for the purposes of forwarding the submission for review.
6) Manufacturers are permitted to provide other information they feel may be important to the review of a submission (e.g., selected references or additional studies completed after a Drug Product had been submitted to the TPD, Health Canada). Comparative studies with other listed Drug Products are most relevant.
7) Drug Products that have been previously listed on the List and have had a lapse in coverage for two (2) years or more will require a new submission under the appropriate submission category.
8) Drug Products that have been previously listed on the List and have had a price policy submission denied over a period of two (2) years or more will require a new submission under the appropriate submission category.
9) Drug Product submissions that remain incomplete or that have an incomplete price policy submission for twelve (12) months from the date of the original submission will be returned to the Manufacturer.
10) Information on submission deadlines are posted on the ADBL website which can be accessed at https://www.ab.bluecross.ca/dbl/manufacturers.html.

Notice of Significant Changes - By making a submission (i.e., if a Drug Product is either under review or listed on the List), Manufacturers acknowledge and agree that they are required to notify the Manager, Scientific and Research Services of any significant change to the Drug Product. Significant changes are considered to be changes in NOC, DIN, Drug Product name, Manufacturer or distributor, indication, product monograph, packaging, formulation, manufacturing specifications, issuance of safety advisories or warnings, business/marketing or cross-licensing agreements and any change that could potentially affect the bioavailability or bioequivalence of a Drug Product. Please note: Changes to product monographs must be itemized in covering or separate correspondence with the Date of Revision of the product monograph clearly stated.

Correspondence and Receipt of Submissions

Manufacturers may provide submissions for consideration for potential addition to the ADBL via email to the following address: submissions@ab.bluecross.ca

Submissions sent to other email addresses will not be considered for potential addition to the ADBL. It is recommended that manufacturers place the drug name(s) and strength(s) of the submitted product(s) in the subject header in order to ensure that multiple emails can be easily associated with one another.

Manufacturers are reminded that hard copies of submissions must follow by mail and should be sent to the attention of:

Manager
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

A copy of covering correspondence and summary documents **only** should be forwarded to:

Executive Director
Pharmaceuticals & Supplementary Health Benefits
Alberta Health
11th floor, 10025 Jasper Avenue
Edmonton, Alberta T5J 1S6

Questions or comments regarding submissions can be addressed to:

Coordinator
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5
Phone: (780) 498-8098
Fax: (780) 498-3534
Email: submissions@ab.bluecross.ca

Manufacturers should note that only **complete submissions, satisfying all the submission requirements of the applicable category of Drug Product received by 4:30 p.m. Mountain Standard / Daylight Savings Time (as applicable) on the deadline**, will be put forward for consideration by the Expert Committee on Drug Evaluation and Therapeutics or Expedited Review, as applicable. There is no guarantee that every completed submission will be reviewed and/or a recommendation made at the next scheduled meeting of the Expert Committee.

Criteria for Listing Drug Products

- **The *Criteria for Listing Drug Products*, as adjudicated by the Expert Committee on Drug Evaluation and Therapeutics (Expert Committee), apply to all Drug Product submissions.**
- **If more than one criterion apply, at the sole discretion of the Expert Committee, Alberta Health or the Minister, the most stringent and/or appropriate combination of criteria will apply.**
- **For Multisource Drug Products seeking a designation of interchangeability, the Drug Product must also meet the additional criteria outlined under "*Interchangeable Drug Products - Additional Criteria*".**

1. Clinical studies must have demonstrated the safety and efficacy of the product in appropriate populations.

2. The product must:

   a. possess therapeutic advantage (as defined in No. 3) for the disease entity for which the product is indicated, or
   b. be more cost-effective than presently accepted therapy.

3. Assessment of therapeutic advantage may include consideration of:

   i. clinical efficacy;
   ii. risk/benefit ratio;
   iii. toxicity;
   iv. compliance;
   v. clinical outcomes;
   vi. Health Canada or any other International Regulatory Agency issued warnings and advisories;
   vii. population health issues; or
   viii. any other factor which affects the therapeutic value of the product.

4. The Expert Committee, Alberta Health and/or the Minister may, in addition to all of the factors listed above, also consider any factors that they consider appropriate, including but not limited to any or all of the following:

   i. the recommendations from the CDR review,
   ii. failure by a manufacturer to supply a sufficient quantity of Drug Product to meet the demand in Alberta (as determined by Alberta Health at its sole discretion, and based on any information it deems appropriate),
   iii. failure by a manufacturer to provide
      (A) a Price Confirmation, or
      (B) a Price Confirmation or Confirmed Price in accordance with the Price Policy and/or the Alberta Price Confirmation (APC) Terms and Conditions;

iv. failure by a manufacturer to comply with any APC Terms and Conditions;
v. type of drug, Drug Product, class or category and indications for use,
vi. other available alternative products, treatments or therapies,
vii. whether the product is interchangeable,
viii. cost of the product and/or potential cost savings or impact on drug expenditures under the List,
ix. volume of use and amounts paid out for similar products, classes or categories,
x. utilization patterns
xi. expenditure management and resources,
xii. patent issues,
xiii. coverage provided by other programs,
xiv. for interchangeable products, concerns that are related to or affect the interchangeability of the Drug Product,
xv. issues, concerns, objectives, goals and/or mandates related to any government policies, plans or programs, and
xvi. patient care concerns related to factors external to the Drug Product.

5. Products not eligible for review under the CDR Procedure may, at the sole discretion of Alberta Health and/or the Minister, be considered for priority review and possible addition to the List if the product submission is otherwise complete, and the product has been granted “Priority Review” status by the TPD, Health Canada. A copy of documentation from the TPD granting ‘Priority Review’ status is required.

6. The onus is on the Manufacturer to formally request, in writing, consideration on a priority review basis if, in the opinion of the manufacturer, the product meets any of the above priority review criteria. Request for priority review does not automatically mean that the submission will be considered on that basis. The decision whether to conduct a priority review will be made by Alberta Health and/or the Minister at their sole option and discretion.

Interchangeable Drug Products - Additional Criteria

Principle:

Decisions respecting interchangeability and drug lists remain in the domain of the institution responsible for the costs of the product which includes hospitals, provincial governments and other third party payers (*6/9/95 Canada Gazette Part ll, Vol. 129, No. 18)*

Preface:

The Alberta Drug Benefit List *(*ADBL) contains designations of interchangeability for approved Multisource Drug Products. The Expert Committee on Drug Evaluation and Therapeutics makes recommendations on interchangeability to Alberta Health through the Executive Director, Pharmaceuticals & Supplementary Health Benefits. The Minister of Health makes the final decisions on interchangeability after reviewing the recommendations of the Expert Committee and/or Alberta Health.

Definitions:

(Note: additional definitions in the applicable Appendices may apply)

Canadian Innovator Reference Product (CIRP): A CIRP is a Drug Product that is marketed in Canada by the innovator manufacturer of the Drug Product and for which safety and efficacy have been demonstrated clinically.

Canadian Non-Innovator Reference Product (CNIRP): A CNIRP is a subsequent-entry generic Drug Product that is used as a Reference Product in a comparative study (e.g., bioequivalence, pharmacodynamic, therapeutic equivalence, or physical-chemical comparison) when the CIRP or a suitable Non-Canadian Innovator Reference Product (NCIRP) is no longer available on the market. *See also 4 d) of the Additional Criteria.*

Cross Licensed Product: A cross licensed or pseudo-generic Drug Product is a Drug Product that is manufactured according to the identical master formula and manufacturing and quality control specifications as a) the innovator brand of the drug; or b) any Drug Product that is currently listed on the ADBL within the submission product's interchangeable grouping.

Interchangeable Drug Product: An Interchangeable Drug Product is a Drug Product that has been designated as interchangeable by the Minister of Health after reviewing the recommendations of the Expert Committee or Alberta Health. Recommendations regarding interchangeability are made taking into consideration the scientific, therapeutic, clinical and socio-economic merits of Drug Products in accordance with the published criteria. Drug Products designated as interchangeable are expected to be safe when interchanged with other Drug Products in the interchangeable grouping, and to have the same therapeutic effectiveness when administered to patients under the conditions specified in the labeling. The designation of interchangeability is made only for the purpose of funding of drug benefits covered under the Alberta government-sponsored drug benefit programs and is not to be used as a scientific reference or prescribing guide.

Multisource Drug Product: Drug Products are considered to be Multisource Drug Products when they are manufactured and/or distributed by more than one manufacturer.

Non-Canadian Innovator Reference Product (NCIRP): A NCIRP is a Drug Product that is marketed elsewhere in the world by the same innovator, corporate entity, or through a licensing arrangement with the innovator or corporate entity, that currently markets or historically marketed, the same drug in the same dosage form in Canada.

Pharmaceutical Alternative: Drug Products may be considered to be pharmaceutical alternatives if they use the same route of administration and contain the same active therapeutic ingredient(s) but are different salts, esters or complexes of that moiety, or are different dosage forms or strengths.

Pharmaceutical Equivalent: Drug Products are considered to be pharmaceutical equivalents if they contain the same active therapeutic ingredient(s), are of comparable dosage form(s), route of administration, and are identical in strength or concentration.

TPD Reports - refers collectively to the following TPD, Health Canada guidance publications as of April 1, 2015:

- *Guidance Document: Conduct and Analysis of Comparative Bioavailability Studies (2012)*; (which may be referred to in the List as "**TPD Report No.1**"); and
- *Guidance Document*: *Comparative Bioavailability Standards: Formulations Used for Systemic Effects (2012);* (which may be referred to in the List as "**TPD Report No.2**")

Review of Interchangeable Drug Product Submissions:

A. The Expert Committee and/or Alberta Health and/or the Minister may, in addition to considering the *Interchangeable Drug Products - Additional Criteria*, also consider any other criteria in the ADBL, including but not limited to the *Criteria for Listing Drug Products*.

B. Recommendations regarding interchangeability are made taking into consideration the scientific, therapeutic, clinical and socio-economic merits of Drug Products in accordance with the published criteria. Drug Products designated as interchangeable are expected to be safe when interchanged with other Drug Products in the interchangeable grouping, and to have the same therapeutic effect when administered to patients under the conditions specified in the labeling.

C. Issuance of a Notice of Compliance by the TPD which includes a Declaration of Equivalence does <u>not</u> mean the Drug Product will automatically be designated as interchangeable.

<u>Expedited Reviews</u>

Alberta Health and/or the Minister reserves the right to refer any Drug Product Submission that would otherwise meet the Expedited Review requirements for Full Review by the Expert Committee.

1. Multisource Drug Products seeking a listing designation as interchangeable may be eligible for an Expedited Review if:

a. The Drug Product submission complies with the submission requirements.

b. The Drug Product does **NOT** fall into any of the categories of Drug Products that require a Full Review (below).

c. The Drug Product is a cross licensed Drug Product with the innovator brand of the drug or any Drug Product that is currently listed on the ADBL within the submission product's interchangeable grouping.

d. The Drug Product is **NOT** a subsequent entry biologic (subsequent entry biologics are not eligible for review as interchangeable products).

e. The Drug Product has been granted a Notice of Compliance (NOC) by Health Canada that includes a declaration of equivalence with a CIRP that is listed (or at the sole discretion of Alberta Health and/or the Minister, has been previously listed) on the Alberta Drug Benefit List.

f. The Drug Product must be a pharmaceutical equivalent to the CIRP.

g. The proposed price in Alberta provided in the manufacturer's submission complies with the Price Policy.

h. Even if the drug submission review is expedited, the Minister may decide not to list a Drug Product, or the listing of the Drug Product may be delayed, if the manufacturer has failed
(A) to provide a Price Confirmation,
(B) to provide a Price Confirmation or Confirmed Price in accordance with the Price Policy and/or the applicable APC Terms and Conditions; or
(C) to comply with the terms and conditions of an applicable APC.

Full Reviews

Multisource Drug Products seeking a listing designation as interchangeable that fall within the categories listed below are required to undergo a Full Review by the Expert Committee. The following additional interchangeability criteria will apply to Full Reviews:

1. The Drug Product must be a
   a. pharmaceutical equivalent; or
   b. pharmaceutical alternative,
   as determined at the sole discretion of the Expert Committee.

2. The Drug Product is not a subsequent entry biologic (subsequent entry biologics are not eligible for review as interchangeable products).

3. The proposed price in Alberta contained in the manufacturer's submission complies with the Price Policy.

4. The Drug Product has been demonstrated to be bioequivalent, or has provided evidence of comparative therapeutic efficacy, with the reference Drug Product as outlined below:

   a. For Drug Products in the following categories, for which comparative bioequivalence studies CAN be conducted:

i. For Critical Dose Drug Products, the Drug Product must meet the criteria in the *Critical Dose Drug Product Appendix*.

ii. For Drug Products for which Bioequivalence is Supported by Metabolite Data, the Drug Product must meet the criteria in the *Drug Products with Metabolite Data Appendix.*

iii. For Drug Products for which Bioequivalence is Supported by Measurement of the Drug in a Matrix other than Plasma or Serum (e.g., whole blood, urine, tissue), the Drug Product must meet the criteria in the *Drug Product with Alternate Matrix Measurement Appendix*.

iv. For Old Drug Products, the product must meet the criteria in the *Old Drug Product Appendix*.

v. For Drug Products which possess complex delivery systems, the product must meet the criteria in the *Complex Delivery System Drug Product Appendix*.

b. For Drug Products in the above categories for which comparative bioequivalence studies CANNOT be conducted:

i) Evidence of comparative therapeutic efficacy of the submitted product with the reference product via:

(A) a therapeutic equivalence study; or

(B) Studies that meet the requirements and standards for pharmacodynamic studies outlined in TPD Report No.2; or

(C) surrogate comparisons using *in vivo* or *in vitro* test methods;

and

ii) Sufficient rationale for why a comparative bioequivalence study cannot be conducted and an explanation of why the method submitted is a valid surrogate for bioequivalence assessment**.**

c. For Drug Product submissions using a Canadian Non-Innovator Reference Product (CNIRP) the following criteria apply:

i) The CIRP or a suitable NCIRP for the active therapeutic ingredient(s) contained in a CNIRP is no longer available on the market.

ii) The CNIRP must be currently listed on the ADBL at the time the Drug Product submission is under review.

iii) There must be evidence from historical product reviews for the ADBL that the CNIRP was directly compared with the CIRP in a suitable study/studies and shown to be bioequivalent.

iv) If a subsequent-entry generic drug product was approved on the basis of a comparison with a NCIRP, then the Drug Product is not eligible for consideration as a CNIRP.

v) Once a CNIRP for an interchangeable grouping has been established for the ADBL, the specific CNIRP must be used consistently thereafter in comparative studies for submitted drug products to be considered for a potential interchangeability designation. This is true as long as the established CNIRP is listed on the ADBL.

In situations where a manufacturer wishes to use a CNIRP in a comparative study to support an interchangeability designation on the ADBL, the manufacturer is advised to contact the Scientific and Research Services Department of Alberta Blue Cross to confirm the identity of the CNIRP for the interchangeable grouping in the ADBL, if one has been established.

5. The Drug Product must meet all other criteria outlined in the applicable Appendix.

6. In addition, the Expert Committee may also consider any other factor that may affect the interchangeability of a Drug Product, including but not limited to:

- characteristics of the Drug Product (e.g. shape, scoring, configuration, packaging, labelling);
- excipients and non-medicinal ingredient(s) (e.g. sugar, sodium);
- expiration times;
- storage conditions.

Interchangeable Drug Products - Additional Criteria
APPENDICES

Critical Dose Drug Product Appendix

Critical Dose Drug: Is a drug where comparatively small differences in dose or concentration lead to dose- and concentration-dependent, serious therapeutic failures and/or serious adverse drug reactions which may be persistent, irreversible, slowly reversible or life threatening, which could result in inpatient hospitalization or prolongation of existing hospitalization, persistent disability or incapacity, or death.

Critical dose drugs include:

a) Any drug listed in TPD Report No. 2; and
b) Any other drug that the Expert Committee determines meets the above definition, which determination may include consideration of any other matter that may affect the interchangeability of a product containing a critical dose drug.

Criteria: Comparative bioequivalence studies must meet the requirements and standards in the TPD Reports, with the exception that the following standards will be used:

1. The 90% confidence interval of the relative mean AUC of the test to reference formulation should be within 90.0 to 112.0% inclusive; the relevant AUC or AUCs as described in TPD Report No. 2 are to be determined.
2. The 90% confidence interval of the relative mean Cmax of the test to reference formulation should be between 80.0 and 125.0%.
3. These requirements are to be met in both the fasted and fed states.
4. These standards should be met on log transformed parameters calculated from the measured data.
5. If a steady-state study is required, the 90% confidence interval of the relative mean measured Cmin of the test to reference formulation should also be between 80.0 and 125.0%.

Drug Product with Metabolite Data Appendix

For Drug Product submissions for which evidence of bioequivalence is supported by metabolite, rather than the parent drug, data:

Criteria:

1. Comparative bioequivalence studies must meet the requirements and standards in the TPD Reports.

2. If the parent drug is not detectable due to rapid biotransformation or limitations in available assay methodology, the use of metabolite data may be acceptable.

3. The measured metabolite must be a primary (first step) measureable by a validated assay, and there must be sufficient scientific justification for a waiver of the measurement of the parent drug and the use of metabolite data.

4. The choice of using the metabolite instead of the parent drug is to be clearly stated, *a priori*, in the objective of the study in the study protocol.

5. The use of metabolite concentrations in urine is not acceptable.

Drug Product with Alternate Matrix Measurement Appendix

For Drug Product submissions for which bioequivalence data is supported by measurement of the drug in a matrix other than plasma or serum (e.g., whole blood, urine, extravascular tissue).

Criteria:

1. Comparative bioequivalence studies must meet the requirements and standards in the TPD *Reports.*
2. The assay used for measurement of the drug must be validated for the alternate matrix of measurement.
3. The use of metabolite concentrations in an alternate matrix is not acceptable.
4. Sufficient rationale for why the use of an alternate matrix measurement study is appropriate.

Old Drug Product Appendix

Old Drugs: Are Drug Products where the active moiety or moieties is/are designated as an "old drug" by Health Canada and the Drug Product is approved on the basis of a DIN application (i.e. an NOC is not issued by Health Canada).

Criteria:

1. Comparative bioequivalence studies must meet the requirements and standards in the TPD *Reports.*
2. For old Drug Products for which comparative bioequivalence studies CANNOT be conducted, the submission must include:

    i) Evidence of comparative therapeutic efficacy of the submitted product with the reference product via:

        a) a therapeutic equivalence study; or

        b) studies that meet the requirements and standards for pharmacodynamic studies outlined in TPD Report No. 2; or

        c) surrogate comparisons using *in vivo* or *in vitro* test methods.

        and

    ii) Sufficient rationale for why a comparative bioequivalence study cannot be conducted**.**

Complex Delivery System Drug Product Appendix

Complex Delivery System Drugs: Are Drug Products that possess complex drug release characteristics in the pharmaceutical dosage form that are intended to:

1. deliver the drug at a rate that is independent of time and the concentration of the drug (i.e. zero order process), or
2. deliver the drug to a specific physiological site (i.e. site-specific release).

Criteria:

1. Comparative bioequivalence studies must meet the requirements and standards in the TPD *Reports*.
2. A detailed description of the pharmaceutical dosage forms and specific drug release characteristics of the submitted Drug Product and reference Drug Product must be provided to permit evaluation of the similarity of drug release of the respective formulations.

Review of Benefit Status (ROBS) Criteria

The Expert Committee and/or Alberta Health may at any time review the benefit status of a Drug Product, a group of Drug Products, a class or classes of Drug Products, or a category or categories of Drug Products listed or being considered for listing on the ADBL (collectively "Products"). The Expert Committee and/or Alberta Health may, at their sole option and discretion, recommend altering or discontinuing the benefit status for Products if one or more of the following criteria are met. These are general criteria only, which are intended to be applied flexibly, having regard to each individual case. The criteria may be modified or adapted as the situation may require, and not all criteria will apply to each case:

1. There has been a significant change to the Product(s). Significant changes may include changes in NOC, DIN, product name, manufacturer or distributor, indication, product monograph, packaging, formulation, or any change that could potentially affect the bioavailability or bioequivalence of a product.
2. The Product(s), no longer possesses demonstrated therapeutic advantage compared to other presently accepted therapies or treatments of the disease entity for which the Product(s) is/are indicated. Assessment of therapeutic advantage may include consideration of clinical efficacy, risk/benefit ratio, toxicity, compliance, clinical outcomes, Health Canada advisories, population health issues, and any factor which affects the therapeutic value of the product, class or category.
3. The Product(s) is/are no longer cost-effective compared to other presently accepted therapies or treatments of the disease entity for which the Product(s) is/are indicated.
4. To enable broader coverage of higher priority Product(s).
5. When a product has been discontinued by the manufacturer.
6. When Product(s) is/are changed from prescription to non-prescription status, the Expert Committee may recommend continuing, altering or discontinuing benefit status of the Product(s) based upon scientific, therapeutic, clinical and socio-economic merits of the Product(s).
7. For all ROBS reviews, the Expert Committee, Alberta Health and/or the Minister may, in addition to all of the factors listed above, also consider any factors that they consider appropriate, including but not limited to any of the criteria for listing Drug Products and Interchangeable Drug Products.

Unsolicited information from manufacturers relating to ROBS Reviews will not be put before the Expert Committee. However, if the Expert Committee determines that a change in benefit status may be warranted, manufacturers of the affected Product(s) will be notified and provided with an opportunity to make submissions to the Expert Committee prior to the final recommendation being made. Notification will include advice regarding the form of submission that will be accepted, the deadline for filing the submission and any other relevant advice. Any submissions that do not comply with the notification advice will not be put before the Expert Committee.

SUBMISSION REQUIREMENTS

The following Submission Requirements pertain to submissions for Drug Products not eligible for review under the CDR Procedure.

A) New Chemical Entities/Single Source Drug Products

The following submission requirements pertain to New Chemical Entities or New Combination Products where one or more of the active moieties have never been listed on the List, and other single source Drug Products that have never been listed on the List, and are not eligible for review under the CDR Procedure.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. A hard copy and electronic (CD) copy only of the following from the Common Technical Document:
   - Clinical Overview (Module 2.5), and
   - Clinical Summary (modules 2.7.1, 2.7.3, 2.7.4 and 2.7.6).

   Note: If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu.
4. Copy of completed Drug Identification Number (DIN) notification form
5. Copy of Notice of Compliance (NOC)
6. Current Patent Status
   - a signed statement from the Manufacturer stating that the submitted Drug Product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
7. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
8. TPD-approved Product Monograph
   - A hard copy, and
   - an electronic (CD) copy compatible with Microsoft Word

9. Economic Information
   - a comprehensive pharmacoeconomic analysis in accordance with: the "*Guidelines for the economic evaluation of health technologies: Canada* [3rd Edition]". Ottawa: Canadian Agency for Drugs and Technologies in Health; 2006.; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful, and
   - a completed *Budget Impact Assessment for the* Alberta Drug Benefit List form. The form can be obtained at https://www.ab.bluecross.ca/dbl/manufacturers.html or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.
10. If requested, the Manufacturer must provide written confirmation from the CDR that the Drug Product is not eligible for review under the CDR Procedure.

B) Changes to Special Authorization or Restricted Benefit Status of Listed Single Source Drug Products Due to a New Indication

The following submission requirements pertain to single source Drug Products currently listed via special authorization or as restricted benefits on the List that have received a new indication from Health Canada, where the Manufacturer wishes to request expansion of the coverage criteria or change in benefit status due to the new indication and where the Drug Products are not eligible for review under the CDR Procedure.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Justification for the Expanded Coverage Criteria or Change in Benefit Status
   - a separate document indicating the reason for and evidence to justify the need for the expanded coverage criteria or change in benefit status due to the new indication
4. A hard copy and electronic (CD) copy only of the following from the Common Technical Document:
   - Clinical Overview (Module 2.5), and
   - Clinical Summary (modules 2.7.1, 2.7.3, 2.7.4 and 2.7.6)

   Note: If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu.
5. Copy of Notice of Compliance (NOC) for the new indication.
6. Current Patent Status
   - a signed statement from the Manufacturer stating that the submitted Drug Product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
7. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
8. TPD-approved Product Monograph (revised to include the new indication)
   - A hard copy, and
   - an electronic (CD) copy compatible with Microsoft Word
9. Economic Information
   - a comprehensive pharmacoeconomic analysis **prepared with respect to the new indication only** in accordance with: the "*Guidelines for the economic evaluation of health technologies: Canada* [3rd Edition]". Ottawa: Canadian Agency for Drugs and Technologies in Health; 2006**.**; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful

- a completed Budget Impact Assessment for the Alberta Drug Benefit List form **prepared with respect to the new indication only**. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.html or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

10. If requested, the Manufacturer must provide written confirmation from the CDR that the Drug Product is not eligible for review under the CDR Procedure.

C) Line Extension Drug Products

The following submission requirements pertain to new strengths and formulations or reformulations of Drug Products that are currently listed or are under consideration for listing on the List and where Drug Products are not eligible for review under the CDR Procedure.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Justification for the Line Extension
   - a separate concise, one page document indicating the reason for and evidence to justify the need for the new strength, formulation or reformulation of the Drug Product, AND
   - a separate signed statement clearly identifying:
     i. the DIN of the Drug Product(s) being submitted as a Line Extension, AND
     ii. the DIN of the Manufacturer's Drug Product(s) currently listed or under consideration for listing on the ADBL, to which the submitted Drug Product(s) is/are being directly linked via clinical, bioequivalence or formulation proportionality/dissolution profile data.
4. A hard copy and electronic (CD) copy only of the following from the Common Technical Document:
   - Clinical Overview (Module 2.5), and
   - Clinical Summary (modules 2.7.1, 2.7.3, 2.7.4 and 2.7.6).

   Note: If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu.

   In the event a Comprehensive Summary was not prepared for Health Canada (i.e. clinical studies have not been conducted on the new strength, formulation or reformulation) then the Manufacturer must provide evidence establishing a clear linkage between the submitted Drug Product(s) and a currently listed or under consideration Drug Product(s).

   This can be in the form of:
   i. bioequivalence data; or
   ii. evidence of formulation proportionality (i.e. a comparison of master formulae for all submitted strengths) and evidence of a similar dissolution profile.
5. Copy of completed Drug Identification Number (DIN) notification form
6. Copy of Notice of Compliance (NOC)

7. Current Patent Status
   - a signed statement from the Manufacturer stating that the submitted Drug Product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
8. Copy of completed and approved Certified Product Information Document (CPID)
   - in lieu of the CPID, a Master Formula and Final Product Specifications must be provided
9. Price Information
   - The proposed price for Alberta (which must be in compliance with the Price Policy)
10. TPD-approved Product Monograph (revised to include the line extension)
    - A hard copy, and
    - an electronic (CD) copy compatible with Microsoft Word
11. Economic Information
    - a completed *Budget Impact Assessment for the* Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.html or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.
12. If requested, the Manufacturer must provide written confirmation from the CDR that the Drug Product is not eligible for review under the CDR Procedure.

D) Interchangeable Drug Products

The following submission requirements pertain to Multisource Drug Products submitted for listing in an interchangeable grouping in the List.

For Expedited and Full Reviews:

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Copy of completed Drug Identification Number (DIN) notification form
4. Copy of Notice of Compliance (NOC)
   - Note: For Old Drug Products (a Drug Product where the active ingredient is designated as an “old drug” by Health Canada and the Drug Product was approved on the basis of a DIN application), a Notice of Compliance is not required.
5. Current Patent Status
   - a signed statement from the Manufacturer stating that the submitted Drug Product does not infringe any patents
6. *For Cross Licensed Drug Products:* Letters from both the Manufacturer of the submission Drug Product and the Manufacturer of the innovator brand or a currently listed Drug Product within the submission Drug Product’s interchangeable grouping, stating that the submission Drug Product is manufactured under the identical master formula and manufacturing and quality control specifications, as the innovator brand or the currently listed Drug Product.
7. Price Information
   - The proposed pricing in Alberta must be in compliance with the Price Policy. Exceptions to the Fixed Pricing Rules may be considered at the sole discretion of the Minister. Accordingly, a request for an exception (as per the Price Policy) must accompany a submission that does not meet the Price Policy in order for it to be deemed complete.
8. Copy of completed and approved Certified Product Information Document (CPID)

   Note: In lieu of the CPID, a Master Formula and Final Product Specifications must be provided

9. TPD-approved Product Monograph
   - A hard copy, and
   - an electronic (CD) copy compatible with Microsoft Word

   Note: For Old Drug Products, the Prescribing Information may be provided in lieu of the Product Monograph.

For FULL REVIEWS ONLY, the following ADDITIONAL information must be provided:

10. Evidence that the listing criteria for Interchangeable Drug Products have been met. See *Criteria for Listing Drug Products* **and** *Interchangeable Drug Products* sections for specific applicable criteria.
11. If a submitted drug product has been compared with a Canadian Non-Innovator Reference Product (CNIRP) (as defined in Interchangeable Drug Products - Additional Criteria) in a comparative bioavailability study, the full TPD review of the submitted drug product must be provided. The Comprehensive Summary - Bioequivalence (CS-BE) that is prepared by the manufacturer prior to filing an Abbreviated New Drug Submission (ANDS) is not sufficient.

D) Natural Health Products

Natural Health Product: A Natural Health Product is a Drug Product where the active moiety or moieties are defined as a "natural health product" by Health Canada under the *Natural Health Products Regulations*.

The following submission requirements pertain to Natural Health Products submitted for listing on the Alberta Drug Benefit List.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Natural Health Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Natural Health Product submission and resubmission information and information about the Natural Health Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Natural Health Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Copy of Market Authorization for Sale (current Product License that is not suspended or cancelled at the time the submission is made)
4. Current Patent Status (if applicable)
   - a signed statement from the Manufacturer stating that the submitted Drug Product does not infringe any patents
5. Price Information
   - The proposed price for Alberta (which must be in compliance with the ADBL Price Policy)
6. Copy of completed and approved Certified Product Information Document (CPID)

   Note: In lieu of the CPID, a Master Formula, Final Product Specifications and Certificate of Analysis must be provided
7. Single Ingredient Monographs or Product Monographs
   - The Prescribing Information may be provided in lieu of Single Ingredient Monographs or Product Monographs.
8. The submission must include:
   I. Evidence that the active moiety or moieties or Natural Health Product was previously or is currently listed in the same formulation on the ADBL and;
   II. Evidence from the Manufacturer to demonstrate that there is an unmet need for the submitted Natural Health Product(s) (e.g. therapeutic need, therapeutic dose, stability of supply, formulation).

Note: Submissions for combination products where one or more of the active moieties was previously listed as a single entity will not be accepted. Similarly, submissions for single entity products where one or more of the active moieties was previously listed in a combination product will not be accepted.

9. Interchangeability may be evaluated based upon evidence submitted by the Manufacturer. The Expert Committee on Drug Evaluation and Therapeutics will provide recommendations on interchangeability to the Minister for a final decision. Acceptable evidence to support interchangeability includes:
    1. Bioequivalence studies which meet the requirements and standards in the TPD *Reports.*
    2. For Natural Health Products for which bioequivalence studies CANNOT be conducted, the submission must include:
        i) Evidence of comparative therapeutic efficacy of the submitted product with the reference product via:
            (A) a therapeutic equivalence study; or
            (B) studies that meet the requirements and standards for pharmacodynamic studies outlined in TPD Report No. 2 (as defined in *Interchangeable Drug Products - Additional Criteria*); or
            (C) surrogate comparisons using *in vivo* or *in vitro* test methods;
            and
        ii) Sufficient rationale for why a bioequivalence study cannot be conducted.
10. Economic Information
    - A completed *Budget Impact Assessment* for the Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.html or by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca

E) Non-Interchangeable Old Drug Products

Non-Interchangeable Old Drug Products: Are Drug Products where the active moiety or moieties are designated as an "Old Drug" by Health Canada and evidence to support interchangeability CANNOT be provided. The Drug Product is approved on the basis of a DIN application (i.e. a NOC is not issued by Health Canada).

Previously Listed means the Drug Product was previously listed in the same formulation on the ADBL at anytime in the past.

Not Previously Listed means the Drug Product was NOT previously listed in the same formulation on the ADBL at anytime in the past

The following submission requirements pertain to both **Previously Listed** and **Not Previously Listed** Non-Interchangeable Old Drug Products that are submitted for listing, but not as interchangeable, with another Drug Product that is currently listed in the ADBL.

1. Consent Letter
   - an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
2. Letter Confirming Ability to Supply
   - a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.
3. Copy of completed Drug Identification Number (DIN) notification form
4. Current Patent Status
   - a signed statement from the Manufacturer stating that the submitted product does not infringe any patents
5. Price Information
   - The proposed price for Alberta (which must be in compliance with the ADBL Price Policy)
6. Copy of completed and approved Certified Product Information Document (CPID)

   Note: In lieu of the CPID, a Master Formula, Final Product Specifications and Certificate of Analysis must be provided
7. Product Monograph
   - The Prescribing Information may be provided in lieu of the Product Monograph.
7. Evidence from the Manufacturer to demonstrate that there is an unmet need for the submitted Drug Products (e.g., therapeutic need, therapeutic dose, stability of supply, formulation)
9. Economic Information
   - A completed *Budget Impact Assessment* for the Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.html or by phone at

(780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca

For Non-Interchangeable Old Drug Products that were Previously Listed ONLY, the following ADDITIONAL information must be provided:

10. Evidence that the Drug Product was previously listed on the ADBL for the same indication and use in the past; and

- Assurance that the formulation of the Drug Product has remained unchanged since the time of listing, or
- If any Notifiable Changes have occurred since the time of listing, summary documentation describing the changes that have occurred since the time of listing must be provided.

For Non-Interchangeable Old Drug Products that were NOT Previously Listed ONLY, the following ADDITIONAL information must be provided:

11 Clinical evidence for the efficacy and safety of the active therapeutic ingredient(s) for the submitted indication that may be in the form of (in order of preference):

- An electronic (CD) copy only of the following from the Common Technical Document:
  - Clinical Overview (Module 2.5), and
  - Clinical Summary (Modules 2.7.1, 2.7.3, 2.7.4 and 2.7.6).
- If a Common Technical Document was not prepared for Health Canada, a Comprehensive Summary may be acceptable in lieu.
- If a Comprehensive Summary was not prepared for Health Canada, a concise summary of the efficacy and safety evidence based on an up-to-date literature review of the current medical literature may be acceptable in lieu.

F) Resubmissions

Resubmission Requests – General

1. A resubmission request may be made for a Drug Product that is not currently listed on the ADBL in a case where the Drug Product:

    a. was previously listed on the ADBL;
    b. was the subject of a previous submission for listing on the ADBL; or
    c. is listed on the ADBL but is subject to restrictions.

2. A resubmission request:

    a. must comply with the requirements set out below; and
    b. may be made by a Manufacturer for a Drug Product only once in a 12 month period, running from April 1st through to March 31st, unless the Minister of Health (Minister), in the Minister's sole discretion, invites a Manufacturer to make a resubmission request.

3. The Minister, the Expert Committee on Drug Evaluation and Therapeutics (Expert Committee), and Alberta Health:

    a. may request information in addition to the requirements set out below; and
    b. may from time to time set deadlines by which a resubmission request may be made, or a request for additional information must be provided.

4. In the case where:

    a. additional information has been requested by the Minister, the Expert Committee or Alberta Health, the resubmission request is not considered to be complete unless and until the requested additional information is provided to the Minister, the Expert Committee or Alberta Health; and
    b. a deadline has been set as referred to above, failure to provide a complete resubmission request within such deadline means that a resubmission request will not be reviewed by the Expert Committee or Alberta Health or considered by the Minister.

5. The Minister may, in the Minister's sole discretion, refer a Drug Product, that was the subject of a resubmission request which meets the requirements set out in this policy, to an Alberta Price Confirmation (APC) or Interim APC process.

6. In the event that a Drug Product is referred to an APC or Interim APC process, the Manufacturer must comply with the Price Policy and the Terms and Conditions of the APC or Interim APC. A referral to an APC or Interim APC or the submission of a Price Confirmation or Confirmed Price for the Drug Product by the Manufacturer does not obligate the Minister to list a Drug Product on the ADBL.

7. In the event that the Minister, in the Minister's sole discretion, requires additional advice or input on a resubmission request, the Minister may refer the resubmission request to the CDR Procedure, the Expert Committee or any other entity for further advice or a full review.

8. For additional clarity, the provisions outlined under the "Submissions for Drug Reviews" are also deemed to apply to resubmission requests except as specifically modified by the provisions in this subsection "G) Resubmissions", in which case this subsection applies.

Resubmission Requests Requiring Expert Committee Review

9. In addition to the requirements in "Resubmission Requests – General" above, this section applies to a resubmission request for a Drug Product that was reviewed by the Expert Committee and a decision was made by the Minister to:

    a. not add the Drug Product to the ADBL for reasons other than those specified in section 12 below;
    b. add the Drug Product to the ADBL with restrictions; or
    c. maintain current listing status of the Drug Product on the ADBL despite the Manufacturer's request for change.

10. A general resubmission request may be made for a previously submitted Drug Product on the *Resubmission for the* Alberta Drug Benefit List form. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.html or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

11. A resubmission request must be complete and must include:

    a. a completed *Resubmission for the* Alberta Drug Benefit List form. A resubmission request requires review by the Expert Committee and a recommendation made by the Expert Committee for the Minister's consideration for listing or not listing the Drug Product on the ADBL. The form must contain new information not previously submitted for a review of the Drug Product by the Expert Committee, unless otherwise indicated;

    b. an unconditional consent letter authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory;

c. a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements; and

d. a revised Budget Impact Assessment (BIA) form in the case where new economic information about the Drug Product is available, that has not been previously submitted, to support the resubmission request. The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.html or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

Resubmission Requests based on the ADBL Price Policy

12. In addition to the requirements in "Resubmission Requests – General" above, this section applies to resubmission requests for a Drug Product that:

    a. has not been listed on the ADBL, or that has been removed from the ADBL, by the Minister where the requirements of an Alberta Price Confirmation (APC), Interim APC or the Price Policy were not satisfied; or

    b. has been removed from the ADBL at the request of the Manufacturer.

13. A price policy resubmission request may be made on the *Alberta Price Policy Resubmission Form for the* Alberta Drug Benefit List*.* The form can be obtained at www.ab.bluecross.ca/dbl/manufacturers.html or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross by phone at (780) 498-8098, by fax at (780) 498-3534, or by email at submissions@ab.bluecross.ca.

14. A resubmission request must be complete and must include:
    a. a completed *Alberta Price Policy Resubmission Form for the* Alberta Drug Benefit List;

    b. an unconditional consent letter authorizing Alberta Health and its employees, contractors , consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory; and

    c. a confirmation letter signed by a senior official of the Manufacturer stating that the Manufacturer is able and willing to supply the Alberta market with the subject Drug Product in a quantity consistent with applicable APC or Interim APC requirements.

Non-Innovator Policy

1. The Minister may request submissions or direct Alberta Health and/or the Expert Committee to request submissions for products from time to time. Specifically, the Minister may request submissions for Multisource Drug Products seeking a listing designation as interchangeable with a CIRP that is not currently listed on the *Alberta Drug Benefit List (*ADBL) when that CIRP has been identified by the Minister.

2. The Minister may identify a CIRP which has been considered but never listed on the ADBL and where the availability of a Multisource Drug Product(s) may now alter the cost effectiveness of the molecule:

    a. During the Minister's evaluation of a CIRP to be identified under this Policy, the Minister will provide written notice of the evaluation to the CIRP manufacturer who may, at their discretion, provide materials to the Minister to be considered as part of the evaluation.

3. If such a CIRP is identified by the Minister, it will be included in the list included in this Non-Innovator Policy and any manufacturers with a valid NOC may make a submission (including the CIRP manufacturer).

4. Submissions must fulfill the applicable submission guidelines outlined below:

    a. For Interchangeable products, the applicable Expedited or Full Submission Guidelines outlined in the ADBL as if the CIRP was currently listed on the ADBL including compliance with the prevailing Price Policy.

    b. CIRP manufacturers must fulfill the following Submission Requirements outlined in Section A) New Chemical Entities/Single Source Drug Products in the ADBL (Section 1.25 – 1.26): Consent Letter, Letter Confirming Ability to Supply, Hard Copy and CD copy of the following Common Technical Document sections (Module 2.5 and 2.7.1, 2.7.3, 2.7.4 and 2.7.6), Copy DIN Notification Form, Copy of NOC, Current Patent Status, Price Information, TPD- approved Product Monograph:

    c. Only pricing information submitted according to the prevailing Price Policy will be evaluated for CIRPs under this Non-Innovator Policy. The Product Listing Agreement Policy will not be considered.

5. For clarity, Special Authorization requests for coverage of a specific brand under the Special Authorization Guidelines outlined in the ADBL will not be considered unless the specific brand requested is a benefit on the ADBL.

6. Where the Minister has requested submissions for a specific Drug Product through this Requested Submissions Policy by including it in Section 7 below, but no submissions are received and the drug product continues to be funded through an Alberta Government Sponsored program (for example, Health Benefits Exception Committee), Alberta Health may publish the price established for the molecule through that pan-Canadian Generic Initiative (please refer to the Price Policy for further details) and will pay no more than that price for beneficiaries under any Government of Alberta Sponsored Drug program.

7. Submissions are currently being accepted for Multisource Drug Products for the following non-listed CIRPs. For clarity, the CIRP itself continues to be eligible to submit for listing on the ADBL.

    - Lyrica (pregabalin) 25 mg, 50 mg, 75 mg, 150 mg & 300 mg capsules
    - Revia (naltrexone hydrochloride) 50 mg tablet
    - Truvada (emtricitabine/ tenofovir disoproxil fumarate) 200 mg/300 mg tablet

Supply Shortages

Where a Manufacturer has not supplied, or is not supplying, a sufficient quantity of Drug Product to meet the demand in Alberta (as determined by Alberta Health at its sole option and discretion, and based on any information it deems appropriate):

1. If the unavailable Drug Product is a Single Source Drug Product on the List, Drug Products not otherwise allowed as benefits may be added temporarily or temporarily reimbursed for the Alberta government-sponsored drug programs.
2. Drug Products added or reimbursed under this policy may remain as temporary benefits until the supply shortage is rectified.
3. In order to remain as benefits after the shortage is rectified, Manufacturers of these products must follow the usual submission and review process for listing.
4. Alberta Health may recover any cost difference from the manufacturer unable to supply a Drug Product.
5. Alberta Health may at its sole discretion, take any other steps or require any information from a manufacturer or other person that is reasonably required to manage a supply shortage.
6. Alberta Health may:

    - refuse to list any product of the manufacturer,
    - refuse to consider any product submission of the manufacturer for expedited or priority review; or
    - cancel or modify the listing of the product that is not meeting the supply demand.

Units of Issue for Pricing

These units of issue are used for presenting prices in the List.

Dosage Form	Unit of Issue Priced in *ADBL*
Ampoules	Millilitre
Bladder Irrigation Solutions	Millilitre
Dental Pastes	Gram
Devices	Device
Inhalation Capsules	Capsule
Inhalation Cartridges	Cartridge, Dose
Inhalation Disks	Disk
Inhalation Solutions or Suspensions	Millilitre – all preparations including nebules
Inhalation Unit Dose Solution	Millilitre, Dose, Actuation
Injections	Vial – where reconstitution is required (or Millilitre or Unit where indicated)
Injections	Millilitre – where no reconstitution is required (or Vial where indicated)
Injections – Cartridges	Millilitre
Injections – Emulsion	Millilitre
Injections – Syringes	Syringe (or Millilitre where indicated)
Injection – Implant	System
Injection Syringe/Oral Capsule	Kit
Injection Vial/Oral Capsule	Kit
Injection Vial/Oral Tablet	Kit
Injection Syringe/Oral Tablet	Kit
Intrauterine Insert	System
Irrigating Solutions	Millilitre
Lock Flush	Millilitre
Metered Dose Aerosols	Dose
Metered Inhalation Powder	Dose
Nasal Metered Dose Aerosols	Dose
Nasal Metered or Unit Dose Sprays	Dose
Nasal Solutions	Millilitre
Nasal Sprays	Millilitre
Ophthalmic Solutions or Suspensions or Drops	Millilitre
Ophthalmic Gels or Ointment	Gram
Ophthalmic Long Acting Gellan Solutions	Millilitre
Oral Caplets	Caplet
Oral Capsules – all formulations	Capsule
Oral Drops	Millilitre
Oral Granules	Bulk size – Gram
Individual Packet	Packet

Units of Issue for Pricing, continued

Dosage Form	Unit of Issue Priced in ADBL
Oral Liquids – all formulations	Millilitre
Oral Powders	Gram (or Dose where indicated)
Oral Powder Packets	Individual Packet
Oral Rinses	Millilitre
Oral Tablets – all formulations	Tablet
Oral Tablets – oral contraceptives	Tablet
Oral Tablet/Capsule	Kit
Oral Wafer	Wafer
Otic Ointments or Gels	Gram
Otic Solutions or Suspensions or Drops	Millilitre (or Vial where indicated)
Rectal Enemas	Enema
Rectal Foams	Gram
Rectal Ointments	Gram
Rectal Retention Enemas	Enema
Rectal Suppositories - all formulations	Suppository
Scalp Lotions	Millilitre
Scalp Solutions	Millilitre
Sublingual Metered Dose Spray	Dose
Sublingual Tablet	Tablet
Topical Bars	Gram
Topical Cleansers	Millilitre
Topical Creams/Ointments - all formulations	Gram
Topical Gauzes	Dressing
Topical Gels - all formulations	Gram
Topical Jellies	Millilitre
Topical Lotions	Millilitre or Gram
Topical Powders	Gram
Topical Solutions	Millilitre
Topical Washes	Millilitre or Gram
Transdermal Gel	Gram
Transdermal Patches	Patch
Vaginal Capsules or Ovules or Tablets	Capsule or Ovule or Tablet
Vaginal Creams or Ointments or Gels	Gram
Vaginal Douches	Millilitre
Vaginal Ovule/Topical Cream	Kit
Vaginal Slow Release Rings	Ring
Vaginal Suppositories	Suppository

Alberta Health Expert Committee on Drug Evaluation and Therapeutics: Policy for Administering Interchangeability Challenges

Note: This Policy is not applicable for Drug Products that are eligible for, and are reviewed under, the Expedited Review Process for Interchangeable Drug Products.

From time-to-time, the Expert Committee on Drug Evaluation and Therapeutics receives unsolicited information ("Challenge Information") from a Manufacturer (the "Challenger") suggesting that additional information should be taken into account when a submission for interchangeability for a Multisource product is being considered by the Expert Committee. Alberta Health is not prepared to have any Challenge Information considered by the Expert Committee unless the Manufacturer whose Drug Product is being challenged (the "Applicant") is provided with a full copy of the Challenge Information and is given an opportunity to respond to it.

As a result, Alberta Health has developed and approved the following process for the handling of Challenge Information.

1. Challenge Information must comply with the following conditions.
2. Challenge Information must be received by Alberta Blue Cross:
   - For first-entry interchangeable product submissions – Within 15 days of the date of issuance of the NOC for the Applicant's product.
   - For all other submissions, by the submission deadline date.
3. All Challenge Information must include an unconditional Written Consent, signed by the Challenger, authorizing Alberta Health and its employees, contractors, consultants and agents to collect and use information respecting a Drug Product and to disclose the subject information to Alberta Health, its employees, contractors, consultants and agents, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), Alberta Health Services (AHS) and the government of a province or territory in Canada. Information that may be collected, used and disclosed includes, but is not limited to, all Drug Product submission and resubmission information and information about the Drug Product in the possession of Health Canada, CADTH, all persons, parties or entities involved in the CDR Procedure, PMPRB, AHS, Alberta Health, the Expert Committee, and the government of a province or territory.
4. If the above unconditional Written Consent is not submitted as required, the Challenge Information will not be considered by the Expert Committee.
5. If Written Consent is submitted as required, the Challenge Information will be duplicated in its entirety and forwarded by Alberta Blue Cross to the Applicant, inviting a response ("Applicant Response"). The Applicant Response must be received by Alberta Blue Cross no later than 15 days after the date of the letter from Alberta Blue Cross.
6. If an Applicant Response is not received by Alberta Blue Cross within the time provided, only the Challenge Information will be provided to the Expert Committee for consideration. If an Applicant Response is received within the time provided, both the Applicant Response and the Challenge Information will be provided to the Expert Committee for consideration.
7. No further information may be submitted to the Expert Committee for consideration.
8. The Applicant Response should only address information contained in the Challenge Information. Anything in the Applicant Response that does not relate to information

contained in the Challenge Information may, at the sole discretion of the Expert Committee, be disregarded.

9. It is a condition of each and every Submission and Challenge that the terms, conditions, criteria and time limitations contained in this policy will apply and that:
   a) Applicants, by filing a Submission and Applicant Response; and,
   b) Challengers, by submitting Challenge Information agree to and are bound by this policy.
10. In the event the anticipated Applicant submission is not received, Challenge Information will be destroyed 6 months after receipt.

Inquiries may be made to:

Manager
Scientific and Research Services
Alberta Blue Cross
10009 - 108 Street NW
Edmonton AB T5J 3C5
Phone: (780) 498-8098
Fax: (780) 498-3534

Your Comments are Important to Us

To improve the high standards established for this publication, the Alberta Health Expert Committee on Drug Evaluation and Therapeutics would like to offer you an opportunity for input. Should you have any concerns and/or suggestions concerning product listings or criteria for coverage of products available via special authorization, etc. please let us know. If you are writing in support of a product listing change or a revision to the special authorization criteria for coverage, you must provide evidence in support of your comments from the peer-reviewed scientific literature. In order to meet the expectations of stakeholders relative to objectivity and transparency, all individuals providing comments are required to advise the Expert Committee of any potential conflicts of interest below (please check appropriate box):

Please note: This is not a mechanism for an appeal for a specific patient.

Conflict of Interest: ☐ **Yes** ☐ **No**

If Yes, please indicate the nature of the potential conflict of interest below:

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Please provide your comments in the space provided below:

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Contact Information:

Name and Address: _____

Phone/Fax: _____

Please print form and mail/fax to:

Alberta Health Expert Committee on Drug Evaluation and Therapeutics
c/o Manager
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5
FAX to: (780) 498-3534

The DBL is not a prescribing or a diagnostic tool. Prescribers should refer to drug monographs and utilize professional judgment.

RESTRICTED BENEFITS

Selected devices or Drug Products are eligible benefits with restrictions in the Alberta Drug Benefit List. For these products a comment is displayed in the List after the ingredient name. The comment initially states "RESTRICTED BENEFIT" and is followed by an explanation of the restriction. For an example, refer to the Legend in the Introduction section of the List.

Products Designated as Restricted Benefits

The products listed below are restricted benefits in the List.

PTC 00:00:02

- **Diabetic Supplies** Blood Glucose Test Strips, Blood Letting Lancet, Insulin Pen Needles, Insulin Syringes, Urine Test Strips

PTC 08:12.06.04

- **Cefadroxil** 500 mg oral capsule

PTC 08:12.07.08

- **Ertapenem** 1 g/vial injection
- **Imipenem/ Cilastatin Sodium** 500 mg/vial / 500 mg/vial injection
- **Meropenem** 500 mg/vial and 1 g/vial injection

PTC 08:12.07.12

- **Cefoxitin Sodium** 1 g/vial and 2 g/vial injection

PTC 08:12.12.92

- **Azithromycin** 600 mg oral tablet

PTC 08:12.16.08

- **Ampicillin** 250 mg and 500 mg oral capsule

PTC 08:12.16.16

- **Piperacillin Sodium/ Tazobactam Sodium** 2 g/vial / 250 mg/vial, 3 g/vial / 375 mg/vial, and 4 g/vial / 500 mg/vial injection

PTC 08:12.28.24

- **Linezolid** 600 mg oral tablet

PTC 08:14.08

- **Fluconazole** 10 mg/ml oral suspension
- **Itraconazole** 10 mg/ml oral suspension
- **Voriconazole** 50 mg and 200 mg oral tablet, 200 mg/vial injection and 40 mg/ml oral suspension

PTC 08:14.16

- **Caspofungin** 50 mg/vial and 70 mg/vial injection

PTC 08:16.92

- **Rifabutin** 150 mg oral capsule

PTC 08:18.08.20

- **Lamivudine** 100 mg oral tablet
- **Tenofovir Disoproxil Fumarate** 300 mg oral tablet

PTC 08:18.20

- **Peginterferon Alfa-2A** 180 mcg/0.5 ml injection syringe

PTC 08:18.32

- **Adefovir Dipivoxil** 10 mg oral tablet
- **Entecavir** 0.5 mg oral tablet

PTC 12:20.04

- **Cyclobenzaprine HCL** 10 mg oral tablet

PTC 12:92:00

- **Varenicline Tartrate** 0.5 mg and 1 mg oral tablet, 0.5 mg/1 mg oral tablet

PTC 20:12.04.92

- **Rivaroxaban** 10 mg oral tablet

PTC 20:12.18

- **Ticagrelor** 90 mg oral tablet

PTC 28:08.08

- **Codeine Phosphate/ Acetaminophen** 1.6 mg/ml / 32 mg/ml oral elixir

PTC 28:16.08.04

- **Aripiprazole** 2 mg and 5 mg oral tablet
- **Risperidone Tartrate** 1 mg/ml oral solution

PTC 28:20.04

- **Lisdexamfetamine Dimesylate** 20 mg, 30 mg, 40 mg, 50 mg, 60 mg oral capsule

PTC 28:20.92

- **Methylphenidate HCL** 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg oral controlled-release capsule

PTC 28:32.28

- **Almotriptan Malate** 6.25 mg and 12.5 mg oral tablet
- **Naratriptan HCL** 1 mg and 2.5 mg oral tablet
- **Rizatriptan Benzoate** 5 mg oral tablet, 10 mg oral tablet, 5 mg oral disintegrating tablet and 10 mg oral disintegrating tablet
- **Sumatriptan Hemisulfate** 5 mg/dose and 20 mg/dose nasal unit dose spray
- **Sumatriptan Succinate** 50 mg oral tablet, 100 mg oral tablet and 6 mg/syringe injection
- **Zolmitriptan** 2.5 mg oral tablet, 2.5 mg oral dispersible tablet and 5 mg/dose nasal unit dose spray

PTC 48:10.24

- **Montelukast Sodium** 4 mg oral chewable tablet, 4 mg oral granule, 5 mg oral chewable tablet, and 10 mg oral tablet

PTC 52:92:00

- **Aflibercept** 2 mg/vial injection
- **Ocriplasmin** 0.5 mg/vial injection
- **Ranibizumab** 2.3 mg/vial injection

PTC 56:22.92

- **Aprepitant** 80 mg oral capsule
- **Aprepitant/Aprepitant** 80 mg/125 mg oral capsule

PTC 68:04:00

- **Mometasone Furoate** 100 mcg/dose metered inhalation powder

PTC 86:12:00

- **Propiverine Hydrochloride** 5 mg oral tablet

PTC 92:00:00

- **Ulipristal Acetate** 5 mg oral tablet

PTC 92:36:00

- **Leflunomide** 10 mg and 20 mg oral tablet

PTC 94:00:00

- **Aerosol Holding Chamber** device
- **Aerosol Holding Chamber/Mask** infant, pediatric and adult chamber/mask device

Limited Restricted Benefits

Selected Drug Products are eligible benefits with limits and restrictions in the Alberta Drug Benefit List. For these products a comment is displayed in the List after the ingredient name. The comment initially states “LIMITED RESTRICTED BENEFIT” and is followed by an explanation of the limits and restrictions. For an example, refer to the Legend in the Introduction of the List.

SPECIAL AUTHORIZATION GUIDELINES

Special Authorization Policy

Drug Products Eligible for Consideration by Special Authorization

Drug Products may be considered for coverage by special authorization under one or more of the following circumstances, unless a specific product falls under the criteria for Drug Products **not** eligible for consideration by special authorization. Please see the end of this section for information regarding Drug Products not eligible for consideration by special authorization.

1. The drug is covered by Alberta Health under specified criteria (listed in the following sections). Drug Products and indications other than those specified are not eligible for consideration by special authorization.
2. The Drug Product is normally covered by another government program or agency for a specific approved clinical condition, but is needed for the treatment of a clinical condition that is not covered by that government program or agency.
3. The Drug Product is required because other Drug Products listed in the Alberta Drug Benefit List are contraindicated or inappropriate because of the clinical condition of the patient.
4. The particular brand of Drug Product is considered essential in the care of a patient, where the LCA price policy would otherwise apply. Coverage of a specific brand may be considered where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with alternate brands in an interchangeable grouping. Coverage of a brand name product will not be considered in situations where the interchangeable grouping includes a pseudo-generic to the brand name Drug Product.
5. A particular Drug Product or dosage form of a Drug Product is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the Drug Product level. Coverage may be considered only where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with the Drug Product which establishes the MAC pricing.

Prior approval must be granted by Alberta Blue Cross to ensure coverage by special authorization. For those special authorization requests that are approved, the effective date for authorization is the beginning of the month in which the physician's request is received by Alberta Blue Cross.

Special authorization is granted for a defined period as indicated in each applicable special authorization Drug Product criteria (the "Approval Period"). If continued treatment is necessary beyond the Approval Period, it is the responsibility of the patient and physician to **re-apply for coverage prior to the expiration date of the Approved Period, unless the Auto-Renewal Process or Step Therapy Approval Process apply** (see below).

Auto-Renewal Process

Selected Drug Products are eligible for the following auto-renewal process (for eligibility, see the Special Authorization criteria for each Drug Product).

1. For initial approval, a special authorization request must be submitted. If approval is granted, it will be effective for the Approval Period outlined in the Drug Product's Special Authorization criteria.
2. As long as the patient has submitted a claim for the Drug Product within the preceding Approval Period (example: within the preceding 6 months), approval will be automatically

renewed for a further Approval Period (example: a further 6 months). There is no need for the prescriber to submit a new request as the automated real-time claims adjudication system will read the patient's claims history to determine if a claim has been made within the preceding Approval Period.

3. If the patient does not make a claim for the Drug Product during the Approval Period, the approval will lapse and a new special authorization request must be submitted.

Step Therapy Approval Process

Select Drug Products are eligible for coverage via the step therapy process, outlined below.

1. If the patient has made a claim for the First-Line* Drug Product(s) within the preceding 12 months, the claim for the step therapy Drug Product will be approved.
2. The automated real-time claims adjudication system will read the patient's claims history to determine if the required First-Line* Drug Product(s) have been claimed within the preceding 12 months.
3. Subsequent claims for Drug Product(s) permitted by step therapy will continue to be approved as long as the Drug Product has been claimed within the preceding 12 months.
4. The regular special authorization approval process will continue to be available for step therapy approvals for those patients whose First-Line* drug claims cannot be adjudicated through the automated real-time claims adjudication system.

* A First-Line Drug Product includes any drug(s) or Drug Product(s) that, under the Drug Product's Special Authorization criteria, are required to be utilized before reimbursement for the Drug Product is permitted.

Drug Products *Not Eligible* for Consideration by Special Authorization

The following categories of Drug Products are **not** eligible for special authorization:

1. Drug Products **deleted** from the List.
2. Drug Products **not yet reviewed** by the Alberta Health Expert Committee on Drug Evaluation and Therapeutics. This applies to:
   * products where a complete submission has been received from the Manufacturer and the product is under review,
   * products where an incomplete submission has been received from the Manufacturer, and
   * Drug Products where the Manufacturer has not made a submission for review.

   Drug Products not yet reviewed may encompass new pharmaceutical Drug Products, new strengths of Drug Products already listed, reformulated products and new interchangeable (generic) products.
3. Drug Products that have **completed the review** process and are **not included** on the List.
4. Most Drug Products available through Health Canada's Special Access Program.
5. Drug Products when prescribed for cosmetic indications.
6. Nonprescription or over-the-counter Drug Products are generally not eligible.

Special Authorization Procedures

A prescriber's request for special authorization should be directed by mail or fax to:

Clinical Drug Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

FAX: (780) 498-8384 in Edmonton and area
1-877-828-4106 toll-free fax for all other areas

1. A separate request is required for each patient.

2. For a request for special authorization to be considered, the prescriber (an individual authorized by law to prescribe) must contact Alberta Blue Cross and provide the following information:

Patient Identification
- patient's name, address and card holder's name (if different than the patient's),
- Alberta Blue Cross identification number or coverage number/client number of any other applicable coverage (e.g. Alberta Human Services or Alberta Personal Health number, and
- date of birth.

Prescriber Identification
- name of prescriber (e.g. physician, dentist, or optometrist),
- address,
- telephone number and FAX number (if applicable), and
- professional association registration number (e.g. College of Physicians and Surgeons, Alberta Dental Association, or Alberta College of Optometrists registration number).

Drug Requested
- name, strength and dosage form,
- dosage schedule, and
- proposed duration of therapy.

Reason for the Request
- diagnosis and/or indication for which the drug is being used,
- information regarding previous medications which have been used and the patient's response to therapy where appropriate,
- proposed results of therapy, and
- any additional information that may assist in making a decision on the request for special authorization.

3. For most drug products, written requests from a prescriber may be submitted on the general *Drug Special Authorization Request* (ABC 60015).

   Special authorization request forms can be found on the following pages.

Special Authorization Forms

Special Authorization forms can be found on the following pages:

- *Drug Special Authorization Request Form* (ABC 60015)
- *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* (ABC 60034) - All requests for donepezil HCl, galantamine hydrobromide or rivastigmine hydrogen tartrate and must be submitted using this form only.
- *Darbepoetin/Epoetin Special Authorization Request Form* (ABC 60006) - All requests for darbepoetin or epoetin alfa must be submitted using this form only.
- *Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/ Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60027) - All requests for abatacept, adalimumab, anakinra, certolizumab, etanercept, golimumab, infliximab, sarilumab, tocilizumab or tofacitinib for Rheumatoid Arthritis must be submitted using this form only.
- *Ezetimibe Special Authorization Request Form* (ABC 60036) - All requests for ezetimibe must be submitted using this form only.
- *Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form* (ABC 60045) - All requests for peginterferon alfa-2a for Chronic Hepatitis C must be submitted using this form only.
- *Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60011) - All requests for adalimumab, etanercept or tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be submitted using this form only.
- *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form* (ABC 60029) - All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab, ixekizumab, or secukinumab for Psoriatic Arthritis must be submitted using this form only.
- *Select Quinolones Special Authorization Request Form* (ABC 60042) - All requests for ciprofloxacin, levofloxacin or moxifloxacin must be submitted using this form only.
- *Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form* (ABC 60043) - All requests for alendronate, raloxifene, or risedronate for Osteoporosis must be submitted using this form only.
- *Celecoxib Special Authorization Request Form* (ABC 60032) – All requests for celecoxib must be submitted using this form only.
- *Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form* (ABC 60013) – All requests for filgrastim, pegfilgrastim or plerixafor must be submitted using this form only.
- *Fentanyl Special Authorization Request Form* (ABC 60005) - All requests for fentanyl or fentanyl citrate must be submitted using this form only.
- *Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form* (ABC 60030) - All requests for adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab for Plaque Psoriasis must be submitted using this form only.
- *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form* (ABC 60028) - All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab or secukinumab for Ankylosing Spondylitis must be submitted using this form only.

- *Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* (ABC 60031) - All requests for adalimumab or vedolizumab for Moderately to Severely Active Crohn's Disease or infliximab for Moderately to Severely Active Crohn's/Fistulizing Crohn's Disease must be submitted using this form only.
- *Rituximab for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60046) - All requests for rituximab for Rheumatoid Arthritis must be submitted using this form only.
- *Imiquimod Special Authorization Request Form* (ABC 60038) – All requests for imiquimod must be submitted using this form only.
- *Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form* (ABC 60024) – All requests for aripiprazole/paliperidone/risperidone prolonged release injection must be submitted using this form only.
- *Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60010) - All requests for abatacept for Polyarticular Juvenile Idiopathic Arthritis must be submitted using this form only.
- *Montelukast/Zafirlukast Special Authorization Request Form* (ABC 60039) – All requests for montelukast or zafirlukast must be submitted using this form only.
- *Febuxostat Special Authorization Request Form* (ABC 60037) – All requests for febuxostat must be submitted using this form only.
- *Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form* (ABC 60007) – All requests for denosumab 60 mg/syr injection syringe or for zoledronic acid 0.05 mg/ml injection for osteoporosis must be submitted using this form only.
- *Omalizumab for Asthma Special Authorization Request Form* (ABC 60020) - All requests for omalizumab for Asthma must be submitted using this form only.
- *Eculizumab Special Authorization Request Form* (ABC 60009) – All requests for eculizumab must be submitted using this form only.
- *Eculizumab Consent Form* (ABC 60035) -– All requests for eculizumab must be accompanied by this form.
- *Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form* (ABC 60018) -– All requests for rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis must be submitted using this form only.
- *Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60048) – All requests for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be submitted using this form only.
- *DPP-4/SGLT2 Inhibitors Special Authorization Request Form* (ABC 60012) - All requests for saxagliptin, saxagliptin+metformin, sitagliptin, sitagliptin+metformin, linagliptin, linagliptin+metformin, canagliflozin, dapagliflozin, dapagliflozin+metformin, empagliflozin or empagliflozin+metformin must be submitted using this form only.
- *Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form* (ABC 60019) – All requests for apixaban 2.5 mg & 5 mg, dabigatran 110 mg & 150 mg, edoxaban 15 mg, 30 mg & 60 mg, or rivaroxaban 15 mg & 20 mg must be submitted using this form only.
- *Tacrolimus Topical Ointment Special Authorization Request Form* (ABC 60047) - All requests for tacrolimus topical ointment must be submitted using this form only.
- *Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form* (ABC 60001) - All requests for dimethyl fumarate, glatiramer acetate, interferon beta-1a, ocrelizumab, peginterferon beta-1a or teriflunomide for RRMS or interferon beta-1b for SPMS or RRMS must be submitted using this form only.

- *Alemtuzumab/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form* (ABC 60000) - All requests for alemtuzumab, fingolimod or natalizumab must be submitted using this form only.
- *Ivacaftor Special Authorization Request Form* (ABC 60004) – All requests for ivacaftor must be submitted using this form only.
- *Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form* (ABC 60008) – All requests for adalimumab, golimumab, infliximab or vedolizumab for ulcerative colitis must be submitted using this form only.
- *Antivirals for Chronic Hepatitis C Special Authorization Request Form* (ABC 60022) – All requests for asunaprevir, daclatasvir, elbasvir/grazoprevir, sofosbuvir, sofosbuvir/ledipasvir, sofosbuvir/velpatasvir, or sofosbuvir/velpatasvir/voxilaprevir must be submitted using this form only.
- *Proton-Pump Inhibitors Pricing Authorization Request Form (*ABC 60049) – All requests for pricing authorization for Proton-Pump Inhibitor products that are subject to MAC and LCA pricing on the iDBL must be submitted using this form only. Please refer to the iDBL for full listing of Proton-Pump Inhibitor products.
- *Nintedanib/Pirfenidone Special Authorization Request Form* (ABC 60051) – All requests for nintedanib or pirfenidone must be submitted using this form only.
- *Deferiprone Special Authorization Request Form* (ABC 60054) – All requests for deferiprone must be completed using this form only.
- *Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form* (ABC 60025) - All requests for aclidinium bromide + formoterol fumarate dihydrate, budesonide + formoterol fumarate dihydrate, fluticasone furoate + vilanterol trifenatate, indacaterol maleate + glycopyrronium bromide, salmeterol xinafoate + fluticasone propionate, tiotropium bromide + olodaterol hydrochloride or umeclidinium bromide + vilanterol trifenatate must be submitted using this form only.
- *Eplerenone/Ivabradine/Sacubitril* + *Valsartan Special Authorization Request Form* (ABC 60050) – All requests for eplerenone, ivabradine or sacubitril + valsartan must be submitted using this form only.
- *Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form* (ABC 60058) – All requests for adalimumab for Hidradenitis Suppurativa must be completed using this form only.
- *Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form* (ABC 60056) – All requests for omalizumab for Chronic Idiopathic Urticaria must be completed using this form only.
- *Mepolizumab Special Authorization Request Form* (ABC 60061) – All requests for mepolizumab must be completed using this form only.
- *Alirocumab/Evolocumab for HeFH Special Authorization Request Form* (ABC 60060) – All requests for alirocumab or evolocumab for Heterozygous Familial Hypercholesterolemia must be completed using this form only.
- *Fidaxomicin Special Authorization Request Form* (ABC 60014) – All requests for fidaxomicin must be submitted using this form only.
- *Asfotase Alfa Special Authorization Request Form* (ABC 60063) – All requests for asfotase alfa must be submitted using this form only.
- *Asfotase Alfa Consent Form* (ABC 60057) -– All initial requests for asfotase alfa must be accompanied by this form.

- *Nusinersen Special Authorization Request Form* (ABC 60064) – All requests for nusinersen must be submitted using this form only.
- *Obeticholic Acid Special Authorization Request Form* (ABC 60065) – All requests for obeticholic acid must be submitted using this form only.
- *Tocilizumab for Giant Cell Arteritis Special Authorization Request Form* (ABC 60066) – All requests for tocilizumab for Giant Cell Arteritis must be submitted using this form only.
- *Ocrelizumab for PPMS Special Authorization Request Form* (ABC 60067) – All requests for ocrelizumab for PPMS must be submitted using this form only.

Prescriber Registration Forms

Prescriber registration forms can be found on the following pages:

- *Registration for MS Neurologist Status Form* (ABC 60002) - Special authorization requests for eligible MS Disease Modifying Therapies must be submitted by a "Registered MS Neurologist". Neurologists may apply to be a "Registered MS Neurologist" by completing the Registration for MS Neurologist Status Form (ABC 60002).
- *Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form* (ABC 60021) - Ophthalmologists with training in the administration of intravitreal injections may apply to be a Registered Prescriber by completing this form. Registration allows for practitioner's patients to receive coverage of Jetrea. Ophthalmologists who choose not to apply to be a Registered Prescriber may also prescribe Jetrea, but patients will not be eligible for payment under the program for such prescriptions. The patient may choose to receive the product at their own expense.
- *Registration for Designated Prescriber Status for Alberta Drug Benefit List Claim Coverage – Select Quinolone Antibiotics* (ABC 60041) - Refer to Section 3A of the *Alberta Drug Benefit List* for criteria for Optional Special Authorization of select quinolone drug products and the form for *Registration for Designated Prescriber Status for Alberta Drug Benefit List Claim Coverage – Select Quinolone Antibiotics*

The following official forms are provided for your convenience to photocopy and use as required. Submit completed forms by FAX to Alberta Blue Cross:

(780) 498-8384 in Edmonton and area

1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please DO NOT mail or re-fax your request

Drug Special Authorization Request Form

On the reverse is the official *Drug Special Authorization Request Form* (ABC 60015).

- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DRUG SPECIAL AUTHORIZATION REQUEST

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

☐ **NEW** ☐ **RENEWAL DRUG REQUEST** **Note: Request may or may not be approved by Alberta Blue Cross**

Drug(s), dosage(s) and duration requested

Diagnosis and/or indication which drug is being used to treat

Previous medications and patient response to therapy

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Donepezil/Galantamine/Rivastigmine Special Authorization Request Form

On the reverse is the official *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* (ABC 60034).

- All requests for donepezil HCl, galantamine hydrobromide or rivastigmine hydrogen tartrate must be submitted using the *Donepezil/Galantamine/Rivastigmine Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DONEPEZIL/GALANTAMINE/RIVASTIGMINE SPECIAL AUTHORIZATION REQUEST FORM

Please complete ALL sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY , PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of DONEPEZIL, GALANTAMINE, RIVASTIGMINE

For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Special Authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug.

Note: an MMSE score below 10 or an InterRAI-Cognitive Performance Scale score greater than 4 at any time will result in discontinuation of coverage.

PLEASE COMPLETE ALL SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

Indicate which drug is requested

- ☐ **Donepezil (e.g. Aricept)**
- ☐ **Galantamine (e.g. Reminyl ER)**
- ☐ **Rivastigmine (e.g. Exelon)**

Please confirm the diagnosis for which this drug is requested

For the treatment of

- ☐ Dementia of the Alzheimer's Type
- ☐ other (please specify) _____

Please provide a current MMSE or InterRAI-Cognitive Performance Scale score* <u>and</u> the date the exam was administered

MMSE score _____ Date of exam _____

InterRAI-Cognitive Performance Scale score _____ Date of exam _____

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Darbepoetin/Epoetin Special Authorization Request Form

On the reverse is the official *Darbepoetin/Epoetin Special Authorization Request Form* (ABC 60006).

- All requests for darbepoetin or epoetin alfa must be submitted using the *Darbepoetin/Epoetin Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DARBEPOETIN/EPOETIN SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested (check one box) ☐ **Darbepoetin** ☐ **Epoetin**

PLEASE COMPLETE ALL APPLICABLE SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

ANEMIA OF CHRONIC RENAL FAILURE (does not apply to epoetin 30,000 or 40,000 IU/syringe strengths)

☐ anemia of chronic renal failure

☐ other (please specify) _____

This section applies only to patients who received a renal transplant
Please indicate if the renal transplant is failing or has failed
☐ Yes ☐ No

NEW patients
a) Provide pre-treatment hemoglobin level (g/L) _____

b) Is the hemoglobin level falling? ☐ Yes ☐ No

Patients currently on darbepoetin or epoetin
Provide current hemoglobin level (g/L)

Please provide the current iron status: Transferrin saturation is >20% ☐ Yes ☐ No

CHEMOTHERAPY-INDUCED ANEMIA (includes epoetin 30,000 and 40,000 IU/syringe strengths)

Please specify the type of cancer

_____

☐ other (please specify) _____

For the treatment of anemia
Please indicate if the anemia is chemotherapy-induced
☐ Yes ☐ No, please specify _____

Please provide the patient's hemoglobin level (g/L)

Please specify the reason why blood transfusions are not an option
☐ Transfusion reactions in the past ☐ Difficulty cross-matching the patient
☐ Iron overload ☐ Other, please specify:_____

ANEMIA IN AZT-TREATED/HIV INFECTED PATIENTS (does not apply to darbepoetin or epoetin 30,000 or 40,000 IU/syringe strengths)

☐ anemia in AZT-treated/HIV infected patients

☐ other, please specify _____

Additional information relating to request

PRESCRIBER 'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

ALBERTA BLUE CROSS®

DARBEPOETIN/EPOETIN SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for coverage

DARBEPOETIN

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for 12 months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 300 mcg per month."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25 per cent. Special authorization will be granted for 12 months."

In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.

In order to comply with the second criterion, if the patient has iron overload, the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation along with results of liver function tests if applicable.

For the second criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.

The following product(s) are eligible for auto-renewal for the indication of the treatment of anemia of chronic renal failure.

EPOETIN (ALL strengths except 30,000 and 40,000 IU/syringe)

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for 12 months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 60,000 units per month."

"For the treatment of anemia in AZT-treated/HIV infected patients. Special authorization will be granted for twelve months."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25%. Special authorization will be granted for 12 months."

In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.

In order to comply with the third criterion: if the patient has iron overload, the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the third criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.

The following product(s) are eligible for auto-renewal for the indication of treatment of anemia of chronic renal failure.

EPOETIN 30,000 and 40,000 IU/syringe strengths

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25 per cent. Patients may be granted a maximum allowable dose of 40,000 IU per week. Special authorization will be granted for 12 months."

In order to comply with this criterion, if the patient has iron overload, the prescriber must state this in the request, or alternatively, information is required regarding the patient's transferrin saturation along with the results of liver function tests, if applicable.

Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on therapy.

ABC 60006 (2017/08)

Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/ Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/ Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60027).

- All requests for abatacept, adalimumab, anakinra, certolizumab, etanercept, golimumab, infliximab, sarilumab, tocilizumab or tofacitinib for Rheumatoid Arthritis must be submitted using the *Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/ Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ABATACEPT/ ADALIMUMAB/ ANAKINRA/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ SARILUMAB/ TOCILIZUMAB/ TOFACITINIB for Rheumatoid Arthritis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis
- ☐ Rheumatoid Arthritis
- ☐ Other (specify)

Indicate requested drug

☐ Actemra	☐ *Enbrel	☐ *Inflectra	☐ Orencia	☐ Simponi
☐ *Brenzys	☐ *Erelzi	☐ Kevzara	☐ *Remicade	☐ Xeljanz
☐ Cimzia	☐ Humira	☐ Kineret	☐ *Renflexis	

***Note:** all new requests for Enbrel for etanercept naïve patients will be assessed for coverage with Brenzys or Erelzi, and all new requests for Remicade for infliximab naïve patients will be assessed for coverage with Inflectra or Renflexis. Enbrel and Remicade will not be approved for new starts; however, coverage for these brands will continue for patients who are currently well maintained and are considered a 'responder' as defined in criteria.

Current weight (kg)

Dosage

Frequency

***Pre-treatment scores**

DAS28 Score ___.____ Date _____

HAQ Score ___.___ ___ Date _____

Current scores

DAS28 Score ___.____ **OR** ☐ ACR20 (renewals only) Date _____

HAQ Score ___.___ ___ Date _____

*Requests for patients new to the requested drug and requests for patients new to coverage but currently maintained on the requested drug require pre-treatment scores. All scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places.

Please provide reason if a switch to a different drug is requested

Note: patients will not be permitted to switch back to a previously trialed drug if they were deemed unresponsive to therapy.

For all drugs EXCEPT Abatacept
Will the patient be maintained on methotrexate in combination with the requested drug? ☐ YES ☐ NO

For Abatacept ONLY
Will the patient be maintained on methotrexate or another DMARD in combination with Abatacept? ☐ YES ☐ NO

If NO to any of the above, please specify reason

Please provide the following information for all NEW requests

Previous medications utilized - Dose, duration and response are required for ALL FOUR of the following

- ☐ Methotrexate PO _____
- ☐ Methotrexate SC or IM _____
- ☐ Methotrexate with another DMARD other than leflunomide (specify agent) _____
- ☐ Leflunomide _____

Please provide the following information for all NEW anakinra requests

Previous medications utilized - Indicate the contraindication or adverse effects related to the following

☐ Abatacept	_____	☐ Infliximab	_____
☐ Adalimumab	_____	☐ Golimumab	_____
☐ Certolizumab	_____	☐ Rituximab	_____
☐ Etanercept	_____	☐ Tocilizumab	_____

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Ezetimibe Special Authorization Request Form

On the reverse is the official *Ezetimibe Special Authorization Request Form* (ABC 60036).

- All requests for ezetimibe must be submitted using the *Ezetimibe Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

EZETIMIBE
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of EZETIMIBE

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

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

Special authorization may be granted for 6 months. This product is eligible for auto-renewal.

**High cardiovascular risk is defined as possessing one of the following*

1) *pre-existing cardiovascular disease and/or cerebrovascular disease*
2) *diabetes*
3) *familial hypercholesterolemia*
4) *greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool*
5) *three or more of the following risk factors:*
   - *family history of premature cardiovascular disease*
   - *smoking*
   - *hypertension*
   - *obesity*
   - *glucose intolerance*
   - *renal disease.*

Please provide the following information for all NEW requests

A. Diagnosis ☐ hypercholesterolemia ☐ other (please specify) _____

B. Information regarding previous STATIN use

☐ Statin(s) HAS been utilized. Please specify which statin has been utilized (including dose and duration) _____

Nature of response to STATIN: ☐ Intolerance ☐ Failure to achieve target LDL ☐ Other _____

☐ Statin(s) has NOT been utilized. Contraindication? ☐ Yes ☐ No Please elaborate _____

C. Presence of CARDIOVASCULAR risk factors (CHECK ALL THAT APPLY)

*In order to comply with the above criteria check **at least three** of the following*

☐ family history of premature cardiovascular disease ☐ smoking ☐ hypertension ☐ obesity ☐ glucose intolerance ☐ renal disease

AND/OR

*In order to comply with the above criteria check **at least one** of the following*

☐ pre-existing cardiovascular disease and/or cerebrovascular disease ☐ diabetes ☐ familial hypercholesterolemia

☐ greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool

D. Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form

On the reverse is the official *Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form* (ABC 60045).

- All requests for peginterferon alfa-2a for Chronic Hepatitis C must be submitted using the *Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

PEGINTERFERON ALFA-2A for Chronic Hepatitis C
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL

BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

NOTIFICATION

You may be eligible to receive Pegasys drug benefits. Information from your prescriber is required to determine eligibility. Your consent is required: (A) for your prescriber to release necessary and relevant information to Alberta Blue Cross, Alberta Health and, if requested, to Alberta Human Services; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health.

PATIENT CONSENT

I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health, and (if they request it) to Alberta Human Services (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.

Date Patient's signature

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other

REGISTRATION NUMBER

PHONE

FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Diagnosis of chronic hepatitis C

	YES	NO	Not tested
Is the patient serum HCV RNA positive (by PCR), pre-treatment….....	☐	☐	☐

Evidence of active liver disease:

At least one of the following

	YES	NO	Not tested
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment ……	☐	☐	☐
OR			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis)……	☐	☐	☐
OR			
c) does the patient have elevated liver stiffness as demonstrated by transient elastography (fibrosis)……	☐	☐	☐

If the patient is currently on peginterferon alfa-2a, indicate start date (YYY-MM-DD):

INITIAL REQUEST:

Is the patient intolerant to ribavirin? ☐ YES ☐ NO

Is a baseline serum sample stored for future testing? ☐ YES ☐ NO

Initial length of approval

- ☐ **Advanced fibrosis or cirrhosis** (regardless of genotype)…...48 weeks
- ☐ **Genotype 1**……..……..……14 weeks
- ☐ **Genotype 2 or 3** ……..……14 weeks
- ☐ **Genotype 4, 5 or 6** ……14 weeks

EXTENSION REQUEST:

Request for treatment extension at 14 weeks (excluding patients with advanced fibrosis and cirrhosis)

Is the patient serum HCV RNA negative at 12 weeks?

- ☐ YES → Patient may be eligible for an additional 34 weeks of coverage (total 48 wks)
- ☐ NO → Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)?
  - ☐ YES → Patient may be eligible for an additional 34 weeks of coverage (total 48 wks)
  - ☐ NO

PREVIOUS THERAPY: Consideration may be given to patients who have previously received therapy and who meet at least one of the following

- ☐ Advanced fibrosis or cirrhosis
- ☐ Patient relapsed following non-pegylated interferon/ribavirin combination therapy

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE

Please forward this request to

- **Alberta Blue Cross, Clinical Drug Services**
  10009 108 Street NW, Edmonton, Alberta T5J 3C5
- FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form

On the reverse is the official *Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60011).

- All requests for adalimumab, etanercept or tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be submitted using the *Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ADALIMUMAB/ETANERCEPT/TOCILIZUMAB for Polyarticular Juvenile Idiopathic Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH:YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Indicate requested drug**	**For tocilizumab requests, indicate current weight (kg)**	**Dosage** **Dosing frequency**
☐ Polyarticular Juvenile Idiopathic Arthritis ☐ Other (please specify) _____	☐ Adalimumab ☐ Tocilizumab ☐ Etanercept		

Please provide reason if a switch to a different biologic agent is requested

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy

Pre-treatment ACR Pedi 30 score (provide for NEW requests for treatment naïve and treatment experienced patients)	**Current ACR Pedi 30 score (provide for ALL RENEWAL requests and for INITIAL requests for treatment experienced patients)**
Date of assessment _____	Date of assessment _____
1. Rheumatologist global assessment (0-10) _____	1. Rheumatologist global assessment (0-10) _____
2. Patient global assessment (0-10) _____	2. Patient global assessment (0-10) _____
3. No. of active joints* _____	3. No. of active joints* _____
4. No. of joints with LROM _____	4. No. of joints with LROM _____
5. CHAQ (0-3) _____	5. CHAQ (0-3) _____
6. ESR (mm/hr) _____ or CRP _____	6. ESR (mm/hr) _____ or CRP _____
*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both	*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both

Please provide the following information for ALL NEW requests

Previous DMARDs utilized (specify agents): Dose, duration and response is required

Additional information relating to request (e.g. reasons why any of the above therapies were not tried)

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/ Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form

On the reverse is the official *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/ Secukinumab for Psoriatic Arthritis Special Authorization Request Form* (ABC 60029).

- All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab, ixekizumab, or secukinumab for Psoriatic Arthritis must be submitted using the *Adalimumab/Certolizumab/ Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ADALIMUMAB/CERTOLIZUMAB/ETANERCEPT/ GOLIMUMAB/INFLIXIMAB/IXEKIZUMAB/SECUKINUMAB for Psoriatic Arthritis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER	

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

☐ CPSA ☐ ACO REGISTRATION NUMBER
☐ CARNA ☐ ADA+C
☐ ACP ☐ Other

PHONE | FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

- ☐ Polyarticular Psoriatic Arthritis
- ☐ Pauciarticular Psoriatic Arthritis
  - →Joints affected
    - ☐ Knee joint(s)
    - ☐ Hip joint(s)
    - ☐ Other (specify) _____
- ☐ Other (specify) _____

Indicate requested drug

- ☐ Cimzia
- ☐ Cosentyx
- ☐ Enbrel
- ☐ Humira
- ☐ *Inflectra
- ☐ *Remicade
- ☐ *Renflexis
- ☐ Simponi
- ☐ Taltz

***Note: all new requests for Remicade for infliximab naïve patients will be assessed for coverage with Inflectra or Renflexis. Remicade will not be approved for new infliximab starts; however, coverage for Remicade will continue for patients who are currently well maintained on Remicade and are considered a 'responder' as defined in criteria.**

Current weight (kg)

Dosage

Frequency

***Pre-treatment scores**

DAS28 score ___.____ Date _____

HAQ score ___.___ ___ Date _____

Current scores

DAS28 score ___.____ **OR** ☐ ACR20 (renewals only) Date _____

HAQ score ___.___ ___ Date _____

*Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores. All scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places.

Please provide reason if a switch to a different biologic agent is requested

Note: patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Will the patient be maintained on methotrexate in combination with the requested biologic?

☐ YES ☐ NO (If not, please specify reason) _____

Please provide the following information for all NEW requests

Previous medications utilized - dose, duration and response are required for ALL THREE of the following

☐ Methotrexate PO _____

☐ Methotrexate SC or IM _____

☐ DMARD other than MTX (specify agent) _____

For Cosentyx requests only: has the patient had an inadequate response to previous therapy with an anti-TNF alpha agent? ☐ YES ☐ NO

Additional information relating to request (such as reasons why any of the above therapies were not tried)

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Select Quinolones Special Authorization Request Form

On the reverse is the official *Select Quinolones Special Authorization Request Form* (ABC 60042).

- All requests for ciprofloxacin, levofloxacin or moxifloxacin must be submitted using the *Select Quinolones Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

SELECT QUINOLONES*

*ciprofloxacin/levofloxacin/moxifloxacin

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed. Incomplete requests CANNOT BE EXPEDITED.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Only the following conditions may be authorized for coverage.
Drug requested and condition requiring quinolone treatment: Please check the boxes that apply to your patient.

☐ CIPROFLOXACIN

Respiratory tract infection

- ☐ End stage COPD with or without bronchiectasis, where there has been documentation of previous *Pseudomonas aeruginosa* colonization/infection
- ☐ Pneumonic illness in cystic fibrosis

Genitourinary tract infection

- ☐ Urinary Tract Infection
- ☐ Prostatitis
- ☐ Prophylaxis of urinary tract surgical procedures
- ☐ Gonococcal infection

Skin and soft tissue / bone and joint infection

- ☐ Malignant / invasive otitis externa
- ☐ Bone / joint infection due to gram-negative organisms
- ☐ Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole (e.g. diabetic foot infection, decubitus ulcers)

Gastrointestinal tract infection

- ☐ Bacterial gastroenteritis where antimicrobial therapy is indicated
- ☐ Typhoid fever (enteric fever)
- ☐ Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole (e.g. intra-abdominal infections)

Other

- ☐ Prophylaxis of adult contacts of cases of invasive meningococcal disease
- ☐ Therapy / step-down therapy of hospital acquired gram-negative infections
- ☐ Empiric therapy of febrile neutropenia in combination with other appropriate agents
- ☐ Exception case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references (e.g. AMA CPGs or Bugs and Drugs)

⬇

Please specify details _____

- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases

☐ LEVOFLOXACIN ☐ MOXIFLOXACIN

- ☐ 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
- ☐ 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 three months, HIV/AIDS, or smoking)
- ☐ 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
- ☐ Acute sinusitis 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, in patients with β–lactam (penicillin & cephalosporin) allergy
- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in infectious diseases

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **(780) 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

ALBERTA BLUE CROSS®

BACKGROUND INFORMATION REGARDING SELECT QUINOLONE SPECIAL AUTHORIZATION PROCESS

Optional Special Authorization for Quinolones

Select quinolones covered through optional special authorization for Alberta Government sponsored drug programs include **ciprofloxacin, levofloxacin** and **moxifloxacin**. Norfloxacin continues to be eligible for coverage as an unrestricted benefit.

Rationale

These criteria are the result of a comprehensive evidence-based review undertaken as an initiative of the Alberta Health Expert Committee on Drug Evaluation and Therapeutics through the Review of Benefit Status (ROBS) process. This review examined systemic antimicrobial agents currently covered via the *Alberta Drug Benefit List*. The mandate of the review was to encourage optimal utilization and to help prevent antimicrobial resistance. The review was conducted according to the established ROBS process and included systematic reviews of the medical literature and analysis of current utilization patterns. External Alberta physicians and pharmacists with expertise in the treatment of infectious diseases provided advice and assistance for this review process. Information and experience from other provincial jurisdictions that have undertaken similar antimicrobial reviews were also taken into consideration in this review.

The review was completed in accordance with pre-determined guiding principles that sought to allow optimal practice to proceed, ensuring optimal use and helping prevent resistance, while at the same time being unencumbered by undue paperwork and unnecessary restrictions.

Role of Physicians

In conjunction with these new criteria, physicians have two options by which patients may be eligible for coverage of these specific antimicrobial products. This offers a streamlined alternative to traditional Special Authorization.

1) Physicians can register to be a designated prescriber. Registration allows for patients to receive coverage of quinolones **without Special Authorization as long as the prescription is written for one of the criteria for coverage** set out in the *Alberta Drug Benefit List*, and referenced on this form. *Should a designated physician wish to prescribe one of the select quinolones outside the coverage criteria, they may do so but must indicate this on the prescription; however, patients will not be eligible for payment under the government-sponsored program for such prescriptions and the patient may choose to receive the product at their expense*.

2) **Physicians who choose not to register will be considered 'non-designated prescribers'**.
   - Such physicians **will be required to apply for Special Authorization** on the patient's behalf.
   - A patient's claims for prescriptions written by non-designated physicians will be subject to a first fill forgiveness rule. This means the first claim will be paid but subsequent claims for the same active ingredient (irrespective of strength, route and form) within a 90-day period will require Special Authorization.
   - Special authorization requests must be submitted using the *Select Quinolones Special Authorization Request Form*. If the appropriate sections of this request form are completed *and* coverage criteria are met, the request will be processed within approximately six to 18 hours of receiving the request. Subsequent claims will be rejected unless Special Authorization is granted.

To register to become a designated prescriber please complete the *Select Quinolone Antibiotics Registration for Designated Prescriber Status* Form found at www.health.alberta.ca/services/drug-benefit-list.html and return your completed registration by FAX to 1-877-305-9911.

For more information, please contact Clinical Drug Services, Alberta Blue Cross, at 780-498-8480 in Edmonton, and 1-866-998-8480 toll-free all other areas.

Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form

On the reverse is the official *Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form* (ABC 60043).

- All requests for alendronate, raloxifene, or risedronate for Osteoporosis must be submitted using the *Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ALENDRONATE / RALOXIFENE / RISEDRONATE for Osteoporosis SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX or the most recent (2010) version of the Canadian Association of Radiologist and Osteoporosis Canada (CAROC) table.

*** Alendronate 70 mg and risedronate 35 mg are regular benefits not requiring Special Authorization.**

** Alendronate and risedronate also have Special Authorization criteria for Paget's disease. Please refer to the Alberta Drug Benefit List for alendronate and risedronate's other criteria for the indication of Paget's disease: http://www.health.alberta.ca/services/drug-benefit-list.html

Please provide the following information for ALL requests

Indicate which drug is requested (check ONE box) ☐ Alendronate ☐ Raloxifene ☐ Risedronate

Please provide the following information for all NEW requests

Diagnosis ☐ For the treatment of Osteoporosis ☐ Osteopenia ☐ Other (please specify) _____

Fracture risk

a) Has the patient experienced FRACTURES related to the diagnosis? ☐ No ☐ Yes

b) Does the patient have a 20% or greater 10-year fracture risk? ☐ No ☐ Yes

Information regarding previous alendronate 70mg or risedronate 35mg use

☐ alendronate 70mg or risedronate 35mg HAS been utilized.

Nature of response ☐ Intolerance

☐ Other (please specify) _____

☐ alendronate 70mg or risedronate 35mg has NOT been utilized (please specify) _____

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		• **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Celecoxib Special Authorization Request Form

On the reverse is the official *Celecoxib Special Authorization Request Form* (ABC 60032).

- All requests for celecoxib must be submitted using the *Celecoxib Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 401-1150 in Edmonton and area
  1-888-401-1150 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

CELECOXIB
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE: / FAX:
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of CELECOXIB

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

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

Special authorization may be granted for six months.

This product is eligible for auto-renewal.

☐ **NEW** **Please provide the following information for NEW requests (check ALL that apply):**

1) Is this patient at high risk of upper GI complications? ☐ Yes ☐ No

2) Does this patient have a documented history of ulcers? ☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FOR CELECOXIB REQUESTS ONLY:** • FAX: **780-401-1150** in Edmonton • **1-888-401-1150** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form

On the reverse is the official *Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form* (ABC 60013)

- All requests for filgrastim, pegfilgrastim or plerixafor must be submitted using the *Filgrastim/ Pegfilgrastim/Plerixafor Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

FILGRASTIM / PEGFILGRASTIM / PLERIXAFOR SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested (check ONE box)

- ☐ ***Grastofil (filgrastim) → complete Section I or II**
- ☐ ***Neupogen (filgrastim) → complete Section I or II**
- ☐ **Neulasta (pegfilgrastim) → complete Section I only**
- ☐ **Plerixafor (e.g. Mozobil) → complete Section III only**

***Note: all requests for filgrastim will be assessed for coverage with Grastofil. Neupogen will not be approved for new filgrastim starts or repeat treatments; however, coverage for Neupogen will continue for pediatric patients and patients with congenital, cyclic or idiopathic neutropenia who are currently maintained on Neupogen.**

Section I (Filgrastim requests for the first criterion and all pegfilgrastim requests, check ALL that apply)

a) Please **SPECIFY** the type of cancer being treated with chemotherapy for curative intent _____

b) Please provide the indication for which the drug is requested

- ☐ patient has febrile neutropenia
- ☐ patient had febrile neutropenia from a previous cycle of the same chemotherapy
- ☐ patient will be undergoing a *high dose* or *aggressive* chemotherapy where febrile neutropenia is very likely to occur
- ☐ other (please **SPECIFY**) _____

Section II (Filgrastim requests for other criteria, check ALL that apply)

a) Please provide the indication for which filgrastim is requested

- ☐ patient has neutropenia AND a diagnosis of ☐ congenital, cyclic or idiopathic neutropenia OR ☐ acute myeloid leukemia
- ☐ other, please **SPECIFY** _____

Section III (Plerixafor requests, check ALL that apply)

a) Please provide the patient's current weight (kg) _____

b) Please **SPECIFY** the type of cancer being treated

- ☐ multiple myeloma (MM) ☐ Non-Hodgkin's lymphoma (NHL) ☐ other, please **SPECIFY** _____

c) Please provide the indication for which the drug is requested

- ☐ patient is undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy
- ☐ other (please **SPECIFY**) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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FILGRASTIM / PEGFILGRASTIM / PLERIXAFOR SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

Criteria for coverage

FILGRASTIM (e.g. Grastofil, Neupogen) Special Authorization Criteria
Effective April 1, 2017, all Special Authorization requests for filgrastim will be assessed for coverage with Grastofil. Neupogen will not be approved for new filgrastim starts or repeat treatments (e.g. new course of chemotherapy); however, coverage for Neupogen will continue for pediatric patients and patients with congenital, cyclic or idiopathic neutropenia who are currently maintained on Neupogen. 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. Following induction and consolidation treatment for acute myeloid leukemia, for the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization." "In patients with a diagnosis of congenital, cyclic or idiopathic neutropenia, to increase neutrophil counts and to reduce the incidence and duration of infection." Please note for the first criterion: coverage cannot be considered for palliative patients.
PEGFILGRASTIM (e.g. Neulasta) Special Authorization Criteria
"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." Please note: coverage cannot be considered for palliative patients.
PLERIXAFOR (e.g. Mozobil) Special Authorization Criteria
"For the treatment of patients with Non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM) undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy, in combination with filgrastim, when prescribed by a designated prescriber." Coverage may be approved for a maximum of 4 doses (0.24mg/kg given daily) for a single mobilization attempt. Special authorization may be granted for 12 months.

Fentanyl Special Authorization Request Form

On the reverse is the official *Fentanyl Special Authorization Request Form* (ABC 60005).

- All requests for fentanyl or fentanyl citrate must be submitted using the *Fentanyl Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

FENTANYL
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				COVERAGE TYPE
PATIENT LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION		
PRESCRIBER LAST NAME FIRST NAME INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	
STREET ADDRESS		
CITY, PROVINCE	PHONE	FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

CRITERIA FOR COVERAGE OF FENTANYL

Fentanyl injection	Fentanyl patch
For the treatment of persistent, severe chronic pain in those patients who cannot swallow or who are intolerant of morphine and/or hydromorphone if not contraindicated. Special authorization may be granted for six months. This product is eligible for auto-renewal.	For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who cannot swallow. Special authorization may be granted for six months. For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who require opioid therapy at a total daily dose of at least 60 mg/day oral morphine equivalents. Patients must have tried and not been able to tolerate at least two discrete courses of therapy with two of the following agents: morphine, hydromorphone and oxycodone, if not contraindicated. Special authorization may be granted for six months. This product is eligible for auto-renewal.

Product(s) requested ☐ **FENTANYL INJECTION** ☐ **FENTANYL PATCH**

Nature of the patient's pain ☐ **Persistent, severe chronic pain** ☐ **Other:**

For FENTANYL PATCH requests

Patients must have tried at least two discrete courses* of therapy with two of the required agents: morphine, hydromorphone and oxycodone.

* A *discrete course* is defined as a separate treatment course, which may involve more than one agent used at one time to manage the patient's condition.

Treatment course 1 MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug)

☐ morphine _____

☐ hydromorphone _____

☐ oxycodone _____

☐ other (specify) _____

Treatment course 2 MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug)

☐ morphine _____

☐ hydromorphone _____

☐ oxycodone _____

☐ other (specify) _____

For FENTANYL INJECTION requests

Previous MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug)

☐ morphine _____

☐ hydromorphone _____

If patient is unable to swallow, please provide information regarding specific reasons patient is unable take oral medications

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **780-498-8384** Edmonton · **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/ Ustekinumab for Plaque Psoriasis Special Authorization Request Form

On the reverse is the official *Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form* (ABC 60030).

- All requests for adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab for Plaque Psoriasis must be submitted using the *Adalimumab/Etanercept/ Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request

ALBERTA BLUE CROSS®

ADALIMUMAB/ ETANERCEPT/ INFLIXIMAB/ IXEKIZUMAB/ SECUKINUMAB/ USTEKINUMAB for Plaque Psoriasis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY , PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Indicate requested drug**	**Current weight (kg)**	**Dosage**
☐ Plaque Psoriasis ☐ Other (specify)	☐ Cosentyx ☐ Humira ☐ *Remicade ☐ Stelara ☐ Enbrel ☐ *Inflectra ☐ *Renflexis ☐ Taltz ***Note: all new requests for Remicade for infliximab naïve patients will be assessed for coverage with Inflectra or Renflexis. Remicade will not be approved for new infliximab starts; however, coverage for Remicade will continue for patients who are currently well maintained on Remicade and are considered a 'responder' as defined in criteria.**		**Frequency**

Location: Prior to treatment with the requested biologic, did the patient have significant involvement of the face, palms of the hands, soles of the feet or genital region? ☐ YES ☐ NO

***Pre-treatment scores**		**Current scores**	
PASI _____	Date _____	PASI _____	Date _____
DLQI _____	Date _____	DLQI _____	Date _____

*Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores.
Note: PASI and DLQI scores are required for all requests including those requests for patients that have significant involvement of the face, palms, soles of the feet or genital region.

Please provide reason if a switch to a different biologic agent is requested

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Please provide the following information for all NEW requests

Previous medications/therapies utilized: Check all that apply and indicate dose, duration and response.

☐ Methotrexate PO _____

☐ Methotrexate SC or IM _____

☐ Cyclosporine _____

☐ Phototherapy _____

Additional information relating to request (e.g. reasons why any of the above therapies were not tried)

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780- 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

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Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/ Secukinumab for Ankylosing Spondylitis Special Authorization Request Form

On the reverse is the official *Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form* (ABC 60028).

- All requests for adalimumab, certolizumab, etanercept, golimumab, infliximab or secukinumab for Ankylosing Spondylitis must be submitted using the *Adalimumab/ Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ADALIMUMAB/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ SECUKINUMAB for Ankylosing Spondylitis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Ankylosing Spondylitis (meeting modified NY criteria)

☐ Other (specify)

Indicate requested drug

☐ *Brenzys ☐ Cosentyx ☐ *Erelzi ☐ *Inflectra ☐ *Renflexis

☐ Cimzia ☐ *Enbrel ☐ Humira ☐ *Remicade ☐ Simponi

***Note: all new requests for Enbrel for etanercept naïve patients will be assessed for coverage with Brenzys or Erelzi, and all new requests for Remicade for infliximab naïve patients will be assessed for coverage with Inflectra or Renflexis. Enbrel and Remicade will not be approved for new starts; however, coverage for these brands will continue for patients who are currently well maintained and are considered a 'responder' as defined in criteria.**

Current weight (kg)

Dosage

Frequency

Please provide the following information for all NEW requests

Previous medications utilized

Have two or more NSAIDs been tried for a minimum of 4 weeks each at maximum tolerated or recommended doses?

☐ YES (please **SPECIFY** below) ☐ NO

	Please **SPECIFY** the NSAID	Please **SPECIFY** the dose, duration, and response
NSAID #1		
NSAID #2		

Other, please **SPECIFY**

NEW requests: Please provide *pre-treatment scores

BASDAI #1	Date (YYYY-MM-DD)
BASDAI #2	Date (YYYY-MM-DD)
Spinal Pain VAS #1 (cm)	Date (YYYY-MM-DD)
Spinal Pain VAS #2 (cm)	Date (YYYY-MM-DD)

* Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores. Scores 1 and 2 for each parameter must be at least 8 weeks apart.

RENEWAL requests: Please provide current scores

BASDAI	Date (YYYY-MM-DD)
Spinal pain VAS (cm)	Date (YYYY-MM-DD)

Please provide reason if a switch to a different biologic agent is requested

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to ▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/ Fistulizing Crohn's Disease Special Authorization Request Form

On the reverse is the official *Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* (ABC 60031).

- All requests for adalimumab or vedolizumab for Moderately to Severely Active Crohn's Disease or infliximab for Moderately to Severely Active Crohn's/Fistulizing Crohn's Disease must be submitted using the *Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ADALIMUMAB / VEDOLIZUMAB for Crohn's / INFLIXIMAB for Crohn's / Fistulizing Crohn's Disease
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY , PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis
- ☐ Moderately to Severely Active Crohn's (MSAC)
- ☐ Fistulizing Crohn's
- ☐ Other (please specify)

Indicate requested drug
- ☐ Entyvio
- ☐ Humira
- ☐ *Inflectra
- ☐ *Remicade
- ☐ *Renflexis

***Note: All new requests for Remicade for infliximab naïve patients will be assessed for coverage with Inflectra or Renflexis. Remicade will not be approved for new infliximab starts; however, coverage for Remicade will continue for patients who are currently well maintained on Remicade and are considered a "responder" as defined in criteria.**

Current weight (kg)

Dosage

Frequency

Date of last dose

For INITIAL requests, please indicate if the drug is requested for a
- ☐ NEW patient who has never been treated with the requested drug by any health care provider
- ☐ EXISTING patient who is being treated, or have previously been treated with the requested drug

Please provide reason if a switch to a different biologic agent or change in dose is requested.

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy

Infliximab For Fistulizing Crohn's Disease

INITIAL requests

Dose, duration and response are required for all medications previously utilized.

Azathioprine

6-mercaptopurine

Antibiotic(s) (specify drug name)

NEW patient

Does the patient have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite previous therapy?

☐ Yes ☐ No

EXISTING patient

Please indicate response to treatment with Infliximab

- ☐ Closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline.
- ☐ Incomplete response (please specify) _____
- ☐ Loss of response to 5mg/kg dosing: increase to 10mg/kg required

Adalimumab, Infliximab or Vedolizumab for MSAC

INITIAL requests

Dose, duration and response are required for all medications previously utilized.

Azathioprine

6-mercaptopurine

Methotrexate

Mesalamine

Glucocorticoid(s) (specify drug name)

ALL requests

Modified Harvey-Bradshaw Index score _____

Date of score _____

For Infliximab requests for an increase to 10mg/kg dosing

1) Is the patient already maintained on infliximab 10 mg/kg?

☐ Yes ☐ No

2) Confirm the patient had an incomplete response to Infliximab 5mg/kg dosing:

☐ Yes ☐ No (explain) _____

3) Most recent Modified Harvey-Bradshaw Index score from when the patient was *responding* to 5mg/kg dosing _____ Date_____

Additional information relating to request (e.g. reasons why any of the prerequisite therapies were not tried)

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX 780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Rituximab for Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Rituximab for Rheumatoid Arthritis Special Authorization Request Form* (ABC 60046).

- All requests for rituximab for Rheumatoid Arthritis must be submitted using the *Rituximab for Rheumatoid Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

RITUXIMAB for Rheumatoid Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests:

Diagnosis
☐ Rheumatoid Arthritis
☐ Other (specify)

***Pre-treatment scores**

DAS28 score _____

Date _____

AND

HAQ score _____

Date _____

Dosage

Dosing frequency

Requests for re-treatment after 2 dose course

Date of initial dose of the previous course of therapy

_____

Response scores 16 to 24 weeks after initial dose of previous course of therapy

DAS28 score _____ Date _____

AND HAQ score _____ Date _____

Current scores

DAS28 score _____ Date _____

AND HAQ score _____ Date _____

Please provide reason if a switch from a different biologic agent to rituximab is requested

Date of last dose

_____

Note Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

* New requests for patients currently maintained on the requested biologic also require pre-treatment scores. Scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places.

Will the patient be maintained on methotrexate in combination with rituximab?

☐ YES ☐ NO (If not, please specify reason)

Please provide the following information for all NEW requests:

Previous medications/therapies utilized - Dose, duration and response is required for ALL FIVE of the following:

☐ Methotrexate PO

☐ Methotrexate SC or IM

☐ Methotrexate with another DMARD other than leflunomide (specify agent)

☐ Leflunomide

☐ Anti-TNF therapy

Additional information relating to request (e.g. reasons why any of the above therapies were not tried)

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX 780 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

Imiquimod Special Authorization Request Form

On the reverse is the official *Imiquimod Special Authorization Request Form* (ABC 60038).

- All requests for imiquimod must be submitted using the *Imiquimod Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

IMIQUIMOD
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of IMIQUIMOD

For the treatment of Actinic Keratosis located on the head and neck in patients who have failed treatment with cryotherapy (where appropriate) and 5-fluorouracil (5-FU). Special authorization may be granted for six months.

This product is eligible for auto-renewal.

Please provide the following information for NEW requests (check ALL that apply)

Diagnosis

☐ Actinic Keratosis → Area affected

☐ Head or neck ☐ Other (please specify) _____

☐ Other (please specify)

Previous medications/therapies utilized

Please indicate if the following medication/therapy have been tried and the response

1) cryotherapy ☐ Yes → Response

☐ Lack of response ☐ Intolerance ☐ Other (please specify) _____

☐ No → ☐ Not appropriate ☐ Other (please specify) _____

AND

2) 5-fluorouracil (5-FU) ☐ Yes→ Response

☐ Lack of response ☐ Intolerance ☐ Other (please specify) _____

☐ No (specify reason, if applicable) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form

On the reverse is the official *Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form* (ABC 60024).

- All requests for aripiprazole, paliperidone or risperidone prolonged release injection must be submitted using the *Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ARIPIPRAZOLE/PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested

☐ **Aripiprazole Prolonged Release Injection (e.g. Abilify Maintena)**

☐ **Risperidone Prolonged Release Injection (e.g. Risperdal Consta)**

☐ **Paliperidone 1-Month Prolonged Release Injection (e.g. Invega Sustenna)**

☐ **Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Trinza)**

Diagnosis

☐ Schizophrenia or related psychotic disorder ☐ Other (please specify) _____

Compliance issues

Has this patient demonstrated a pattern of significant non-compliance with other dosage forms that is compromising or has compromised this patient's therapeutic success?

☐ Yes ☐ No, specify reason _____

Previous drug therapy (CHECK ALL THAT APPLY) In order to comply with criteria, check at least one of the following

☐ experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; or

☐ is refractory to trials of at least two other antipsychotic therapies.

Risperidone or paliperidone requests only	**Aripiprazole requests only**
Previous risperidone or paliperidone therapy: does the patient possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy? ☐ Yes ☐ No, specify reason _____	**Previous aripiprazole therapy:** does the patient possess clinical evidence of previous successful treatment with aripiprazole therapy? ☐ Yes ☐ No, specify reason _____

Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Trinza) requests only

Has this patient been maintained on Paliperidone 1-Month Prolonged Release Injection (e.g. Invega Sustenna) for at least four months?

☐ Yes ☐ No, specify reason _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

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ALBERTA BLUE CROSS®

ARIPIPRAZOLE/PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION
SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government-sponsored drug programs.

Criteria for coverage

ARIPIPRAZOLE PROLONGED RELEASE INJECTION (e.g. Abilify Maintena)

"For the maintenance treatment of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with aripiprazole therapy;

AND who meet at least one of the following criteria:

-Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
-Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

PALIPERIDONE 1-MONTH PROLONGED RELEASE INJECTION (e.g. Invega Sustenna)

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

PALIPERIDONE 3-MONTH PROLONGED RELEASE INJECTION (e.g. Invega Trinza)

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
- Is refractory to trials of at least two other antipsychotic therapies.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

RISPERIDONE PROLONGED RELEASE INJECTION (e.g. Risperdal Consta)

"For the management of the manifestations of schizophrenia and related psychotic disorders in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form

On the reverse is the official *Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60010).

- All requests for abatacept for Polyarticular Juvenile Idiopathic Arthritis must be submitted using the *Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ABATACEPT for Polyarticular Juvenile Idiopathic Arthritis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH: YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA
- ☐ CARNA
- ☐ ACP
- ☐ ACO
- ☐ ADA+C
- ☐ Other

REGISTRATION NUMBER

PHONE	FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

- ☐ Polyarticular Juvenile Idiopathic Arthritis
- ☐ Other (please specify) _____

Current weight (kg)

Dosage

Dosing frequency

Please provide reason if a switch from a different biologic agent to abatacept is requested

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy

Current ACR Pedi 30 FLARE score (provide for ALL requests)

Date of assessment_____

1. Rheumatologist global assessment (0-10) _____
2. Patient global assessment (0-10) _____
3. No. of active joints* _____
4. No. of joints with LROM _____
5. CHAQ (0-3) _____
6. ESR (mm/hr) _____ or CRP _____

*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both

ACR Pedi 30 RESPONSE score at 16 to 20 weeks after first dose of previous abatacept treatment (provide for RETREATMENT requests)

Date of assessment_____

1. Rheumatologist global assessment (0-10) _____
2. Patient global assessment (0-10) _____
3. No. of active joints* _____
4. No. of joints with LROM _____
5. CHAQ (0-3) _____
6. ESR (mm/hr) _____ or CRP _____

*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both

Please provide the following information for ALL NEW requests

Previous medications utilized: Dose, duration and response is required

- ☐ DMARD(s) (please specify agents)
- ☐ Adalimumab
- ☐ Etanercept
- ☐ Tocilizumab
- ☐ Other (please specify agent)

Additional information relating to request (e.g. reasons why any of the above therapies were not tried)

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

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ABC 60010 (2016/10)

Montelukast/Zafirlukast Special Authorization Request Form

On the reverse is the official *Montelukast/Zafirlukast Special Authorization Request Form* (ABC 60039).

- All requests for montelukast or zafirlukast must be submitted using the *Montelukast/ Zafirlukast Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

MONTELUKAST/ZAFIRLUKAST
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate drug requested (check one box): ☐ **Montelukast 5mg + 10mg (e.g. Singulair)** ☐ **Zafirlukast 20mg (e.g. Accolate)**

Criteria for Coverage of MONTELUKAST / ZAFIRLUKAST

For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:

a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, OR

b) cannot operate inhaler devices.

For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists.

Special Authorization for both criteria may be granted for six months. This product is eligible for auto-renewal.

Note: Refer to the Alberta Drug Benefit List for Restricted Benefit coverage of patients two to 18 years of age inclusive for Montelukast and 12 to 18 years of age inclusive for Zafirlukast.

Please provide the following information for NEW requests (Section 1 and Section 2 or 3 must be completed)

Section 1: Indication

☐ Prophylaxis and chronic treatment of asthma (If yes, proceed to Section 2A or 2B only)
☐ Prophylaxis of exercise-induced bronchoconstriction (If yes, proceed to Section 3 only)
☐ Other (please specify) _____

Section 2: Prophylaxis and chronic treatment of asthma

A. Previous Medication Use

a) Please indicate if an inhaled glucocorticosteroid was used
☐ Yes ☐ No (If no, please specify reason) _____

b) Please indicate if a long-acting beta 2 agonist (e.g. salmeterol or formoterol) was tried
☐ Yes → Response: ☐ Persistent symptoms
☐ Other (please specify) _____
☐ No (If no please specify) _____

B. Use of Inhaler Device

Please indicate if the patient has difficulty using an inhaler device:
☐ Yes (Please elaborate on the nature of the difficulty)_____
_____
☐ No

Section 3: Prophylaxis of exercise induced bronchoconstriction

Does this patient have tachyphylaxis with long-acting beta 2 agonists? ☐ Yes ☐ No ☐ Other (please specify) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Febuxostat Special Authorization Request Form

On the reverse is the official *Febuxostat Special Authorization Request Form* (ABC 60037).

- All requests for febuxostat must be submitted using the *Febuxostat Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

FEBUXOSTAT
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of FEBUXOSTAT

For patients with symptomatic gout who have documented hypersensitivity OR severe intolerance to allopurinol, AND intolerance or lack of response to sulfinpyrazone. Special Authorization may be granted for six months. This product is eligible for auto-renewal.

Please note: Coverage cannot be considered for lack of response to allopurinol.

Please provide the following information for NEW requests (check ALL that apply)

Diagnosis

☐ Symptomatic gout ☐ Other (please specify) _____

Previous medications utilized: Information is required for **EACH** of the following

1) ☐ Allopurinol has been utilized

☐ Documented hypersensitivity ☐ Severe intolerance ☐ Other (please specify)_____

☐ Allopurinol has NOT been utilized. Please specify reason, if applicable _____

_____

AND

2) ☐ Sulfinpyrazone has been utilized

☐ Intolerance ☐ Lack of response ☐ Other (please specify) _____

☐ Sulfinpyrazone has NOT been utilized. Please specify reason, if applicable _____

_____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form

On the reverse is the official *Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form* (ABC 60007).

- All requests for denosumab 60 mg/syringe injection or for zoledronic acid 0.05 mg/ml injection for osteoporosis must be submitted using the *Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DENOSUMAB / ZOLEDRONIC ACID FOR OSTEOPOROSIS
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested (check ONE box) ☐ **Denosumab 60 mg/syr** ☐ **Zoledronic Acid 0.05 mg/ml**

Indicate diagnosis ☐ **Osteoporosis** ☐ **Other (specify)** _____

Indicate fracture risk and history (check ALL that apply)

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

☐ high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture

☐ moderate 10-year fracture risk (i.e.,10-20%)

☐ prior fragility fracture

Indicate which of the following pertain to this patient (check ALL that apply)

☐ oral bisphosphonates are contraindicated due to an abnormality of the esophagus which delays esophageal emptying

☐ persistent severe gastrointestinal intolerance to a course of therapy with either alendronate or risedronate

☐ unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for 1 year and evidence of a decline in BMD below pre-treatment baseline level)

Denosumab requests only

☐ bisphosphonates are contraindicated due to drug-induced hypersensitivity (i.e., immunologically mediated)

☐ bisphosphonates are contraindicated due to severe renal impairment (i.e., creatinine clearance < 35 mL/min)

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Omalizumab for Asthma Special Authorization Request Form

On the reverse is the official *Omalizumab for Asthma Special Authorization Request Form* (ABC 60020).

- All requests for omalizumab for Asthma must be submitted using the *Omalizumab for Asthma Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

OMALIZUMAB for Asthma
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE ☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH(YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

SPECIALIST IN RESPIROLOGY OR CLINICAL IMMUNOLOGIST INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	Current weight (kg)	Smoking status	**Please indicate if this patient is**
☐ Severe persistent asthma ☐ Other (please specify) _____		☐ Smoker ☐ Non-smoker	☐ starting drug upon approval …… . **complete section I** ☐ new to coverage but currently maintained on drug …**complete section I and II** ☐ submitting renewal request ……..**complete section II**

Section I: Please provide <u>pre-treatment</u> information for NEW requests for treatment-naive and treatment-experienced patients

Total serum human immunoglobulin (IgE) (IU/ml)	Date	AQLQ – Juniper score		Date
☐ Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing	Date	ACQ-5 scores	Score #1	Date
FEV1 (pre-bronchodilator per cent predicted)	Date		Score #2	Date

***Number of exacerbations of asthma within the 12-month period <u>prior to starting omalizumab</u> that resulted in**

a) an emergency room visit/hospitalization _____

b) physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids _____

***Please provide <u>exact</u> numbers. If the patient has had no exacerbations, it should be reported as 'zero (0)'.**

Previous medications utilized: Check all that apply and include name of medication, dose, duration and response.

☐ High-dose inhaled corticosteroids

☐ Long-acting beta-2 agonists

☐ Oral corticosteroids

Please check if the following applies

Chronic use (greater than 50 per cent of the year) of oral corticosteroids prior to initiation of omalizumab? Yes ☐ No ☐

Section II: Complete the following for all RENEWAL requests and for INITIAL requests for treatment-experienced patients

Current FEV1 (pre-bronchodilator % predicted)	Date	Current AQLQ – Juniper score	Date	Current ACQ-5 score	Date

***Number of exacerbations of asthma within the previous 12-month period <u>while on omalizumab</u> that resulted in**

a) an emergency room visit/hospitalization _____

b) physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids _____

***Please provide <u>exact</u> numbers. If the patient has had no exacerbations, it should be reported as 'zero (0)'**

Please check if the following applies:

☐ Patient demonstrated at least a 25per cent reduction in the number of exacerbations, which required oral corticosteroids from the 12 months prior to initiation of omalizumab that required systemic corticosteroids; or

☐ For patients that were on chronic (greater than 50per cent of the year) courses of oral corticosteroids in the 12 months prior to initiation of omalizumab, tapering of oral corticosteroid use by at least 25 per cent from baseline.

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Eculizumab Special Authorization Request Form and Consent Form

On the reverse is the official *Eculizumab Special Authorization Request Form* (ABC 60009) and the official *Eculizumab Consent Form* (ABC 60035)

- All requests for eculizumab must be submitted using the *Eculizumab Special Authorization Request Form* and *Eculizumab Consent Form*.
- **Photocopy these forms and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 401-1150 in Edmonton and area
  1-888-401-1150 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ECULIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

Patient last name	First name	Middle initial	Gender M / F	Date of birth YYYY	MM	DD	Alberta Personal Health Number

Street address	City	Province	Postal code

ID/client/coverage number	Coverage type	
	☐Alberta Blue Cross ☐Alberta Human Services	☐Other

SPECIALIST IN HEMATOLOGY INFORMATION

Last name	First name	Middle initial

Street address	City	Province	Postal code

Telephone number	Fax number	College of Physicians and Surgeons registration number

Date form completed	Last consult date	Specialist in hematology signature

PHARMACY INFORMATION

Pharmacy name	Telephone number	Fax number

INFORMATION REQUIRED

For **INITIAL COVERAGE (new to drug),** please complete the first two pages, and submit laboratory data and consent form as attachments

For **CONTINUED COVERAGE (on drug now or prior use of drug),** please complete applicable sections of all pages and submit laboratory data as an attachment

Note: Additional pages may be attached as required; please submit all required pages and attachments together

TREATMENT REQUESTED

Dosage and frequency requested

CONFIRMATION OF DIAGNOSIS

	Yes	No	Date (YYYY/MM/DD)	Lab result
Does the patient have a PNH granulocyte or monocyte clone size (by flow cytometry and/or FLAER test) equal to or greater than 10 per cent?	☐granulocyte ☐monocyte	☐		
Does the patient have a Lactate/Dehydrogenase (LDH) level at least 1.5 times the upper limit of normal?	☐	☐		

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

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ECULIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only) _____

ADDITIONAL CLINICAL CRITERIA

Does the patient have any of the following?	Yes	No	Comment
a) Thrombosis: Evidence that the patient has had a thrombotic or embolic event which required the institution of therapeutic anticoagulant therapy.	☐	☐	
b) Transfusions: Evidence that the patient has been transfused with at least four units of red blood cells in the last 12 months.	☐	☐	
c) Anemia: Evidence that the patient has chronic or recurrent anemia where causes other than hemolysis have been excluded and demonstrated by more than one measure of less than or equal to 70g/L or by more than one measure of less than or equal to 100 g/L with concurrent symptoms of anemia.	☐	☐	
d) Pulmonary insufficiency: Evidence that the patient has debilitating shortness of breath and/or chest pain resulting in limitation of normal activity (New York Heart Association Class III) and/or established diagnosis of pulmonary arterial hypertension where causes other than PNH have been excluded.	☐	☐	
e) Renal insufficiency: Evidence that the patient has a history of renal insufficiency, demonstrated by an eGFR less than or equal to 60mL/min/1.73m^2, where causes other than PNH have been excluded.	☐	☐	
f) Smooth muscle spasm: Evidence that the patient has recurrent episodes of severe pain requiring hospitalisation and/or narcotic analgesia where causes other than PNH have been excluded	☐	☐	

CONTRAINDICATIONS TO COVERAGE

Does the patient have any of the following?	Yes	No
Small clone size - granulocyte and monocyte clone sizes below 10 percent.	☐	☐
Aplastic anaemia with two or more of the following: neutrophil count below 0.5 x 10^9/L, platelet count below 20 x 10^9/L, reticulocytes below 25 x 10^9/L or severe bone marrow hypocellularity.	☐	☐
Presence of another life threatening or severe disease where the long term prognosis is unlikely to be influenced by therapy (for example acute myeloid leukaemia or high-risk myelodysplastic syndrome).	☐	☐
Presence of another medical condition that might reasonably be expected to compromise a response to therapy	☐	☐

IMMUNIZATION

		Yes	No	Date (YY/MM/DD)
All patients must receive meningococcal immunization with a quadravalent vaccine (A, C, Y and W135) at least two weeks prior to receiving the first dose of eculizumab. Treating physicians will be required to submit confirmation of meningococcal immunizations in order for their patients to continue to be eligible for treatment with eculizumab. Pneumococcal immunization with a 23-valent polysaccharide vaccine and a 13-valent conjugate vaccine, and a Haemophilus influenza type b (Hib) vaccine, must be given according to current clinical guidelines. All patients must be monitored and reimmunized according to current clinical guidelines for vaccine use.	Meningococcal (A,C,Y and W135)	☐	☐	
	Pneumococcal 23-valent	☐	☐	
	Pneumococcal 13-valent	☐	☐	
	Hib	☐	☐	

TRANSFUSION HISTORY

Transfusion date (YYYY/MM/DD)	RBC units	Comments

Case Number _____

MONITORING REQUIREMENTS (please attach the following laboratory results with each request)

- Lactate dehydrogenase (LDH)
- Full blood count and reticulocytes
- Iron studies
- Urea, electrolytes and eGFR
- PNH Granulocyte or Monocyte clone size (initial coverage and every 12 months)

Recent clinical history (update for each request, attach additional pages as required)

Case Number

ALBERTA BLUE CROSS®

ECULIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only)

Progress report on the clinical symptoms that formed the basis of initial eligibility (update annually, attach additional pages as required)

❑Thrombosis ❑Transfusions ❑Anemia ❑Pulmonary insufficiency ❑Renal insufficiency ❑Smooth muscle spasm

Quality of life, through clinical narrative (update annually, attach additional pages as required)

Case Number

ALBERTA BLUE CROSS®

ECULIZUMAB CONSENT FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER M/F	DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

ID/CLIENT/COVERAGE NUMBER	COVERAGE TYPE	
		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other

SPECIALIST IN HEMATOLOGY INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

TELEPHONE NUMBER	FAX NUMBER	COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER

PATIENT CONSENT FOR SERVICE

I have received a copy of the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (the Policy) and have read and understand the requirements of a patient receiving Alberta government sponsored funded treatment.

I agree to comply with the requirements for coverage as set out in the Policy, including (without limitation) the requirements for monitoring, review and data collection.

I understand and agree that I must continue to qualify for, and continue to be a member of, an Alberta government sponsored drug program to continue to be eligible for eculizumab coverage in accordance with the Policy.

I understand and agree that approval for initial and continued coverage is conditional upon meeting and continuing to meet the requirements of the Policy.

I understand that my consent must be and is ongoing and my failure to comply with the requirements as set out in the Policy may preclude me from continuing to be eligible for eculizumab coverage.

I understand that prior to potential discontinuance of eculizumab coverage, as outlined in the Policy, my Specialist in Hematology will receive notice of this in writing. I understand that my Specialist in Hematology has a responsibility to notify me, and to work with me to address the reason for potential withdrawal of eculizumab coverage.

I understand that therapy may be withdrawn at the request of the patient or the patient's parent/guardian at any time. Notification of withdrawal from therapy must be made by the Specialist in Hematology or patient in writing. I understand there may be side effects from medication and I have discussed the risks and benefits of this treatment with my Specialist in Hematology.

I, either as the patient or as the patient's parent/guardian (as appropriate), and on behalf of the patient's heirs and my estate and any other person claiming through the patient, hereby release the Minister, the Minister's delegate, the Minister's agents and employees from any and all liability and all claims for any and all damages, injuries, loss and costs which may arise directly or indirectly in relation to or in connection with the Application and coverage, funding and use of eculizumab for the patient pursuant to the Policy, including (without limitation) all claims relating to coverage, any changes in coverage, any restrictions or conditions of coverage, discontinuance of coverage, and the patient's use of eculizumab. I agree and acknowledge that this release is binding on the patient, the patient's heirs and estate, and any other person claiming through the patient against the Minister, the Minister's agents and employees.

Name of patient _____

Signature of patient (for patients > or equal to 18 years old) _____ Date _____

Name of parent/guardian (for patients <18 years old) _____

Signature of parent/guardian (for patients <18 years old) _____ Date _____

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

ECULIZUMAB CONSENT FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

I give consent for my Specialist in Hematology to disclose relevant health registration, assessment, diagnostic, and treatment information to, the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy) for the purpose of determining my initial and continued eligibility for, or discontinuance of, eculizumab coverage. I understand that the Expert Advisors are specialists engaged by the Alberta government to provide advice to the Minister or the Minister's delegate in accordance with the Policy.

I also give consent to the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the Policy to disclose relevant health registration, assessment, diagnostic, and treatment information to each other and to my Specialist in Hematology, for the purpose of determining my initial and continued eligibility for, or discontinuance of, eculizumab coverage.

I understand that I have been asked to disclose my health information in order to determine eligibility for funding for eculizumab and payment for this drug. I understand the risks and benefits of consenting or refusing to consent. I understand that I may revoke this consent at any time by giving notice in writing to Alberta Blue Cross at the address below. I understand and agree that if I revoke this consent, this revocation is deemed a request for withdrawal of coverage.

This consent is effective on execution and will remain in effect unless revoked with notice in writing.

Name of patient _____

Signature of patient (for patients > or equal to 18 years old) _____ Date _____

Name of parent/guardian (for patients <18 years old) _____

Signature of parent/guardian (for patients <18 years old) _____ Date _____

SPECIALIST IN HEMATOLOGY CONSENT

I agree to comply with the requirements for monitoring, review and data collection as set out in the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy).

I understand that information about the patient's ongoing eligibility, and possible discontinuation (if appropriate), will be supplied to me, and that I will be responsible for passing this information on to my patient or my patient's parent/guardian.

I understand that reviews of my patient will be ongoing and my failure to provide monitoring data on behalf of my patient, as set out in the Policy, may preclude my patient from continuing to receive Alberta government funded treatment.

I understand that prior to the potential withdrawal of eculizumab coverage as outlined in the Policy, I will receive notice of this in writing. I understand that it is my responsibility to notify my patient and work with my patient to address the reason for potential withdrawal of eculizumab coverage.

I have provided my patient or my patient's parent/guardian with the Policy so that they are aware of the requirements of a patient receiving Alberta government sponsored funded treatment. I have also read the Policy and understand what is required of me, as the treating physician.

Name of specialist in hematology _____

Signature of specialist in hematology _____ Date _____

Completed Eculizumab Consent Forms or written withdrawal of consent should be directed by mail or FAX to:

Alberta Blue Cross, Clinical Drug Services
10009 108 Street NW, Edmonton, Alberta T5J 3C5
FAX: **780-401-1150** in Edmonton • **1-888-401-1150** toll free all other areas

Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form

On the reverse is the official *Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form* (ABC 60018).

- All requests for rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis must be submitted using the *Rituximab for Granulomatosis with Polyangiitis / Microscopic Polyangiitis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

RITUXIMAB for Granulomatosis with Polyangiitis / Microscopic Polyangiitis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
			☐ CPSA ☐ ACO	REGISTRATION NUMBER	
STREET ADDRESS			☐ CARNA ☐ ADA+C		
			☐ ACP ☐ Other		
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

Indication for use	**Patient's body surface area (per square metre)**	**Requested dose** **Dosing frequency**
☐ Induction of remission of granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis) ☐ Induction of remission of microscopic polyangiitis (MPA) ☐ Other (please specify) _____		

Please provide the following information for all NEW requests

Severity and organ(s) affected	**Laboratory evidence of disease**
a) Is the patient's disease life- or organ-threatening? ☐ Yes ☐ No b) **If yes,** specify the organ(s) affected _____ _____ c) **If yes,** specify how the organ(s) is/are threatened _____ _____	**Does the patient have a positive serum as say for either a) or b) below? (Note: copy of the lab report must be provided)** **YES NO Not tested** a) proteinase 3-ANCA ……... ☐ ☐ ☐ b) myeloperoxidase-ANCA…… ☐ ☐ ☐

Previous cyclophosphamide usage: ONE of the following reasons must be specified

- ☐ The patient has failed a minimum of six intravenous pulses of cyclophosphamide
- ☐ The patient has failed three months of oral cyclophosphamide therapy.
- ☐ The patient has a severe intolerance or an allergy to cyclophosphamide. Specify the nature of intolerance:
- ☐ Cyclophosphamide is contraindicated. Specify the nature of contraindication:
- ☐ The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide

Requests for treatment of RELAPSE following a rituximab-induced remission

Severity and organ(s) affected

a) Is the patient's disease life- or organ-threatening? ☐ Yes ☐ No

b) Is the patient experiencing worsening symptoms in two or more organs? ☐ Yes ☐ No

c) **If yes to a) or b),** specify the organ(s) affected _____

d) **If yes to a) or b),** specify how the organ(s) is/are threatened _____

Note: Additional coverage may be approved no sooner than six months after previous rituximab treatment.

Please provide the date of the last dose of the previous course of treatment with rituximab _____

Additional information relating to request (e.g. reasons why any of the above therapies were not tried)

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form

On the reverse is the official *Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form* (ABC 60048).

- All requests for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be submitted using the *Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

TOCILIZUMAB for Systemic Juvenile Idiopathic Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Patient's current weight (kg)**	**Requested dose (mg/kg)**
☐ Systemic Juvenile Idiopathic Arthritis ☐ Other (please specify)_____		**Dosing frequency**

Please provide the following information for NEW requests

Please check all of the following that apply

☐ Fever (>38°C) for at least two weeks
☐ Rash of systemic JIA
☐ Serositis
☐ Lymphadenopathy
☐ Hepatomegaly
☐ Splenomegaly

Previous medications utilized (specify agents): Dose, duration and response is required

☐ NSAIDs

☐ Systemic corticosteroids

Please provide the following information for RENEWAL requests

The patient is a responder as demonstrated by (check all that apply)

☐ JIA ACR30
☐ Absence of fever
☐ Reduction in inflammatory markers (e.g. CRP concentration of less than 15 mg/L or reduction in ESR)
☐ Other (specify):

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to ▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **(780) 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

DPP-4/SGLT2 Inhibitors Special Authorization Request Form

On the reverse is the official *DPP-4/SGLT2 Inhibitors Special Authorization Request Form* (ABC 60012).

- All requests for saxagliptin, saxagliptin + metformin, sitagliptin, sitagliptin + metformin, linagliptin, linagliptin + metformin, canagliflozin, dapagliflozin, dapagliflozin + metformin, empagliflozin or empagliflozin + metformin must be submitted using the *DPP-4/SGLT2 Inhibitors Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DPP- 4/SGLT2 INHIBITORS
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION		
PRESCRIBER LAST NAME / FIRST NAME / INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS	PHONE	FAX
CITY , PROVINCE		
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Indicate which drug is requested

For the treatment of Type 2 diabetes	**Criteria for coverage***	**Complete section(s)**
☐ CANAgliflozin (e.g. Invokana) ☐ LINAgliptin (e.g. Trajenta) ☐ LINAgliptin + metformin (e.g. Jentadueto) ☐ SAXAgliptin (e.g. Onglyza) ☐ SAXAgliptin + metformin (e.g. Komboglyze) ☐ SITAgliptin (e.g. Januvia) ☐ SITAgliptin + metformin (e.g. Janumet, Janumet XR)	First-line drug product(s): metformin Second-line drug product(s): sulfonylureas And where insulin is not an option	Sections I & II
☐ DAPAgliflozin (e.g. Forxiga) ☐ DAPAgliflozin + metformin (e.g. Xigduo)	First-line drug product(s): metformin or sulfonylureas Second-line drug product(s): sulfonylureas or metformin And where insulin is not an option	Sections I & II
For the treatment of Type 2 diabetes OR Type 2 diabetes and established CV diseases as defined in the criteria for coverage	**Criteria for coverage***	**Complete section(s)**
☐ EMPAgliflozin (e.g. Jardiance) ☐ EMPAgliflozin + metformin (e.g. Synjardy)	*See page 2 for complete criteria	Sections I &/or II (as applicable)

Section I. Please indicate if **metformin** was tried for **at least 6 months**

☐ Yes ☐ No, specify reason _____

Section II. Please indicate if a **sulfonylurea** was tried

☐ Yes ☐ No, specify reason _____

Please indicate if **insulin** was tried

☐ Yes ☐ No, indicate why insulin is not an option for this patient

☐ Cognitive impairment ☐ Manual dexterity concerns

☐ Needle phobia ☐ Visual impairment

☐ Other, specify _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

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ALBERTA BLUE CROSS®

DPP- 4/SGLT2 INHIBITORS SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

Criteria for coverage

CANAgliflozin (e.g. Invokana), LINAgliptin (e.g. Trajenta), LINAgliptin + metformin (e.g. Jentadueto), SAXAgliptin (e.g. Onglyza), SAXAgliptin + metformin (e.g. Komboglyze), SITAgliptin (e.g. Januvia) and SITAgliptin + metformin (e.g. Janumet, Janumet XR) special authorization criteria

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

DAPAgliflozin (e.g. Forxiga) and DAPAgliflozin + metformin (e.g. Xigduo) special authorization criteria

FIRST-LINE DRUG PRODUCT(S): METFORMIN OR SULFONYLUREAS
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS OR METFORMIN
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy to metformin or a sulfonylurea for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin who have a contraindication or intolerance to a sulfonylurea, OR a sulfonylurea who have a contraindication or intolerance to metformin,
- AND for whom insulin is not an option.

Special authorization may be granted for 24 months.

EMPAgliflozin (e.g. Jardiance) and EMPAgliflozin + metformin (e.g. Synjardy) special authorization criteria

FIRST-LINE DRUG PRODUCT(S): METFORMIN

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes and established cardiovascular diseases who have an inadequate glycemic control, if the following criteria are met:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- established cardiovascular disease* as defined in the EMPA-REG OUTCOME trial.

* Established cardiovascular disease is defined on the basis of one of the following:
1) History of myocardial infarction (MI)
2) Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
3) Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress or discharged from hospital with a documented diagnosis of unstable angina within the last 12 months
4) Last episode of unstable angina greater than 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease
5) History of ischemic or hemorrhagic stroke
6) Occlusive peripheral artery disease

Special authorization may be granted for 24 months.

ABC 60012 (2019/01)

Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form

On the reverse is the official *Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form* (ABC 60019).

- All requests for apixaban 2.5 mg & 5 mg or dabigatran 110 mg & 150 mg, edoxaban 15 mg, 30 mg, or 60 mg or rivaroxaban 15 mg & 20 mg must be submitted using the *Apixaban/ Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

APIXABAN/ DABIGATRAN/ EDOXABAN/ RIVAROXABAN

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

***Note:** Rivaroxaban 10 mg is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total knee replacement surgery. Coverage is restricted to two 14-day courses of therapy per patient per year. Rivaroxaban 10 mg is also a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total hip replacement surgery. Coverage is restricted to two 35-day courses of therapy per patient per year. Rivaroxaban 10 mg is not eligible for special authorization for coverage beyond these restrictions.

Drug requested (check ONE box)

- ☐ **Apixaban (e.g. Eliquis) → complete Section I, II, and/or III**
- ☐ **Dabigatran (e.g. Pradaxa) → complete Section I only**
- ☐ **Edoxaban (e.g. Lixiana) → complete Section I and/or II**
- ☐ **Rivaroxaban (e.g. Xarelto) → complete Section I and/or II**

Section I Prevention of stroke and systemic embolism in atrial fibrillation (AF) patients

a) Does the patient have non-valvular atrial fibrillation (AF)?

☐ Yes ☐ No

b) Please indicate if **warfarin** was used:

☐ Yes → If yes, please indicate if a **two month trial of warfarin** was used

☐ Yes ☐ No, please specify reason _____

☐ No → If no, please elaborate

a) If the patient has a contraindication to warfarin, provide information regarding the nature of the contraindication

_____

b) If this patient is unable to monitor via INR testing services, please specify the reason

_____

Section II APIXABAN 2.5mg/5mg (e.g. Eliquis), EDOXABAN (e.g. Lixiana) and RIVAROXABAN 15mg/20mg (e.g. Xarelto) for treatment of venous thrombolic events

****Special authorization may be granted for up to six months****

a) Is the request for **treatment** of deep vein thrombosis (DVT)?

☐ No ☐ Yes → date of most recent event _____

b) Is the request for **treatment** of a pulmonary embolism (PE)?

☐ No ☐ Yes → date of most recent event _____

Section III APIXABAN 2.5mg (e.g. Eliquis) for prophylaxis of venous thromboembolism (VTE) following elective total hip or total knee replacement surgery

a) Has the patient had elective total **hip** replacement surgery?

☐ Yes ☐ No

b) Has the patient had elective total **knee** replacement surgery?

☐ Yes ☐ No

PRESCRIBER 'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Tacrolimus Topical Ointment Special Authorization Request Form

On the reverse is the official *Tacrolimus Topical Ointment Special Authorization Request Form* (ABC 60047).

- All requests for tacrolimus topical ointment must be submitted using the *Tacrolimus Topical Ointment Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

TACROLIMUS TOPICAL OINTMENT SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY , PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

☐ CPSA ☐ ACO REGISTRATION NUMBER
☐ CARNA ☐ ADA+C
☐ ACP ☐ Other

PHONE	FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Indicate which drug is requested (check one box)

☐ Tacrolimus 0.03% Topical Ointment (e.g. Protopic 0.03%) ☐ Tacrolimus 0.1% Topical Ointment (e.g. Protopic 0.1%)

Please provide the following information for all NEW requests

Diagnosis

☐ For the treatment of atopic dermatitis ☐ Other (please specify) _____

Areas affected (check all that apply)

☐ Face ☐ Flexures
☐ > 30% of body surface area ☐ Other (please specify) _____

Information regarding previous topical steroid therapy

☐ Topical steroid therapy HAS been utilized → **please complete both a) and b)**

a) Name of topical steroid(s) tried including strength and dosage form

_____

b) Response to topical steroid therapy

☐ Failure ☐ Requires ongoing use
☐ Intolerance ☐ Other (please specify) _____

☐ Topical steroid therapy has NOT been utilized

☐ Contraindication. Please elaborate_____

☐ Other reasons topical steroid therapy was NOT tried (please specify)_____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		• **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

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ALBERTA BLUE CROSS®

TACROLIMUS TOPICAL OINTMENT SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for Coverage

TACROLIMUS 0.03 % TOPICAL OINTMENT
"For use in patients 2 to 15 years of age inclusive with atopic dermatitis who are unable to tolerate or have failed topical steroid therapy." "For use in patients 2 to 15 years of age inclusive with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids." "For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy." "For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30% of body surface area." "Special authorization for all criteria may be granted for 6 months." Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the third criterion, information is also required regarding the area(s) affected. In order to comply with the fourth criterion, information is also required regarding the percentage body surface area affected. These products are eligible for auto-renewal.

TACROLIMUS 0.1 % TOPICAL OINTMENT
"For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy." "For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30% of body surface area." "Special authorization for all criteria may be granted for 6 months." Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the first criterion, information is also required regarding the area(s) affected. In order to comply with the second criterion, information is also required regarding the percentage body surface area affected. These products are eligible for auto-renewal.

Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/ Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/ Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form

On the reverse is the official *Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/ Peginterferon Beta-1a/Teriflunomide for RRMS/ Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form* (ABC 60001).

- All requests for dimethyl fumarate, glatiramer acetate, interferon beta-1a, ocrelizumab, peginterferon beta 1a, or teriflunomide for RRMS or interferon beta-1b for SPMS or RRMS must be submitted using the *Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/ Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/ Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DIMETHYL FUMARATE / GLATIRAMER ACETATE / INTERFERON BETA-1A / OCRELIZUMAB / PEGINTERFERON BETA-1A / TERIFLUNOMIDE for RRMS / INTERFERON BETA-1B for SPMS or RRMS

SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Indicate which MS disease modifying therapy (DMT) is requested (check one box)

☐ **Aubagio** (teriflunomide)
☐ ***Copaxone** (glatiramer acetate)
☐ **Plegridy** (peginterferon beta-1a)
☐ **Avonex PS/Pen** (interferon beta-1a)
☐ ***Glatect** (glatiramer acetate)
☐ **Rebif** (interferon beta-1a)
☐ **Betaseron / Extavia** (interferon beta-1b)
☐ **Ocrevus** (ocrelizumab)
☐ **Tecfidera** (dimethyl fumarate)

*** All new special authorization requests for glatiramer-naïve patients will be assessed for coverage with Glatect. Copaxone will not be approved for new glatiramer acetate starts; however, coverage for Copaxone will continue for patients who are currently well maintained on Copaxone as per maintenance coverage criteria. Additionally, patients will not be permitted to switch from Glatect to Copaxone.**

☐ **NEW request** (i.e to MS DMT and/or coverage). **If patient is already on MS DMT, specify date started** _____

☐ **RENEWAL request** ☐ **RESTART request** ☐ **MS DMT Switch**

Diagnosis

☐ Relapsing-remitting multiple sclerosis (RRMS)
☐ Secondary-progressive multiple sclerosis (SPMS) with relapses
☐ Other (please specify) _____

Current *EDSS _____ . _____ **Date** _____

***If the current EDSS is 7.0 or above,** has the EDSS score been sustained at 7.0 or above for one year or more?

☐ Yes ☐ No

Please provide the following information for all NEW requests and for RESTART after treatment interruption

Qualifying relapses: provide dates of two relapses within the last two years, OR the two years prior to starting MS DMT

Date of relapse (YYYY/MM/DD)	**Type of relapse** (one MRI relapse may substitute for one clinical relapse)
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesions)
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesions)

a) Has the patient been on MS DMT since the relapses ☐ No ☐ Yes

b) Indicate if there have been any interruptions in therapy since starting MS DMT ☐ No ☐ Yes → **If yes, indicate**

i) Reason for the interruption in therapy _____

ii) Specify time period of interruption **from** (YYYY-MM-DD) _____ **to** (YYYY-MM-DD) _____

iii) How many relapses did the patient experience while off therapy? _____

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

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Alemtuzumab/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form

On the reverse is the official *Alemtuzumab/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form* (ABC 60000).

- All requests for alemtuzumab, fingolimod or natalizumab must be submitted using the *Alemtuzumab/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ALEMTUZUMAB/FINGOLIMOD/NATALIZUMAB
For Multiple Sclerosis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests.

Indicate which MS disease modifying therapy (DMT) is requested (check one box)

☐ **Lemtrada** (alemtuzumab) ☐ **Gilenya** (fingolimod) ☐ **Tysabri** (natalizumab)

☐ **NEW request** (i.e. new to MS DMT and/or coverage). **If patient is already on MS DMT**, **specify date started** _____

☐ **RENEWAL request** ☐ **RESTART request** ☐ **MS disease modifying therapy (DMT) switch**

Diagnosis

☐ Relapsing-remitting multiple sclerosis

☐ Other (please specify) _____

Current *EDSS _____. _____ Date_____

***If the current EDSS is 7.0 or above,** has the EDSS score been sustained at 7.0 or above for one year or more? ☐ Yes ☐ No

Please provide the following information for all NEW requests and for RESTART of fingolimod or natalizumab after treatment interruption.

Qualifying relapses: Provide the dates of two relapses within the last two years OR the two years prior to starting MS DMT.

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))

a) Has the patient been on MS DMT since the relapse(s)? ☐ No ☐ Yes

b) Indicate if there have been any interruptions in therapy since starting MS DMT ☐ No ☐ Yes → **If yes, indicate:**

i) Reason for the interruption in therapy _____

ii) Specify time period of interruption: **from** (YYYY-MM-DD) _____ **to** (YYYY-MM-DD) _____

iii) How many relapses did the patient experience while off therapy? _____

NEW requests: Provide response to ONE of the following:

DIMETHYL FUMARATE; GLATIRAMER ACETATE; INTERFERON BETA; PEGINTERFERON BETA; TERIFLUNOMIDE

Name of MS DMT utilized _____ **and date of treatment initiation (YYYY-MM-DD)** _____

☐ **INTOLERANCE** despite the use of symptom management techniques; **OR** ☐ **REFRACTORY** → answer a) and b)

a) Does the patient have clinically significant titres of neutralizing antibodies to interferon beta? ☐ Yes ☐ No ☐ N/A

b) Within a consecutive 12-month period while on the MS DMT, did the patient experience at least two relapses of MS?

☐ No ☐ Yes → **Provide the dates of either 2 clinical relapses OR 1 clinical relapse and 1 MRI relapse**

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))

For fingolimod or natalizumab: RENEWAL requests and NEW requests for patients already on drug, please provide the following information:

a) Has the patient experienced **more than one** relapse event per year since starting treatment? ☐ Yes ☐ No

b) If yes and the patient experienced four or more relapses in the year prior to starting treatment, has the patient demonstrated a 50 per cent reduction in relapse events since starting treatment? ☐ Yes ☐ No

Please provide the following information for the first natalizumab RENEWAL request only:

Natalizumab neutralizing antibody test result

☐ Negative for natalizumab antibodies ☐ Positive for natalizumab antibodies Date of the test _____

PRESCRIBER 'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

Ivacaftor Special Authorization Request Form

On the reverse is the official *Ivacaftor Special Authorization Request Form* (ABC 60004).

- All requests for ivacaftor must be submitted using the *Ivacaftor Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

IVACAFTOR
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH:YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER.

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

☐ **NEW Please provide the following information for NEW requests**

Diagnosis

☐ Cystic Fibrosis

☐ Other (please specify) _____

Mutation affecting the *Cystic Fibrosis Transmembrane conductance Regulator (CFTR)* gene

☐ G551D mutation

☐ Other (please specify) _____

Please provide the following pre-treatment information for NEW requests

Sweat Chloride test (mmol/L)	Date
FEV_1 (pre-bronchodilator % predicted)	Date

☐ **RENEWAL Please provide the following current information for RENEWAL requests**

Initial renewal		**Subsequent renewals**	
Sweat Chloride test (mmol/L)	Date	Sweat Chloride test (mmol/L)	Date
FEV_1 (pre-bronchodilator % predicted) one month after starting treatment	Date	FEV_1 (pre-bronchodilator % predicted)	Date
FEV_1 (pre-bronchodilator % predicted) three months after starting treatment	Date		

Note: If the expected reduction in sweat chloride does not occur, the patient's CF clinician will first explore any problems in following the recommended dosing schedule for ivacaftor. The patient's sweat chloride will then be re-tested around one week later and funding discontinued if the patient does not meet criteria.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form

On the reverse is the official *Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form* (ABC 60008).

- All requests for adalimumab, golimumab, infliximab or vedolizumab must be submitted using the *Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ADALIMUMAB / GOLIMUMAB / INFLIXIMAB / VEDOLIZUMAB for Ulcerative Colitis SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL

BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA
- ☐ CARNA
- ☐ ACP
- ☐ ACO
- ☐ ADA+C
- ☐ Other

REGISTRATION NUMBER

STREET ADDRESS

CITY, PROVINCE

PHONE

FAX

POSTAL CODE

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

- ☐ Ulcerative Colitis
- ☐ Other (please specify)

Indicate requested drug

- ☐ Entyvio
- ☐ Humira
- ☐ *Inflectra
- ☐ *Remicade
- ☐ *Renflexis
- ☐ Simponi

***Note: all new requests for Remicade for infliximab naïve patients will be assessed for coverage with Inflectra or Renflexis. Remicade will not be approved for new infliximab starts; however, coverage for Remicade will continue for patients who are currently well maintained and are considered a 'responder' as defined in criteria.**

Current weight (kg)

Dosage

Frequency

Date of last dose

Please provide reason if a switch to a different biologic agent or change in dose is requested

Note patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

***Pre-treatment score**

Partial Mayo score _____ Date _____

Current score

Partial Mayo score _____ Date _____

*Requests for patients new to the requested drug and requests for patients new to coverage but currently maintained on the requested drug require pre-treatment scores. The Partial Mayo Score is a 9 point score consisting of 3 domains (same as full mayo except endoscopic findings are eliminated). Please provide exact score(s).

For INITIAL requests - dose, duration and response are required for all medications previously utilized. If the following medications were not tried, please provide reason.

- ☐ Mesalamine
- ☐ Corticosteroids (please specify drug name)
- ☐ Other (please specify)

For requests to increase maintenance dosing to Infliximab 10 mg/kg or Golimumab 100 mg

1) Is the patient already maintained on a dose of infliximab 10 mg/kg or golimumab 100 mg? ☐ Yes ☐ No

2) Has the patient had a *secondary loss of response* while on maintenance dosing with Infliximab 5 mg/kg or Golimumab 50 mg?
☐ Yes ☐ No (explain) _____

3) Provide the most recent partial Mayo score from when the patient was *responding* to maintenance dosing with Infliximab 5 mg/kg or Golimumab 50 mg _____ Date of Score _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE

Please forward this request to
Alberta Blue Cross, Clinical Drug Services
10009 108 Street NW, Edmonton, Alberta T5J 3C5
FAX 780-498-8384 in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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Antivirals for Chronic Hepatitis C Special Authorization Request Form

On the reverse is the official *Antivirals for Chronic Hepatitis C Special Authorization Request Form* (ABC 60022).

- All requests for asunaprevir, daclatasvir, elbasvir/grazoprevir, sofosbuvir, sofosbuvir/ledipasvir**,** sofosbuvir/velpatasvir, or sofosbuvir/velpatasvir**/**voxilaprevir must be submitted using the *Antivirals for Chronic Hepatitis C Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ANTIVIRALS FOR CHRONIC HEPATITIS C SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
STREET ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

1) Indicate the requested drug regimen and the patient's Hepatitis C Virus (HCV) Genotype

***Drug regimen requested**	**Corresponding HCV genotype**
☐ Elbasvir/grazoprevir (e.g. Zepatier) +/- ribavirin (e.g. Ibavyr)	☐ Genotype 1 → Specify subtype _____ ☐ Genotype 4
☐ Glecaprevir/pibrentasvir (e.g. Maviret)	Genotype _____ (optional if treatment naïve)
☐ Sofosbuvir (e.g. Sovaldi) + daclatasvir (e.g. Daklinza)	☐ Genotype 3
☐ Sofosbuvir (e.g. Sovaldi) + ribavirin (e.g. Ibavyr)	☐ Genotype 2 ☐ Genotype 3
☐ Sofosbuvir/ledipasvir (e.g. Harvoni) +/- ribavirin (e.g. Ibavyr)	☐ Genotype 1
☐ Sofosbuvir/velpatasvir (e.g. Epclusa) +/- ribavirin (e.g. Ibavyr)	Genotype _____ (optional)
☐ Sofosbuvir/velpatasvir/voxilaprevir (e.g. Vosevi)	Genotype _____ (optional if prior NS5A inhibitor)

*Duration of therapy and coverage of ribavirin in combination with the selected drug regimen will be approved according to criteria specified in the *Alberta Drug Benefit List.*

2 a) Does the patient have a quantitative HCV RNA value within six months of this request?

☐ **Yes** → Provide test date (YYYY-MM-DD) _____ ☐ **No** ☐ **Not tested**

2 b) For sofosbuvir/ledipasvir requests, is the patient's most recent viral load greater than 6 M IU/mL? ☐ **Yes** ☐ **No**

3) What is the patient's fibrosis stage (optional)? ☐ **F0** ☐ **F1** ☐ **F2** ☐ **F3** ☐ **F4** ☐ **Not tested**

4) Does the patient have cirrhosis?

☐ **Yes, compensated cirrhosis with Child-Turcotte-Pugh A** (i.e. score five to six)

☐ **Yes, decompensated cirrhosis with Child-Turcotte-Pugh B or C** (i.e. score seven or above)

☐ **No**

5) Is treatment requested post liver transplant? ☐ **Yes** ☐ **No**

6) Has the patient previously been treated with an HCV antiviral drug regimen?

☐ **Yes** → Specify drug regimen previously used _____

→ Specify the patient's response

☐ failure (i.e. null or partial response or virologic breakthrough/rebound) ☐ intolerance ☐ relapse

☐ other; specify _____

☐ **No,** the patient is treatment-naïve

7) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) _____

8) Indicate the specialist consulted, where applicable _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

Proton-Pump Inhibitors Pricing Authorization Request Form

On the reverse is the official *Proton-Pump Inhibitors Pricing Authorization Request Form (*ABC 60049).

- All requests for pricing authorization for Proton-Pump Inhibitor products that are subject to MAC and LCA pricing on the iDBL must be submitted using the *Proton-Pump Inhibitors Pricing Authorization Request Form* only. Please refer to the iDBL for full listing of Proton-Pump Inhibitor products.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

PROTON-PUMP INHIBITORS PRICING AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other: _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Which sections do I need to complete? (See page 2 for Maximum Allowable Cost (MAC) reference products and FAQs)

- ☐ Request for a generic brand Proton-Pump Inhibitor (PPI) …… **complete section I**
- ☐ Request for brand name Losec, Pantoloc or Prevacid …… **complete sections I and II**
- ☐ Request for brand name Pariet or Tecta …… **complete section II**

Section I. Pricing Authorization request where the patient is unable to use the MAC reference product

1) Select PPI and indicate if the corresponding MAC reference product has been used

Requested PPI (please check one)	**Has the patient used the MAC reference product for the requested PPI?**
☐ lansoprazole 15 mg ☐ omeprazole 10 mg	☐ Yes, rabeprazole sodium 10 mg was used. ☐ No, rabeprazole sodium 10 mg was not used. Please specify reasons. _____
☐ lansoprazole 30 mg ☐ omeprazole 20 mg ☐ pantoprazole sodium 40 mg	☐ Yes, pantoprazole magnesium 40 mg was used. ☐ No, pantoprazole magnesium 40 mg was not used. Please specify reasons. _____

2) If the patient has used the MAC reference product for the requested PPI, what was the response?

- ☐ Therapeutic failure of the MAC reference product. Please specify diagnosis _____
- ☐ Adverse effects. Please elaborate on the nature and severity of the adverse effects experienced by your patient on the MAC reference product _____
  - → Has the patient used the MAC reference product for a sufficient duration to determine that the adverse effects will not resolve over time? ☐ Yes ☐ No

Section II. Pricing Authorization request where the brand name PPI is required

1) Requested brand name PPI and strength _____

2) Has the patient used the Least Cost Alternative (LCA) generic product for the requested brand name PPI?

☐ Yes, specify generic used _____ ☐ No, specify reasons _____

3) If the patient has used the LCA generic product for the requested brand name PPI, what was the response?

- ☐ Therapeutic failure of the LCA generic product. Please specify diagnosis _____
- ☐ Adverse effects. Please elaborate on the nature and severity of the adverse effects experienced by your patient on the LCA generic product _____
  - → Has the patient used the LCA generic product for a sufficient duration to determine that the adverse effects will not resolve over time? ☐ Yes ☐ No
- ☐ Other; please elaborate _____

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **(780) 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

ALBERTA BLUE CROSS®

PROTON-PUMP INHIBITORS PRICING AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PPI products* that are subject to MAC and LCA pricing on the iDBL. MAC pricing will be applied as follows effective April 1, 2018.

Active ingredient	LCA/MAC price	
LANSOPRAZOLE 15 MG	$0.0669	*MAC pricing has been applied based on the LCA price for rabeprazole sodium 1 X 10 mg enteric-coated tablet.*
OMEPRAZOLE 10 MG		
RABEPRAZOLE SODIUM 10 MG		
LANSOPRAZOLE 30 MG	$0.1875	*MAC pricing has been applied based on the LCA price for pantoprazole magnesium 1 X 40 mg enteric-coated tablet.*
OMEPRAZOLE 20 MG		
PANTOPRAZOLE MAGNESIUM 40 MG		
PANTOPRAZOLE SODIUM 40 MG		
RABEPRAZOLE SODIUM 20 MG	*These products are not affected by MAC pricing. Least cost alternative pricing will continue to apply.*	

***Please refer to the iDBL for a full listing of PPI products.**

Frequently asked questions

1. What is the difference between LCA and MAC pricing?

The **Least Cost Alternative (LCA) price** means the maximum amount that will be paid by the Government of Alberta for a drug product in an established or new interchangeable grouping for members of a plan. For example, Prevacid 30 mg is in a grouping with several generic brands of lansoprazole 30 mg that are interchangeable with brand name Prevacid 30 mg. The maximum unit price paid for Prevacid 30 mg is thus based on the lowest-priced generic interchangeable product within the grouping.

A **MAC grouping** means a grouping of drug products that have been listed on the *Alberta Drug Benefit List (ADBL)* as being subject to a maximum price. Note that a MAC grouping may include one or more groupings of interchangeable drugs. For example, PPIs have been grouped together such that the maximum unit price paid for select higher strength PPIs (lansoprazole 30 mg, omeprazole 20 mg, pantoprazole magnesium 40 mg or pantoprazole sodium 40 mg) will be based on the cost of pantoprazole magnesium 40 mg, which is $0.1875 per unit (tablet).

2. What happens if a product is subject to both LCA and MAC pricing?

If a product is subject to both MAC and LCA pricing, the maximum unit price paid for the Drug Product will be based on the unit cost of the product that establishes the MAC grouping. For example, Prevacid 30 mg is subject to both LCA and MAC pricing and as such, the maximum unit price paid will be based on the product that establishes the MAC grouping; in this case, pantoprazole magnesium 40 mg, which is $0.1875 per unit (tablet).

3. My patient cannot use the reference product that establishes the MAC grouping; which sections of the form do I need to complete?

If, for example, your patient cannot use the reference product for the higher-strength PPIs (i.e. pantoprazole magnesium 40 mg), you will need to complete section I of the form.

4. My patient cannot use the generic version of a PPI; which sections of the form do I need to complete?

If your patient cannot use the generic version of a PPI, both sections I and II must be completed except in the case of brand name Pariet or Tecta. If brand name Pariet or Tecta are required, only section II must be completed. For example, if your patient requires brand name Losec 10 mg, you will need to complete both sections I and II. Section I is completed in order to identify why the patient cannot use the reference product that establishes the MAC grouping (i.e. rabeprazole sodium 10 mg). Section II is completed in order to determine why the patient cannot use the generic omeprazole 10 mg products, which are interchangeable with brand name Losec 10 mg.

Nintedanib/Pirfenidone Special Authorization Request Form

On the reverse is the official *Nintedanib/Pirfenidone Special Authorization Request Form* (ABC 60051).

- All requests for nintedanib or pirfenidone must be submitted using the *Nintedanib/Pirfenidone Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

NINTEDANIB/PIRFENIDONE SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY , PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested (choose *ONE only): ☐ **Nintedanib (e.g. Ofev)** ☐ **Pirfenidone (e.g. Esbriet)**

*Note: Combination use of pirfenidone and nintedanib will not be funded.

Please provide the following information for NEW requests: Initial approval period for patients meeting criteria: seven months (allow four weeks for repeat pulmonary function tests)

a) Diagnosis

☐ Mild to moderate idiopathic pulmonary fibrosis (IPF)

☐ Other (please specify) _____

b) Has the diagnosis been confirmed by a respirologist and a high-resolution CT scan within the previous 24 months? ☐ Yes ☐ No (explain) _____

c) Have all other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) been excluded? ☐ Yes ☐ No (explain) _____

d) Please provide the following pre-treatment information for NEW requests

Forced Vital Capacity (FVC) (% predicted)	Date

Initial Renewal (at six months): Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% from initiation of therapy until renewal (initial six-month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted four weeks later. Approval period for patients meeting criteria is six months

Forced Vital Capacity (FVC) (% predicted)	Date
In the case of disease progression as defined above, please provide a confirmatory Forced Vital Capacity (FVC) conducted four weeks later (% predicted)	Date

Second and subsequent renewals (at 12 months and thereafter): Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% within any 12-month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted four weeks later. Approval period for patients meeting criteria is 12 months

Forced Vital Capacity (FVC) (% predicted)	Date
In the case of disease progression as defined above, please provide a confirmatory Forced Vital Capacity (FVC) conducted four weeks later (% predicted)	Date

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

ALBERTA BLUE CROSS®

NINTEDANIB/PIRFENIDONE SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for coverage

NINTEDANIB (e.g. Ofev) and PIRFENIDONE (e.g. Esbriet)

Initial approval criteria:

Adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF):
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded.
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.
- Patient is under the care of a physician with experience in IPF.

Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests)

Initial renewal criteria (at 6 months):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 6 months

Second and subsequent renewals (at 12 months and thereafter):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

Patients who have experienced intolerance or failure to pirfenidone or nintedanib will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria.

Deferiprone Special Authorization Request Form

On the reverse is the official *Deferiprone Special Authorization Request Form* (ABC 60054).

- All requests for deferiprone must be submitted using the *Deferiprone Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DEFERIPRONE
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS				
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for NEW requests

Criteria for Coverage

"For the treatment of transfusional iron overload due to thalassemia syndromes in patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications to deferoxamine may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

Diagnosis

☐ Transfusional iron overload due to thalassemia syndromes
☐ Other (please specify) _____

Please indicate if **deferoxamine (e.g. Desferal)** was tried for **at least six months**

☐ Yes
☐ No; please indicate why deferoxamine was not tried for at least six months.
- ☐ Known or suspected sensitivity to deferoxamine
- ☐ Recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis)
- ☐ Inability to obtain or maintain vascular access (please elaborate) _____
- ☐ Severe needle phobia
- ☐ Concomitant bleeding disorders (please specify) _____
- ☐ Immunocompromised with a risk of infection with parenteral administration
- ☐ Risk of bleeding due to anticoagulation
- ☐ Other (please specify) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form

On the reverse is the official *Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form* (ABC 60025).

- All requests for aclidinium bromide + formoterol fumarate dihydrate, budesonide + formoterol fumarate dihydrate, fluticasone furoate + vilanterol trifenatate, indacaterol maleate + glycopyrronium bromide, salmeterol xinafoate + fluticasone propionate, tiotropium bromide + olodaterol hydrochloride or umeclidinium bromide + vilanterol trifenatate must be submitted using the *Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Long-Acting Fixed-Dose Combination Products for Asthma/COPD
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs

Please complete all required sections to allow your request to be processed

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTHDATE (Year / Month / Day)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please select requested drug (and strength, where applicable)	**Complete the following section(s)**
☐ Budesonide + formoterol fumarate dihydrate (e.g. Symbicort) ☐ Fluticasone furoate + vilanterol trifenatate (e.g. Breo Ellipta) → **Applicable strength** ☐ 100 mcg/25 mcg ☐ Fluticasone propionate + salmeterol xinafoate (e.g. Advair) → **Applicable products** ☐ Advair 250 Diskus ☐ Advair 500 Diskus	Section I and/or II
☐ Fluticasone furoate + vilanterol trifenatate (e.g. Breo Ellipta) → **Applicable strength** ☐ 200 mcg/25 mcg ☐ Fluticasone propionate + salmeterol xinafoate (e.g. Advair) → **Applicable products** ☐ Advair 100 Diskus ☐ Advair 125 MDI ☐ Advair 250 MDI	Section I only
☐ Aclidinium bromide + formoterol fumarate dihydrate (e.g. Duaklir Genuair) ☐ Glycopyrronium bromide + indacaterol maleate (e.g. Ultibro Breezhaler) ☐ Tiotropium bromide + olodaterol hydrochloride (e.g. Inspiolto Respimat) ☐ Umeclidinium bromide + vilanterol trifenatate (e.g. Anoro Ellipta)	Section II only

Section I. Inhaled combination drug products for the treatment of asthma

Has the patient tried a single-entity inhaled corticosteroid [ICS] (e.g. beclomethasone, budesonide, ciclesonide, fluticasone, mometasone)?

☐ Yes ☐ No → Please specify reason _____

Section II. Inhaled combination drug products for the treatment of COPD

Please confirm if one or more of the following applies

☐ patient has severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)

☐ patient has tried a single-entity long-acting beta-2 agonist [LABA] (e.g. formoterol, indacaterol or salmeterol)

☐ patient has tried a single-entity long-acting muscarinic antagonist [LAMA] (e.g. aclidinium, glycopyrronium, tiotropium or umeclidinium)

OR if none of the above apply, please specify reason why the patient has not tried a single-entity LABA or LAMA product

_____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

Long-Acting Fixed-Dose Combination Products for Asthma/COPD
SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs

Criteria for Coverage

BUDESONIDE + FORMOTEROL FUMARATE DIHYDRATE (e.g. Symbicort) **FLUTICASONE FUROATE + VILANTEROL TRIFENATATE (e.g. Breo Ellipta 100 mcg/25 mcg)** **FLUTICASONE PROPIONATE + SALMETEROL XINAFOATE (e.g. Advair 250 Diskus, Advair 500 Diskus)**
ASTHMA FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS) "For the treatment of asthma in patients uncontrolled on inhaled steroid therapy." CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA]) "For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])." "For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)." "Special authorization may be granted for 24 months."
FLUTICASONE FUROATE + VILANTEROL TRIFENATATE (e.g. Breo Ellipta 200 mcg/25 mcg) **FLUTICASONE PROPIONATE + SALMETEROL XINAFOATE (e.g. Advair 100 Diskus, Advair125 MDI, Advair 250 MDI)**
ASTHMA FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS) "For the treatment of asthma in patients uncontrolled on inhaled steroid therapy." "Special authorization may be granted for 24 months."
ACLIDINIUM BROMIDE + FORMOTEROL FUMARATE DIHYDRATE (e.g. Duaklir Genuair) **GLYCOPYRRONIUM BROMIDE + INDACATEROL MALEATE (e.g. Ultibro Breezhaler)** **TIOTROPIUM BROMIDE + OLODATEROL HYDROCHLORIDE (e.g. Inspiolto Respimat)** **UMECLIDINIUM BROMIDE + VILANTEROL TRIFENATATE (e.g. Anoro Ellipta)**
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA]) "For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])." "For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)." "Special authorization may be granted for 24 months."

Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form

On the reverse is the official *Eplerenone/Ivabradine/Sacubitri + Valsartan Special Authorization Request Form* (ABC 60050).

- All requests for eplerenone, ivabradine or sacubitril + valsartan must be submitted using the *Eplerenone/Ivabradine/Sacubitril + Valsartan Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

EPLERENONE / IVABRADINE / SACUBITRIL+VALSARTAN SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services
				☐ Other _____
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested

☐ **Eplerenone (e.g. Inspra) → complete section I only**

☐ **Ivabradine (e.g. Lancora) → complete sections I, II and III**

☐ **Sacubitril+Valsartan (e.g. Entresto) → complete sections I, II and IV**

Note: - For coverage of Ivabradine or Sacubitril+Valsartan, the drug must be initiated by a specialist in cardiology or internal medicine.

- If the patient is already on the requested drug, information provided should reflect the patient's status prior to starting the drug.

Section I. For ALL requests, please specify the following:

a) Diagnosis

☐ Heart failure (HF) → chronic? ☐ Yes ☐ No

☐ Other (specify) _____

b) Left ventricular ejection fraction (LVEF) (%) _____

c) New York Heart Association (NYHA) class _____

Section II. For Ivabradine or Sacubitril+Valsartan requests, please provide the following information

d) Drugs utilized ***prior to the requested drug***: Please check ALL that apply and indicate the name of the drugs utilized and response to each. If there is a contraindication to a particular therapy, elaborate as to its nature.

☐ Angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor antagonist (ARB) _____

☐ Beta-blocker _____

☐ Aldosterone antagonist _____

☐ Other recommended therapies _____

e) Are the HF symptoms present/active despite at least FOUR weeks of treatment with a stable dose of an ACEI or an ARB in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)?

☐ Yes ☐ No, explain _____

f) If the patient is already on the requested drug, please indicate treatment start date _____

Section III. For Ivabradine requests, please provide the following information:

g) Resting Heart Rate _____ bpm (on average using either an ECG on at least three separate visits or by continuous monitoring)

h) In sinus rhythm? ☐ Yes ☐ No

i) Number of hospitalizations due to HF in the last 12 months _____

Section IV. For Sacubitril+Valsartan requests, please provide the following information:

j) Plasma B-type natriuretic peptide (BNP) level (pg/mL) _____ and date _____; **OR**

N-terminal prohormone B-type natriuretic peptide (NT-proBNP) level (pg/mL) _____ and date _____

k) Has been hospitalized for HF within the past 12 months prior to the BNP or NT-proBNP testing date? ☐ Yes ☐ No

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

ALBERTA BLUE CROSS®

EPLERENONE/SACUBITRIL+VALSARTAN SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

Criteria for coverage

EPLERENONE (e.g. Inspra) special authorization criteria

"For persons suffering from New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction with ejection fraction less than or equal to 35 per cent as a complement to standard therapy."

Special authorization will be granted for 12 months.

This product is eligible for auto-renewal.

IVABRADINE (e.g. Lancora) special authorization criteria

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (less than or equal to 35%)

And

2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of optimal treatment with

- a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)

- in combination with a beta-blocker and, if tolerated, a mineralcorticoid receptor antagonist (MRA)

And

3) Who are in sinus rhythm with a resting heart rate greater than or equal to 77 beats per minute (bpm) on average using either an ECG on at least three separate visits or by continuous monitoring

And

4) Who had at least one hospitalization due to HF in the last year

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

SACUBITRIL + VALSARTAN (e.g. Entresto) special authorization criteria

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (< 40%)

And

2) New York Heart Association (NYHA) class II or Ill HF symptoms despite at least FOUR weeks of treatment with

- a stable dose of an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)

- in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)

And

3) Who have Plasma B-type natriuretic peptide (BNP) >= 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) >= 600 pg/mL; or

- if the patient has been hospitalized for HF within the past 12 months and has plasma BNP >= 100 pg/mL or NT-proBNP >= 400 pg/mL levels

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months.

This product is eligible for auto-renewal.

ABC 60050 (2018/11)

Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form

On the reverse is the official *Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form* (ABC 60058).

- All requests for adalimumab for Hidradenitis Suppurativa must be submitted using the *Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ADALIMUMAB
for Hidradenitis Suppurativa
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTHDATE (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis ☐ Active moderate to severe Hidradenitis Suppurativa

☐ Other (specify) _____

Please provide the following information for INITIAL requests

1) Total abscess and nodule (AN) count at pre-treatment baseline _____ and date of count _____

2) Does the patient have lesions in at least two distinct anatomical areas? ☐ Yes ☐ No

3) Does the patient have Hurley Stage II or III lesions in at least one anatomical area? ☐ Yes ☐ No

4) Previous therapy

a) Have systemic antibiotics been tried for at least 90 days?

☐ Yes → Specify antibiotics and response _____

☐ No → Specify reason _____

b) Is there documented non-response to conventional therapy other than systemic antibiotics?

☐ Yes → Specify which therapies have been tried, including dose and duration

_____

_____

☐ No → Specify reason _____

Please provide the following information for RENEWAL requests

1) Current AN count _____ and date of count _____

2) Indicate the patient's response to treatment (check ALL that apply)

☐ Fifty per cent or greater reduction in AN count from pre-treatment baseline.

☐ No increase in abscess count or draining fistula count relative to pre-treatment baseline.

Note: Treatment with adalimumab should be discontinued if there is insufficient improvement after 12 weeks of treatment.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY/MM/DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form

On the reverse is the official *Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form* (ABC 60056).

- All requests for omalizumab for Chronic Idiopathic Urticaria must be submitted using the *Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

OMALIZUMAB for Chronic Idiopathic Urticaria SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Moderate to severe Chronic Idiopathic Urticaria (CIU)

☐ Other (specify) _____

Please indicate if this patient is

☐ Starting drug upon approval …….. **complete section I**

☐ New to coverage but currently maintained on drug … **complete section I and II**

☐ Renewal request …….. **complete section II**

Section I: Please provide <u>pre-treatment</u> information for all INITIAL requests

i) Has the patient had a therapeutic trial with H1 antihistamines?

☐ Yes → a) Specify H1 antihistamines used _____

b) Specify response to therapy ☐ Failure ☐ Intolerance ☐ Other (specify) _____

☐ No → Provide reason _____

ii) Were oral therapies other than H1 antihistamines tried?

☐ Yes → Specify drugs utilized, including dose, duration and patient's response _____

_____

☐ No → Provide reason _____

iii) Baseline (pre-treatment) measure of disease severity

Urticaria Activity Score over seven days (UAS7) _____ Date _____

iv) Is the patient currently on therapy with omalizumab? ☐ Yes → Indicate start date of therapy _____ ☐ No

Section II: Complete for ADDITIONAL 24-WEEK TREATMENT COURSE requests and TREATMENT RE-INITIATION requests

i) Measure of disease severity at the end of the previous 24-week treatment course of omalizumab

UAS7 score _____ Date _____

ii) If the patient's UAS7 score recorded above for i) is zero (0), was this complete symptom control maintained for at least 12 consecutive weeks? ☐ Yes ☐ No ☐ Not applicable (patient's UAS7 at the end of treatment was not zero)

iii) Has omalizumab been discontinued due to temporary symptom control? ☐ Yes → Answer a) and b) below ☐ No

a) Provide the date of discontinuation of previous course of omalizumab _____

b) Provide the current measure of disease severity: UAS7 score _____ Date _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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ALBERTA BLUE CROSS®

OMALIZUMAB
for Chronic Idiopathic Urticaria
SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

Criteria for coverage

For the treatment of adults and adolescents (12 years of age and above) with moderate to severe chronic idiopathic urticaria (CIU), defined as having a baseline Urticaria Activity Score over seven days (UAS7) of greater than or equal to 16, who remain symptomatic (presence of hives and/or associated itching) despite optimum management with available oral therapies. Oral therapies should include a therapeutic trial with H_1 antihistamines, unless contraindicated or not tolerated.

For coverage, the drug must be initiated and monitored by a Specialist in Dermatology, Clinical Immunology or Allergy.

Coverage may be approved for a period of 24 weeks at a maximum dose of 300 mg every four weeks.
Patients will be limited to receiving a one-month supply of omalizumab per prescription at their pharmacy.
Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Continued coverage of a further 24-week treatment period may be considered if the patient has experienced:
- complete symptom control (i.e. UAS7 of 0) for less than 12 consecutive weeks; OR
- partial symptom control, with a reduction in baseline UAS7 of greater than or equal to 9.5 points.

Treatment cessation should be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24-week treatment period.

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation should be considered should CIU symptoms reappear.

Mepolizumab Special Authorization Request Form

On the reverse is the official *Mepolizumab Special Authorization Request Form* (ABC 60061).

- All requests for mepolizumab must be submitted using the *Mepolizumab Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

MEPOLIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS			PHONE	FAX
CITY, PROVINCE				
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

Diagnosis

☐ Severe Eosinophilic Asthma

☐ Other (please specify) _____

Please indicate if this patient is

☐ Starting drug upon approval …… . **complete section I**

☐ New to coverage but currently maintained on drug …**complete section I and II**

☐ Renewal request ……..**complete section II**

Section I: Please provide <u>pre-treatment</u> information for NEW requests for treatment-naive and treatment-experienced patients

Blood eosinophil count

1) At treatment initiation _____ (cells/mcL) Date _____

2) If eosinophil count provided above for 1) is less than 150 cells/mcL, provide a count greater than or equal to 300 cells/mcL in the 12 months prior to treatment initiation _____ (cells/mcL) Date _____

Number* of clinically significant exacerbations of asthma within the 12-month period <u>prior to starting mepolizumab</u>

(defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized) _____

***Please provide an exact number. If the patient has had no exacerbations, it should be reported as 'zero (0)'.**

☐ Confirmation of reversibility on pulmonary function tests (i.e. of at least 12% and 200 mL in FEV1)

Previous medications utilized: Check all that apply and include name of medication, dose, duration and response

☐ High-dose inhaled corticosteroids _____

☐ Oral corticosteroids (OCS) _____

→ Patient requires daily OCS prior to initiation of mepolizumab? ☐ Yes ☐ No

☐ Other asthma controllers (e.g. long-acting beta-2 agonist, please specify) _____

Section II: Complete the following for all RENEWAL requests and for INITIAL requests for treatment-experienced patients

Number* of exacerbations of asthma within the previous 12-month period <u>while on mepolizumab</u>

(defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department visit or was hospitalized) _____

***Please provide an <u>exact</u> number. If the patient has had no exacerbations, it should be reported as 'zero (0)'.**

Check if the following applies to the patient in the previous 12-month period while on mepolizumab

☐ A decrease in the maintenance OCS dose of at least 25% from pre-treatment baseline

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX: 780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Alirocumab/Evolocumab for HeFH Special Authorization Request Form

On the reverse is the official *Alirocumab/Evolocumab for HeFH Special Authorization Request Form* (ABC 60060).

- All requests for alirocumab or evolocumab for Heterozygous Familial Hypercholesterolemia must be submitted using the *Alirocumab/Evolocumab for HeFH Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:

  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ALIROCUMAB / EVOLOCUMAB for HeFH
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

1) Drug requested ☐ Praluent ☐ Repatha

2) Dosage and frequency

3) Diagnosis

☐ **Definite or Probable** diagnosis of heterozygous familial hypercholesterolemia (HeFH)

→Was the diagnosis confirmed using the Simon Broome or Dutch Lipid Network criteria, or genetic testing? ☐Yes ☐No

☐ Other (specify) _____

Please provide the following information for INITIAL requests for treatment-naive and treatment-experienced patients

1) Pre-treatment Low Density Lipoprotein-Cholesterol (LDL-C) _____ (mmol/L) Date _____

Note *Pre-treatment refers to the LDL-C level taken prior to initiation of the requested drug, rather than the untreated baseline LDL-C level.*

2) Previous therapy *(check the applicable box)*

☐ Adherence to **high dose statin** (e.g. atorvastatin 80 mg or rosuvastatin 40 mg) in combination with **ezetimibe** for at least three months

→Specify statin utilized _____ **Dose** _____

OR

☐ Adherence to **ezetimibe** for at least three months *[please confirm if patient meets a) or b) below by checking the applicable box]*

→ **a)** ☐ **Statins are contraindicated** (specify) _____

→ **b)** ☐ **Patient was unable to tolerate high dose statin** *[please complete i) to v) below]*

i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose *[specify 2 statins utilized including dose and check ALL that apply for ii) to v) for each statin below]*

☐ **Statin #1** _____ **Dose** _____ ☐ **Statin #2** _____ **Dose** _____

ii)	Dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality [creatine kinase (CK) > five times the upper limit of normal (ULN)] resolution rather than discontinuation of statin altogether	☐ Statin #1	☐ Statin #2
iii)	Intolerable symptoms (myopathy) or abnormal biomarkers (CK > five times the ULN) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate	☐ Statin #1	☐ Statin #2
iv)	Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out	☐ Statin #1	☐ Statin #2
v)	Patient developed confirmed and documented rhabdomyolysis	☐ Statin #1	☐ Statin #2

3) Despite the above previous therapy, is the patient unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention)? ☐Yes ☐No

4) If the patient is currently on the requested drug, please indicate start date (YYYY-MM-DD) _____

Please provide the following information for RENEWAL requests and for INITIAL requests for treatment-experienced patients

1) Is the patient adherent to therapy? ☐Yes ☐No

2) Current LDL-C _____ (mmol/L) Date _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX 780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

Fidaxomicin Special Authorization Request Form

On the reverse is the official *Fidaxomicin Special Authorization Request Form* (ABC 60014).

- All requests for fidaxomicin must be submitted using the *Fidaxomicin Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

FIDAXOMICIN
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Special authorization criteria

For the treatment of:
1) C. difficile infection (CDI) where the patient has failed, or is intolerant of oral vancomycin; or
2) Patients with third or greater recurrence of CDI (ie. fourth or greater episode of CDI)

Note:
- Fidaxomicin should not be used as an add-on to existing therapy (metronidazole or vancomycin).
- Not studied in multiple recurrences or those with life-threatening or fulminant CDI, toxic megacolon or inflammatory bowel disease.

Special authorization coverage for fidaxomicin will be provided for one treatment course (10 days) plus one additional treatment course for an early relapse occurring within eight weeks of the start of the most recent fidaxomicin course.

New episode of CDI after eight weeks will require treatment with first line therapy before fidaxomicin coverage may be considered.

Please provide the following information for ALL requests

1) Indicate diagnosis ☐ Clostridium difficile infection (CDI) ☐ Other (specify) _____

2) Is this the third or greater recurrence of CDI (i.e. fourth or greater episode of CDI)? ☐ Yes ☐ No

3) **Re-treatment requests ONLY:** Please indicate if treatment is requested for ☐ an early relapse OR ☐ a new CDI episode

Note: a CDI episode occurring ≥ 8 weeks after a previous episode with no intermittent recurrence of symptoms would be considered a new CDI episode.

4) **Previous medications utilized**

☐ Oral vancomycin has been used

a) Provide start date of most recent course (YYYY-MM-DD) _____

b) Specify response ☐ Failure ☐ Intolerance ☐ Other (specify) _____

☐ Oral vancomycin has NOT been used. Please provide reason _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Asfotase Alfa Special Authorization Request Form and Consent Form

On the reverse is the official *Asfotase Alfa Special Authorization Request Form* (ABC 60063) followed by the official *Asfotase Alfa Consent Form* (ABC 60057).

- All requests for asfotase alfa must be submitted using the *Asfotase Alfa Special Authorization Request Form* and all initial requests must be accompanied by the *Asfotase Alfa Consent Form*.
- **Photocopy these forms and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 401-1150 in Edmonton and area
  1-888-401-1150 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ASFOTASE ALFA
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION

Patient last name	First name	Initial	Gender M / F	Birth date YYYY	MM	DD	Alberta Personal Health Number

Street address	City	Province	Postal code

ID/client/coverage number	Coverage type	
		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____

METABOLIC SPECIALIST INFORMATION

Last name	First name	Initial

Street address	City	Province	Postal code

Telephone number	Fax number	College of Physicians and Surgeons registration number

Date form completed (YYYY-MM-DD)	Last consult date (YYYY-MM-DD)	Metabolic Specialist signature

PHARMACY INFORMATION

Pharmacy name	Telephone number	Fax number

INFORMATION REQUIRED

For **INITIAL COVERAGE (new to drug)**, please complete applicable sections of all pages, and submit together with the consent form.

For **CONTINUED COVERAGE (on drug now or prior use of drug)**, please complete page 1 and the response to therapy section on page 4. For first requests for patients currently/previously on the drug, please complete all pages and submit together with the consent form.

Note: Additional pages may be attached as required; please submit the request form and attachments together.

TREATMENT REQUESTED

Dosage and frequency requested

DIAGNOSIS

☐ **Hypophosphatasia (HPP)**

→ Specify type ☐ Antenatal ☐ Newborn ☐ Infantile ☐ Juvenile (Childhood) ☐ Adult

→ Specify age at onset and nature of first symptom _____

☐ Other, specify _____

CONFIRMATION OF DIAGNOSIS

Does the patient have **perinatal/infantile or juvenile-onset HPP** confirmed by	**Yes**	**No**	**Details (attach laboratory reports)**
a) Genetic testing (documented tissue-nonspecific alkaline phosphatase [TNSALP] gene mutation(s))?	☐	☐	
b) Serum alkaline phosphatase (ALP) level below the age-adjusted normal range?	☐	☐	
c) Plasma pyridoxal-5-phosphate (PLP) above the upper limit of normal established and validated in testing laboratory?	☐	☐	
d) Documented history of HPP-related skeletal abnormalities confirmed radiologically?	☐	☐	

FOR TREATMENT EXPERIENCED PATIENTS

1) Patient is currently on therapy? ☐ Yes ☐ No → specify stop date and reason	
2) Indicate initial therapy start date	3) Patient started therapy prior to 18 years of age? ☐ Yes ☐ No

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only) _____

ADDITIONAL CLINICAL CRITERIA

System	Details (Check ALL that apply and attach relevant reports)
1) Growth	Current height _____ cm (_____ %) Current head circumference _____ cm (_____ %) Current weight _____ kg (_____ %) ☐ Poor growth ☐ Poor weight gain ☐ Failure to thrive ☐ Growth chart attached Comments
2) Dental	☐ OdontoHPP ☐ Early loss of primary teeth → age at first tooth loss _____ ☐ Poor dentition Comments
3) Skeletal	☐ Severe hypomineralization/osteopenia ☐ Fractures, specify number, location and if non-healing/healed _____ ☐ Orthopedic surgical procedures, specify type of surgery, age at procedure _____ ☐ Rickets/Osteomalacia ☐ Scoliosis ☐ Skeletal deformities (e.g. knock-knees, bowed legs), specify _____ ☐ Craniosynostosis → With systemic signs and symptoms, including muscle weakness, fractures, rickets, pain or nephrocalcinosis, and/or bony disease? ☐ Yes ☐ No ☐ Joint swelling, specify _____ ☐ Weakness, specify _____ ☐ Abnormal gait/running, specify _____ Motor development ☐ Appropriate for age ☐ Delayed → Gross motor delay with substantial skeletal disease? ☐ Yes ☐ No → Delayed walking (>15 months)? ☐ Yes ☐ No ☐ 6 Minute Walk Test result attached ☐ Use of assistive devices, specify _____ ☐ Participates in sports ☐ Misses school Patient's/parent's assessment of pain and QOL _____ Comments (provide RGIC and Thacher scores)

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only) _____

ADDITIONAL CLINICAL CRITERIA (continued)

System	Details (Check ALL that apply and attach relevant reports)
4) Pain	☐ Muscle pain ☐ Bone pain ☐ Joint pain Type of pain, location, pain at rest or with activity, daytime or at night _____ Interventions ☐ Analgesics, specify drug(s) and dose _____ ☐ Heating pad ☐ Massage ☐ Other, specify _____ Response to previous interventions _____ ☐ Visual analog for pain report attached Comments
5) X-ray findings	☐ Skeletal survey, specify age at X-rays, X-ray findings, and most recent X-ray results _____ ☐ X-ray report attached
6) Renal	☐ Nephrocalcinosis ☐ Renal failure/reduced renal function ☐ Lab report attached Comments
7) Respiratory	☐ Lung hypoplasia ☐ Decreased thoracic volume ☐ Respiratory failure ☐ Supplemental O2 required ☐ Assisted ventilation Comments
8) Biochemical	☐ Lab reports attached for calcium, phosphate, magnesium, alkaline phosphatise (ALP), PTH, 25 OH vitamin D, pyridoxal-5-phosphate (PLP), urine phosphoethanolamine (PEA)
9) Other	☐ Hearing Loss, specify _____ ☐ Seizures → B6 responsive? ☐ Yes ☐ No ☐ Delayed cognitive development, specify _____ Comments
Additional information relating to request	

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA
SPECIAL AUTHORIZATION REQUEST FORM

Patient's Alberta Personal Health Number (only)

MONITORING AND GOALS OF THERAPY

1) Signs and symptoms to be monitored depend on age at diagnosis and may include, in addition to the parameters listed in the "Additional Clinical Criteria" table on page 2 of this form:

For perinatal/infantile HPP: Discontinuation or reduction of ventilatory support, increased mobility (improvement in gait vs. baseline), attainment of age-appropriate gross motor milestones.

For juvenile HPP: Healing of rickets, improvement of bone mineralization and/bony deformities, fewer fractures, less pain, need for less pain medication, improved growth, increased mobility.

Please indicate which clinical, radiological and biochemical parameters and goals of therapy will be monitored for this patient:

2) Documented compliance by patient and family with respect to follow up visits and re-evaluation of laboratory and radiological parameters.

RESPONSE TO THERAPY (update for each request for continuation of therapy, attach additional pages as required)

1) Were the pre-specified goals of therapy met? (include documented signs/symptoms noted above)

2) Were the patient and family compliant with respect to follow up visits and re-evaluation of laboratory and radiological parameters?

Please mail this request to	Or fax to	**Case number**
▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**	▪ **780-401-1150** in Edmonton ▪ **1-888-401-1150** toll free all other areas	

ALBERTA BLUE CROSS®

ASFOTASE ALFA CONSENT FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

METABOLIC SPECIALIST INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER	
STREET ADDRESS			PHONE	FAX
CITY, PROVINCE				
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

PATIENT CONSENT FOR SERVICE

I have received a copy of the policy relating to asfotase alfa in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (the Policy) and have read and understand the requirements of a patient receiving Alberta government sponsored funded treatment.

I agree to comply with the requirements for coverage as set out in the Policy, including (without limitation) the requirements for monitoring, review and data collection.

I understand and agree that I must continue to qualify for, and continue to be a member of, an Alberta government sponsored drug program to continue to be eligible for asfotase alfa coverage in accordance with the Policy.

I understand and agree that approval for initial and continued coverage is conditional upon meeting and continuing to meet the requirements of the Policy.

I understand that my consent must be and is ongoing and my failure to comply with the requirements as set out in the Policy may preclude me from continuing to be eligible for asfotase alfa coverage.

I understand that prior to potential discontinuance of asfotase alfa coverage, as outlined in the Policy, my Metabolic Specialist will receive notice of this in writing. I understand that my Metabolic Specialist has a responsibility to notify me, and to work with me to address the reason for potential withdrawal of asfotase alfa coverage.

I understand that therapy may be withdrawn at the request of the patient or the patient's parent/guardian at any time. Notification of withdrawal from therapy must be made by the Metabolic Specialist or patient in writing. I understand there may be side effects from medication and I have discussed the risks and benefits of this treatment with my Metabolic Specialist.

I, either as the patient or as the patient's parent or guardian (as appropriate), and on behalf of the patient's heirs and my estate and any other person claiming through the patient, hereby release the Minister, the Minister's delegate, the Minister's agents and employees from any and all liability and all claims for any and all damages, injuries, loss and costs which may arise directly or indirectly in relation to or in connection with the Application and coverage, funding and use of asfotase alfa for the patient pursuant to the Policy, including (without limitation) all claims relating to coverage, any changes in coverage, any restrictions or conditions of coverage, discontinuance of coverage, and the patient's use of asfotase alfa. I agree and acknowledge that this release is binding on the patient, the patient's heirs and estate, and any other person claiming through the patient against the Minister, the Minister's agents and employees.

Name of patient _____

Signature of patient (for patients 18 years of age or older) _____ Date _____

Name of parent or guardian (for patients under the age of 18) _____

Signature of parent or guardian (for patients under the age of 18) _____ Date _____

ALBERTA BLUE CROSS®

ASFOTASE ALFA CONSENT FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

I give consent for my Metabolic Specialist to disclose relevant health registration, assessment, diagnostic, and treatment information to, the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the policy relating to asfotase alfa in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy) for the purpose of determining my initial and continued eligibility for, or discontinuance of, asfotase alfa coverage. I understand that the Expert Advisors are specialists engaged by the Alberta government to provide advice to the Minister or the Minister's delegate in accordance with the Policy.

I also give consent to the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the Policy to disclose relevant health registration, assessment, diagnostic, and treatment information to each other and to my Metabolic Specialist, for the purpose of determining my initial and continued eligibility for, or discontinuance of, asfotase alfa coverage.

I understand that I have been asked to disclose my health information in order to determine eligibility for funding for asfotase alfa and payment for this drug. I understand the risks and benefits of consenting or refusing to consent. I understand that I may revoke this consent at any time by giving notice in writing to Alberta Blue Cross at the address below. I understand and agree that if I revoke this consent, this revocation is deemed a request for withdrawal of coverage.

This consent is effective on execution and will remain in effect unless revoked with notice in writing.

Name of patient _____

Signature of patient (for patients 18 years of age or older) _____ Date _____

Name of parent or guardian (for patients under the age of 18) _____

Signature of parent or guardian (for patients under the age of 18) _____ Date _____

METABOLIC SPECIALIST CONSENT

I agree to comply with the requirements for monitoring, review and data collection as set out in the policy relating to asfotase alfa in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy).

I understand that information about the patient's ongoing eligibility, and possible discontinuation (if appropriate), will be supplied to me, and that I will be responsible for passing this information on to my patient or my patient's parent or guardian.

I understand that reviews of my patient will be ongoing and my failure to provide monitoring data on behalf of my patient, as set out in the Policy, may preclude my patient from continuing to receive Alberta government funded treatment.

I understand that prior to the potential withdrawal of asfotase alfa coverage as outlined in the Policy, I will receive notice of this in writing. I understand that it is my responsibility to notify my patient and work with my patient to address the reason for potential withdrawal of asfotase alfa coverage.

I have provided my patient or my patient's parent or guardian with the Policy so that they are aware of the requirements of a patient receiving Alberta government sponsored funded treatment. I have also read the Policy and understand what is required of me, as the treating physician.

Name of Metabolic Specialist _____

Signature of Metabolic Specialist _____ Date _____

Completed consent form or written withdrawal of consent should be directed by mail or FAX to:

Alberta Blue Cross, Clinical Drug Services
10009 108 Street NW, Edmonton, Alberta T5J 3C5
FAX: **780-401-1150** in Edmonton • **1-888-401-1150** toll free all other areas

Tocilizumab for Giant Cell Arteritis Special Authorization Request Form

On the reverse is the official *Tocilizumab for Giant Cell Arteritis Special Authorization Request Form* (ABC 60066). All requests for must be submitted using this form only.

- All requests for tocilizumab for Giant Cell Arteritis must be submitted using the *Tocilizumab for Giant Cell Arteritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

TOCILIZUMAB for Giant Cell Arteritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
			☐ CPSA ☐ ACO REGISTRATION NUMBER	
STREET ADDRESS			☐ CARNA ☐ ADA+C	
			☐ ACP ☐ Other	
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

Diagnosis	**Dosage & frequency**	**Please indicate if this patient is**
☐ Giant cell arteritis (GCA) ☐ Other (specify)		☐ Starting first treatment course upon approval ……..**complete section I** ☐ Renewal request at 12 to 16 weeks of therapy.....**complete section II** ☐ New to coverage but currently maintained on drug…..**complete sections I and II** ☐ Re-treatment requests .....**complete sections I and III**

Section I: Please complete for all NEW requests for first or subsequent treatment courses (Initial approval for 16 weeks)

1) The current tocilizumab treatment course will be (or was) initiated in combination with a glucocorticoid?

☐ Yes → specify glucocorticoid _____

☐ No → indicate reason(s) _____

2) If the patient is currently on tocilizumab, indicate start date of treatment course (YYYY-MM-DD) _____

3) For coverage, tocilizumab must be initiated in consultation with a specialist in internal medicine, rheumatology or neurology.
Please indicate the specialist consulted for the current treatment course, where applicable _____

Section II: Please complete for RENEWAL requests at 12 to 16 weeks of therapy (Renewal approval for 36 weeks)

4) Has the patient's disease flared* while on tocilizumab? ☐ Yes ☐ No

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

5) Has the patient's C-reactive protein (CRP) normalized to <1 mg/dL?

☐ Yes → indicate CRP level _____ (mg/dL) and date (YYYY-MM-DD) _____

☐ No → explain _____

Section III: Please complete for RE-TREATMENT requests

6) Provide the date of discontinuation of the previous tocilizumab treatment course (YYYY-MM-DD) _____

7) Has the patient's disease flared* **after discontinuation** of treatment with tocilizumab?

☐ Yes

☐ No → explain _____

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5**

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Nusinersen Special Authorization Request Form

On the reverse is the official *Nusinersen Special Authorization Request Form* (ABC 60064).

- All requests for nusinersen must be submitted using the *Nusinersen Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

NUSINERSEN
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE ☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis ☐ 5q Spinal Muscular Atrophy (SMA) Type 1 ☐ Other (specify) _____	Current weight (kg)	**Please indicate if this patient is** ☐ starting drug upon approval ……..... **complete section I** ☐ new to coverage but currently maintained on drug …...**complete section I and II** ☐ submitting renewal request ……..…...**complete section II**

Dosage and frequency requested	Treatment start date	Date of last dose

Section I: Please provide <u>pre-treatment</u> information for all INITIAL requests

Confirmed diagnosis date	Date	Disease duration at treatment initiation	_____
☐ Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote **Note: copy of the test report must be provided**	Date	Age of onset of clinical signs and symptoms consistent with SMA	_____
☐ Genetic documentation of two copies of the Survival Motor Neuron 2 (SMN2) gene **Note: copy of the test report must be provided**	Date	Were symptoms present at birth? ☐ Yes ☐ No	

Ventilation status

Patient requires ventilation at treatment initiation? ☐ Yes, specify how many hours per day _____ ☐ No

Patient requires permanent invasive ventilation* at treatment initiation? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Motor function score (Hammersmith Infant Neurological Examination [HINE] Section 2)

Pre-treatment score _____ Date _____

Section II: Please complete the following for all RENEWAL requests

Motor function score (Hammersmith Infant Neurological Examination [HINE] Section 2)

Current score _____ Date _____

Ventilation status

Patient currently requires ventilation? ☐ Yes, specify how many hours per day _____ ☐ No

Patient currently requires permanent invasive ventilation*? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Obeticholic Acid Special Authorization Request Form

On the reverse is the official *Obeticholic Acid Special Authorization Request Form* (ABC 60065).

- All requests for obeticholic acid must be submitted using the *Obeticholic Acid Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

OBETICHOLIC ACID
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for NEW requests (check ALL that apply)

Diagnosis ☐ Primary biliary cholangitis (PBC) → confirmed by ☐ Positive antimitochondrial antibodies (AMA)
☐ Liver biopsy results consistent with PBC
☐ Other (specify) _____

Previous therapy

Ursodeoxycholic acid (UDCA) has been used? ☐ Yes ☐ No (explain) _____

a) UDCA has been used for a minimum of 12 months? ☐ Yes ☐ No

b) Indicate response ☐ Inadequate response
☐ Documented and unmanageable intolerance
☐ Other (specify) _____

Concomitant use of UDCA

For patients who had an inadequate response to UDCA alone, will obeticholic acid be used in combination with UDCA?

☐ Yes ☐ No (explain) _____

Baseline measures

a) Alkaline phosphatase (ALP) _____ Units/L
Date _____
Reference range _____

b) Bilirubin _____ mmol/L
Date _____
Reference range _____

Please provide the following information for RENEWAL requests

Current measures

Alkaline phosphatase (ALP) _____ Units/L Date _____ Reference range _____

Concomitant use of UDCA? ☐ Yes ☐ No (explain) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

ALBERTA BLUE CROSS®

OBETICHOLIC ACID
SPECIAL AUTHORIZATION CRITERIA

Criteria for coverage

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

OBETICHOLIC ACID (e.g. Ocaliva) special authorization criteria

For the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA, where the following criteria are met:

I. A confirmed diagnosis of PBC, defined as:

- Positive antimitochondrial antibodies (AMA); or

- Liver biopsy results consistent with PBC.

AND

II.a. The patient has received ursodeoxycholic acid (UDCA) for a minimum of 12 months and has experienced an inadequate response to UDCA and can benefit from the addition of obeticholic acid. An inadequate response is defined as:

- alkaline phosphatase (ALP) >= 1.67 x upper limit of normal (ULN) and/or

- bilirubin > ULN and < 2 x ULN.

OR

II.b. The patient has experienced documented and unmanageable intolerance to UDCA and can benefit from switching therapy to obeticholic acid.

AND

III. Initiated by a gastroenterologist or hepatologist (or an internal medicine specialist with an interest in gastroenterology / hepatology on a case-by-case basis, in geographic areas where access to these specialities is not available).

Initial coverage may be approved for a period of 12 months.

Ongoing coverage may be considered only if the patient continues to benefit from treatment with obeticholic acid as evidenced by:

- A reduction in the ALP level to less than 1.67 x ULN; or

- A 15 per cent reduction in the ALP level compared with values before beginning treatment with obeticholic acid.

Continued coverage may be approved for up to 12 months.

ABC 60065 (2019/01)

Ocrelizumab for PPMS Special Authorization Request Form

On the reverse is the official *Ocrelizumab for PPMS Special Authorization Request Form* (ABC 60067).

- All requests for ocrelizumab for PPMS must be submitted using the *Ocrelizumab for PPMS Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

OCRELIZUMAB for PPMS
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

☐ NEW request for patient starting ocrelizumab upon approval

☐ NEW request for patient currently maintained on ocrelizumab (i.e. new to coverage)

☐ RENEWAL request ☐ RESTART request

Diagnosis

☐ Primary progressive multiple sclerosis (PPMS)

→ Diagnosis meets 2017 McDonald criteria? ☐ Yes

☐ No, explain _____

☐ Other (specify) _____

Current EDSS _____ Date _____

Please provide the following information for NEW requests for patients new to ocrelizumab or to coverage

EDSS prior to ocrelizumab initiation _____ Date _____

Functional Systems Scale score for the pyramidal system due to lower extremity findings (at ocrelizumab initiation)

_____ Date _____

Are there documented imaging features characteristic of inflammatory activity?

☐ Yes ☐ No, explain _____

Disease duration (at ocrelizumab initiation) _____

If patient is already on ocrelizumab, specify date started (YYYY-MM-DD) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

Registration for MS Neurologist Status Form

On the reverse is the official *Registration for MS Neurologist Status Form* (ABC 60002).

- All requests to become a "Registered MS Neurologist" must be submitted using the *Registration for MS Neurologist Status Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ALBERTA GOVERNMENT SPONSORED DRUG BENEFIT PROGRAMS

REGISTRATION FOR MS NEUROLOGIST STATUS
for *Alberta Drug Benefit List* Special Authorization Coverage

Eligible MS Disease Modifying Therapies
(e.g., alemtuzumab, dimethyl fumarate, fingolimod hydrochloride, glatiramer acetate, interferon beta-1a, interferon beta-1b, natalizumab, teriflunomide)

Requests for special authorization coverage of eligible MS Disease Modifying Therapies is restricted to those neurologists who have registered with Alberta Blue Cross as an "MS Neurologist". Approval of patient coverage may or may not be granted based on the information provided on the Special Authorization Request Form.

Responsibilities of a registered "MS Neurologist" & including the following:

- Maintain adequate knowledge regarding multiple sclerosis (MS) and its treatment.
- Maintain expertise in treating/managing patients with MS.
- Provide adequate follow-up for their patients. This includes assessment of adverse events including discussion of concerns brought by the patient to the MS Special Therapies Nurse. It also includes assessment of tolerance, effectiveness, indications for continuation (on at least a yearly basis) and completion of the renewal request for continued coverage.

Neurologists who choose not to apply to be a registered "MS Neurologist" may also prescribe MS Disease Modifying Therapies, but patients will not be eligible for coverage under the program for such prescriptions. The patient may choose to receive the product at their own expense.

Please complete all sections of this form and return it by fax to Alberta Blue Cross

Registrations will be accepted on an ongoing basis

NEUROLOGIST LAST NAME	FIRST NAME	INITIAL	OFFICE PHONE	FAX

OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER
OR PROFESSIONAL REGISTRATION NUMBER

I agree to abide by the responsibilities of a registered "MS Neurologist" and submit special authorization requests for eligible MS Disease Modifying Therapies in accordance with policies and criteria as updated from time to time in the Special Authorization section of the *Alberta Drug Benefit List*.

SIGNATURE OF PRESCRIBER (required) ☐ _____ **DATE** _____

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-828-4106

Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form

On the reverse is the official *Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form* (ABC 60021).

- All requests to become a "Registered Prescriber" must be submitted using the *Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  1-877-330-5211 toll-free

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

APPLICATION FOR REGISTERED PRESCRIBER STATUS for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs

Jetrea

Coverage of Jetrea is restricted to those patients for whom the drug is prescribed by a Registered Prescriber.

- Ophthalmologists with training in the administration of intravitreal injections may apply to be a Registered Prescriber by completing this form. Registration allows for practitioner's patients to receive coverage of Jetrea.
- Ophthalmologists who choose not to apply to be a Registered Prescriber may also prescribe Jetrea but patients will not be eligible for payment under the program for such prescriptions. The patient may choose to receive the product at their own expense.

Please complete all sections of this form and return it by fax to Alberta Blue Cross

Registrations will be accepted on an ongoing basis

PRESCRIBER SURNAME	FIRST NAME	INITIAL	PHONE	FAX

ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER
OR PROFESSIONAL REGISTRATION NUMBER

I have reviewed the criteria for coverage of Jetrea as attached and I agree to abide with these criteria as updated from time to time in the *Alberta Drug Benefit List* for coverage under the program.

SIGNATURE OF PRESCRIBER (required) ✗ _____ **DATE** _____

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-330-5211

ALBERTA BLUE CROSS®

Jetrea
COVERAGE CRITERIA

Coverage may only be considered if the following criteria are met.

Criteria for Coverage

JETREA

For the treatment of symptomatic vitreomacular adhesion (VMA) if the following clinical criteria and conditions are met:

Clinical Criteria
- Diagnosis of VMA should be confirmed through optical coherence tomography.
- Patient does not have any of the following: large diameter macular holes (> 400 micrometre), high myopia (> 8 dioptre spherical correction or axial length > 28 millimetre), aphakia, history of retinal detachment, lens zonule instability, recent ocular surgery or intraocular injection (including laser therapy), proliferative diabetic retinopathy, ischemic retinopathies, retinal vein occlusions, exudative age-related macular degeneration or vitreous hemorrhage.

Conditions
- For coverage, this drug must be prescribed by an ophthalmologist who is registered with Alberta Blue Cross as a Registered Prescriber. To register to become a Registered Prescriber, please complete the Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea form.
- Treatment with ocriplasmin should be limited to a single injection per eye (e.g. retreatments are not covered).

SECTION 2

Price Policy

ADBL - Updated Price Policy
Effective February 13, 2019

PRICE POLICY

DEFINITIONS

In this Price Policy,

Alberta Blue Cross or ABC or Blue Cross means the ABC Benefits Corporation,

Alberta Drug Benefit List, List or ADBL means, unless otherwise indicated, the most recent drug benefit list (including drug benefit listing policies and processes and benefit supplements) published by the Minister from time to time,

Alberta Price Confirmation, APC or Interim APC means an electronic Alberta Price Confirmation process that may be issued by the Minister from time to time and administered by ABC on behalf of the Minister,

APC Terms and Conditions means the terms and conditions outlined in a Non-Fixed Price APC, Fixed Price APC, Pan-Canadian Select Molecule Price Initiative APC, Interim Non-Fixed Price APC or an Interim Fixed Price APC,

Brand Drug means an originator/brand Drug Product listed or under consideration for listing on the ADBL,

Brand Price means the price of the Brand Drug published in the February ADBL in an Established IC Grouping or, if there is more than one originator/brand product in the Established IC Grouping, the Brand Price is the lowest published price of a Brand Drug in the Established IC Grouping,

Claim means a submission for reimbursement to the Plan for a Drug Product,

Confirmed Price means a Confirmed Price in compliance with clauses 3, 4 and 5, and as submitted by the Manufacturer via the Price Confirmation **or as adjusted by the Minister pursuant to clauses 18(d), 23 or 25(b)**,

Device means a product approved by Health Canada as a device and listed or under consideration for listing by the Minister on the ADBL,

Drug Product means anything that is listed or under consideration for listing by the Minister on the ADBL,

Drug Program Act or **DPA** means the *Drug Program Act* of Alberta,

Effective Period means the Effective Period stated in the applicable APC Terms and Conditions,

Entry IC Drug means a Drug Product that is under consideration for listing in a New IC Grouping or Established IC Grouping,

Established IC Grouping means an IC Grouping that was established on or before February 1, 2019 and listed in the February ADBL,

February ADBL means the ADBL published by the Minister on or about February 1, 2019,

Fixed Price means the applicable Fixed Price as set out in the Fixed Pricing Rules,

Fixed Price APC Terms and Conditions means the Terms and Conditions outlined in a Fixed Price APC and includes the Signature Page as defined in such Terms and Conditions,

IC Drug means a Drug Product that is listed, or is under consideration for listing, as interchangeable with one or more Drug Products as determined by the Minister in accordance with the requirements relating to interchangeability in Section 1 of the ADBL,

IC Grouping means a category on the ADBL where there are two or more IC Drugs listed or under consideration for listing as part of one grouping on the ADBL as determined by the Minister,

Interim APC means an Interim Fixed Price APC or an Interim Non-Fixed Price APC,

Interim Fixed Price APC means an APC issued by the Minister for one or more Fixed Price Drug Products, or one or more categories or groupings of Fixed Price Drug Products during an Effective Period,

Interim Fixed Price APC Terms and Conditions means the terms and conditions outlined in an Interim Fixed Price APC,

Interim Non-Fixed Price APC means an APC issued by the Minister for one or more Non-Fixed Price Drug Products, or one or more categories or groupings of Non-Fixed Price Drug Products during an Effective Period,

Interim Non-Fixed Price APC Terms and Conditions means the terms and conditions outlined in an Interim Non-Fixed Price APC,

Least Cost Alternative Price or LCA Price means the maximum amount established by the Minister which will be paid by the Government of Alberta for a Drug Product in an Established IC Grouping or New IC Grouping for members of a Plan,

MAC Grouping means a grouping of Drug Products that have been listed on the ADBL and are subject to a MAC Price; a MAC Grouping may include a grouping of IC Drugs, in which case the grouping shall be treated as an Established IC Grouping,

Manufacturer means an entity that manufactures, sells or distributes a Drug Product,

Market Exit Assessment Form: An assessment form provided through the Pan-Canadian Generic Initiative that identifies a newly established price of a Fixed Price Drug Product that may be adjusted pursuant to the conditions identified in clause 18,

Maximum Allowable Cost Price or MAC Price means the maximum amount established by the Minister that will be paid by the Government of Alberta for a Drug Product in a MAC Grouping for members of a Plan,

Maximum Term means the Maximum Term stated in the applicable APC Terms and Conditions,

Minister means Her Majesty the Queen in right of Alberta, as represented by the Minister of Health,

New IC Grouping means an IC Grouping that was established or may be established after February 1, 2019,

Non-Fixed Price means the applicable Non-Fixed Price as set out in the Non-Fixed Pricing Rules,

Non-Fixed Price APC Terms and Conditions means the Terms and Conditions outlined in a Non-Fixed Price APC and includes the Signature Page as defined in such Terms and Conditions,

Nutritional Product means a product categorized as a caloric agent once listed or under consideration for listing on the ADBL,

Pan-Canadian Competitive Value Price Initiative for Generic Drugs or Pan-Canadian Generic Initiative is a collaboration of participating Canadian jurisdictions to establish the prices of generic Drug Products in accordance with the Pan-Canadian Generic Value Price Initiative which is established through the Pan-Canadian Generic Initiative Point of Entry process as further described in clause 18,

Pan-Canadian Select Molecule Price Initiative means the price-setting approach established by the Health Care Innovation Working Group of the Council of the Federation to set the price for select generic drug molecules in the Participating Jurisdictions as outlined in Appendix A of the Pan-Canadian Select Molecule Price Initiative Terms and Conditions,

Pan-Canadian Select Molecule Price Initiative Terms and Conditions means the Terms and Conditions outlined in Pan-Canadian Select Molecule Price Initiative APC and includes the Signature Page as defined in such Terms and Conditions,

Participating Jurisdiction has the same meaning as defined in the Pan-Canadian Select Molecule Price Initiative Terms and Conditions,

Plan means a plan or program for which the Government of Alberta provides benefits in respect of Drug Products listed on the ADBL,

Price Confirmation means the package of documents identified in an APC which must be completed and submitted in accordance with this Price Policy and the applicable APC Terms and Conditions,

Product Listing Agreement or PLA means a product listing agreement that is entered into or may be entered into by the Minister in respect of any Drug Product in accordance with the Minister's Product Listing Agreement Policy, including any Drug Product that is listed or under consideration for listing on the ADBL,

Product Listing Agreement Policy means any product listing agreement policy (including any processes related thereto) that may be published by the Minister from time to time.

ALBERTA PRICE CONFIRMATION (APC) FOR NON-FIXED PRICE, FIXED PRICE AND PAN-CANADIAN SELECT MOLECULE PRICE INITIATIVE DRUG PRODUCTS

1. The Minister may from time to time issue an Alberta Price Confirmation (APC) or an Interim APC, where a Manufacturer will be invited to submit a Price Confirmation, with one or more Confirmed Prices, in accordance with the applicable APC Terms and Conditions.

2. The Manufacturer must ensure that a Price Confirmation and a Confirmed Price submitted by a Manufacturer comply with:

    a. the Price Policy published at the time of an APC or Interim APC;

    b. the applicable APC Terms and Conditions issued for the Price Confirmation;

    c. the Pan-Canadian Generic Initiative, where applicable; and

    d. the Pan-Canadian Select Molecule Price Initiative, where applicable.

3. The Confirmed Price is the price that, if accepted by the Minister, shall be published in the ADBL.

4. For purposes of an APC and submitting a Price Confirmation, and subject to exceptions permitted by and approved under the Price Policy, the **Confirmed Price for a Drug Product is**:

    a. **For a Drug Product subject to the Fixed Pricing Rules**, a price as set out in clause 18 of the Price Policy.

    b. **For a Drug Product subject to the Non-Fixed Pricing Rules,** a price that is less than or equal to the Non-Fixed price (per unit of issue) as set out in clause 19 of the Price Policy.

5. In addition, **a Confirmed Price**:

    a. is applicable to a Drug Product regardless of the package size for each Drug Product;

    b. must not include the Goods and Services Tax (GST) or any other tax; and must not include any additional fees and/or charges; and

    c. For clarity, notwithstanding clause 5(b), Drug Products that are nutritional products that are subject to provincially mandated container recycling fees in Alberta may include recycling fees within their Confirmed Price.

6. The Minister may extend the duration of the Effective Period for a period, or periods, of time up to and including the last day of the Maximum Term.

7.

    a. The Manufacturer is responsible for ensuring that sufficient supply of a Drug Product is available to the Alberta market prior to the acceptance of an APC, for which a Confirmed Price has been submitted, and is available for the Alberta market at the Confirmed Price for the duration of the Maximum Term.

    b. If the Manufacturer anticipates that it may be unable to comply with the provisions of clause 7(a), the Manufacturer must advise Alberta Blue Cross immediately in writing via email to APCINQ@ab.bluecross.ca.

        c. Where a Manufacturer is unable to supply a Drug Product after the Drug Product has been listed, the Manufacturer may be required to reimburse Alberta Health the difference in cost of covering a higher priced LCA Drug Product, the Brand Price or providing a temporary benefit, as described in the Supply Shortages policy in Section 1 of the ADBL, when one or more of the following criterion are met:

i. Manufacturers of Entry IC Drug Product(s) or Non-Fixed Price Drug Product(s) under consideration for listing that have confirmed ability to supply the Alberta market through the following mechanisms:

1. Letter confirming ability to supply the Alberta market as per the ADBL Submission Requirements located in Section 1 of the ADBL,

2. Signing and returning the applicable Alberta Price Confirmation Signature Page, and

3. The Minister has received confirmation that the Manufacturer's Pan-Canadian Generic Initiative price confirmation form has been accepted and the applicable tier has been established by the Pan-Canadian Generic Initiative.

ii. Manufacturers of Drug Product(s) listed in a New IC or Established IC Grouping or currently listed Non-Fixed Drug Product(s) that have been confirmed as unable to supply by Alberta Blue Cross for at least six months.

d. Manufacturers of Drug Product(s) listed on the ADBL that fall under either clause 7(c)(i) or 7(c)(ii) will be granted the opportunity to provide rationale and documentation that the supply shortage of their Drug Product(s) was due to extraordinary events beyond the Manufacturers control. Based on the information provided, the Minister will consider whether reimbursement by the Manufacturer in accordance with clause 7(c) is required.

8. The Minister may consider a Confirmed Price and may accept none, one or more Confirmed Prices (with or without any request for an exception to the Fixed Pricing and Non-Fixed Pricing Rules (as applicable)) submitted in one or more Price Confirmations.

9. Notwithstanding the acceptance of a Confirmed Price, the Minister is not obligated to pay that price for members of a Plan, but may establish special or exceptional prices, including but not limited to establishing:

a. an LCA Price,

b. a MAC Price, or

c. a special or exceptional price.

10. When considering a Confirmed Price for acceptance, and in determining whether to establish an LCA Price, a MAC Price, or a special or exceptional price, the Minister may consider any factor or criteria outlined in the ADBL, any matter permitted by the *Drug Program Act*, any matter arising from the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative, or any matter that the Minister determines is in the public interest.

INTERIM APC

11. Notwithstanding the acceptance of a Confirmed Price by the Minister, in the event that:

    a. a new Drug Product is being considered for listing in an Established IC Grouping, New IC Grouping or MAC Grouping;

    b. a Drug Product is being considered by the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative;

    c. Manufacturer submits a price reduction in accordance with clause 26 of this Price Policy;

    d. for any reason that the Minister determines that it is advisable to do so,

    the Minister may issue an Interim APC for one or more Drug Products, or one or more groupings of Drug Products.

12. If a Manufacturer submits a new Drug Product submission for review and listing on the ADBL, and an Interim APC is issued, the Manufacturer must submit a Confirmed Price for that Drug Product that:

    a. is equal to or less than the price as outlined in the Drug Product submission, and

    b. does not exceed the prices permitted under this Price Policy,

    or the Drug Product may not be listed or the listing of the Drug Product may be delayed.

13. When a Pan-Canadian Select Molecule Price Initiative APC or Interim Fixed Price APC are issued, all Manufacturers who have a Fixed Price Drug Product listed in the affected Established IC Grouping, New IC Grouping or MAC Grouping will be required to submit a new Price Confirmation and Confirmed Price for the affected Fixed Price Drug Product in accordance with the Pan-Canadian Generic Initiative and the Pan-Canadian Select Molecule Price Initiative and the Fixed Pricing Rules as per clause 18 of this Price Policy. In the event that a new Confirmed Price for an affected Fixed Price Drug Product is not submitted or if the Confirmed Price for the affected Fixed Price Drug Product is greater than the price prescribed through the Pan-Canadian Generic Initiative, Pan-Canadian Select Molecule Price Initiative or the Fixed Pricing Rules then the affected Fixed Price Drug Product will be delisted.

14. In the event the Minister issues an Interim APC, and one or more Confirmed Prices are accepted as a result of the Interim APC, the applicable APC Terms and Conditions supersede any previous APC Terms and Conditions for the affected Drug Products for the remainder of the Effective Period.

15. Publication of amended Confirmed Prices is at the discretion of the Minister.

16. Unless permitted in this Price Policy or by the Minister, a Confirmed Price may not exceed a Confirmed Price for a Drug Product that has been submitted and approved by the Minister through a prior APC relating to such Drug Product.

17. The provisions in this Price Policy that apply to an APC also apply to an Interim APC, and where the term APC is used in such clauses, it shall be deemed to read Interim APC in the case of an Interim APC.

FIXED PRICING RULES

18. The Fixed Pricing Rules apply to any Drug Product, other than a Brand Drug, that is listed or under consideration for listing on the ADBL.

    a. During an APC or Interim Fixed Price APC, for a Fixed Price Drug Product listed or under consideration for listing that is not subject to the Pan-Canadian Select Molecule Price Initiative, it is the Manufacturer's responsibility to submit a Confirmed Price that is less than or equal to the LCA price of the most recently published ADBL, the price established through the Pan-Canadian Generic Initiative, or the price published in the February ADBL, whichever is lower.

    b. Where the Pan-Canadian Generic Initiative issues a Market Exit Assessment Form Manufacturers who have Drug Products that are in the same IC Grouping as the Drug Product identified in a Market Exit Assessment Form will receive a single opportunity to adjust the affected Drug Product's Confirmed Price to be equal to or less than the maximum price established through the Pan-Canadian Generic Initiative during an APC or Interim Fixed Price APC. Manufacturers are not required to adjust their current prices if current prices are equal or lower than the price identified on the Market Exit Assessment Form.

    c. During an APC or Interim Fixed Price APC, Manufacturers submitting a Confirmed Price for an IC Drug product subject to the Pan-Canadian Select Molecule Price Initiative must submit a price equal to the price established by the Pan-Canadian Select Molecule Price Initiative.

    d. **The Minister may decrease the price of a Fixed Price Drug Product(s) when a lower price than what is currently listed on the ADBL has been established through the Pan-Canadian Generic Initiative with or without issuing an APC or Interim APC and regardless of whether an Entry IC Drug is being added to the IC Grouping. Such price shall become the Confirmed Price.** If a Manufacturer does not agree with this rule they should not submit a Confirmed Price to an APC or Interim APC. Manufacturers who decline to submit a Confirmed Price through the initial APC or an initial Interim APC of the Effective Period for the affected Drug Products may not be listed on the ADBL.

    e. The Minister may defer the listing of an Entry IC Drug Product if a price has not been received by the Pan-Canadian Generic Initiative.

    f. The Minister may request written evidence from the Pan-Canadian Generic Initiative that the price has been submitted and accepted in accordance with the Pan-Canadian Generic Value Price Initiative Point of Entry process.

Additional information regarding the Pan-Canadian Generic Initiative and the Pan-Canadian Select Molecule Price Initiative may be found at:

http://formulary.drugplan.ehealthsask.ca/PanCanadian.aspx

Questions regarding the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative can be directed to:

PCPAGenericsOffice@ontario.ca

NON-FIXED PRICING RULES

19. The Non-Fixed Pricing Rules apply to Brand Drugs.

    a. The Confirmed Price must be:

        i. less than or equal to the previous price of that Drug Product listed on the February ADBL, or

        ii. the submitted price where that Drug Product was not previously listed on the ADBL, or

        iii. the previous price of the Drug Product listed on the February ADBL, plus an increase that is less than or equal to the current Patented Medicine Prices Review Board (PMPRB) Guidelines which will be used to determine acceptable price increases, up to a maximum of 5 per cent. Price increases will only be considered if a Manufacturer has entered into the Non-Fixed Price APC Terms and Conditions.

    b. In order to meet the PMPRB Guidelines, the Confirmed Price must be less than or equal to 2.4 per cent higher than it was February 2019 AND must be less than or equal to 4.2 per cent higher than it was on the December 31, 2016 ADBL.

    c. Manufacturers requesting a price increase must review the published price their Drug Product was listed at on the December 2016 ADBL, the published price their Drug Product was listed at on the 2019 February ADBL; and the PMPRB guidelines for allowable CPI increases for 2019. If the Non-Fixed Priced Drug Product was not listed on the December 2016 ADBL, the Manufacturer will be required to determine the applicable PMPRB guidelines and the appropriate publication of the ADBL to determine allowable price increases for April 1, 2019.

    PMPRB Guidelines can be found at http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1353&lang=en

    d. The Confirmed Price in respect of a Drug Product may only increase from the price most recently published in an ADBL once per 12 month period for the APC which would be effective on or about April 1, 2019.

    e. PMPRB may be provided with Confirmed Prices submitted through the APC to determine compliance with the PMPRB Guidelines.

EXCEPTIONS

20. Notwithstanding the Fixed Pricing Rules and the Non-Fixed Pricing Rules, a Manufacturer may request the Minister consider an exception to the Fixed Pricing Rules or the Non-Fixed Pricing Rules.

21. Notwithstanding anything else in this Price Policy, exception requests for Drug Products that are subject to either the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative, both of which fall under the Fixed Pricing Rules, will not be considered.

22. The Minister may, but is not required to, consider exceptions:

    a. for Drug Products with less than 250 Claims or an annual net cost of less than $50,000 for Plans, as calculated by the Minister and based on Claims experience information provided by Alberta Blue Cross relating to Plans, for the period of time that the Drug Product was listed on the ADBL in the previous 12 months;

b. where the manufacturing and distribution costs for a Drug Product exceed the maximum price for such Drug Product permitted by the Fixed Pricing Rules or the Non-Fixed Pricing Rules, as applicable:

   i. The Manufacturer must provide detailed written evidence of the following:

      1. The costs for each raw material separately, including that of the active pharmaceutical ingredient,

      2. The cost of manufacturing (excluding costs of raw materials),

      3. Cost of distribution (including direct distribution fees paid to distributors but excluding all rebates and/or professional allowances), and

      4. Other costs, as applicable.

   ii. All costs must be stated per unit of issue;

   or,

c. where exceptional circumstances exist.

   i. Exceptional circumstances include, but are not limited to, circumstances where, in the opinion of the Minister, significant patient safety or access concerns or significant increased costs to the Plans could result if the Drug Product was not available on the ADBL. The Manufacturer must provide detailed written evidence outlining the exceptional circumstance;

23. Where an exception is requested, the maximum price increase which will be granted by the Minister is 5 per cent above the February ADBL price for that Drug Product. **Manufacturers who are granted an exception, but have requested a price increase above 5 per cent will be listed at 5 per cent above the price listed on the February ADBL. Such price shall become the Confirmed Price.** For clarity, for Non-Fixed Price Drug Products the maximum 5 per cent price increase is inclusive of any PMPRB increase as per clause 19.

24. The Minister reserves the right to defer consideration of the exception and request such additional evidence and information in support of such request as the Minister deems appropriate.

25.

a. If an exception is requested for a Drug Product in an APC, but is not approved by the Minister, the Manufacturer will not be given another opportunity to submit a new Confirmed Price in respect of such Drug Product, unless:

   i. the Minister determines it is advisable to do so; or

   ii. the Manufacturer follows the applicable Resubmission process referred to in Section 1 of the ADBL.

b. Notwithstanding clause 25(a), if an exception request for a Drug Product is not approved by the Minister, the Minister may continue to list a Drug Product that was listed on the ADBL at the time the exception request was made in accordance with the following rules:

i. Drug Products subject to the Fixed Pricing Rules will continue to be listed at the previous price of the Drug Product listed on the February ADBL. Such price shall become the Confirmed Price; and

ii. Drug Products subject to the Non-Fixed Pricing Rules will continue to be listed at the previous price of the Drug Product listed on the February ADBL, plus an increase that is equal to the current Patented Medicine Prices Review Board (PMPRB) Guidelines. Such price shall become the Confirmed Price.

PRICE REDUCTIONS

26. During an Effective Period, further price reduction requests for Drug Products listed on the ADBL will be considered as follows:

    i. For Drug Products listed in an Established IC Grouping or MAC Grouping the proposed price reduction must be at least 5 per cent less than the LCA price or MAC Price published at the time Alberta Blue Cross receives the proposed price reduction.

    ii. For all other Non-Fixed Price Drug Products, by notifying the Minister by sending a written notice to Alberta Blue Cross.

    iii. Price reductions will not be considered for IC Drug Products subject to the Pan-Canadian Select Molecule Price Initiative.

    If accepted by the Minister, the Minister will issue an Interim APC for the Manufacturer to provide the reduced Confirmed Price. Establishment of a new LCA Price or MAC Price and publication of a reduced price is the Minister's sole discretion.

MINISTER'S AUTHORITY

27. Notwithstanding anything to the contrary, where

    a. no Price Confirmation or Confirmed Price is submitted in respect of a Drug Product;

    b. there is a failure to issue an APC, or submit a Price Confirmation or Confirmed Price(s) in respect of a Drug Product in accordance with the applicable APC Terms and Conditions;

    c. there is a rejection or non-acceptance of all or part of an APC, Price Confirmation or Confirmed Price(s), or of a request for an exception to either the Fixed Pricing Rules or Non-Fixed Pricing Rules;

    d. a Price Confirmation or a Confirmed Price of an IC Drug in an APC or an Interim APC is lower than the Confirmed price or the Price Confirmation of any other IC Drug Products in an IC Grouping;

    e. there is a failure by the Manufacturer to comply with the ADBL Price Policy, the applicable APC Terms and Conditions and/or the Pan-Canadian Generic Initiative or the Pan-Canadian Select Molecule Price Initiative in respect of a Drug Product listed or under consideration for listing on the ADBL;

    f. the Minister considers that a PLA that is satisfactory to the Minister must be entered into prior to and/or as a condition of the listing, or continued listing, of a Drug Product on the ADBL;

the Minister may do any one or more of the following:

i. cancel the listing of,

ii. modify the listing of,

iii. refuse to add to the ADBL,

iv. refuse to expedite the submission of,

v. cancel or modify the benefit payable for,

vi. modify or impose rules, terms, restrictions or conditions (including the execution of a PLA satisfactory to the Minister) relating to, or

vii. take any other action

in relation to the Drug Product for any period of time deemed appropriate by the Minister.

28. Notwithstanding any other provision in this Price Policy, the Minister has and retains the sole right to determine all matters relating to the listing or continued listing of a Drug Product on the ADBL, including (without limitation) the sole right to:

a. determine whether or not the Fixed Pricing Rules, the Non-Fixed Pricing Rules, the Pan-Canadian Generic Initiative, the Pan-Canadian Select Molecule Price Initiative, or any other rules apply to a Drug Product,

b. determine whether or not a Drug Product is to be considered a Brand Drug for purposes of this Price Policy and an APC,

c. determine whether or not to extend the Effective Period of an APC pursuant to clause 6,

d. determine whether or not a PLA must be executed as a condition of the listing or continued listing of a Drug Product on the ADBL,

e. make any decisions or take any steps to amend a published price, an LCA Price, a MAC Price, a special or exceptional price, the Price Policy, the Product Listing Agreement Policy, the ADBL or make any other adjustments the Minister considers advisable,

f. make any decisions, take any actions or steps, or do anything that is authorized by the *Drug Program Act*,

g. pursue, negotiate and enter into agreements with one or more Manufacturers, distributors or vendors, including (without limitation) a PLA or other contractual agreement,

h. make arrangements with other persons to provide access to Drug Products for members of the Plans,

i. make any decisions, or take any actions or steps, or do anything that the Minister considers appropriate, or

j. terminate an APC, a Price Confirmation, or all or part of a Price Confirmation, or one or more Confirmed Prices, or the listing of any or all Drug Products on the ADBL, upon 10 days written notice to any affected Manufacturer, which notice is deemed to be given by the

Minister and received by the Manufacturer upon (a) publication of the written notice on the ADBL website operated by Alberta Blue Cross, or (b) by sending the notice via fax to the last known fax number of the Manufacturer, and the method of notice is at the Minister's discretion,

in order to maintain the integrity of the ADBL, to ensure reasonable access to treatment for members of the Plans, or to serve the public interest.

29. For further clarity, in all cases where the execution of a PLA in respect of a Drug Product is required as a condition of the listing or continued listing of a Drug Product on the ADBL, the provisions of the Product Listing Agreement Policy must be satisfied. Nothing in this Price Policy is intended to limit or override the application or any provisions of the Product Listing Agreement Policy. The requirements for listing or continued listing of a Drug Product outlined in the ADBL, including (without limitation) this Price Policy, as well as the Product Listing Agreement Policy must be satisfied.

30. Subject to clause 28(e), where the Minister amends the Price Policy during an Effective Period, the Minister shall provide Manufacturers of Drug Products listed on the ADBL as at that date with 30 days' notice of such amendment, and the Minister may also issue an Interim APC in relation to any Drug Product affected by such amendment.

31. The Minister reserves the right to pursue any remedies available to the Minister in the event of any non-compliance with, or any breach of, the Price Policy, or any applicable APC Terms and Conditions.

32.

    a. The Minister, Alberta Blue Cross, and their respective officers, employees, and agents, are not liable for any actions, damages, claims, liabilities, costs, expenses, or losses in any way, including consequential, special, indirect, incidental, punitive or special damages, costs, expenses, or losses (including, without limitation, lost profits and opportunity costs) arising out of or relating to an APC, an Interim APC, any Price Confirmation, a Confirmed Price, the Pan-Canadian Generic Initiative, the Pan-Canadian Select Molecule Price Initiative, or the ADBL, even if the Minister or Alberta Blue Cross have been advised of the possibility of such damages beforehand. The provisions of this clause shall apply regardless of the form of action, damage, claim, liability, cost, expense, or loss, whether in contract, statute, tort (including, without limitation, negligence), or otherwise, and

    b. In no event shall the maximum aggregate liability of the Minister, Alberta Blue Cross, and their respective officers, employees, and agents, for damages related to an APC, an Interim APC, a Price Confirmation, a Confirmed Price, the Pan-Canadian Generic Initiative, the Pan-Canadian Select Molecule Price Initiative, or the ADBL be greater than $25,000, or the Manufacturer's actual costs of preparing and submitting a Price Confirmation in response to an APC, whichever is less.

Least Cost Alternative (LCA) Price Policy

1. The Least Cost Alternative Price or LCA Price means the maximum amount established by the Minister which will be paid by the Government of Alberta for a Drug Product in an Established or New IC Grouping for members of a Plan.

2. Where the Minister establishes a LCA Price in Established and New IC Groupings the LCA Price:

    a. is the lowest unit per issue cost for a Drug Product in an IC Grouping that was submitted by the Manufacturer and accepted by the Minister in the most recent Alberta Price Confirmation.

    b. appears in bold type in the far right column of the ADBL.

    c. applies to all Drug Products in the applicable IC Grouping, unless the Minister determines that an exception should be made.

3. Notwithstanding clause 2 above, the LCA Price Policy does not apply to:

    - conjugated estrogens;
    - Devices; and
    - injectable Drug Products with different package sizes in an IC Grouping.

4. Subject to a Special Authorization being granted pursuant to clause 5 below, where a physician prescribes or a patient chooses an IC Drug that is priced higher than the LCA Price established by the Minister in the applicable IC Grouping, the patient will be responsible for any additional costs (being the difference in price between the higher-priced IC Drug and the LCA Price).

5. A physician may request Special Authorization if an IC Drug that is priced higher than the applicable LCA Price is essential in the care of a patient. For further information refer to the Special Authorization Guidelines clause of the ADBL.

Maximum Allowable (MAC) Price Policy

1. The MAC Price means the maximum amount established by the Minister which will be paid by the Government of Alberta for a Drug Product in a MAC Grouping for members of a Plan.

2. A MAC Grouping means a grouping of Drug Products that have been listed on the ADBL or the List as being subject to a MAC Price; a MAC Grouping may include a grouping of IC Drugs, in which case the grouping shall be treated as an Established IC Grouping.

3. Where the Minister has established a MAC Price for a MAC Grouping, the MAC Price appears in ***bold italic*** type and is displayed in the ADBL in the second column from the right where two price columns are listed. A comment in ***bold italic*** type appears following a MAC Grouping to explain the basis for establishing the MAC Price.

4. The MAC Price Policy applies to the following MAC Groupings:

    - PTC 28:08.04.92

      Selected Oral Modified-Release Dosage Forms of Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)

    - PTC 40:12

      Potassium Chloride (K+) 8 mEq Oral Sustained-Release Tablets
      Potassium Chloride (K+) 20 mEq Oral Tablet / Sustained-Release Tablets Potassium Chloride (K+)(CL-) 1.33 mEq / ml Oral Liquid

    - PTC 56:28:36

      Antiulcer Agents and Acid Suppressants (proton-pump inhibitors)

5. Subject to a Special Authorization being granted, where a physician prescribes or a patient chooses a Drug Product in a MAC Grouping that is priced higher than a MAC Price established by the Minister for the applicable MAC Grouping, the patient will be responsible for any additional costs (being the difference in price between the higher-priced Drug Product and the MAC Price).

6. A physician may request Special Authorization if the Drug Product that is priced higher than the applicable MAC Price is essential in the care of a patient. For further information refer to the Special Authorization Guidelines clause of the ADBL.

Transitional Period Price Policy

1. With the exception of IC Drug Products affected by the Pan-Canadian Select Molecule Price Initiative, the Minister may establish a transitional period of up to 30 days to provide a temporary benefit or payment for a Drug Product in accordance with the following:

    a. If a new IC Drug is added to the List which results in the establishment of a New IC Grouping, the Minister may temporarily pay the cost of the Brand Drug in that New IC Grouping for up to 30 days from the date the new IC Drug is listed;

    b. If a new IC Drug is added to the List in an Established IC Grouping at a lower price than the LCA Price , the Minister may temporarily pay the cost of the Drug Product that was the LCA Price prior to the addition of the new IC Drug for up to 30 days from the date the new IC Drug is listed;

    c. If a Drug Product is discontinued or removed from the ADBL, the Minister may continue the affected Drug Product as a temporary benefit for up to 30 days from the date of the notice that the Drug Product is discontinued, or the date the listing was cancelled;

    d. Where the Transitional Period Price Policy is implemented because of a supply shortage, and an alternate Drug Product is added to temporarily replace the Drug Product in short supply:

        i. If the supply shortage is rectified in 30 days or less, no transitional period applies to the alternate Drug Product;

        ii. If the supply shortage is rectified in more than 30 days, the alternate Drug Product added and reimbursed under the Supply Shortages policy may continue to be reimbursed for up to 30 days after the supply shortage is rectified.

2. The Minister may make adjustments to the application of the Transitional Period Price Policy as required.

SECTION 3

Criteria for Special Authorization of Select Drug Products

CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

The drug products listed in this section may be considered for coverage by special authorization for patients covered under Alberta Health-sponsored drug programs. (For Alberta Human Services clients, the special authorization criteria for coverage can be found in the Criteria for Special Authorization of Select Drug Products section of the *Alberta Human Services Drug Benefit Supplement.)*

Special Authorization Policy

DRUG PRODUCTS ELIGIBLE FOR CONSIDERATION BY SPECIAL AUTHORIZATION

Drug products may be considered for coverage by special authorization under one or more of the following circumstances, unless a specific product falls under the criteria for drug products **not** eligible for consideration by special authorization. Please see the end of this section for information regarding drug products not eligible for consideration by special authorization.

1. The drug is covered by Alberta Health under specified criteria (listed in the following sections). Drug Products and indications other than those specified are not eligible for consideration by special authorization.
2. The drug is normally covered by another government program or agency for a specific approved clinical condition, but is needed for the treatment of a clinical condition that is not covered by that government program or agency.
3. The drug is required because other drug products listed in the *Alberta Drug Benefit List* are contraindicated or inappropriate because of the clinical condition of the patient.
4. The particular brand of drug is considered essential in the care of a patient, where the LCA price policy would otherwise apply. Coverage of a specific brand may be considered where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with alternate brands in an interchangeable grouping. Coverage of a brand name product will not be considered in situations where the interchangeable grouping includes a pseudo-generic to the brand name drug.
5. A particular drug product or dosage form of a drug is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the product level. Coverage may be considered only where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with the drug product which establishes the MAC pricing.

Prior approval must be granted by Alberta Blue Cross to ensure coverage by special authorization. For those special authorization requests that are approved, the effective date for authorization is the beginning of the month in which the physician's request is received by Alberta Blue Cross.

Special authorization is granted for a defined period as indicated in each applicable special authorization drug product criteria (the "Approval Period"). If continued treatment is necessary beyond the Approval Period, it is the responsibility of the patient and physician to **re-apply for coverage prior to the expiration date of the Approved Period, unless the Auto-Renewal Process or Step Therapy Approval Process apply** (see below).

AUTO-RENEWAL PROCESS

Selected drug products are eligible for the following auto-renewal process (for eligibility, see the Special Authorization criteria for each drug product).

1. For initial approval, a special authorization request must be submitted. If approval is granted, it will be effective for the Approval Period outlined in the drug product's Special Authorization criteria
2. As long as the patient has submitted a claim for the drug product within the preceding Approval Period (example: within the preceding 6 months), approval will be automatically renewed for a further Approval Period (example: a further 6 months). There is no need for the prescriber to submit a new request as the automated real-time claims adjudication system will read the patient's claims history to determine if a claim has been made within the preceding Approval Period.
3. If the patient does not make a claim for the drug product during the Approval Period, the approval will lapse and a new special authorization request must be submitted.

STEP THERAPY APPROVAL PROCESS

Select drug products are eligible for coverage via the step therapy process, outlined below.

1. If the patient has made a claim for the First-Line* drug product(s) within the preceding 12 months, the claim for the step therapy drug will be approved.
2. The automated real-time claims adjudication system will read the patient's claims history to determine if the required First-Line* drug product(s) have been claimed within the preceding 12 months.
3. Subsequent claims for drug product(s) permitted by step therapy will continue to be approved as long as the drug product has been claimed within the preceding 12 months.
4. The regular special authorization approval process will continue to be available for step therapy approvals for those patients whose First-Line* drug claims cannot be adjudicated through the automated real-time claims adjudication system.

* A First-Line drug product includes any drug(s) or drug product(s) that, under the drug product's Special Authorization criteria, are required to be utilized before reimbursement for the drug product is permitted.

DRUG PRODUCTS NOT ELIGIBLE FOR CONSIDERATION BY SPECIAL AUTHORIZATION

The following categories of drug products are **not** eligible for special authorization:

1. Drug products **deleted** from the *List*.
2. Drug products **not yet reviewed** by the Alberta Health Expert Committee on Drug Evaluation and Therapeutics. This applies to:
   * products where a complete submission has been received from the manufacturer and the product is under review,
   * products where an incomplete submission has been received from the manufacturer, and
   * products where the manufacturer has not made a submission for review.

   Drug products not yet reviewed may encompass new pharmaceutical products, new strengths of products already listed, reformulated products and new interchangeable (generic) products.
3. Drug products that have **completed the review** process and are **not included** on the *List.*
4. Most drugs available through Health Canada's Special Access Program.
5. Drug products when prescribed for cosmetic indications.
6. Nonprescription or over-the-counter drug products are generally not eligible.

Criteria for Coverage

Wording that appears within quotation marks (“ ”) in this section is the official special authorization criteria, as recommended by the Alberta Health Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health. Wording that is not enclosed in quotation marks outlines specific information required to interpret criteria, guidelines for submitting requests and/or information regarding conditions under which coverage cannot be provided.

Products Available through Health Canada’s Special Access Program

PEMOLINE

“For the treatment of attention deficit hyperactivity disorder where approval has been provided by Health Canada’s Special Access Program.”

37.5 MG	**ORAL TABLET**
DIN N/A*	CYLERT
75 MG	**ORAL TABLET**
DIN N/A*	CYLERT

**As Cylert has been withdrawn from market, the DINs are no longer valid. Where authorizations for Cylert have been granted, coverage for this product will be provided under PIN 00000999917.*

Other Products

The remaining drug products in this section are listed alphabetically according to the generic ingredient name of the drug. These products can be found on the following pages.

ABATACEPT

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate or other DMARDS, for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

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

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

- Initial coverage may be approved for 12 weeks as follows:
- Abatacept intravenous infusion: five doses of up to 1000 mg/dose administered at 0, 2, 4, 8 and 12 weeks. Patients will be limited to receiving one dose of abatacept per prescription at their pharmacy.
- Abatacept subcutaneous injection: a single IV loading dose of up to 1000 mg/dose followed by 125 mg subcutaneous injection within a day, then once-weekly 125 mg SC injections. Patients who are unable to receive an infusion may initiate weekly subcutaneous injections without an intravenous loading dose. Patients will be limited to receiving one-month supply of abatacept subcutaneous injection per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial 12 weeks to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for abacept will be provided for one intravenous dose of up to 1000 mg every 4 weeks, or one weekly 125 mg subcutaneous injection. Ongoing coverage

ABATACEPT

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 abatacept 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).

125 MG / SYR INJECTION

00002402475	ORENCIA	BMS	$	373.7875

ABATACEPT

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate or other DMARDS, for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

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

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

- Initial coverage may be approved for 12 weeks as follows:
- Abatacept intravenous infusion: five doses of up to 1000 mg/dose administered at 0, 2, 4, 8 and 12 weeks. Patients will be limited to receiving one dose of abatacept per prescription at their pharmacy.
- Abatacept subcutaneous injection: a single IV loading dose of up to 1000 mg/dose followed by 125 mg subcutaneous injection within a day, then once-weekly 125 mg SC injections. Patients who are unable to receive an infusion may initiate weekly subcutaneous injections without an intravenous loading dose. Patients will be limited to receiving one-month supply of abatacept subcutaneous injection per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial 12 weeks to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for abacept will be provided for one intravenous dose of up to 1000 mg every 4 weeks, or one weekly 125 mg subcutaneous injection. Ongoing coverage

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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 abatacept for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Polyarticular Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 6 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), AND
- Are refractory to or intolerant to etanercept and/or adalimumab (minimum 12 week trial).

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

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary ("Pediatric Rheumatology Specialist").

- Coverage may be approved for one dose of 10 mg/kg (maximum dose 1000 mg) at 0, 2, 4, 8, 12 and 16 weeks (total of six doses).
- Patients will be limited to receiving one dose of abatacept 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 potential coverage for retreatment with abatacept following a subsequent disease flare, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after the initial 16 weeks, but no longer than 20 weeks after, treatment with this biologic agent to

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determine and document initial treatment response.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient is a responder that meets the following criteria (ACR Pedi 30):
- 30% improvement from baseline in at least three of the following six response variables, with worsening of 30% or more in no more than one of the six variables. The variables include:
i. global assessment of the severity of the disease by the Pediatric Rheumatology Specialist,
ii. global assessment of overall well-being by the patient or parent,
iii. number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),
iv. number of joints with limitation of motion,
v. functional ability based on CHAQ scores,
vi. ESR or CRP
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported.

Following assessment and confirmation of initial treatment response, coverage for retreatment with abatacept may be approved for one dose of 10 mg/kg (maximum dose 1000 mg) at 0, 2*, 4, 8, 12 and 16 weeks (total of up to six doses; *the week 2 dose on retreatment is optional, to be administered at the discretion of the Pediatric Rheumatology Specialist). In order to be considered for coverage for retreatment, the patient must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist and the presence of disease flare confirmed. Disease flare is defined as worsening of at least 30% or greater in at least 3 of 6 ACR Pedi 30 variables for pJIA and 30% or greater improvement in no more than one variable.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has had an initial treatment response (as assessed above) and that the patient has experienced a disease flare (as defined above)."

Please note: Coverage is provided for treatment of disease flares only. However, if a patient experiences a subsequent flare within 12 months of initiation of treatment with abatacept, they may be eligible for continuous coverage (i.e., one dose of 10 mg/kg (maximum dose 1000 mg) every 4 weeks) for a maximum period of two years, provided the patient has demonstrated a response to initial treatment."

All requests (including renewal requests) for abatacept for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60010).

250 MG / VIAL (BASE)	INJECTION			
00002282097	ORENCIA	BMS	$	500.3400

ACAMPROSATE CALCIUM

"For the treatment of alcohol use disorder in patients who have been abstinent for at least four days and as a component of an alcohol counseling program.

Initial approval period: 6 months

Renewal may be considered for an additional 6 months.

Continued coverage requests beyond 12 months may be considered on a case by case basis."

333 MG (BASE)	ORAL	DELAYED-RELEASE TABLET		
00002293269	CAMPRAL	MYP	$	0.8000

ACLIDINIUM BROMIDE/ FORMOTEROL FUMARATE DIHYDRATE

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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for aclidinium bromide + formoterol fumarate dihydrate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

400 MCG / DOSE * 12 MCG / DOSE	**INHALATION**	**METERED INHALATION POWDER**		
00002439530	DUAKLIR GENUAIR	AZC	$	1.0000

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Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily)

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for five doses as follows: An initial 40 mg dose, followed by additional 40 mg doses at 2, 4, 6 and 8 weeks after the first dose.
- Patients will be limited to receiving a one-month supply of adalimumab 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 five doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial five doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 40 mg every other 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

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requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for adalimumab 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).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 40 mg administered every other week for 8 weeks.
- Patients will be limited to receiving a one-month supply of adalimumab 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, 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 doses of 40 mg every other 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:

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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 adalimumab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 12 weeks as follows: An initial 40 mg dose, followed by additional 40 mg doses administered every two weeks for up to 12 weeks after the first dose.
- Patients will be limited to receiving a one-month supply of adalimumab 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 12 weeks by an RA Specialist after the initial 12 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 one 40 mg dose every

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

Moderately to Severely Active Crohn's Disease:

"Special authorization coverage may be approved for coverage of adalimumab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease in patients who meet the following criteria:

- Adalimumab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for adalimumab for coverage for the treatment of Moderately to Severely Active Crohn's Disease patients ('Specialist').
- Patients must be 18 years of age or older to be considered for coverage of adalimumab.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) 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.

Prior to initiation of adalimumab therapy for New Patients:

'New Patients' are patients who have never been treated with adalimumab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of adalimumab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; AND refractory to, or dependent on, glucocorticoids: following at least one tapering dosing schedule of 40 mg/day, tapering by 5 mg each week to 20 mg, then tapering by 2.5 mg each week to zero, or similar.

[Note: Patients who have used the above treatments in combination will not be required to be challenged with individual treatments as monotherapy]

AND
b) Immunosuppressive therapy as follows:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 3 months; OR
- Methotrexate: minimum or 15 mg/week for a minimum of 3 months.
OR
- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects

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or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease

- New Patients must meet the criteria above prior to being considered for approval.
- All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

- Coverage for Induction Dosing may only be approved for New Patients (those who have never been treated with adalimumab by any health care provider).
- 'Induction Dosing' means a maximum of one 160 mg dose of adalimumab per New Patient at week 0 followed by an 80 mg dose at week 2.
- New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.
- As an interim measure, 40 mg doses of adalimumab will be provided at weeks 4, 6, 8 and 10 to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.

Maintenance Dosing:

'Maintenance Dosing' means one 40 mg dose of adalimumab per patient provided no more often than every other week starting at week 4 for a period of 12 months to:
- New Patients following the completion of Induction Dosing; OR
- Existing Patients, who are patients that are being treated, or have previously been treated, with adalimumab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:

- The New Patient must be assessed by a Specialist within 12 weeks after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease; AND
- The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's.

Maintenance Dosing for Existing Patients:

- The patient must be assessed by a Specialist annually (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's Disease; AND
- these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 40 mg dose of adalimumab per patient provided no more often than every other week for a period of 12 months, if the following criteria are met at the end of each 12 month period:

- The New Patient or the Existing Patient must be assessed by a Specialist annually (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of

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adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's Disease; AND
- For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's; OR
- For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score."

All requests (including renewal requests) for adalimumab for Moderately to Severely Active Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Special Authorization Request Form (ABC 60031).

Plaque Psoriasis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating 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 an initial dose of 80 mg, followed by one 40 mg dose every other week beginning one week after the first dose, for a total of nine doses.
- Patients will be limited to receiving a one-month supply of adalimumab 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 nine doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial nine doses to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, OR
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or

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equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every other 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 adalimumab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Polyarticular Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 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 24 mg per square meter body surface area (maximum dose 40 mg) every other week for 12 weeks.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of abatacept) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from abatacept to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient is a responder that meets the following criteria (ACR Pedi 30):
- 30% improvement from baseline in at least three of the following six response variables, with worsening of 30% or more in no more than one of the six variables. The variables include:
i. global assessment of the severity of the disease by the Pediatric Rheumatology Specialist,
ii. global assessment of overall well-being by the patient or parent,
iii. number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),
iv. number of joints with limitation of motion,

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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 24 mg per square meter body surface area (maximum dose 40 mg) every other week, 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 Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for adalimumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Ulcerative Colitis:

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for an initial dose of 160 mg, followed by an 80 mg dose at week 2, then one 40 mg dose at weeks 4, 6 and 8. As an interim measure, an additional 40 mg dose of adalimumab will be provided at week 10 to allow time to determine whether the New Patient meetscoverage criteria for Maintenance Dosing below, for a total of six doses.

- Patients will be limited to receiving a one-month supply of adalimumab 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).

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- 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 the initial coverage period, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 8 and 12 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 40 mg every 2 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of adalimumab therapy."

All requests (including renewal requests) for adalimumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

Hidradenitis Suppurativa

"Special authorization may be provided for the treatment of adult patients with active moderate to severe Hidradenitis Suppurativa who meet all of the following criteria:

- A total abscess and nodule (AN) count of 3 or greater.
- Lesions in at least two distinct anatomical areas, one of which must be Hurley Stage II or III.
- An inadequate response to a 90-day trial of systemic antibiotics AND documented non response to conventional therapy.
For coverage, this drug must be initiated by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved for 12 weeks as follows: an initial dose of 160 mg, followed by one 80 mg dose two weeks later, then 40 mg every week beginning four weeks after the initial dose, for a total of eleven doses.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial approval period the patient must meet the following criteria:

1) The patient must be assessed by a Dermatology Specialist after 12 weeks of treatment 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 50% reduction in AN count from pre-treatment baseline AND
- no increase in abscess count or draining fistula count relative to pre-treatment baseline.

Note: Treatment with adalimumab should be discontinued if there is insufficient improvement after 12 weeks of treatment.

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Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every week for an additional 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."

All requests (including renewal requests) for adalimumab for Hidradenitis Suppurativa must be completed using the Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form (ABC 60058).

40 MG / SYR INJECTION SYRINGE				
00002258595	HUMIRA (40 MG/0.8 ML INJ SYR)	ABV	$	762.5700

ALEMTUZUMAB

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the treatment of relapsing remitting multiple sclerosis (RRMS) to reduce the frequency of clinical relapses, to decrease the number and volume of active brain lesions identified on magnetic resonance imaging (MRI) scans and to delay the progression of physical disability, in adult patients (18 years of age or older) who are refractory or intolerant to:

At least ONE of the following:
- interferon beta
- glatiramer acetate
- dimethyl fumarate
- teriflunomide
- peginterferon beta.

Definition of 'intolerant'
Demonstrating serious adverse effects or contraindications to treatments as defined in the product monograph, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of MS disease modifying therapy (DMT).

Definition of 'refractory'
-Development of neutralizing antibodies to interferon beta.
-When the above MS DMTs are taken at the recommended doses for a full and adequate course of treatment, within a consecutive 12-month period while the patient was on the MS DMT, the patient has:

1) Been adherent to the MS DMT (greater than 80% of approved doses have been administered);

2) Experienced at least two relapses* of MS confirmed by the presence of neurologic deficits on examination.

i. The first qualifying clinical relapse must have begun at least one month after treatment initiation.

ii. Both qualifying relapses must be classified with a relapse severity of moderate, severe or very severe**.

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

**Relapse severity: with moderate relapses modification or more time is required to carry out activities of daily living; with severe relapses there is inability to carry out some activities of daily living; with very severe relapses activities of daily living must be completed by others.
For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist.

To register to become an MS Neurologist, please complete the Registration for MS Neurologist Status Form (ABC 60002).
Coverage may be considered only if the following criteria are met:

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS DMT. In most cases this will be

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satisfied by the 'refractory' to treatment criterion but if a patient failed an MS DMT more than one year earlier, ongoing active disease must be confirmed.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 5).

Coverage will not be approved when any MS DMT or other immunosuppressive therapy is to be used in combination with alemtuzumab.

Coverage of alemtuzumab will not be approved if the patient was deemed to be refractory to alemtuzumab in the past.

Following assessment of the request, alemtuzumab may be approved for coverage at a dose of 12 mg/day administered by intravenous (IV) infusion for 2 treatment courses:
- Initial Treatment Course: 12 mg/day for 5 consecutive days (60 mg total dose)
- Second Treatment Course: 12 mg/day for 3 consecutive days (36 mg total dose) administered 12 months after the initial treatment course.

Patients will be limited to receiving one treatment course (60 mg or 36 mg) of alemtuzumab per prescription at their pharmacy.

Coverage is limited to two treatment courses (i.e., eight doses)."

All requests for alemtuzumab must be completed using the Alemtuzumab/Fingolimod/Natalizumab For Multiple Sclerosis Special Authorization Request Form (ABC 60000).

12 MG / VIAL INJECTION

00002418320	LEMTRADA	GZM	$ 13031.1100

ALENDRONATE SODIUM

Osteoporosis:

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

All requests for alendronate sodium for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form (ABC 60043).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

Paget's Disease:

"For the treatment of Paget's disease. Special Authorization for this criteria may be granted to a maximum of 6 months."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

10 MG ORAL TABLET				
00002381486	**ALENDRONATE SODIUM**	**AHI**	$	**0.4986**
00002248728	**APO-ALENDRONATE**	**APX**	$	**0.4986**
00002388545	**AURO-ALENDRONATE**	**AUR**	$	**0.4986**
00002288087	**SANDOZ ALENDRONATE**	**SDZ**	$	**0.4986**
40 MG ORAL TABLET				
00002258102	ACT ALENDRONATE	APH	$	3.0832

ALFUZOSIN HCL

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

FIRST-LINE DRUG PRODUCT(S): DOXAZOSIN OR TERAZOSIN

"For the treatment of the symptoms of benign prostatic hyperplasia (BPH) in patients who are unresponsive to a six-week trial with a non-selective alpha-blocker (e.g., terazosin) or in whom non-selective alpha-blockers are not tolerated or are contraindicated."

"Special authorization may be granted for 24 months"

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

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

10 MG ORAL SUSTAINED-RELEASE TABLET

00002447576	**ALFUZOSIN**	**SIV**	$	**0.2601**
00002315866	**APO-ALFUZOSIN**	**APX**	$	**0.2601**
00002443201	**AURO-ALFUZOSIN**	**AUR**	$	**0.2601**
00002304678	**SANDOZ ALFUZOSIN**	**SDZ**	$	**0.2601**
00002245565	XATRAL	SAV	$	1.0404

ALIROCUMAB

"Special authorization coverage may be provided for the reduction of Low Density Lipoprotein Cholesterol (LDL-C) if the following clinical criteria and conditions are met:

I) Patient has a definite or probable diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) using the Simon Broome or Dutch Lipid Network criteria or genetic testing

AND

II) Patient is unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention) despite:

a) Confirmed adherence to high dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for at least 3 months.

OR

b) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is unable to tolerate high dose statin, defined as meeting all of the following:
i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose,
AND
ii) For each statin (two statins in total), dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality (creatine kinase (CK) > 5 times the upper limit of normal) resolution rather than discontinuation of statin altogether,
AND
iii) For each statin (two statins in total), intolerable symptoms (myopathy) or abnormal biomarkers (CK > 5 times the upper limit of normal) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate,
AND
iv) One of either:
- Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out,
OR
- Patient developed confirmed and documented rhabdomyolysis.

OR

c) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is statin contraindicated, i.e., active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal.

Initial coverage may be approved for either 75 mg once every two weeks or 300 mg once every 4 weeks for a period of 12 weeks.

- Patients prescribed alirocumab 300 mg once every 4 weeks must use the 150 mg/dose formulation.
- Patients will be limited to receiving a 4 week supply of alirocumab per prescription at their pharmacy.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
- Patient is adherent to therapy.
- Patient has achieved a reduction in LDL-C of at least 40% from baseline (4-8 weeks after initiation of alirocumab).

Continued coverage may be approved for either 75 mg once every 2 weeks or 300 mg once every 4 weeks for a period 12 months. The dosage may be adjusted to the maximum dosage of 150 mg administered every 2 weeks, depending on patient response.
- Patients are limited to 26 syringes/pens per year.

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Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
- Patient is adherent to therapy.
- Patient continues to have a significant reduction in LDL-C (with continuation of alirocumab) of at least 40% from baseline since initiation of PCSK9 inhibitor. LDL-C should be checked periodically with continued treatment with PCSK9 inhibitors (e.g., every 6 months)."

All requests (including renewal requests) for alirocumab for Heterozygous Familial Hypercholesterolemia must be completed using the Alirocumab/Evolocumab for HeFH Special Authorization Request Form (ABC 60060).

75 MG / ML INJECTION				
☒ 00002453754	PRALUENT	SAV	$	279.3600
☒ 00002453819	PRALUENT	SAV	$	279.3600
150 MG / ML INJECTION				
☒ 00002453762	PRALUENT	SAV	$	279.3600
☒ 00002453835	PRALUENT	SAV	$	279.3600

ALMOTRIPTAN MALATE

(Refer to 28:32.28 of the Alberta Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using almotriptan malate prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

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

6.25 MG (BASE) ORAL TABLET				
00002405792	**APO-ALMOTRIPTAN**	**APX**	$	**7.0433**
00002398435	**MYLAN-ALMOTRIPTAN**	**MYP**	$	**7.0433**
12.5 MG (BASE) ORAL TABLET				
00002466821	**ALMOTRIPTAN**	**SNS**	$	**2.3478**
00002405806	**APO-ALMOTRIPTAN**	**APX**	$	**2.3478**
00002398443	**MYLAN-ALMOTRIPTAN**	**MYP**	$	**2.3478**
00002405334	**SANDOZ ALMOTRIPTAN**	**SDZ**	$	**2.3478**

AMPICILLIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of infections caused by susceptible Shigella and Salmonella."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

250 MG ORAL CAPSULE				
00000020877	NOVO-AMPICILLIN	TEV	$	0.4223
500 MG ORAL CAPSULE				
00000020885	NOVO-AMPICILLIN	TEV	$	0.8006

ANAKINRA

"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) in whom other biologics are contraindicated or in patients who have experienced serious adverse events while on other biologics 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 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 one 100 mg dose administered daily for 8 weeks.
- Patients will be limited to receiving a one-month supply of anakinra 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 one 100 mg dose administered once daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.

ANAKINRA

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 anakinra must be completed using the Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

100 MG / SYR	**INJECTION**	**SYRINGE**		
00002245913	KINERET	BVM	$	50.0700

APIXABAN

AT RISK PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage Criteria

"Subject to the Exclusions From Coverage noted below, Members of Alberta Government Sponsored Drug Plans who are At-Risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following at least a two month trial of warfarin; OR
- Anticoagulation using warfarin is contraindicated or not possible due to inability to regularly monitor the patient via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, or at home).

Exclusions from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <25 mL/min),
- Patients who are greater than or equal to 75 years of age and who do not have Documented Stable Renal Function,
- Patients who have hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis, or,
- Patients who have a prosthetic heart valve.

Definitions:
- "At-Risk" means patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Prescribers may consider an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.
- "Inadequate Anticoagulation" is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- "Documented Stable Renal Function" is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months

Notes:
- The usual recommended dose for the Drug Products is 5mg twice daily. A reduced dose of 2.5mg twice daily is recommended for patients with at least two (2) of the following three (3) characteristics:
- an age that is equal to or greater than 80 years
- a body weight that is equal to or lower than 60kg, and
- serum creatinine that is equal to or greater than 133 micromole/litre.
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Products monograph).
- Patients starting on the Drug Products should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Products provide adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so the Drug Products are not recommended in these populations.

Special Authorization may be granted for up to 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.

APIXABAN

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

PROPHYLAXIS OF VENOUS THROMBOEMBOLISM

SPECIAL AUTHORIZATION

Coverage Criteria:

"For the prophylaxis of venous thromboembolism ("VTE") following elective total hip replacement surgery or elective total knee replacement surgery, where the initial post-operative doses are administered in an acute care (hospital) setting.

OTHER CRITERIA:

The dosage shall be 2.5mg twice daily.

DURATION OF COVERAGE:

Up to a total of 35 days of coverage following elective total hip replacement; or,
Up to a total of 14 days of coverage following elective total knee replacement.

Notes:

- The total duration of therapy includes the period during which doses are administered post-operatively in an acute care (hospital) setting, and the approval period is for the balance of the total duration after discharge.
- The first dose is typically administered 12 to 24 hours after surgery, assuming adequate hemostasis has been achieved.
- Due to the lack of evidence for the efficacy or safety of sequential use of a low molecular weight heparin followed by the Drug Products for the prophylaxis of VTE, coverage is not intended for this practice.
- Clinical judgment is warranted to assess the increased risk for VTE and/or adverse effects in patients with a history of previous VTE, myocardial infarction, transient ischemic attack or ischemic stroke; a history of intraocular or intracerebral bleeding; a history of gastrointestinal disease with gastrointestinal bleeding; moderate or severe renal insufficiency (estimated creatinine clearance < 30mL/min); severe liver disease; concurrent use of other anticoagulants; or age greater than 75 years.
- The Drug Products have not been studied in clinical trials in patients undergoing hip fracture surgery, and is not recommended in these patients."

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

The recommended dose of apixaban for patients initiating DVT or PE treatment is 10 mg twice daily for 7 days, followed by 5 mg taken orally twice daily.

Drug plan coverage for apixaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, apixaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for apixaban must be completed using the

APIXABAN

Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

2.5 MG ORAL TABLET

00002377233	ELIQUIS	BMS	$	1.6336

APIXABAN

AT RISK PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage Criteria

"Subject to the Exclusions From Coverage noted below, Members of Alberta Government Sponsored Drug Plans who are At-Risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following at least a two month trial of warfarin; OR
- Anticoagulation using warfarin is contraindicated or not possible due to inability to regularly monitor the patient via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, or at home).

Exclusions from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <25 mL/min),
- Patients who are greater than or equal to 75 years of age and who do not have Documented Stable Renal Function,
- Patients who have hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis, or,
- Patients who have a prosthetic heart valve.

Definitions:
- "At-Risk" means patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Prescribers may consider an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.
- "Inadequate Anticoagulation" is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- "Documented Stable Renal Function" is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months

Notes:
- The usual recommended dose for the Drug Products is 5mg twice daily. A reduced dose of 2.5mg twice daily is recommended for patients with at least two (2) of the following three (3) characteristics:
- an age that is equal to or greater than 80 years
- a body weight that is equal to or lower than 60kg, and
- serum creatinine that is equal to or greater than 133 micromole/litre.
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Products monograph).
- Patients starting on the Drug Products should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Products provide adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so the Drug Products are not recommended in these populations.

Special Authorization may be granted for up to 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.

APIXABAN

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

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

The recommended dose of apixaban for patients initiating DVT or PE treatment is 10 mg twice daily for 7 days, followed by 5 mg taken orally twice daily.

Drug plan coverage for apixaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, apixaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for apixaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

5 MG ORAL TABLET				
00002397714	ELIQUIS	BMS	$	1.6336

ARIPIPRAZOLE

"For the maintenance treatment of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with aripiprazole therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

All requests (including renewal requests) for aripiprazole prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

300 MG / VIAL INJECTION				
00002420864	ABILIFY MAINTENA	OTS	$	456.1800
400 MG / VIAL INJECTION				
00002420872	ABILIFY MAINTENA	OTS	$	456.1800

ASENAPINE MALEATE

"For the acute treatment of manic or mixed episodes associated with bipolar I disorder as co-therapy with lithium or divalproex sodium."

"For the acute treatment of manic or mixed episodes associated with bipolar I disorder as monotherapy, after a trial of lithium or divalproex sodium has failed due to intolerance or lack of response, or the presence of a contraindication to lithium or divalproex sodium as defined by the product monographs."

"Special authorization coverage may be granted for 24 months."

These products are eligible for auto-renewal.

5 MG (BASE) ORAL SUBLINGUAL TABLET				
00002374803	SAPHRIS	LBC	$	1.4848
10 MG (BASE) ORAL SUBLINGUAL TABLET				
00002374811	SAPHRIS	LBC	$	1.4848

ASFOTASE ALFA

1. ELIGIBILITY CRITERIA FOR ASFOTASE ALFA COVERAGE

In order to maintain the integrity of the ADBL, and having regard to the financial and social implications of covering asfotase alfa for the treatment of perinatal/infantile or juvenile-onset hypophosphatasia (HPP), the following special authorization criteria must be satisfied.

In order to be eligible for asfotase alfa coverage for the treatment of HPP, a patient must have submitted a completed Application and have satisfied all of the following requirements:

The patient must:
1) Be diagnosed with HPP in accordance with the requirements specified in the Clinical Criteria for asfotase alfa;
2) Have Alberta government-sponsored drug coverage;
3) Meet the Registration Requirements;
4) Satisfy the Clinical Criteria for asfotase alfa (initial or continued coverage, as appropriate); AND
5) Meet the criteria specified in Discontinuance of Coverage.

There is no guarantee that any application, whether for initial or continued coverage, will be approved. Depending on the circumstances of each case, the Minister or the Minister's delegate may:
- approve an Application;
- approve an Application with conditions;
- deny an Application;
- discontinue an approved Application; OR
- defer an Application pending the provision of further supporting information.

The process for review and approval is explained in further detail below.

2. REGISTRATION REQUIREMENTS

If the patient is a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of one (1) year prior to an application for coverage unless:
- the patient is less than one (1) year of age at the date of the application, then the patient's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of one (1) year; OR
- the patient has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for asfotase alfa in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for asfotase alfa as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

If the patient is not a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five (5) years prior to an application for coverage unless:
- the patient is less than five years of age at the date of the application, then the patients parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years; OR
- the patient has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for asfotase alfa in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for asfotase alfa as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

The Minister reserves the right to modify or waive the Registration Requirements applicable to a given patient if the patient or the patient's parent/guardian/legal representative can establish to the satisfaction of the Minister that the patient has not moved to Alberta for the sole/primary

ASFOTASE ALFA

purpose of obtaining coverage of asfotase alfa.

3. CLINICAL CRITERIA

"For enzyme replacement therapy (ERT) in patients with a confirmed diagnosis of perinatal/infantile or juvenile -onset hypophosphatasia (HPP). These patients must have been diagnosed prior to 12 years of age and have documented onset of signs/symptoms of HPP prior to 12 years of age.

Initiation Criteria:

1. Confirmed diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia (HPP) as defined below:
- Confirmed diagnosis via genetic testing (documented tissue-nonspecific alkaline phosphatase (TNSALP) gene mutations(s) AND
- Serum alkaline phosphatase (ALP) level below the age-adjusted normal range (these are age and gender adjusted norms developed through CALIPER which are used as reference https://apps.sbgh.mb.ca/labmanual/test/view?seedId=3662) AND
NOTE: Below upper limit of normal refers to 2 or lower standard deviations above the mean
- Plasma pyridoxal-5-phosphate (PLP) above the upper limit of normal established and validated in testing laboratory AND
- Documented history of HPP-related skeletal abnormalities confirmed radiologically:
For Infantile HPP: Full skeletal survey done at baseline - examine chest, wrist, knees, and skull. Changes to monitor include: abnormalities of skeletal mineralization including severely undermineralized and even "absence" of some or all bones; undermineralized skull; functional craniosynostosis; gracile bones; thin ribs; chest deformities; evidence of recent/ healed fractures; non-traumatic fractures, recurrent or poorly healing fractures; at the ends of long bones evaluate widening of the growth plate (physis) with irregularity of the provisional zone of calcification; metaphyseal radiolucencies, flaring and fraying at ends of metaphyses and metadiaphyseal patchy focal sclerosis

For Juvenile HPP: Similar to above however generally milder

AND

2. Assessed by a metabolic specialist who determines that the criteria noted above has been met as well as documented signs/symptoms that includes:

a. For Infantile HPP: Failure to thrive AND poor growth AND gross motor delay with substantial skeletal disease. May also have hypercalcemia, B6-responsive seizures and/or respiratory failure, respiratory compromise, including decreased thoracic volume and/or pulmonary hypoplasia; need for respiratory support;

b. For Juvenile HPP: Poor weight gain; unusual gait or running; delayed walking (>15 months); impaired mobility, need for ambulatory assistance; knock-knees; or rickets/bowed legs; muscle weakness/hypotonia; joint pain; muscle pain; bone pain sufficient to limit activity and require medication

c. Childhood HPP (after 6 months of age): gait disturbance, fractures, rickets and RGIC score(NOTE: RGIC score is a 7-point score of Radiographic Global Impressive of Change ie RGIC score assesses changes from baseline and is obtained on paired sequential radiographs with a score of +2 indicating substantial healing/improvement in HPP-related skeletal abnormalities), Thacher score (NOTE: Thacher score is a 10-point Rickets Severity Scale validated for Vitamin D deficiency rickets (and also valid for HPP); score of 10 = severe rickets and 0 = no rickets based on quantified growth plate abnormalities at wrists and knees), bowing of legs, short stature unexplained by other reasons and/or pain score. RGIC and Thacher scores are ideal as they are validated in HPP but a comparable radiologic assessment by an expert bone pediatric radiologist could also be considered

3. Patient is not an adult (ie > 18 years of age) at the time treatment is initiated AND

ASFOTASE ALFA

4. Patient does not have odontoHPP, IE premature loss of deciduous teeth alone or pseudoHPP and vitamin D deficiency to be ruled out. Patients with craniosynostosis alone who do not have other criteria noted above for the diagnosis of HPP need to be followed closely as initiation of treatment with ERT may be indicated if other systemic signs and symptoms develop including muscle weakness, fractures, rickets, pain or nephrocalcinosis and/or if bony disease develops clinically and radiologically AND

5. Patients should be initiated on treatment and followed in a specialized clinic with expertise in the diagnosis and management of HPP. Goals of therapy should be developed on a case-by-case basis prior to the initiation of therapy depending on age and signs and symptoms at presentation.

Signs and symptoms to be monitored depend on age at diagnosis and may include:

a) For perinatal/infantile would expect in addition to above parameters to be followed goals of therapy should include discontinuation or reduction of ventilatory support, increased mobility (improvement in gait vs. baseline), attainment of age-appropriate gross motor milestones. Clinical, radiological and biochemical criteria should be surveilled and these pre-specified goals met at Coverage should be reassessed following a trial of 24 weeks of therapy or more frequently depending on clinical status of patient at initiation of therapy.

b) For juvenile Healing of rickets, improvement of bone mineralization and/bony deformities, fewer fractures, less pain, need for less pain medication, improved growth, increased mobility.

If Initiation Criteria met, 24 week trial to be followed by reassessment by a metabolic specialist

Of Note: Treatment with ERT may not be recommended for newborns who are unable to be successfully ventilated and who have respiratory failure, irreversible pulmonary hypoplasia (underdeveloped lungs with reduced number of alveoli for air exchange) as assessed postnatally by established clinical and radiologic criteria (narrow chest circumference and apparent low lung volumes, evidence for increased pulmonary resistance, MRI changes consistent with lung hypoplasia), very small chest walls, very thin or absent ribs radiologically as assessed by pediatric respirologist, radiologist and treating metabolic specialist. A 6 month trial of ERT may however be recommended for such infants by the treating metabolic specialist and consultants with the consent of the parents. Discontinuation of ERT should be considered at this point and baby moved to palliative care.

Continuation Criteria:
- Assessed by a metabolic specialist who determines that the pre-specified goals have been met and includes documented signs/symptoms noted above.
- Documented compliance by patient and family with respect to follow up visits and reevaluation of laboratory and radiological parameters.
- Additional 24 week trials to be followed by reassessment by a metabolic specialist.

If Continuation Criteria are not met, the treatment should not be continued. In addition, ERT should be discontinued for lack of compliance or if patient does not come for follow up appointments, in spite of all efforts to assist patient and family in this regard, development of craniosynostosis or premature loss of deciduous teeth alone would not signify failure of treatment and ERT should be continued provided other continuation criteria are met.

Stopping Criteria:
- Consider discontinuation after growth is completed based on objective measurement of height and closure of growth plates (closure to be confirmed by Xray criteria and report from a Radiologist).
- Criteria for tapering and discontinuing treatment should be developed by expert committee and evaluated on a case-by-case basis at all age groups.
- Babies with perinatal/infantile HPP who fail treatment trials of 6 months as described above may be discontinued from ERT and moved to palliative care.

*Reference will be made re: dosing and approved vial use to minimize wastage"

ASFOTASE ALFA

4. PROCESS FOR ASFOTASE ALFA COVERAGE

For both initial and continued coverage the following documents (the Application) must be completed and submitted:

- An Asfotase alfa Special Authorization Request Form completed by the patient's Metabolic Specialist;
- An Asfotase alfa Consent Form completed by the patient, or a patient's parent/guardian/legal representative, and the patients Metabolic Specialist (for any initial coverage application); AND
- Any other documentation that may be required by the Minister or the Minister's delegate.

a. Expert Review

Once the Minister or the Minister's delegate has confirmed that the patient meets the Registration Requirement or granted a waiver of the Registration Requirement, the Application will be given to one or more Expert Advisors for review.

The Application, together with the recommendation or recommendations of the Expert Advisor(s), is then forwarded to the Minister or the Minister's delegate for a decision regarding coverage.

After the Minister or Minister's delegate has rendered a decision, the patient's Metabolic Specialist and the patient or patient's parent/guardian/legal representative will be notified by letter of the Minister's decision.

5. APPROVAL OF COVERAGE

The Minister or the Minister's delegate's decision in respect of an Application will specify the effective date of asfotase alfa coverage, if coverage is approved.

Initial coverage may be approved for a period of up to 26 weeks as follows: One dose of 2 mg/kg of asfotase alfa administered three times a week or one dose of 1 mg/kg of asfotase alfa administered six times a week (total of 78 doses for the 2mg/kg dosage regimen and a total of 156 doses for the 1 mg/kg dosage regimen).

Continued coverage may be approved for up to one dose of 2 mg/kg of asfotase alfa administered three times a week or one dose of 1 mg/kg of asfotase alfa administered six times a week for a period of six (6) months (total of 78 doses for the 2mg/kg dose and a total of 156 doses for the 1 mg/kg dose).

If a patient is approved for coverage, prescriptions for asfotase alfa must be written by a Metabolic Specialist. To avoid wastage, prescription quantities are limited to a two week supply. Extended quantity and vacation supplies are not permitted. The Government is not responsible and will not pay for costs associated with wastage or improper storage of asfotase alfa.

Approval of coverage is granted for a specific period, to a maximum of 26 weeks. If continued treatment is necessary, it is the responsibility of the patient or patient's parent/guardian/legal representative and the Metabolic Specialist to submit a new Application to re-apply for asfotase alfa coverage, and receive a decision thereon, prior to the expiry date of the authorization period.

6. WITHDRAWAL

Therapy may be withdrawn at the request of the patient or the patient's parent/guardian/legal representative at any time. Notification of withdrawal from therapy must be made by the Metabolic Specialist or patient in writing.

Applications, withdrawal requests, and any other information to be provided must be sent to Clinical Drug Services, Alberta Blue Cross.

ASFOTASE ALFA

18 MG / VIAL INJECTION				
00002444615	STRENSIQ	APG	$	1358.6400
28 MG / VIAL INJECTION				
00002444623	STRENSIQ	APG	$	2113.4400
40 MG / VIAL INJECTION				
00002444631	STRENSIQ	APG	$	3019.2000
80 MG / VIAL INJECTION				
00002444658	STRENSIQ	APG	$	6038.4000

AZITHROMYCIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the prevention of disseminated Mycobacterium avium complex disease in patients with advanced HIV infection or other immunocompromised conditions.

Special authorization may be granted for 6 months."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

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

600 MG ORAL TABLET				
00002261642	PMS-AZITHROMYCIN	PMS	$	7.6250

AZTREONAM

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

FIRST-LINE DRUG PRODUCT(S): TOBRAMYCIN INHALATION SOLUTION

"For the treatment of chronic pulmonary Pseudomonas aeruginosa infections when used as cyclic treatment (28-day cycles) in patients 6 years of age and older with moderate to severe cystic fibrosis (CF) and deteriorating clinical condition despite treatment with inhaled tobramycin.

Coverage will not be considered when inhaled aztreonam and other inhaled antibiotic(s) (e.g. levofloxacin, tobramycin) are intended for use in combination.

Special authorization may be granted for 6 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

75 MG / VIAL INHALATION POWDER FOR SOLUTION				
00002329840	CAYSTON	GIL	$	44.0631

BRIVARACETAM

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Patients are not receiving concurrent therapy with levetiracetam, AND,
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for brivaracetam, eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

10 MG ORAL TABLET				
00002452936	BRIVLERA	UCB	$	4.3200
25 MG ORAL TABLET				
00002452944	BRIVLERA	UCB	$	4.3200
50 MG ORAL TABLET				
00002452952	BRIVLERA	UCB	$	4.3200
75 MG ORAL TABLET				
00002452960	BRIVLERA	UCB	$	4.3200
100 MG ORAL TABLET				
00002452979	BRIVLERA	UCB	$	4.3200

BUDESONIDE

"For the treatment of inflammatory bowel disease (e.g. Crohn's, ulcerative colitis, ulcerative ileitis, etc.). This drug product must be prescribed by a specialist in Gastroenterology, Internal Medicine or Pediatrics (or by a specialist in General Surgery on a case-by-case basis, in geographic areas where access to these specialties is not available).

Special authorization may be granted for 12 months."

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

3 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002229293	ENTOCORT	TPG	$	1.7071

BUDESONIDE/ FORMOTEROL FUMARATE DIHYDRATE

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for budesonide + formoterol fumarate dihydrate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

100 MCG / DOSE * 6 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002245385	SYMBICORT 100 TURBUHALER	AZC	$	0.5700
200 MCG / DOSE * 6 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002245386	SYMBICORT 200 TURBUHALER	AZC	$	0.7410

BUSERELIN ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

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

1 MG / ML (BASE) NASAL SOLUTION				
00002225158	SUPREFACT INTRANASAL	SAV	$	8.5530
1 MG / ML (BASE) INJECTION				
00002225166	SUPREFACT	SAV	$	12.1873
6.3 MG (BASE) INJECTION IMPLANT				
00002228955	SUPREFACT DEPOT	SAV	$	827.8500

CABERGOLINE

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

FIRST-LINE DRUG PRODUCT(S): BROMOCRIPTINE

"For the treatment of hyperprolactinemia in patients who are intolerant to or who have failed bromocriptine. 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

0.5 MG ORAL TABLET

00002455897	**APO-CABERGOLINE**	**APX**	$	**12.3941**
00002242471	DOSTINEX	PAL	$	15.1156

CANAGLIFLOZIN

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for canagliflozin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

100 MG ORAL TABLET

00002425483	INVOKANA	JAI	$	2.8090

300 MG ORAL TABLET

00002425491	INVOKANA	JAI	$	2.8090

CASPOFUNGIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For treatment of esophageal candidiasis in patients who are resistant or intolerant to fluconazole or itraconazole.

For treatment of invasive candidiasis resistant or intolerant to fluconazole.

For treatment of Invasive Aspergillosis in patients who are refractory to or intolerant of other therapies."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

50 MG / VIAL INJECTION				
00002460947	**CASPOFUNGIN**	**MDA**	$	**188.7000**
00002244265	CANCIDAS	MFC	$	222.0000
70 MG / VIAL INJECTION				
00002460955	**CASPOFUNGIN**	**MDA**	$	**188.7000**
00002244266	CANCIDAS	MFC	$	222.0000

CEFADROXIL

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of skin and skin structure infections."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

500 MG ORAL CAPSULE				
00002240774	**APO-CEFADROXIL**	**APX**	$	**0.8421**
00002235134	**TEVA-CEFADROXIL**	**TEV**	$	**0.8421**

CEFOXITIN SODIUM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of Mycobacterium abscessus infection."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

1 G / VIAL (BASE) INJECTION				
00002291711	**CEFOXITIN**	**APX**	$	**10.6000**
00002128187	**CEFOXITIN SODIUM**	**TEV**	$	**10.6000**
2 G / VIAL (BASE) INJECTION				
00002291738	**CEFOXITIN**	**APX**	$	**21.2500**
00002128195	**CEFOXITIN SODIUM**	**TEV**	$	**21.2500**

CELECOXIB

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

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

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

All requests for celecoxib must be completed using the Celecoxib Special Authorization Request Form (ABC 60032).

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

100 MG ORAL CAPSULE

00002420155	**ACT CELECOXIB**	**APH**	$	**0.1279**
00002418932	**APO-CELECOXIB**	**APX**	$	**0.1279**
00002445670	**AURO-CELECOXIB**	**AUR**	$	**0.1279**
00002426382	**BIO-CELECOXIB**	**BMD**	$	**0.1279**
00002429675	**CELECOXIB**	**SIV**	$	**0.1279**
00002436299	**CELECOXIB**	**SNS**	$	**0.1279**
00002291975	**GD-CELECOXIB**	**GMD**	$	**0.1279**
00002424533	**JAMP-CELECOXIB**	**JPC**	$	**0.1279**
00002420058	**MAR-CELECOXIB**	**MAR**	$	**0.1279**
00002412497	**MINT-CELECOXIB**	**MPI**	$	**0.1279**
00002355442	**PMS-CELECOXIB**	**PMS**	$	**0.1279**
00002412373	**RAN-CELECOXIB**	**RAN**	$	**0.1279**
00002442639	**SDZ CELECOXIB**	**SDZ**	$	**0.1279**
00002239941	CELEBREX	PFI	$	0.6992

200 MG ORAL CAPSULE

00002420163	**ACT CELECOXIB**	**APH**	$	**0.2558**
00002418940	**APO-CELECOXIB**	**APX**	$	**0.2558**
00002445689	**AURO-CELECOXIB**	**AUR**	$	**0.2558**
00002426390	**BIO-CELECOXIB**	**BMD**	$	**0.2558**
00002429683	**CELECOXIB**	**SIV**	$	**0.2558**
00002436302	**CELECOXIB**	**SNS**	$	**0.2558**
00002291983	**GD-CELECOXIB**	**GMD**	$	**0.2558**
00002424541	**JAMP-CELECOXIB**	**JPC**	$	**0.2558**
00002420066	**MAR-CELECOXIB**	**MAR**	$	**0.2558**
00002412500	**MINT-CELECOXIB**	**MPI**	$	**0.2558**
00002355450	**PMS-CELECOXIB**	**PMS**	$	**0.2558**
00002412381	**RAN-CELECOXIB**	**RAN**	$	**0.2558**
00002442647	**SDZ CELECOXIB**	**SDZ**	$	**0.2558**
00002239942	CELEBREX	PFI	$	1.3988

CERTOLIZUMAB PEGOL

Rheumatoid Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily)

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for an initial dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) at Weeks 0, 2 and 4. As an interim measure, coverage will be provided for additional doses of 400 mg per 4 weeks up to week 12, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.
- Patients will be limited to receiving a one-month supply of certolizumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial five doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 400 mg per 4 weeks, for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, or
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1)

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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 certolizumab 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).

Ankylosing Spondylitis

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

Initial coverage may be approved for an initial dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) at Weeks 0, 2 and 4. As an interim measure, coverage will be provided for additional doses of 400 mg per 4 weeks up to week 12, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.
- Patients will be limited to receiving a one-month supply of certolizumab 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 by an RA Specialist after the initial 5 doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for 400 mg per 4 weeks, 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."

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All requests (including renewal requests) for certolizumab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Psoriatic Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial). Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for an initial dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) at Weeks 0, 2 and 4. As an interim measure, coverage will be provided for additional doses of 400 mg per 4 weeks up to week 12, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.
- Patients will be limited to receiving a one-month supply of certolizumab 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 by an RA Specialist after the initial 5 doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 400 mg per 4 weeks, for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or

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- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests. It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for certolizumab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

200 MG / SYR INJECTION SYRINGE

☒ 00002331675	CIMZIA	UCB	$	664.5100
☒ 00002465574	CIMZIA AUTO-INJECTOR	UCB	$	664.5100

CLINDAMYCIN PHOSPHATE/ BENZOYL PEROXIDE

"For the treatment of severe acne as defined by scarring acne.

Special Authorization may be granted for 6 months."

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

1 % * 3 % TOPICAL GEL

00002382822	CLINDOXYL ADV	GSK	$	0.7800

"For the treatment of severe acne as defined by scarring acne.

Special Authorization may be granted for 6 months."

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

1 % (BASE) * 5 % TOPICAL GEL

00002440180	**TARO-CLINDAMYCIN/BENZOYL PEROXIDE**	**TAR**	$	**0.6857**
00002243158	CLINDOXYL	GSK	$	0.9524

"For the treatment of severe acne as defined by scarring acne.

Special Authorization may be granted for 6 months."

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

1 % (BASE) * 5 % TOPICAL GEL

00002464519	**TARO-BENZOYL PEROXIDE/CLINDAMYCIN KIT**	**TAR**	$	**0.7422**
00002248472	BENZACLIN	VCL	$	1.0141

CYCLOSPORINE

"For the treatment of severe psoriasis in those patients where other standard therapy has failed. This drug product must be prescribed by a specialist in Dermatology."

"For the treatment of severe rheumatoid arthritis in patients who are unable to tolerate or have failed an adequate trial of methotrexate. This drug product must be prescribed by a specialist in Rheumatology (or by a Specialist in Internal Medicine with an interest in Rheumatology on a case-by-case basis, in geographic areas where access to this specialty is not available)."

"For the treatment of steroid dependent and steroid resistant nephrotic syndrome. Consideration will be given where cyclosporine is used for the induction and maintenance of remissions or for the maintenance of steroid induced remissions. This drug product must be prescribed by a specialist in Pediatrics or Nephrology."

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

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

10 MG ORAL CAPSULE				
00002237671	NEORAL	NOV	$	0.6495
25 MG ORAL CAPSULE				
00002247073	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**1.3050**
00002150689	NEORAL	NOV	$	1.5100
50 MG ORAL CAPSULE				
00002247074	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**2.5450**
00002150662	NEORAL	NOV	$	2.9450
100 MG ORAL CAPSULE				
00002242821	**SANDOZ CYCLOSPORINE**	**SDZ**	$	**5.0900**
00002150670	NEORAL	NOV	$	5.8920
100 MG / ML ORAL SOLUTION				
00002150697	NEORAL	NOV	$	5.2386

CYPROTERONE ACETATE

"When prescribed for non-cancer, non-cosmetic indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

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

50 MG ORAL TABLET				
00000704431	**ANDROCUR**	**PMS**	$	**1.4000**
00002245898	**CYPROTERONE**	**AAP**	$	**1.4000**
00002390760	**MED-CYPROTERONE**	**GMP**	$	**1.4000**
100 MG / ML INJECTION				
00000704423	ANDROCUR DEPOT	PMS	$	32.8000

CYSTEAMINE BITARTRATE

"For use in patients with an established diagnosis of infantile nephropathic cystinosis with documented cystinosin, lysosomal cystine transporter gene mutation.

For coverage, this drug must be prescribed by or in consultation with physician with experience in the diagnosis and management of cystinosis.

Special authorization may be granted for 12 months."

This product is eligible for auto-renewal.

25 MG ORAL DELAYED-RELEASE CAPSULE				
00002464705	PROCYSBI	RAP	$	10.3500
75 MG ORAL DELAYED-RELEASE CAPSULE				
00002464713	PROCYSBI	RAP	$	31.0500

DABIGATRAN ETEXILATE

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

FIRST-LINE DRUG PRODUCT(S): WARFARIN

For at-risk patients (CHADS2 score of greater than or equal to 1) with non-valvular atrial fibrillation (AF) for the prevention of stroke and systemic embolism AND in whom:

a) Anticoagulation is inadequate (at least 35% of INR testing results outside the desired range) following a reasonable trial on warfarin (minimum two months of therapy); OR
b) Anticoagulation with warfarin is contraindicated as per the product monograph or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate less than 30mL/min) OR hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR prosthetic heart valves.should not receive dabigatran.

Patients 75 years of age and greater should have documented stable renal function (creatinine clearance or estimated glomerular filtration rate maintained for at least three months of 30-49 ml/min for 110mg twice daily dosing or greater than or equal to 50 ml/min for 150mg twice daily dosing).

Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product Monograph).

Patients starting the drug product should have ready access to appropriate medical services to manage a major bleeding event.

There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

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

All requests for dabigatran must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

110 MG ORAL CAPSULE				
00002312441	PRADAXA	BOE	$	1.7121
150 MG ORAL CAPSULE				
00002358808	PRADAXA	BOE	$	1.7121

DACLATASVIR DIHYDROCHLORIDE

For use as combination therapy with sofosbuvir for treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by a hepatologist, gastroenterologist, infectious disease specialist, or a designated prescriber;
AND
II) Laboratory confirmed hepatitis C infection with genotype 3;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (2) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive or treatment-experienced genotype 3, without cirrhosis: 12 weeks in combination with sofosbuvir

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis

Notes:
1. Treatment-experienced is defined as those who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor.
2. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
3. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the selected drugs, including use in special populations.

All requests for daclatasvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

30 MG (BASE) ORAL TABLET				
00002444747	DAKLINZA	BMS	$	428.5715
60 MG (BASE) ORAL TABLET				
00002444755	DAKLINZA	BMS	$	428.5715

DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN OR SULFONYLUREAS
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS OR METFORMIN
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy to metformin or a sulfonylurea for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin who have a contraindication or intolerance to a sulfonylurea, OR a sulfonylurea who have a contraindication or intolerance to metformin,
- AND for whom insulin is not an option.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for dapagliflozin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

5 MG (BASE) ORAL TABLET				
00002435462	FORXIGA	AZC	$	2.7300
10 MG (BASE) ORAL TABLET				
00002435470	FORXIGA	AZC	$	2.7300

DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE/ METFORMIN HCL

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN OR SULFONYLUREAS
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS OR METFORMIN
AND WHERE INSULIN IS NOT AN OPTION

"For the treatment of Type 2 diabetes in patients with inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin who have a contraindication or intolerance to a sulfonylurea, OR
- a sulfonylurea who have failed a sufficient trial of metformin, AND
- for whom insulin is not an option.

Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for dapagliflozin+metformin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

5 MG * 850 MG ORAL TABLET				
00002449935	XIGDUO	AZC	$	1.2250
5 MG * 1,000 MG ORAL TABLET				
00002449943	XIGDUO	AZC	$	1.2250

DAPTOMYCIN

For the treatment of:
- Culture confirmed gram-positive infections from sterile sites, specifically Methicillin-resistant Staphylococcus aureus (MRSA), AND
- In patients who do not respond to, or exhibit multidrug intolerance to, or allergy to vancomycin, AND
- to facilitate patient discharge from hospital where it otherwise would not be possible.

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

Special Authorization may be granted for 12 months.

500 MG / VIAL INJECTION				
00002465493	CUBICIN RF	CUB	$	186.2000

DARBEPOETIN

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for twelve months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 300 mcg per month."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25%. Special authorization will be granted for twelve months."

In order to comply with the first criterion information must be provided regarding the patient's hemoglobin and transferrin saturation.

In order to comply with the second criterion: if the patient has iron overload the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the second criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.

The following product(s) are eligible for auto-renewal for the indication of the treatment of anemia of chronic renal failure.

All requests for darbepoetin must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 60006).

100 MCG / SYR INJECTION SYRINGE				
00002391775	ARANESP (0.5 ML SYRINGE)	AMG	$	268.0000
10 MCG / SYR INJECTION SYRINGE				
00002392313	ARANESP (0.4 ML SYRINGE)	AMG	$	26.8000
20 MCG / SYR INJECTION SYRINGE				
00002392321	ARANESP (0.5 ML SYRINGE)	AMG	$	53.6000
30 MCG / SYR INJECTION SYRINGE				
00002392348	ARANESP (0.3 ML SYRINGE)	AMG	$	80.4000
40 MCG / SYR INJECTION SYRINGE				
00002391740	ARANESP (0.4 ML SYRINGE)	AMG	$	107.2000
50 MCG / SYR INJECTION SYRINGE				
00002391759	ARANESP (0.5 ML SYRINGE)	AMG	$	134.0000
60 MCG / SYR INJECTION SYRINGE				
00002392356	ARANESP (0.3 ML SYRINGE)	AMG	$	160.8000
80 MCG / SYR INJECTION SYRINGE				
00002391767	ARANESP (0.4 ML SYRINGE)	AMG	$	214.4000
130 MCG / SYR INJECTION SYRINGE				
00002391783	ARANESP (0.65 ML SYRINGE)	AMG	$	348.4000
150 MCG / SYR INJECTION SYRINGE				
00002391791	ARANESP (0.3 ML SYRINGE)	AMG	$	439.7550
200 MCG / SYR INJECTION SYRINGE				
00002391805	ARANESP (0.4 ML SYRINGE)	AMG	$	607.2900
300 MCG / SYR INJECTION SYRINGE				
00002391821	ARANESP (0.6 ML SYRINGE)	AMG	$	929.3200
500 MCG / SYR INJECTION SYRINGE				
00002392364	ARANESP (1.0 ML SYR)	AMG	$	1548.8700

DARIFENACIN HYDROBROMIDE

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

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA."

"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

7.5 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002273217	ENABLEX	SLP	$	1.5820
15 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002273225	ENABLEX	SLP	$	1.5820

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Jadenu (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

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

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

90 MG ORAL TABLET

00002452219	JADENU	NOV	$	10.5210

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Jadenu (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

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

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

180 MG ORAL TABLET

00002452227	JADENU	NOV	$	21.0440

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Jadenu (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

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

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

360 MG ORAL TABLET

00002452235	JADENU	NOV	$	42.0910

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Exjade (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

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

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

125 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461544	**APO-DEFERASIROX**	**APX**	$	**2.6204**
00002464454	**SANDOZ DEFERASIROX**	**SDZ**	$	**2.6204**
00002463520	**TARO-DEFERASIROX**	**TAR**	$	**2.6204**
00002407957	**TEVA-DEFERASIROX**	**TEV**	$	**2.6204**
00002287420	EXJADE	NOV	$	10.6625

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Exjade (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

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

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

250 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461552	**APO-DEFERASIROX**	**APX**	$	**5.2410**
00002464462	**SANDOZ DEFERASIROX**	**SDZ**	$	**5.2410**
00002463539	**TARO-DEFERASIROX**	**TAR**	$	**5.2410**
00002407965	**TEVA-DEFERASIROX**	**TEV**	$	**5.2410**
00002287439	EXJADE	NOV	$	21.3257

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Exjade (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

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

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

500 MG ORAL DISPERSIBLE TABLET FOR SUPPLY

00002461560	**APO-DEFERASIROX**	**APX**	$	**10.4824**
00002464470	**SANDOZ DEFERASIROX**	**SDZ**	$	**10.4824**
00002463547	**TARO-DEFERASIROX**	**TAR**	$	**10.4824**
00002407973	**TEVA-DEFERASIROX**	**TEV**	$	**10.4824**
00002287447	EXJADE	NOV	$	42.6532

DEFERIPRONE

"For the treatment of transfusional iron overload due to thalassemia syndromes in patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications to deferoxamine may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

All requests (including renewal requests) for deferiprone must be completed using the Deferiprone Special Authorization Request Form (ABC 60054).

1,000 MG ORAL TABLET				
00002436558	FERRIPROX	APP	$	31.8780
100 MG / ML ORAL SOLUTION				
00002436523	FERRIPROX	APP	$	3.1878

DENOSUMAB

"For the treatment of osteoporosis in patients who have:

A high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture,
OR
A moderate 10-year fracture risk (10-20%) and have experienced a prior fragility fracture;

AND

at least one of the following:

1) For whom oral bisphosphonates are contraindicated due to drug-induced hypersensitivity (i.e., immunologically mediated),

OR

2) For whom oral bisphosphonates are contraindicated due to an abnormality of the esophagus which delays esophageal emptying,

OR

3) For whom bisphosphonates are contraindicated due to severe renal impairment (i.e. creatinine clearance < 35 mL/min),

OR

4) Who have demonstrated persistent severe gastrointestinal intolerance to a course of therapy with either alendronate or risedronate,

OR

5) Who had an unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for 1 year and evidence of a decline in BMD below pre-treatment baseline level).

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

Special authorization may be granted for 12 months.

Patients will be limited to receiving one dose of denosumab per prescription at their pharmacy.

-Coverage cannot be provided for two or more osteoporosis medications (alendronate, denosumab, raloxifene, risedronate, zoledronic acid) when these medications are intended for use as combination therapy.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

All requests for denosumab must be completed using the Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form (ABC 60007).

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

60 MG / SYR	INJECTION	SYRINGE			
00002343541	PROLIA		AMG	$	370.3600

DIENOGEST

"For the management of pelvic pain associated with endometriosis in patients for whom one or more less costly hormonal options are either ineffective or not tolerated."

"Special authorization may be granted for 6 months."

"This Drug Product is eligible for auto-renewal."

2 MG ORAL TABLET

00002374900	VISANNE	BAI	$	2.0461

DIMETHYL FUMARATE

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory adult patients (18 years of age or older) with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The adult patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The adult patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Adult patients will be limited to receiving a one-month supply of dimethyl fumarate per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the adult patient must meet the following criteria:

1) The adult patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The adult patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in an adult patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Adult patients may receive up to 100 days' supply of dimethyl fumarate per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

DIMETHYL FUMARATE

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the adult patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for dimethyl fumarate must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

120 MG	ORAL	DELAYED-RELEASE CAPSULE			
00002404508	TECFIDERA		BIO	$	17.2101

DONEPEZIL HCL

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Special authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug."

All requests (including renewal requests) for donepezil HCI must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 60034).

5 MG ORAL TABLET

00002362260	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400561	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412853	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420597	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426846	**DONEPEZIL**	**SNS**	$	**0.4586**
00002402645	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002404419	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002416948	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402092	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002439557	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322331	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381508	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328666	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428482	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340607	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232043	ARICEPT	PFI	$	5.0779

10 MG ORAL TABLET

00002362279	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400588	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412861	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420600	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426854	**DONEPEZIL**	**SNS**	$	**0.4586**
00002402653	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002404427	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002416956	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402106	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002439565	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322358	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381516	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328682	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428490	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340615	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232044	ARICEPT	PFI	$	5.0779

ECULIZUMAB

ECULIZUMAB

1. ELIGIBILITY CRITERIA FOR ECULIZUMAB COVERAGE

In order to maintain the integrity of the ADBL, and having regard to the financial and social implications of covering eculizumab for the treatment of paroxysmal nocturnal hemoglobinuria (PNH), the following special authorization criteria must be satisfied.

In order to be eligible for eculizumab coverage for the treatment of PNH, a patient must have submitted a completed Application and have satisfied all of the following requirements:

The patient must:
1) Be diagnosed with PNH in accordance with the requirements specified in the Clinical Criteria for eculizumab;
2) Have Alberta government-sponsored drug coverage;
3) Meet the Registration Requirements;
4) Satisfy the Clinical Criteria for eculizumab (initial or continued coverage, as appropriate); AND
5) Meet the criteria specified in Contraindications to Coverage and Discontinuance of Coverage.

There is no guarantee that any application, whether for initial or continued coverage, will be approved. Depending on the circumstances of each case, the Minister or the Minister's delegate may:
- approve an Application;
- approve an Application with conditions;
- deny an Application;
- discontinue an approved Application; OR
- defer an Application pending the provision of further supporting information.

The process for review and approval is explained in further detail below.

2. REGISTRATION REQUIREMENTS

If the patient is a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of one (1) year prior to an application for coverage unless:
- the patient is less than one (1) year of age at the date of the application, then the patient's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of one (1) year; OR
- the patient has moved to Alberta from another province or territory in Canada (the" province of origin"), and immediately prior to moving to Alberta, was covered for eculizumab in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for eculizumab as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

If the patient is not a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five (5) years prior to an application for coverage unless:
- the patient is less than five years of age at the date of the application, then the patients parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years; OR
- the patient has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for eculizumab in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for eculizumab as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

The Minister reserves the right to modify or waive the Registration Requirements applicable to a given patient if the patient or the patient's parent/guardian/legal representative can establish to

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the satisfaction of the Minister that the patient has not moved to Alberta for the sole/primary purpose of obtaining coverage of eculizumab.

3. CLINICAL CRITERIA

In addition to meeting Sections 1 and Sections 2 herein, to be considered for coverage of eculizumab, a patient must be assessed by a Specialist in Hematology (i.e. a physician who holds specialty certification in Hematology from the Royal College of Physicians and Surgeons of Canada) and meet all of the following clinical criteria (initial or continued coverage, as appropriate).

a. Clinical Criteria - Initial Coverage
All of the following Clinical Criteria must be established on the basis of evidence to the satisfaction of the Minister or the Minister's delegate for initial coverage:

1) The diagnosis of PNH must have been established by flow cytometry and/or a FLAER test. The proportion of circulating cells of each type which are GPI-deficient and hence of the PNH clone is quantitated by flow cytometry. Patients must have a:
- PNH granulocyte or monocyte clone size equal to or greater than 10%, AND
- Raised LDH (value at least 1.5 times the upper limit of normal for the reporting laboratory).

2) Patients with a granulocyte or monocyte clone size equal to or greater than 10% also require AT LEAST ONE of the following:
- Thrombosis: Evidence that the patient has had a thrombotic or embolic event which required the institution of therapeutic anticoagulant therapy;
- Transfusions: Evidence that the patient has been transfused with at least four (4) units of red blood cells in the last twelve (12) months;
- Anemia: Evidence that the patient has chronic or recurrent anemia where causes other than hemolysis have been excluded and demonstrated by more than one measure of less than or equal to 70g/L or by more than one measure of less than or equal to 100 g/L with concurrent symptoms of anemia;
- Pulmonary insufficiency: Evidence that the patient has debilitating shortness of breath and/or chest pain resulting in limitation of normal activity (New York Heart Association Class III) and/or established diagnosis of pulmonary arterial hypertension, where causes other than PNH have been excluded;
- Renal insufficiency: Evidence that the patient has a history of renal insufficiency, demonstrated by an eGFR less than or equal to 60mL/min/1.73m^2, where causes other than PNH have been excluded; OR
- Smooth muscle spasm: Evidence that the patient has recurrent episodes of severe pain requiring hospitalisation and/or narcotic analgesia, where causes other than PNH have been excluded.

AND

3) All patients must receive meningococcal immunization with a quadravalent vaccine (A, C, Y and W135) at least two (2) weeks prior to receiving the first dose of eculizumab. Treating physicians will be required to submit confirmation of meningococcal immunizations in order for their patients to continue to be eligible for treatment with eculizumab. Pneumococcal immunization with a 23-valent polysaccharide vaccine and a 13-valent conjugate vaccine, and a Haemophilus influenza type b (Hib) vaccine must be given according to current clinical guidelines. All patients must be monitored and reimmunized according to current clinical guidelines for vaccine use.

b. Clinical Criteria - Continued Coverage
All of the following Clinical Criteria must be established on the basis of evidence to the satisfaction of the Minister or the Minister's delegate for continued coverage:
1) Patient eligibility must be reviewed six (6) months after commencing therapy and every six (6) months thereafter;

AND

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2) Continued eligibility will be subject to the assessment of evidence, in accordance with the following monitoring requirements, which demonstrates:
- Clinical improvement in the patient, OR
- Stabilization of the patient's condition;

Monitoring requirements;

The patient's Specialist in Hematology must provide the following monitoring information every six (6) months:
- Lactate dehydrogenase (LDH);
- Full blood count and reticulocytes;
- Transfusion history for previous six months;
- Iron studies;
- Urea, electrolytes and eGFR;
- Recent clinical history; AND
- Any other information requested by the Minister, the Minister's delegate, or an Expert Advisor.

The patient's Specialist in Hematology must provide the following monitoring information every twelve (12) months:
- Confirmation that the patient has been immunized or reimmunized (meningococcal, pneumococcal 23-valent, pneumococcal 13-valent and Hib) according to current clinical guidelines for vaccine use;
- Progress reports on the clinical symptoms that formed the basis of initial eligibility;
- Quality of life, through clinical narrative;
- Granulocyte or monocyte clone size (by flow cytometry): AND
- Any other information requested by the Minister, the Minister's delegate, or an Expert Advisor.

c. Contraindications to Coverage

- Small clone size - granulocyte and monocyte clone sizes below 10%;
- Aplastic anaemia with two or more of the following: neutrophil count below 0.5 x 10^9/L, platelet count below 20 x 10^9/L, reticulocytes below 25 x 10^9/L, or severe bone marrow hypocellularity;
- Patients with a presence of another life threatening or severe disease where the long term prognosis is unlikely to be influenced by therapy (for example acute myeloid leukaemia or high-risk myelodysplastic syndrome); OR
- The presence of another medical condition that in the opinion of the Minister or Minister's delegate might reasonably be expected to compromise a response to therapy.

d. Discontinuation of Coverage

Coverage may be discontinued where one or more of the following situations apply:
- The patient or the patient's Specialist in Hematology fails to comply adequately with treatment or measures, including monitoring requirements, taken to evaluate the effectiveness of the therapy;
- There is a failure to provide the Minister, the Minister's delegate, or an Expert Advisor with information as required or as requested;
- If in the opinion of the Minister or the Minister's delegate, therapy fails to relieve the symptoms of disease that originally resulted in the patient being approved by the Minister or the Minister's delegate;
- The patient has (or develops) a condition referred to in Contraindications to Coverage.

The patient's Specialist in Hematology will be advised if their patient is at risk of being withdrawn from treatment for failure to comply with the above requirements or other perceived "non-compliance" and given a reasonable period of time to respond prior to coverage being discontinued.

4. PROCESS FOR ECULIZUMAB COVERAGE

For both initial and continued coverage the following documents (the Application) must be

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completed and submitted:

- An Eculizumab Special Authorization Request Form completed by the patient's Specialist in Hematology;
- An Eculizumab Consent Form completed by the patient, or a patient's parent/guardian/legal representative, and the patients Specialist in Hematology (for any initial coverage application); AND
- Any other documentation that may be required by the Minister or the Minister's delegate.

a. Expert Review

Once the Minister or the Minister's delegate has confirmed that the patient meets the Registration Requirement or granted a waiver of the Registration Requirement, the Application will be given to one or more Expert Advisors for review.

The Application, together with the recommendation or recommendations of the Expert Advisor(s), is then forwarded to the Minister or the Minister's delegate for a decision regarding coverage.

After the Minister or Minister's delegate has rendered a decision, the patient's Specialist in Hematology and the patient or patient's parent/guardian/legal representative will be notified by letter of the Minister's decision.

5. APPROVAL OF COVERAGE
The Minister or the Minister's delegate's decision in respect of an Application will specify the effective date of eculizumab coverage, if coverage is approved.

Initial coverage may be approved for a period of up to six (6) months as follows: One dose of 600mg of eculizumab administered weekly for the first four (4) weeks of treatment (total of four 600mg doses), followed by one dose of 900mg of eculizumab administered every two (2) weeks from week five (5) of treatment (total of eleven 900mg doses).

Continued coverage may be approved for up to one dose of 900mg of eculizumab administered every two (2) weeks, for a period of six (6) months (total of thirteen 900mg doses). If the patient restarts treatment after a lapse in therapy, continued coverage may be approved for a period of up to six (6) months as follows: One dose of 600mg of eculizumab administered weekly for the first four (4) weeks of treatment (total of four 600mg doses), followed by one dose of 900mg of eculizumab administered every two (2) weeks from week five (5) of treatment (total of eleven 900mg doses).

If a patient is approved for coverage, prescriptions for eculizumab must be written by a Specialist in Hematology. To avoid wastage, prescription quantities are limited to a two week supply. Extended quantity and vacation supplies are not permitted. The Government is not responsible and will not pay for costs associated with wastage or improper storage of eculizumab.

Approval of coverage is granted for a specific period, to a maximum of six (6) months. If continued treatment is necessary, it is the responsibility of the patient or patient's parent/guardian/legal representative and the Specialist in Hematology to submit a new Application to re-apply for eculizumab coverage, and receive a decision thereon, prior to the expiry date of the authorization period.

6. WITHDRAWAL

Therapy may be withdrawn at the request of the patient or the patient's parent/guardian/legal representative at any time. Notification of withdrawal from therapy must be made by the Specialist in Hematology or patient in writing.

Applications, withdrawal requests, and any other information to be provided must be sent to

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Clinical Drug Services, Alberta Blue Cross.

300 MG / VIAL	**INJECTION**			
00002322285	SOLIRIS		APG	$ 6742.0000

EDOXABAN TOSYLATE MONOHYDRATE

"AT RISK PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

For at-risk patients (CHADS2 score of greater than or equal to 1) with non-valvular atrial fibrillation (AF) for the prevention of stroke and systemic embolism AND in whom one of the following is also present:
- Inadequate anticoagulation (at least 35% of INR testing results outside the desired range) following a reasonable trial of warfarin (minimum two months of therapy); OR
- Anticoagulation with warfarin is contraindicated as per the product monograph or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, or at home).

Note: Some or all direct oral anticoagulants may have contraindications to use or precautions with use, for example: related to prosthetic heart valve disease, rheumatic valvular heart disease, renal function, or age. Refer to the product monograph for additional information.

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

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

The recommended dose of edoxaban for patients initiating DVT or PE treatment is 60 mg once daily following initial use of a parenteral anticoagulant for 5-10 days. A reduced dose of 30 mg once daily is recommended for patients with one or more of the following clinical factors:
- moderate renal impairment (creatinine clearance (CrCL) 30-50 mL/min)
- low body weight <= 60 kg (132 lbs)
- concomitant use of p-glycoprotein inhibitors except amiodarone and verapamil.

Drug plan coverage for edoxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, edoxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for edoxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

15 MG (BASE) ORAL TABLET				
00002458640	LIXIANA	SEV	$	2.8400
30 MG (BASE) ORAL TABLET				
00002458659	LIXIANA	SEV	$	2.8400
60 MG (BASE) ORAL TABLET				
00002458667	LIXIANA	SEV	$	2.8400

ELBASVIR/ GRAZOPREVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype 1 or genotype 4;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (2) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive, without cirrhosis or with compensated cirrhosis (3): 12 weeks*
- Treatment-experienced relapsers, without cirrhosis or with compensated cirrhosis (3): 12 weeks
- Treatment-experienced genotype 1b who have had on-treatment virologic failures (4), without cirrhosis or with compensated cirrhosis (3): 12 weeks
- Treatment-experienced genotype 1a or genotype 4 who have had on-treatment virologic failures (4), without cirrhosis or with compensated cirrhosis (3): 16 weeks in combination with ribavirin

*Note: As approved by Health Canada, 8 weeks may be considered in treatment-naive genotype 1b patients without significant fibrosis or cirrhosis as determined by liver biopsy (i.e., Metavir F0-F2) or by non-invasive tests.

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis
- Combination therapy with sofosbuvir will not be considered for any genotypes

Notes:
1. Treatment experienced for patients with genotype 1 is defined as patients who have been previously treated with a pegylated interferon + ribavirin regimen or a protease inhibitor + pegylated interferon + ribavirin regimen and have not experienced adequate response. Treatment experienced for patients with genotype 4 is defined as patients who have been previously treated with a pegylated interferon + ribavirin regimen and have not experienced adequate response.
2. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
3. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
4. On-treatment virologic failures are patients who have not experienced adequate response to prior treatment, including a null response, partial response or virologic breakthrough or rebound.
5. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the selected drug, including use in special populations."

All requests for elbasvir/grazoprevir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

50 MG * 100 MG ORAL TABLET				
00002451131	ZEPATIER	MFC	$	666.9400

EMPAGLIFLOZIN

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

"FIRST-LINE DRUG PRODUCT(S): METFORMIN

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes and established cardiovascular diseases who have an inadequate glycemic control, if the following criteria are met:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- established cardiovascular disease* as defined in the EMPA-REG OUTCOME trial

* Established cardiovascular disease is defined on the basis of one of the following:
1) History of myocardial infarction (MI)
2) Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
3) Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within the last 12 months
4) Last episode of unstable angina greater than 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease
5) History of ischemic or hemorrhagic stroke
6) Occlusive peripheral artery disease

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective"

All requests for empagliflozin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

10 MG ORAL TABLET				
00002443937	JARDIANCE	BOE	$	2.7276
25 MG ORAL TABLET				
00002443945	JARDIANCE	BOE	$	2.7276

EMPAGLIFLOZIN/ METFORMIN HCL

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

"FIRST-LINE DRUG PRODUCT(S): METFORMIN

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes and established cardiovascular diseases who have an inadequate glycemic control, if the following criteria are met:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- established cardiovascular disease* as defined in the EMPA-REG OUTCOME trial

* Established cardiovascular disease is defined on the basis of one of the following:
1) History of myocardial infarction (MI)
2) Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
3) Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within the last 12 months
4) Last episode of unstable angina greater than 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease
5) History of ischemic or hemorrhagic stroke
6) Occlusive peripheral artery disease

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective"

All requests for empagliflozin+metformin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

5 MG * 500 MG ORAL TABLET				
00002456575	SYNJARDY	BOE	$	1.3783
5 MG * 850 MG ORAL TABLET				
00002456583	SYNJARDY	BOE	$	1.3783
5 MG * 1,000 MG ORAL TABLET				
00002456591	SYNJARDY	BOE	$	1.3783
12.5 MG * 500 MG ORAL TABLET				
00002456605	SYNJARDY	BOE	$	1.3783
12.5 MG * 850 MG ORAL TABLET				
00002456613	SYNJARDY	BOE	$	1.3783
12.5 MG * 1,000 MG ORAL TABLET				
00002456621	SYNJARDY	BOE	$	1.3783

EPLERENONE

"For persons suffering from New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction with ejection fraction less than or equal to 35 per cent, as a complement to standard therapy."

Special authorization will be granted for 12 months.

This product is eligible for auto-renewal.

All requests (including renewal requests) for eplerenone must be completed using the Eplerenone/Ivabradine/Sacubitril+Valstartan Special Authorization Request Form (ABC 60050).

25 MG ORAL TABLET				
00002471442	**MINT-EPLERENONE**	**MPI**	$	**2.0595**
00002323052	INSPRA	PFI	$	2.7815
50 MG ORAL TABLET				
00002471450	**MINT-EPLERENONE**	**MPI**	$	**2.0595**
00002323060	INSPRA	PFI	$	2.7815

EPOETIN ALFA

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (< 95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for twelve months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 60,000 units per month."

"For the treatment of anemia in AZT-treated/HIV infected patients. Special authorization will be granted for twelve months."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25%. Special authorization will be granted for twelve months."

In order to comply with the first criterion information must be provided regarding the patient's hemoglobin and transferrin saturation.

In order to comply with the third criterion: if the patient has iron overload the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the third criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.

The following product(s) are eligible for auto-renewal for the indication of treatment of anemia of chronic renal failure.

All requests for epoetin alfa must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 60006).

1,000 UNIT / SYR INJECTION SYRINGE				
00002231583	EPREX (0.5 ML SYRINGE)	JAI	$	14.2500
2,000 UNIT / SYR INJECTION SYRINGE				
00002231584	EPREX (0.5 ML SYRINGE)	JAI	$	28.5000
3,000 UNIT / SYR INJECTION SYRINGE				
00002231585	EPREX (0.3 ML SYRINGE)	JAI	$	42.7500

EPOETIN ALFA

4,000 UNIT / SYR INJECTION SYRINGE				
00002231586	EPREX (0.4 ML SYRINGE)	JAI	$	57.0000
5,000 UNIT / SYR INJECTION SYRINGE				
00002243400	EPREX (0.5 ML SYRINGE)	JAI	$	71.2500
6,000 UNIT / SYR INJECTION SYRINGE				
00002243401	EPREX (0.6 ML SYRINGE)	JAI	$	85.5000
8,000 UNIT / SYR INJECTION SYRINGE				
00002243403	EPREX (0.8 ML SYRINGE)	JAI	$	114.0000
10,000 UNIT / SYR INJECTION SYRINGE				
00002231587	EPREX (1 ML SYRINGE)	JAI	$	142.5000
20,000 UNIT / SYR INJECTION SYRINGE				
00002243239	EPREX (0.5 ML SYRINGE)	JAI	$	308.1200

EPOETIN ALFA

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25%. Patients may be granted a maximum allowable dose of 40,000 IU per week. Special authorization will be granted for twelve months."

In order to comply with this criterion, if the patient has iron overload the prescriber must state this in the request, or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests, if applicable.

Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on therapy.

All requests for epoetin alfa must be completed using the Darbepoetin/Epoetin Special Authorization Request Form (ABC 60006).

30,000 UNIT / SYR INJECTION SYRINGE				
00002288680	EPREX	JAI	$	360.8300
40,000 UNIT / SYR INJECTION SYRINGE				
00002240722	EPREX	JAI	$	462.2100

ERTAPENEM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For therapy of complicated polymicrobial skin and skin structure infections."*

"For the therapy of community-acquired intra-abdominal infections."*

"For culture & susceptibility directed therapy against infections with Enterobacteriaceae producing AmpC or extended-spectrum beta-lactamases (ESBLs) where there is resistance to first line agents."*

"For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

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

1 G / VIAL INJECTION				
00002247437	INVANZ	MFC	$	54.6344

ESLICARBAZEPINE ACETATE

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

200 MG ORAL TABLET				
00002426862	APTIOM	SUN	$	9.8700
400 MG ORAL TABLET				
00002426870	APTIOM	SUN	$	9.8700
600 MG ORAL TABLET				
00002426889	APTIOM	SUN	$	9.8700
800 MG ORAL TABLET				
00002426897	APTIOM	SUN	$	9.8700

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25 MG / VIAL INJECTION

00002242903	ENBREL	AMG	$	200.7100

***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. 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 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 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.

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

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 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

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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).

Polyarticular Juvenile Idiopathic Arthritis:

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

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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:

"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.
- 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.

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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).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 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:

"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 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/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

ETANERCEPT

25 MG / SYR INJECTION SYRINGE

00002462877	ERELZI	SDZ	$	127.5000

***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. 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 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 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.

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

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 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

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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).

Polyarticular Juvenile Idiopathic Arthritis:

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

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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).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 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 bio
logic 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."

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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).

ETANERCEPT

50 MG / SYR INJECTION SYRINGE

☒ 00002455323 BRENZYS SSB $ 255.0000

***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. 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.

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

Rheumatoid Arthritis

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 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

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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).

Ankylosing Spondylitis

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 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).

ETANERCEPT

☒ 00002455331 BRENZYS SSB $ 255.0000

***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. 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.

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

Rheumatoid Arthritis

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 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

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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).

Ankylosing Spondylitis

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 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).

ETANERCEPT

☒ 00002462850 ERELZI SDZ $ 255.0000

***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. 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 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 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.

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

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 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

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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).

Polyarticular Juvenile Idiopathic Arthritis:

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

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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).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 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 bio
logic 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."

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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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***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. 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 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 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.

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

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 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:

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- 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).

Polyarticular Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 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,
iii. number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),

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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).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 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 bio
logic 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.

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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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***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. 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 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 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.

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

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 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.

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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).

Polyarticular Juvenile Idiopathic Arthritis:

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

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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:

"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.
- 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

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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/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 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,

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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:

"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 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

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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/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

EVOLOCUMAB

"Special authorization coverage may be provided for the reduction of Low Density Lipoprotein Cholesterol (LDL-C) if the following clinical criteria and conditions are met:

I) Patient has a definite or probable diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) using the Simon Broome or Dutch Lipid Network criteria or genetic testing.

AND

II) Patient is unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention) despite:

a) Confirmed adherence to high dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for at least 3 months.

OR

b) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is unable to tolerate high dose statin, defined as meeting all of the following:

i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose,
AND
ii) For each statin (two statins in total), dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality (creatine kinase (CK) > 5 times the upper limit of normal) resolution rather than discontinuation of statin altogether,
AND

iii) For each statin (two statins in total), intolerable symptoms (myopathy) or abnormal biomarkers (CK > 5 times the upper limit of normal) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate,
AND
iv) One of either:
- Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out,
OR
- Patient developed confirmed and documented rhabdomyolysis.

OR

c) Confirmed adherence to ezetimibe for at least 3 months.
AND
Patient is statin contraindicated, i.e., active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal.

- Initial coverage may be approved for either 140 mg every two weeks or 420 mg every month for a period of 3 months.
- Patients prescribed evolocumab 420 mg every month must use the 420 mg/dose formulation.
- Patients will be limited to receiving a one-month supply of evolocumab per prescription at their pharmacy.

For continued coverage beyond 3 months, the patient must meet the following criteria:
- Patient is adherent to therapy.
- Patient has achieved a reduction in LDL-C of at least 40% from baseline (4-8 weeks after initiation of evolocumab).

Continued coverage may be approved for 140 mg every 2 weeks or 420 mg every month for a period 12 months. Patients prescribed evolocumab 140 mg every 2 weeks are limited to 26 doses per year. Patients prescribed evolocumab 420 mg every month are limited to 12 doses per year.

EVOLOCUMAB

Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
- Patient is adherent to therapy.
- Patient continues to have a significant reduction in LDL-C (with continuation of evolocumab) of at least 40% from baseline since initiation of PCSK9 inhibitor. LDL-C should be checked periodically with continued treatment with PCSK9 inhibitors (e.g., every 6 months)."

All requests (including renewal requests) for evolocumab for Heterozygous Familial Hypercholesterolemia must be completed using the Alirocumab/Evolocumab for HeFH Special Authorization Request Form (ABC 60060).

120 MG / ML INJECTION				
00002459779	REPATHA	AMG	$	155.9428
140 MG / SYR INJECTION SYRINGE				
00002446057	REPATHA AUTOINJECTOR	AMG	$	251.9100

EZETIMIBE

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

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

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

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

All requests for ezetimibe must be completed using the Ezetimibe Special Authorization Request Form (ABC 60036).

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

10 MG ORAL TABLET				
00002425610	**ACH-EZETIMIBE**	**AHI**	$	**0.1811**
00002427826	**APO-EZETIMIBE**	**APX**	$	**0.1811**
00002469286	**AURO-EZETIMIBE**	**AUR**	$	**0.1811**
00002429659	**EZETIMIBE**	**SIV**	$	**0.1811**
00002431300	**EZETIMIBE**	**SNS**	$	**0.1811**
00002423235	**JAMP-EZETIMIBE**	**JPC**	$	**0.1811**
00002422662	**MAR-EZETIMIBE**	**MAR**	$	**0.1811**
00002423243	**MINT-EZETIMIBE**	**MPI**	$	**0.1811**
00002416409	**PMS-EZETIMIBE**	**PMS**	$	**0.1811**
00002419548	**RAN-EZETIMIBE**	**RAN**	$	**0.1811**
00002416778	**SANDOZ EZETIMIBE**	**SDZ**	$	**0.1811**
00002354101	**TEVA-EZETIMIBE**	**TEV**	$	**0.1811**
00002247521	EZETROL	MFC	$	1.9180

FEBUXOSTAT

"For patients with symptomatic gout who have documented hypersensitivity OR severe intolerance to allopurinol, AND intolerance or lack of response to sulfinpyrazone.

Special authorization may be granted for 6 months."

Please note: Coverage cannot be considered for lack of response to allopurinol.

All requests for febuxostat must be completed using the Febuxostat Special Authorization Request Form (ABC 60037).

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

80 MG ORAL TABLET

00002357380	ULORIC	TAK	$	1.5900

FENTANYL

"For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who cannot swallow. Special authorization may be granted for 6 months."

"For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who require opioid therapy at a total daily dose of at least 60 mg/day oral morphine equivalents. Patients must have tried and not been able to tolerate at least two discrete courses of therapy with two of the following agents: morphine, hydromorphone and oxycodone, if not contraindicated. Special authorization may be granted for 6 months."

Information is required regarding previous medications utilized and the patient's response to therapy. Also, information regarding the number of discrete (separate) courses of these medications is required. A discrete course is defined as a separate treatment course, which may involve more than 1 agent, used at one time to manage the patient's condition.

All requests for fentanyl must be completed using the Fentanyl Special Authorization Request Form (ABC 60005).

(Please note: The following fentanyl products are benefits not requiring special authorization for individuals approved by Alberta Health for Palliative Coverage. Refer to the Palliative Coverage Drug Benefit Supplement for additional information on this coverage.)

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

12 MCG/HR TRANSDERMAL PATCH

00002396696	**MYLAN-FENTANYL MATRIX**	**MYP**	$	**2.2280**
00002341379	**PMS-FENTANYL MTX**	**PMS**	$	**2.2280**
00002330105	**RAN-FENTANYL MATRIX**	**RAN**	$	**2.2280**
00002327112	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**2.2280**
00002311925	**TEVA-FENTANYL**	**TEV**	$	**2.2280**

25 MCG/HR TRANSDERMAL PATCH

00002341387	**PMS-FENTANYL MTX**	**PMS**	$	**3.6560**
00002330113	**RAN-FENTANYL MATRIX**	**RAN**	$	**3.6560**
00002327120	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**3.6560**
00002282941	**TEVA-FENTANYL**	**TEV**	$	**3.6560**

50 MCG/HR TRANSDERMAL PATCH

00002396726	**MYLAN-FENTANYL MATRIX**	**MYP**	$	**6.8820**
00002341395	**PMS-FENTANYL MTX**	**PMS**	$	**6.8820**
00002327147	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**6.8820**
00002282968	**TEVA-FENTANYL**	**TEV**	$	**6.8820**

FENTANYL

75 MCG/HR TRANSDERMAL PATCH				
00002341409	**PMS-FENTANYL MTX**	**PMS**	$	**9.6800**
00002330148	**RAN-FENTANYL MATRIX**	**RAN**	$	**9.6800**
00002327155	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**9.6800**
00002282976	**TEVA-FENTANYL**	**TEV**	$	**9.6800**
100 MCG/HR TRANSDERMAL PATCH				
00002314665	**APO-FENTANYL 100**	**APX**	$	**12.0500**
00002341417	**PMS-FENTANYL MTX**	**PMS**	$	**12.0500**
00002330156	**RAN-FENTANYL MATRIX**	**RAN**	$	**12.0500**
00002327163	**SANDOZ FENTANYL PATCH**	**SDZ**	$	**12.0500**
00002282984	**TEVA-FENTANYL**	**TEV**	$	**12.0500**

FENTANYL CITRATE

"For the treatment of persistent, severe chronic pain in those patients who cannot swallow, or who are intolerant of morphine and/or hydromorphone, if not contraindicated. Special authorization may be granted for 6 months."

All requests for fentanyl must be completed using the Fentanyl Special Authorization Request Form (ABC 60005).

(Please note: The following fentanyl products are benefits not requiring special authorization for individuals approved by Alberta Health for Palliative Coverage. Refer to the Palliative Coverage Drug Benefit Supplement for additional information on this coverage.)

This product is eligible for auto-renewal.

0.05 MG / ML (BASE) INJECTION				
00002240434	FENTANYL CITRATE	SDZ	$	2.7290

FESOTERODINE FUMARATE

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

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA."

"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

4 MG ORAL EXTENDED-RELEASE TABLET				
00002380021	TOVIAZ	PFI	$	1.5000
8 MG ORAL EXTENDED-RELEASE TABLET				
00002380048	TOVIAZ	PFI	$	1.5000

FIDAXOMICIN

For the treatment of:
1) C. difficile infection (CDI) where the patient has failed, or is intolerant of oral vancomycin; or
2) Patients with third or greater recurrence of CDI (i.e. 4th or greater episode of CDI)

Note:
- Fidaxomicin should not be used as an add-on to existing therapy (metronidazole or vancomycin).
- Not studied in multiple recurrences or those with life-threatening or fulminant CDI, toxic megacolon, or inflammatory bowel disease.

Special authorization coverage for fidaxomicin will be provided for one treatment course (10 days) plus one additional treatment course for an early relapse occurring within 8 weeks of the start of the most recent fidaxomicin course.

New episode of CDI after 8 weeks will require treatment with first line therapy before fidaxomicin coverage may be considered.

All requests (including renewal requests) for fidaxomicin must be completed using the Fidaxomicin Special Authorization Request Form (ABC 60014).

200 MG ORAL TABLET				
00002387174	DIFICID	MFC	$	94.6000

FILGRASTIM

Effective April 1, 2017, all Special Authorization requests for filgrastim will be assessed for coverage with Grastofil. Neupogen will not be approved for new filgrastim starts or repeat treatments (e.g. new course of chemotherapy); however, coverage for Neupogen will continue for pediatric patients and patients with congenital, cyclic or idiopathic neutropenia who are currently maintained on Neupogen.

"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."

"Following induction and consolidation treatment for acute myeloid leukemia, for the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization."

"In patients with a diagnosis of congenital, cyclic or idiopathic neutropenia, to increase neutrophil counts and to reduce the incidence and duration of infection."

Please note for the first criterion: Coverage cannot be considered for palliative patients.

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

0.3 MG / ML INJECTION				
00001968017	NEUPOGEN	AMG	$	173.1890
0.3 MG / SYR INJECTION SYRINGE				
00002441489	GRASTOFIL	APX	$	144.3135
0.48 MG / SYR INJECTION SYRINGE				
00002454548	GRASTOFIL	APX	$	230.9017

FINGOLIMOD HYDROCHLORIDE

Relapsing Remitting Multiple Sclerosis (RRMS):

Special authorization coverage may be provided for the treatment of relapsing remitting multiple sclerosis (RRMS) to reduce the frequency of clinical relapses and to delay the progression of physical disability in adult patients (18 years of age or older) who are refractory or intolerant to at least ONE of the following:
- interferon beta
- glatiramer acetate
- dimethyl fumarate
- teriflunomide.

Definition of 'intolerant'

Demonstrating serious adverse effects or contraindications to treatments as defined in the product monograph, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of MS disease modifying therapy (DMT).

Definition of 'refractory'

-Development of neutralizing antibodies to interferon beta.

-When the above MS DMTs (interferon beta, glatiramer acetate, dimethyl fumarate, teriflunomide) are taken at the recommended doses for a full and adequate course of treatment, within a consecutive 12-month period while the patient was on the MS DMT, the patient has:

1) Been adherent to the MS DMT (greater than 80% of approved doses have been administered);

2) Experienced at least two relapses* of MS confirmed by the presence of neurologic deficits on examination.
i. The first qualifying clinical relapse must have begun at least one month after treatment initiation.
ii. Both qualifying relapses must be classified with a relapse severity of moderate, severe or very severe**.

* A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

**Relapse Severity: with moderate relapses modification or more time is required to carry out activities of daily living; with severe relapses there is inability to carry out some activities of daily living; with very severe relapses activities of daily living must be completed by others.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during

FINGOLIMOD HYDROCHLORIDE

the previous two years or in the two years prior to starting an MS DMT. In most cases this will be satisfied by the refractory to treatment criterion but if a patient failed interferon beta, glatiramer acetate, dimethyl fumarate, or teriflunomide more than one year earlier, ongoing active disease must be confirmed.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage will not be approved when any MS DMT or other immunosuppressive therapy is to be used in combination with fingolimod.

Coverage of fingolimod will not be approved if the patient was deemed to be refractory to fingolimod in the past, i.e., has not met the 'responder' criteria below in 'Continued Coverage'.

Following assessment of the request, coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of fingolimod per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more;

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

4) The registered MS Neurologist must confirm in writing that the patient is a 'responder' who has experienced no more than one inflammatory event in the last year (defined as either a clinical relapse or gadolinium-enhancing lesion). In instances where a patient has had four or more clinical relapses in the year prior to starting treatment, there must be at least a 50% reduction in relapse rate over the entire treatment period.

Following assessment of the request, continued coverage may be approved for maintenance therapy for up to 12 months. Patients may receive up to 100 days' supply of fingolimod per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption of therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period.

All requests (including renewal requests) for fingolimod must be completed using the Alemtuzumab/Fingolimod/Natalizumab For Multiple Sclerosis Special Authorization Request Form (ABC 60000).

0.5 MG ORAL CAPSULE

00002365480	GILENYA	NOV	$	86.9525

FINGOLIMOD HYDROCHLORIDE

FLUCONAZOLE

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For susceptible infections in patients who cannot swallow tablets."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

10 MG / ML ORAL SUSPENSION

00002024152	DIFLUCAN	PFI	$	1.1854

FLUTAMIDE

"When prescribed for non-cancer, non-cosmetic indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

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

250 MG ORAL TABLET

00002238560	FLUTAMIDE	AAP	$	1.8255

FLUTICASONE FUROATE/ VILANTEROL TRIFENATATE

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for fluticasone furoate + vilanterol trifenatate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

100 MCG / DOSE * 25 MCG / DOSE (BASE)		**INHALATION**	**METERED INHALATION POWDER**		
00002408872	BREO ELLIPTA		GSK	$	2.8547

FLUTICASONE FUROATE/ VILANTEROL TRIFENATATE

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for fluticasone furoate + vilanterol trifenatate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

200 MCG / DOSE * 25 MCG / DOSE	**INHALATION**	**METERED INHALATION POWDER**		
00002444186	BREO ELLIPTA	GSK	$	4.4200

GALANTAMINE HYDROBROMIDE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Special authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug."

All requests (including renewal requests) for galantamine hydrobromide must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 60034).

8 MG (BASE)	**ORAL**	**EXTENDED-RELEASE CAPSULE**		
00002425157	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443015	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339439	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398370	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**
16 MG (BASE)	**ORAL**	**EXTENDED-RELEASE CAPSULE**		
00002425165	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443023	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339447	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398389	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**

GALANTAMINE HYDROBROMIDE

24 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002425173	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443031	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339455	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398397	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**

GLATIRAMER ACETATE

20 MG / SYR INJECTION SYRINGE

☒ 00002460661 GLATECT PMS $ 32.4000

Effective July 1, 2018, all new Special Authorization requests for the treatment of Relapsing Remitting Multiple Sclerosis (RRMS) for glatiramer-naive patients will be assessed for coverage with Glatect. Copaxone will not be approved for new glatiramer acetate starts for patients with the indication stated above; however, coverage for Copaxone will continue for patients who are currently well maintained on Copaxone as per maintenance coverage criteria. Additionally, patients will not be permitted to switch from Glatect to Copaxone.

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of glatiramer acetate per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of glatiramer acetate per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the

GLATIRAMER ACETATE

patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for glatiramer acetate must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

☒	00002245619	COPAXONE	TMP	$	48.0488

Effective July 1, 2018, all new Special Authorization requests for the treatment of Relapsing Remitting Multiple Sclerosis (RRMS) for glatiramer-naive patients will be assessed for coverage with Glatect. Copaxone will not be approved for new glatiramer acetate starts for patients with the indication stated above; however, coverage for Copaxone will continue for patients who are currently well maintained on Copaxone as per maintenance coverage criteria. Additionally, patients will not be permitted to switch from Glatect to Copaxone.

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of glatiramer acetate per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

GLATIRAMER ACETATE

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of glatiramer acetate per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for glatiramer acetate must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

GLYCEROL PHENYLBUTYRATE

"For chronic management of patients with urea cycle disorders (UCDs) who cannot be managed by dietary protein restriction and/or amino acid supplementation alone.

For coverage, this drug must be prescribed by or in consultation with a metabolic or genetic physician. The diagnosis must be confirmed by blood, enzymatic, biochemical, or genetic testing.

Special authorization may be granted for 12 months."

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

1.1 G / ML ORAL LIQUID

00002453304	RAVICTI	RAP	$	48.0000

GOLIMUMAB

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:
- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

- Initial coverage may be approved for 50 mg once per month for four doses.
- Patients will be limited to receiving one dose (50 mg) of golimumab 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 four doses the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial four doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for 50 mg once per month for a further 12 month period. Should continued coverage criteria be met, coverage will only be granted for 12 doses per 12 month period. 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 golimumab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms 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

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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 month for four doses.
- Patients will be limited to receiving one dose (50 mg) of golimumab 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 four doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after four doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 50 mg per month, for a further 12 month period. Should coverage criteria be met, coverage will only be granted for 12 doses per 12-month period. 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 golimumab for Psoriatic Arthritis must be

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completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4-month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 50 mg per month for a total of four doses.
- Patients will be limited to receiving one dose (50 mg) of golimumab 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 four doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after four doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 50 mg per month, for a further 12 month period. Should continued coverage criteria be met, coverage will

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only be granted for 12 doses per 12 month period. 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 golimumab 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).

Ulcerative Colitis

Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology as recognized by the College of Physicians and Surgeons and/or the Alberta Medical Association or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for 200 mg of golimumab administered by subcutaneous injection at Week 0, followed by 100 mg at Week 2. As an interim measure, an additional dose of 50 mg of golimumab will be provided at weeks 6 and 10 to allow time to determine whether the patient meets coverage criteria for maintenance dosing, see below.
- Patients will be limited to receiving a one-month supply of golimumab 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

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for which it is being prescribed.

For continued coverage beyond three doses, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between week 12 and week 14 to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 50 mg every 4 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of golimumab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 50 mg, the maintenance dose may be adjusted from 50 mg to 100 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for golimumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

50 MG / SYR INJECTION SYRINGE

☒ 00002324776	SIMPONI	JAI	$	1516.0000
☒ 00002324784	SIMPONI	JAI	$	1516.0000

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Ulcerative Colitis

Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology as recognized by the College of Physicians and Surgeons and/or the Alberta Medical Association or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for 200 mg of golimumab administered by subcutaneous injection at Week 0, followed by 100 mg at Week 2. As an interim measure, an additional dose of 50 mg of golimumab will be provided at weeks 6 and 10 to allow time to determine whether the patient meets coverage criteria for maintenance dosing, see below.
- Patients will be limited to receiving a one-month supply of golimumab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between week 12 and week 14 to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 50 mg every 4 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of golimumab therapy

Note: For patients who showed a response to induction therapy then experienced

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secondary loss of response while on maintenance dosing with 50 mg, the maintenance dose may be adjusted from 50 mg to 100 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for golimumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

100 MG / SYR INJECTION SYRINGE				
☒ 00002413175	SIMPONI	JAI	$	1516.0000
☒ 00002413183	SIMPONI	JAI	$	1516.0000

GOSERELIN ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

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

3.6 MG / SYR (BASE) INJECTION SYRINGE				
00002049325	ZOLADEX	TSA	$	422.6778
10.8 MG / SYR (BASE) INJECTION SYRINGE				
00002225905	ZOLADEX LA	TSA	$	1204.7322

ICATIBANT ACETATE

"For the treatment of acute attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients with C1-esterase inhibitor deficiency. Icatibant is to be used for:
- acute non-laryngeal attack(s) of at least moderate severity, or
- acute laryngeal attack(s) of any severity

This medication must be prescribed by, or in consultation with, a physician experienced in the treatment of HAE.

Special authorization may be granted for 12 months.

Patients will be limited to a maximum of two doses of icatibant per prescription at their pharmacy."

This product is eligible for auto-renewal.

30 MG / SYR (BASE) INJECTION				
00002425696	FIRAZYR	SOT	$	2700.0000

IMIPENEM/ CILASTATIN SODIUM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

"For the treatment of:

1) Second-line therapy of intra-abdominal sepsis where there is failure of first-line therapy (e.g. ampicillin + gentamicin + metronidazole), as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy or

2) Second-line therapy of severe polymicrobial skin and skin structure infections (e.g. limb threatening diabetic foot) or

3) Empiric therapy of mixed synergistic necrotizing gangrene (Fournier's gangrene) or

4) Therapy of severe ventilator-associated pneumonia where Pseudomonas and Staphylococcus aureus coverage is needed or

5) Second-line therapy of infections due to gram-negative organisms producing inducible beta-lactamases or extended spectrum beta-lactamases where there is resistance to first-line agents or

6) For use in other Health Canada approved indications in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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

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

00000717282	PRIMAXIN	MFC	$	26.6910

IMIQUIMOD

"For the treatment of Actinic Keratosis located on the head and neck in patients who have failed treatment with cryotherapy (where appropriate) and 5-fluorouracil (5-FU).

Special authorization may be granted for 6 months."

All requests for imiquimod must be completed using the Imiquimod Special Authorization Request Form (ABC 60038).

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

50 MG/G / G TOPICAL CREAM

00002407825	**APO-IMIQUIMOD**	**APX**	$	**44.1200**
00002239505	ALDARA	VCL	$	52.2362

INDACATEROL MALEATE/ GLYCOPYRRONIUM BROMIDE

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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for indacaterol maleate + glycopyrronium bromide must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

110 MCG (BASE)	*** 50 MCG (BASE)**	**INHALATION**	**CAPSULE**			
00002418282	ULTIBRO BREEZHALER			NOV	$	2.6150

INFANT FORMULA

ORAL POWDER

☒ 00000999543 PURAMINO A+ MJO $ 0.1275

"For the dietary management of infants with:
-cow milk protein allergy OR
-soy protein allergy OR
-multiple food protein intolerance OR
-conditions where an amino acid-based diet is indicated:
-short bowel syndrome
-gastroesophageal reflux disease (GERD)
-eosinophilic esophagitis (EoE)
-malabsorption.

AND

Who have failed or are intolerant to an appropriate trial (1 to 2 week trial is recommended) of an extensively hydrolyzed infant formula.

This product must be prescribed by or in consultation with a general pediatrician, neonatologist, pediatric gastroenterologist or pediatric allergist.

Special authorization may be granted for a maximum of 24 months."

(Refer to Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

☒ 00000999568 NEOCATE WITH DHA & ARA NUN $ 0.1535

"For the dietary management of infants with:
-cow milk protein allergy OR
-soy protein allergy OR
-multiple food protein intolerance OR
-conditions where an amino acid-based diet is indicated:
-short bowel syndrome
-gastroesophageal reflux disease (GERD)
-eosinophilic esophagitis (EoE)
-malabsorption.

AND

Who have failed or are intolerant to an appropriate trial (1 to 2 week trial is recommended) of an extensively hydrolyzed infant formula.

This product must be prescribed by or in consultation with a general pediatrician, neonatologist, pediatric gastroenterologist or pediatric allergist.

Special authorization may be granted for a maximum of 24 months."

(Refer to Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

INFLIXIMAB

100 MG / VIAL INJECTION

☒ 00002470373 RENFLEXIS SSB $ 493.0000

***Effective January 1, 2019, all new Special Authorization requests for the treatment of Ankylosing Spondylitis, Plaque Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease or Ulcerative Colitis for infliximab naive patients will be assessed for coverage with Inflectra or Renflexis. Remicade will not be approved for new infliximab starts for patients with the indications stated above; however, coverage for Remicade will continue for patients who are currently well maintained on Remicade and are considered a 'responder' as defined in criteria.
Additionally, patients will not be permitted to switch between infliximab products, if the patient has been previously trialed on any infliximab product and deemed unresponsive to therapy.***

Rheumatoid Arthritis:

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

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

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

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

- Initial coverage may be approved for three doses as follows: An initial dose of 3 mg/kg, followed by additional 3 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 3 mg/kg dose every 8 weeks for a period of 12 months [Note: For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg and/or treating as often as every 4 weeks]. 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:

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- 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 infliximab 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).

Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease:

"Special authorization coverage may be approved for coverage of infliximab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease and/or treatment of Fistulizing Crohn's Disease in patients who meet the following criteria:

- Infliximab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for infliximab for coverage for the treatment of Moderately to Severely Active Crohn's Disease and/or Fistulizing Crohn's Disease patients ('Specialist').
- Patients must be 18 years of age or older to be considered for coverage of infliximab.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) 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.

Prior to initiation of infliximab therapy for New Patients:

'New Patients' are patients who have never been treated with infliximab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; AND refractory to, or dependent on, glucocorticoids:
following at least one tapering dosing schedule of 40 mg/day, tapering by 5 mg each week to 20 mg, then tapering by 2.5 mg each week to zero, or similar;

[Note: Patients who have used the above treatments in combination will not be required to be challenged with individual treatments as monotherapy]

AND
b) Immunosuppressive therapy as follows:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 3 months; OR
- Methotrexate: minimum or 15 mg/week for a minimum of 3 months.
OR
- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

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Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Fistulizing Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite:

a) A course of an appropriate dose of antibiotic therapy (e.g. ciprofloxacin or metronidazole) for a minimum of 3 weeks; AND
b) Immunosuppressive therapy:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 6 weeks; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 6 weeks; OR
- Immunosuppressive therapy discontinued at less than 6 weeks due to serious adverse effects or reactions.

[Note: Patients who have used the above treatments in combination for the treatment of Fistulizing Crohn's will not be required to be challenged with individual treatments as monotherapy]

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease AND/OR Fistulizing Crohn's Disease

- New Patients must meet the criteria above prior to being considered for approval.
- All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

- Coverage for Induction Dosing may only be approved for New Patients (those who have never been treated with infliximab by any health care provider).
- 'Induction Dosing' means a maximum of one 5 mg/kg dose of infliximab per New Patient at each 0, 2 and 6 weeks (for a maximum total of three doses).
- New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.

Maintenance Dosing:

'Maintenance Dosing' means one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months to:
- New Patients following the completion of Induction Dosing; OR
- Existing Patients, who are patients that are being treated, or have previously been treated, with infliximab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:

- The New Patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND
- The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's and/or confirm closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

Maintenance Dosing for Existing Patients:

- The patient must be assessed by a Specialist at least 4 to 8 weeks after the day the last dose of infliximab was administered to the patient and prior to administration of the next dose to obtain: a

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Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND

- these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

(For existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for existing patients with Fistulizing Crohn's who respond then lose their response, the dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months, if the following criteria are met at the end of each 12 month period:

- The New Patient or the Existing Patient must be assessed by a Specialist at least 4 to 6 weeks after the day the last dose of infliximab was administered to the patient and prior to the administration of the next dose to obtain a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND
- For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; OR
- For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

(For new and existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for new and existing patients with Fistulizing Crohn's who respond then lose their response, the maintenance dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)"

All requests (including renewal requests) for infliximab for Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 60031).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms and improvement in physical function 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 three doses as follows: An initial dose of 5 mg/kg, followed

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by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for one 5 mg/kg dose of infliximab every 6 to 8 weeks 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 infliximab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for three doses as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine

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response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 5 mg/kg dose every 8 weeks, 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 infliximab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Plaque Psoriasis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

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

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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.

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For continued coverage beyond three doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial three doses to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, or
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 5 mg/kg dose of infliximab every 8 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 infliximab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Ulcerative Colitis:

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks
AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for three doses of 5 mg/kg of infliximab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a one dose of infliximab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

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Following this assessment, continued coverage may be approved for dose of 5 mg/kg every 8 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of infliximab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg/kg, the maintenance dose may be adjusted from 5 mg/kg to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose."

All requests (including renewal requests) for infliximab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

☒ 00002244016 REMICADE JAI $ 962.6800

***Effective January 1, 2019, all new Special Authorization requests for the treatment of Ankylosing Spondylitis, Plaque Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease or Ulcerative Colitis for infliximab naive patients will be assessed for coverage with Inflectra or Renflexis. Remicade will not be approved for new infliximab starts for patients with the indications stated above; however, coverage for Remicade will continue for patients who are currently well maintained on Remicade and are considered a 'responder' as defined in criteria.
Additionally, patients will not be permitted to switch between infliximab products, if the patient has been previously trialed on any infliximab product and deemed unresponsive to therapy.***

Rheumatoid Arthritis:

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

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

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

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

- Initial coverage may be approved for three doses as follows: An initial dose of 3 mg/kg, followed by additional 3 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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 three doses, the patient must meet the following criteria:

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1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 3 mg/kg dose every 8 weeks for a period of 12 months [Note: For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg and/or treating as often as every 4 weeks]. 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 infliximab 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).

Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease:

"Special authorization coverage may be approved for coverage of infliximab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease and/or treatment of Fistulizing Crohn's Disease in patients who meet the following criteria:

- Infliximab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for infliximab for coverage for the treatment of Moderately to Severely Active Crohn's Disease and/or Fistulizing Crohn's Disease patients (`Specialist').
- Patients must be 18 years of age or older to be considered for coverage of infliximab.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) 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.

Prior to initiation of infliximab therapy for New Patients:

'New Patients' are patients who have never been treated with infliximab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR

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2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; AND refractory to, or dependent on, glucocorticoids:
following at least one tapering dosing schedule of 40 mg/day, tapering by 5 mg each week to 20 mg, then tapering by 2.5 mg each week to zero, or similar;

[Note: Patients who have used the above treatments in combination will not be required to be challenged with individual treatments as monotherapy]

AND
b) Immunosuppressive therapy as follows:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 3 months; OR
- Methotrexate: minimum or 15 mg/week for a minimum of 3 months.
OR
- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Fistulizing Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite:

a) A course of an appropriate dose of antibiotic therapy (e.g. ciprofloxacin or metronidazole) for a minimum of 3 weeks; AND
b) Immunosuppressive therapy:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 6 weeks; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 6 weeks; OR
- Immunosuppressive therapy discontinued at less than 6 weeks due to serious adverse effects or reactions.

[Note: Patients who have used the above treatments in combination for the treatment of Fistulizing Crohn's will not be required to be challenged with individual treatments as monotherapy]

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease AND/OR Fistulizing Crohn's Disease

- New Patients must meet the criteria above prior to being considered for approval.
- All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

- Coverage for Induction Dosing may only be approved for New Patients (those who have never been treated with infliximab by any health care provider).
- 'Induction Dosing' means a maximum of one 5 mg/kg dose of infliximab per New Patient at each 0, 2 and 6 weeks (for a maximum total of three doses).
- New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.

Maintenance Dosing:

'Maintenance Dosing' means one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months to:
- New Patients following the completion of Induction Dosing; OR
- Existing Patients, who are patients that are being treated, or have previously been treated, with

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infliximab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:

- The New Patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND
- The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's and/or confirm closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

Maintenance Dosing for Existing Patients:

- The patient must be assessed by a Specialist at least 4 to 8 weeks after the day the last dose of infliximab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND

- these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

(For existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for existing patients with Fistulizing Crohn's who respond then lose their response, the dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months, if the following criteria are met at the end of each 12 month period:

- The New Patient or the Existing Patient must be assessed by a Specialist at least 4 to 6 weeks after the day the last dose of infliximab was administered to the patient and prior to the administration of the next dose to obtain a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND
- For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; OR
- For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

(For new and existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for new and existing patients with Fistulizing Crohn's who respond then lose their response, the maintenance dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)"

All requests (including renewal requests) for infliximab for Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 60031).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms and

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improvement in physical function 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 three doses as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for one 5 mg/kg dose of infliximab every 6 to 8 weeks 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 infliximab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.

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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 three doses as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 5 mg/kg dose every 8 weeks, 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 infliximab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Plaque Psoriasis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments

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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 as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab 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 three doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial three doses to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, or
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 5 mg/kg dose of infliximab every 8 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 infliximab for Plaque Psoriasis must be completed using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Ulcerative Colitis:

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks
AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

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Initial coverage may be approved for three doses of 5 mg/kg of infliximab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a one dose of infliximab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for dose of 5 mg/kg every 8 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of infliximab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg/kg, the maintenance dose may be adjusted from 5 mg/kg to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose."

All requests (including renewal requests) for infliximab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

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100 MG / VIAL INJECTION

00002419475	INFLECTRA	CHH	$ 525.0000

***Effective January 1, 2019, all new Special Authorization requests for the treatment of Ankylosing Spondylitis, Plaque Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease or Ulcerative Colitis for infliximab naive patients will be assessed for coverage with Inflectra or Renflexis. Remicade will not be approved for new infliximab starts for patients with the indications stated above; however, coverage for Remicade will continue for patients who are currently well maintained on Remicade and are considered a 'responder' as defined in criteria.
Additionally, patients will not be permitted to switch between infliximab products, if the patient has been previously trialed on any infliximab product and deemed unresponsive to therapy.***

Plaque Psoriasis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

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

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from another biologic agent to infliximab 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 infliximab if previously trialed and 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 three doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial three doses to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, or
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 5 mg/kg dose of infliximab every 8 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

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for patients that have significant involvement of the face, palms, soles of feet or genital region.

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

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for three doses as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from another biologic agent to infliximab 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 infliximab if previously trialed and 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.
Following this assessment, continued coverage may be approved for one 5 mg/kg dose every 8 weeks, 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 infliximab for Psoriatic Arthritis must be completed

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using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Rheumatoid Arthritis:

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

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

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

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

- Initial coverage may be approved for three doses as follows: An initial dose of 3 mg/kg, followed by additional 3 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from another biologic agent (with the exception of anakinra) to infliximab 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 infliximab if previously trialed and deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Continued coverage may be approved for one 3 mg/kg dose every 8 weeks for a period of 12 months [Note: For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg and/or treating as often as every 4 weeks]. 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 infliximab for Rheumatoid Arthritis must be completed using the

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Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Ankylosing Spondylitis:

"Special authorization coverage may be provided for the reduction in the signs and symptoms and improvement in physical function 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 three doses as follows: An initial dose of 5 mg/kg, followed by additional 5 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from another biologic agent to infliximab 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 infliximab if previously trialed and 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for one 5 mg/kg dose of infliximab every 6 to 8 weeks 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 infliximab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease:

"Special authorization coverage may be approved for coverage of infliximab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease and/or treatment of Fistulizing Crohn's Disease in patients who meet the following criteria:

- Infliximab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for infliximab for coverage for the treatment of Moderately to Severely Active Crohn's Disease and/or Fistulizing Crohn's Disease patients (`Specialist').
- Patients must be 18 years of age or older to be considered for coverage of infliximab.

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- Patients will be limited to receiving one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from another biologic to infliximab following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) 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 infliximab if previously trialed and 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.

Prior to initiation of infliximab therapy for New Patients:

'New Patients' are patients who have never been treated with infliximab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; AND refractory to, or dependent on, glucocorticoids:
following at least one tapering dosing schedule of 40 mg/day, tapering by 5 mg each week to 20 mg, then tapering by 2.5 mg each week to zero, or similar;

[Note: Patients who have used the above treatments in combination will not be required to be challenged with individual treatments as monotherapy]

AND
b) Immunosuppressive therapy as follows:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 3 months; OR
- Methotrexate: minimum or 15 mg/week for a minimum of 3 months.
OR
- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Fistulizing Crohn's Disease:

Prior to initiation of infliximab therapy, New Patients must have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite:

a) A course of an appropriate dose of antibiotic therapy (e.g. ciprofloxacin or metronidazole) for a minimum of 3 weeks; AND
b) Immunosuppressive therapy:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 6 weeks; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 6 weeks; OR
- Immunosuppressive therapy discontinued at less than 6 weeks due to serious adverse effects or reactions.

[Note: Patients who have used the above treatments in combination for the treatment of Fistulizing Crohn's will not be required to be challenged with individual treatments as monotherapy]

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue

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Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease AND/OR Fistulizing Crohn's Disease

- New Patients must meet the criteria above prior to being considered for approval.
- All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

- Coverage for Induction Dosing may only be approved for New Patients (those who have never been treated with infliximab by any health care provider).
- 'Induction Dosing' means a maximum of one 5 mg/kg dose of infliximab per New Patient at each 0, 2 and 6 weeks (for a maximum total of three doses).
- New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.

Maintenance Dosing:

'Maintenance Dosing' means one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months to:
- New Patients following the completion of Induction Dosing; OR
- Existing Patients, who are patients that are being treated, or have previously been treated, with infliximab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:

- The New Patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND
- The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's and/or confirm closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

Maintenance Dosing for Existing Patients:

- The patient must be assessed by a Specialist at least 4 to 8 weeks after the day the last dose of infliximab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; AND

- these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

(For existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for existing patients with Fistulizing Crohn's who respond then lose their response, the dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 5 mg/kg dose of infliximab per patient provided no more often than every 8 weeks for a period of 12 months, if the following criteria are met at the end of each 12 month period:

- The New Patient or the Existing Patient must be assessed by a Specialist at least 4 to 6 weeks after the day the last dose of infliximab was administered to the patient and prior to the administration of the next dose to obtain a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for

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Fistulizing Crohn's; AND
- For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's; OR
- For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score and/or closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline for Fistulizing Crohn's.

(For new and existing patients with Moderately to Severely Active Crohn's Disease with an incomplete response or for new and existing patients with Fistulizing Crohn's who respond then lose their response, the maintenance dose may be adjusted to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.)"

All requests (including renewal requests) for infliximab for Moderately to Severely Active Crohn's Disease and Fistulizing Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 60031).

Ulcerative Colitis:

Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks
AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for three doses of 5 mg/kg of infliximab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a one dose of infliximab per prescription at their pharmacy.
- Patients will be permitted to switch from another biologic agent to infliximab 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 infliximab if previously trialed and 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for dose of 5 mg/kg every 8

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weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of infliximab therapy

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg/kg, the maintenance dose may be adjusted from 5 mg/kg to 10 mg/kg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for infliximab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

INTERFERON BETA-1A

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of interferon beta-1a per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of interferon beta-1a per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the

INTERFERON BETA-1A

patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1a must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

44 MCG / ML INJECTION CARTRIDGE				
00002318253	REBIF (1.5 ML CARTRIDGE)	SRO	$	259.6350
88 MCG / ML INJECTION CARTRIDGE				
00002318261	REBIF (1.5 ML CARTRIDGE)	SRO	$	316.0775
6 MIU / SYR INJECTION SYRINGE				
00002269201	AVONEX PS/PEN (30 MCG/0.5 ML)	BIO	$	412.6003
22 MCG / SYR INJECTION SYRINGE				
00002237319	REBIF (0.5 ML SYRINGE)	SRO	$	129.8174
44 MCG / SYR INJECTION SYRINGE				
00002237320	REBIF (0.5 ML SYRINGE)	SRO	$	158.0386

INTERFERON BETA-1B

Relapsing Remitting Multiple Sclerosis (RRMS):

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of interferon beta-1b per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of interferon beta-1b per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the

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patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/ Interferon Beta-1a/ Interferon Beta-1b/ Teriflunomide Special Authorization Request Form (ABC 60001).

Secondary Progressive Multiple Sclerosis with Relapses (SPMS with relapses):

"Special authorization coverage may be provided for the slowing of progression in disability and the reduction of the frequency of clinical relapses in patients with secondary progressive multiple sclerosis with relapses.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of SPMS with relapses;

2) The patient must have active disease which is defined as two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms (documented by a physician), lasting at least 72 hours in the absence of fever, not associated with withdrawal from steroids, and preceded by stability for at least one month. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory to 100m without an aid (The registered MS Neurologist must provide an updated Expanded Disability Status Scale (EDSS) score of less than or equal to 5.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of interferon beta-1b per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of SPMS with relapses;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and

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accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of interferon beta-1b per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

9.6 MIU / VIAL INJECTION				
00002169649	**BETASERON (0.3 MG)**	**BAI**	$	**99.3593**
00002337819	**EXTAVIA (0.3 MG)**	**NOV**	$	**99.3593**

IPRATROPIUM BROMIDE

"For use in patients with manual dexterity problems or visual limitations who are unable to prepare a dose of the drug using the multi-dose solution."

"For use in patients who are hypersensitive to preservatives contained in multi-dose solutions."

"Special authorization for both criteria may be granted for 24 months."

Information is required regarding the nature of the difficulties experienced by the patient in preparing a dose using the multi-dose preparation; or the nature of the patient's hypersensitivity to the preservatives contained in the multi-dose solution.

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

125 MCG / ML INHALATION UNIT DOSE SOLUTION				
00002231135	PMS-IPRATROPIUM	PMS	$	1.1505
250 MCG / ML INHALATION UNIT DOSE SOLUTION				
00002231244	**PMS-IPRATROPIUM (1ML)**	**PMS**	$	**0.6590**
00002231245	**PMS-IPRATROPIUM (2ML)**	**PMS**	$	**0.6590**
00002216221	**TEVA-IPRATROPIUM STERINEBS**	**TEV**	$	**0.6590**

ITRACONAZOLE

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of oral and/or esophageal candidiasis in immunocompromised patients who are intolerant to fluconazole, or who have failed fluconazole as evidenced by significant clinical deterioration due to the fungal infection during a course of therapy or no resolution after a full course of therapy."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

10 MG / ML ORAL SOLUTION				
00002231347	SPORANOX	JAI	$	0.8222

IVABRADINE HYDROCHLORIDE

"For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (less than or equal to 35%)
And
2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of optimal treatment with:
- a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)
- in combination with a beta-blocker and, if tolerated, a mineralocorticoid receptor antagonist (MRA)
And
3) Who are in sinus rhythm with a resting heart rate greater than or equal to 77 beats per minute (bpm) on average using either an ECG on at least three separate visits or by continuous monitoring
And
4) Who had at least one hospitalization due to HF in the last year

For coverage, this drug must be initiated by a Specialist in Cardiology or Internal Medicine, and the initial request must be completed by the Specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

All requests (including renewal requests) for ivabradine hydrochloride must be completed using the Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form (ABC 60050).

5 MG (BASE) ORAL TABLET				
00002459973	LANCORA	SEV	$	0.8506
7.5 MG (BASE) ORAL TABLET				
00002459981	LANCORA	SEV	$	1.5568

IVACAFTOR

Special authorization coverage may be provided for the treatment of cystic fibrosis (CF) in patients age 6 years and older who have a G551D mutation in the Cystic Fibrosis Transmembrane conductance Regulator (CFTR) gene.

For coverage, this drug must be prescribed by a prescriber affiliated with one of the following Alberta Cystic Fibrosis Clinics:
- Cystic Fibrosis Clinic, Adult: Kaye Edmonton Clinic
- Cystic Fibrosis Services - Adult Outpatient: Foothills Medical Centre
- Cystic Fibrosis Clinic, Pediatric: Stollery Children's Hospital
- Pediatric Cystic Fibrosis Clinic: Alberta Children's Hospital

Initial coverage may be approved for up to 150mg every 12 hours for 6 months. Patients will be limited to receiving a one-month supply per prescription at their pharmacy.

Renewal Criteria

The sweat chloride test will be repeated at the next routine review appointment after starting ivacaftor to determine whether sweat chloride levels are reducing and to check compliance with the drug regimen. The sweat chloride level will then be re-checked 6 months after starting treatment to determine whether the full reduction (as detailed below) has been achieved. Thereafter sweat chloride levels will be checked annually.

For continued coverage of up to 150mg every 12 hours beyond the initial 6-month authorization, the patient will be considered to have responded to treatment if either:
a) The patient's sweat chloride test falls below 60mmol/litre; OR
b) The patient's sweat chloride test falls by at least 30%

In cases where the baseline sweat chloride test is already below 60mmol/litre, the patient will be considered to have responded to treatment if either
c) The patient's sweat chloride test falls by at least 30%; OR
d) The patient demonstrates a sustained absolute improvement in FEV1 of at least 5%. In this instance FEV1 will be compared with the baseline pre-treatment level one month and three months after starting treatment.

Following this assessment, continued coverage of up to 150mg every 12 hours may be approved for a period of 12 months. Patients will be limited to receiving a one-month supply per prescription at their pharmacy.

If the expected reduction in sweat chloride does not occur, the patient's CF clinician will first explore any problems in following the recommended dosing schedule for ivacaftor. The patient's sweat chloride will then be retested around one week later and funding discontinued if the patient does not meet the above criteria.

All requests (including renewal requests) for ivacaftor must be completed using the Ivacaftor Special Authorization Request Form (ABC 60004).

150 MG ORAL TABLET

00002397412	KALYDECO	VER	$	420.0000

IXEKIZUMAB

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:
- 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 one 160 mg dose (two 80 mg injections) at weeks 0, followed by 80 mg (one injection) at Weeks 2, 4, 6, 8, 10, and 12.
- Patients will be limited to receiving a one-month supply of ixekizumab 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 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 80 mg every 4 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 ixekizumab for Plaque Psoriasis must be completed

IXEKIZUMAB

using the Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

Psoriatic Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:

- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.

'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

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

Initial coverage may be approved for one 160 mg dose (two 80 mg injections) at week 0, followed by 80 mg (one injection) at weeks 4, 8, 12, 16, 20 & 24.

- Patients will be limited to receiving a one-month supply of ixekizumab 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 24 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial 24 weeks to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be considered for 80 mg every 4 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to

IXEKIZUMAB

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 ixekizumab for Psoriatic Arthritis must be completed using the
Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

80 MG / SYR INJECTION SYRINGE

☒ 00002455110	TALTZ	LIL	$	1582.2369
☒ 00002455102	TALTZ AUTOINJECTOR	LIL	$	1582.2369

LACOSAMIDE

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

50 MG ORAL TABLET				
00002475332	**AURO-LACOSAMIDE**	**AUR**	$	**0.6313**
00002478196	**PHARMA-LACOSAMIDE**	**PMS**	$	**0.6313**
00002474670	**SANDOZ LACOSAMIDE**	**SDZ**	$	**0.6313**
00002472902	**TEVA-LACOSAMIDE**	**TEV**	$	**0.6313**
00002357615	VIMPAT	UCB	$	2.4093
100 MG ORAL TABLET				
00002475340	**AURO-LACOSAMIDE**	**AUR**	$	**0.8750**
00002478218	**PHARMA-LACOSAMIDE**	**PMS**	$	**0.8750**
00002474689	**SANDOZ LACOSAMIDE**	**SDZ**	$	**0.8750**
00002472910	**TEVA-LACOSAMIDE**	**TEV**	$	**0.8750**
00002357623	VIMPAT	UCB	$	3.4477
150 MG ORAL TABLET				
00002475359	**AURO-LACOSAMIDE**	**AUR**	$	**1.1763**
00002478226	**PHARMA-LACOSAMIDE**	**PMS**	$	**1.1763**
00002474697	**SANDOZ LACOSAMIDE**	**SDZ**	$	**1.1763**
00002472929	**TEVA-LACOSAMIDE**	**TEV**	$	**1.1763**
00002357631	VIMPAT	UCB	$	4.4862
200 MG ORAL TABLET				
00002475367	**AURO-LACOSAMIDE**	**AUR**	$	**1.4500**
00002478234	**PHARMA-LACOSAMIDE**	**PMS**	$	**1.4500**
00002474700	**SANDOZ LACOSAMIDE**	**SDZ**	$	**1.4500**
00002472937	**TEVA-LACOSAMIDE**	**TEV**	$	**1.4500**
00002357658	VIMPAT	UCB	$	5.5247

LANREOTIDE ACETATE

"For the treatment of acromegaly when prescribed by or in consultation with a Specialist in Internal Medicine.

Special authorization may be granted for 12 months."

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

60 MG / SYR INJECTION SYRINGE				
00002283395	SOMATULINE AUTOGEL (0.3 ML SYRINGE)	ISP	$	1195.8951
90 MG / SYR INJECTION SYRINGE				
00002283409	SOMATULINE AUTOGEL (0.3 ML SYRINGE)	ISP	$	1595.2501
120 MG / SYR INJECTION SYRINGE				
00002283417	SOMATULINE AUTOGEL (0.5 ML SYRINGE)	ISP	$	1996.7757

LEUPROLIDE ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications.

Special authorization may be granted for 6 months."

Information is required regarding the patient's diagnosis/indication for use of this medication.

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

3.75 MG / VIAL INJECTION				
00000884502	LUPRON DEPOT	ABV	$	357.6000
5 MG / ML INJECTION				
00000727695	LUPRON	ABV	$	67.6464
7.5 MG / VIAL INJECTION				
00000836273	LUPRON DEPOT	ABV	$	387.9700
11.25 MG / VIAL INJECTION				
00002239834	LUPRON DEPOT	ABV	$	1065.4400
22.5 MG / VIAL INJECTION				
00002230248	LUPRON DEPOT	ABV	$	1071.0000

LEVOCARNITINE

"For the treatment of primary carnitine deficiency. Information is required regarding the total plasma carnitine levels."

"For the treatment of patients with an inborn error of metabolism that results in secondary carnitine deficiency. Information is required regarding the patient's diagnosis."

"Special authorization may be granted for 6 months."

In order to comply with the first criteria: Information is required regarding pre-treatment total plasma carnitine levels.

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

330 MG ORAL TABLET				
00002144328	CARNITOR	SGM	$	1.8858
100 MG / ML ORAL SOLUTION				
00002144336	CARNITOR	SGM	$	0.5711
200 MG / ML INJECTION				
00002144344	CARNITOR	SGM	$	13.2000

LEVOFLOXACIN

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

FIRST-LINE DRUG PRODUCT(S): TOBRAMYCIN INHALATION SOLUTION

"For the treatment of chronic pulmonary Pseudomonas aeruginosa infections when used as cyclic treatment (28-day cycles) in patients 18 years of age and older with moderate to severe cystic fibrosis (CF) and deteriorating clinical condition despite treatment with inhaled tobramycin."

"Coverage will not be considered when inhaled levofloxacin and other inhaled antibiotic(s) (e.g. tobramycin, aztreonam) are intended for use in combination, either concurrently or for antibiotic cycling during off-treatment periods."

"Special authorization may be granted for 6 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

100 MG / ML INHALATION SOLUTION				
00002442302	QUINSAIR	RAP	$	26.8703

LINAGLIPTIN

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for linagliptin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

5 MG ORAL TABLET

00002370921	TRAJENTA	BOE	$	2.6571

LINAGLIPTIN/ METFORMIN HCL

SPECIAL AUTHORIZATION

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for linagliptin+metformin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

2.5 MG * 500 MG ORAL TABLET				
00002403250	JENTADUETO	BOE	$	1.3897
2.5 MG * 850 MG ORAL TABLET				
00002403269	JENTADUETO	BOE	$	1.3897
2.5 MG * 1,000 MG ORAL TABLET				
00002403277	JENTADUETO	BOE	$	1.3897

LINEZOLID

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For the treatment of:

1) Vancomycin-resistant enterococcus infections or

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

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

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

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

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

600 MG ORAL TABLET

00002426552	**APO-LINEZOLID**	**APX**	$	**37.0500**
00002422689	**SANDOZ LINEZOLID**	**SDZ**	$	**37.0500**
00002243684	ZYVOXAM	PFI	$	75.7024

MEGESTROL ACETATE

"For the treatment of non-cancer indications (e.g. cachexia in HIV/AIDS patients and cancer patients).

Special authorization may be granted for 6 months."

(Please note: The above megestrol acetate products are benefits not requiring special authorization for individuals approved by Alberta Health for Palliative Coverage. Refer to the Palliative Coverage Drug Benefit Supplement for additional information on this coverage.)

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

40 MG ORAL TABLET

00002195917	MEGESTROL	AAP	$	1.3340

"For the treatment of non-cancer indications (e.g. cachexia in HIV/AIDS patients and cancer patients).

Special authorization may be granted for 6 months."

(Please note: The above megestrol acetate products are benefits not requiring special authorization for individuals approved by Alberta Health for Palliative Coverage. Refer to the Palliative Coverage Drug Benefit Supplement for additional information on this coverage.)

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

160 MG ORAL TABLET

00002195925	MEGESTROL	AAP	$	5.8151

MEPOLIZUMAB

"Special authorization coverage may be provided for add-on maintenance treatment of adult patients with severe eosinophilic asthma if the following clinical criteria and conditions are met:
Patient is inadequately controlled with high-dose inhaled corticosteroids (ICS) and one or more additional asthma controller(s) (e.g., a long-acting beta-agonist [LABA]).
AND
Patient has a blood eosinophil count of greater than or equal to 150 cells/mcL at initiation of treatment with mepolizumab or greater than or equal to 300 cells/mcL in the 12 months prior to treatment initiation.
AND
One of the following are met:
1) Patient has experienced two or more clinically significant asthma exacerbations* in the 12 months prior to treatment initiation and shows reversibility (of at least 12% and 200 mL in FEV1) on pulmonary function tests (i.e., spirometry).
OR
2) Patient is treated with daily oral corticosteroids (OCS).
For coverage, the drug must be initiated and monitored by a respirologist or clinical immunologist or allergist.

Initial coverage may be approved for 12 months of 100 mg administered every 4 weeks.

-Patients will be limited to receiving a one-month supply of mepolizumab 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.
-Coverage cannot be provided for mepolizumab when this medication is intended for use in combination with other biologics for the treatment of asthma.

If the following criteria are met, special authorization may be approved for 100 mg administered every 4 weeks for a further 12-month period. Continued coverage may be considered if the following criteria are met at the end of each additional 12-month period:
1) A reduction in the number of clinically significant exacerbations* compared to the 12 months prior to initiation of treatment with mepolizumab.
OR
2) A decrease in the maintenance OCS dose of at least 25% from pre-treatment baseline.
* Clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized."

All requests (including renewal requests) for mepolizumab must be completed using the Mepolizumab Special Authorization Request Form (ABC 60061).

144 MG / VIAL INJECTION

00002449781	NUCALA	GSK	$ 1938.4600

MEROPENEM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

"1) For second-line therapy of infections due to gram-negative organisms producing inducible beta-lactamases or extended spectrum beta-lactamases where there is resistance to first-line agents or

2) For therapy for infections involving multi-resistant Pseudomonas aeruginosa, where there is documented susceptibility to meropenem or

3) For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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

500 MG / VIAL INJECTION				
00002378787	MEROPENEM	SDZ	$	9.2225
1 G / VIAL INJECTION				
00002378795	**MEROPENEM**	**SDZ**	$	**18.4450**
00002436507	**MEROPENEM FOR INJECTION USP**	**STM**	$	**18.4450**

METHYLPREDNISOLONE ACETATE/ NEOMYCIN SULFATE/ ALUMINUM CHLORHYDROXIDE COMPLEX/ SULFUR

"For the treatment of severe acne as defined by scarring acne."

"For the treatment of acne rosacea and seborrheic dermatitis."

"Special authorization may be granted for 6 months."

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

2.5 MG / ML * 2.5 MG / ML * 100 MG / ML * 50 MG / ML TOPICAL LOTION				
00000195057	NEO-MEDROL ACNE	PFI	$	0.2906

MIRABEGRON

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

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA.

Special authorization may be granted for 24 months.

Coverage cannot be provided for mirabegron when this medication is intended for use in combination with other overactive bladder agents."

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

25 MG ORAL EXTENDED-RELEASE TABLET				
00002402874	MYRBETRIQ	ASP	$	1.4600
50 MG ORAL EXTENDED-RELEASE TABLET				
00002402882	MYRBETRIQ	ASP	$	1.4600

MODAFINIL

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

Special authorization may be granted for 6 months."

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

100 MG ORAL TABLET				
00002285398	**APO-MODAFINIL**	**APX**	$	**0.3427**
00002430487	**AURO-MODAFINIL**	**AUR**	$	**0.3427**
00002432560	**MAR-MODAFINIL**	**MAR**	$	**0.3427**
00002420260	**TEVA-MODAFINIL**	**TEV**	$	**0.3427**
00002239665	ALERTEC	TMP	$	1.4057

MONTELUKAST SODIUM

(Refer to 48:10.24 of the Alberta Drug Benefit List for coverage of patients 6 to 18 years of age inclusive).

"For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:
a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, or
b) cannot operate inhaler devices."

"For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists."

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

In order to comply with the first criteria, information should indicate either
a) current use of inhaled steroids and contraindications or poor response to long-acting beta 2 agonists (e.g. salmeterol or formoterol) or,
b) the nature of the patient's difficulties with using inhaler devices.

In order to comply with the second criteria, information should include the nature of the patient's response to long-acting beta 2 agonists (e.g. salmeterol or formoterol).

All requests (including renewal requests) for montelukast must be completed using the Montelukast/Zafirlukast Special Authorization Request Form (ABC 60039).

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

10 MG (BASE) ORAL TABLET

00002374609	**APO-MONTELUKAST**	**APX**	$	**0.4231**
00002401274	**AURO-MONTELUKAST**	**AUR**	$	**0.4231**
00002391422	**JAMP-MONTELUKAST**	**JPC**	$	**0.4231**
00002399997	**MAR-MONTELUKAST**	**MAR**	$	**0.4231**
00002408643	**MINT-MONTELUKAST**	**MPI**	$	**0.4231**
00002379333	**MONTELUKAST**	**SNS**	$	**0.4231**
00002382474	**MONTELUKAST**	**SIV**	$	**0.4231**
00002379236	**MONTELUKAST SODIUM**	**AHI**	$	**0.4231**
00002373947	**PMS-MONTELUKAST FC**	**PMS**	$	**0.4231**
00002389517	**RAN-MONTELUKAST**	**RAN**	$	**0.4231**
00002328593	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.4231**
00002355523	**TEVA-MONTELUKAST**	**TEV**	$	**0.4231**
00002238217	SINGULAIR	MFC	$	2.4823

5 MG (BASE) ORAL CHEWABLE TABLET

00002377616	**APO-MONTELUKAST**	**APX**	$	**0.3082**
00002442361	**JAMP-MONTELUKAST**	**JPC**	$	**0.3082**
00002399873	**MAR-MONTELUKAST**	**MAR**	$	**0.3082**
00002408635	**MINT-MONTELUKAST**	**MPI**	$	**0.3082**
00002379325	**MONTELUKAST**	**SNS**	$	**0.3082**
00002382466	**MONTELUKAST**	**SIV**	$	**0.3082**
00002354985	**PMS-MONTELUKAST**	**PMS**	$	**0.3082**
00002330393	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.3082**
00002355515	**TEVA-MONTELUKAST**	**TEV**	$	**0.3082**
00002238216	SINGULAIR	MFC	$	1.6902

NARATRIPTAN HCL

(Refer to 28:32.28 of the Alberta Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using naratriptan hydrochloride prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

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

1 MG (BASE) ORAL TABLET				
00002314290	**TEVA-NARATRIPTAN**	**TEV**	$	**11.9041**
00002237820	AMERGE	GSK	$	14.7667
2.5 MG (BASE) ORAL TABLET				
00002322323	**SANDOZ NARATRIPTAN**	**SDZ**	$	**6.1436**
00002314304	**TEVA-NARATRIPTAN**	**TEV**	$	**6.1436**
00002237821	AMERGE	GSK	$	15.5646

NATALIZUMAB

Relapsing Remitting Multiple Sclerosis (RRMS):

Special authorization coverage may be provided for the treatment of relapsing remitting multiple sclerosis (RRMS) to reduce the frequency of clinical relapses, to decrease the number and volume of active brain lesions identified on magnetic resonance imaging (MRI) scans and to delay the progression of physical disability, in adult patients (18 years of age or older) who are refractory or intolerant to at least ONE of the following:
- interferon beta
- glatiramer acetate
- dimethyl fumarate
- teriflunomide
- peginterferon beta.

Definition of 'intolerant'

Demonstrating serious adverse effects or contraindications to treatments as defined in the product monograph, or a persisting adverse event that is unresponsive to recommended management techniques and which is incompatible with further use of that class of MS disease modifying therapy (DMT).

Definition of 'refractory'

-Development of neutralizing antibodies to interferon beta.

-When the above MS DMTs are taken at the recommended doses for a full and adequate course of treatment, within a consecutive 12-month period while the patient was on the MS DMT, the patient has:

1) Been adherent to the MS DMT (greater than 80% of approved doses have been administered);

2) Experienced at least two relapses* of MS confirmed by the presence of neurologic deficits on examination.
i. The first qualifying clinical relapse must have begun at least one month after treatment initiation.
ii. Both qualifying relapses must be classified with a relapse severity of moderate, severe or very severe**.

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

**Relapse severity: with moderate relapses modification or more time is required to carry out activities of daily living; with severe relapses there is inability to carry out some activities of daily living; with very severe relapses activities of daily living must be completed by others.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

NATALIZUMAB

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS DMT. In most cases this will be satisfied by the 'refractory' to treatment criterion but if a patient failed an MS DMT more than one year earlier, ongoing active disease must be confirmed.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage will not be approved when any MS DMT or other immunosuppressive therapy is to be used in combination with natalizumab.

Coverage of natalizumab will not be approved if the patient was deemed to be refractory to natalizumab in the past, i.e., has not met the 'responder' criteria below in 'Continued Coverage'.

Following assessment of the request, coverage may be approved for up to 13 doses of 300 mg (i.e., one dose administered every 4 weeks for a period up to 12 months). Patients will be limited to receiving one dose (4 weeks supply) of natalizumab per prescription at their pharmacy.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more;

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

4) At the first renewal there must be evidence that neutralizing antibodies to natalizumab are absent.

5) The registered MS Neurologist must confirm in writing that the patient is a 'responder' who has experienced no more than one inflammatory event in the last year (defined as either a clinical relapse or gadolinium-enhancing lesion). In instances where a patient has had four or more clinical relapses in the year prior to starting treatment, there must be at least a 50% reduction in relapse rate over the entire treatment period.

Following assessment of the request, continued coverage may be approved for maintenance therapy of 300 mg every 4 weeks for a period up to 12 months. Patients will be limited to receiving one dose of natalizumab per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period.

All requests (including renewal requests) for natalizumab must be completed using the Alemtuzumab/Fingolimod/Natalizumab For Multiple Sclerosis Special Authorization Request Form (ABC 60000).

NATALIZUMAB

20 MG / ML INJECTION

00002286386	TYSABRI	BIO	$	176.9525

NINTEDANIB ESILATE

"Initial approval criteria:

Adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF):
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded.
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.
- Patient is under the care of a physician with experience in IPF.

Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests)

Initial renewal criteria (at 6 months):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 6 months

Second and subsequent renewals (at 12 months and thereafter):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

Patients who have experienced intolerance or failure to pirfenidone or nintedanib will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria."

All requests for nintedanib must be completed using the Nintedanib/Pirfenidone Special Authorization Request Form (ABC 60051).

100 MG (BASE) ORAL CAPSULE

00002443066	OFEV	BOE	$	28.3216

150 MG (BASE) ORAL CAPSULE

00002443074	OFEV	BOE	$	56.6431

NITISINONE

"For the treatment of adult and pediatric patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine, when prescribed by a physician with experience in the diagnosis and management of HT-1.

Special authorization may be granted for 12 months."

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

2 MG ORAL TABLET				
00002458616	NITISINONE	CYC	$	12.9500
5 MG ORAL TABLET				
00002458624	NITISINONE	CYC	$	25.0600
10 MG ORAL TABLET				
00002458632	NITISINONE	CYC	$	47.4000
2 MG ORAL CAPSULE				
☒ 00002457717	MDK-NITISINONE	MEN	$	12.9500
☒ 00002459698	ORFADIN	BVM	$	12.9500
5 MG ORAL CAPSULE				
☒ 00002457725	MDK-NITISINONE	MEN	$	25.0600
☒ 00002459701	ORFADIN	BVM	$	25.0600
10 MG ORAL CAPSULE				
☒ 00002457733	MDK-NITISINONE	MEN	$	47.4000
☒ 00002459728	ORFADIN	BVM	$	47.4000
20 MG ORAL CAPSULE				
00002459736	ORFADIN	BVM	$	128.1000

NUSINERSEN SODIUM

"For patients diagnosed with 5q Spinal Muscular Atrophy (SMA) Type 1 under the care of a specialist with experience in the diagnosis and management of SMA, if the following clinical criteria are met:

- Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote, AND
- Genetic documentation of two copies of the survival motor neuron 2 (SMN2) gene, AND
- Disease duration less than 26 weeks with onset of clinical signs and symptoms consistent with SMA after the first week after birth and on or before 7 months of age, AND
- Patient is not currently requiring permanent invasive ventilation.*

Initial coverage may be approved for three 12 mg doses at Day 0, Day 14 and Day 28, followed by one 12 mg dose at Day 63.

Patients will be limited to receiving one dose of nusinersen per prescription at their pharmacy.

For continued coverage, the patient must meet the following criteria:
- there is demonstrated maintenance of motor milestone function (as assessed using the Hammersmith Infant Neurological Examination [HINE] Section 2) compared to pre-treatment baseline; OR
- there is demonstrated improvement in motor milestone function (as assessed using the HINE Section 2) compared to pre-treatment baseline; AND
- patient does not require permanent invasive ventilation*.

Continued coverage may be considered for one 12 mg maintenance dose at a time, to be administered at 4-month intervals.

Each maintenance dose cannot be considered prior to 4 months elapsing from the date of the previous dose.

Treatment should be discontinued if, prior to the fifth dose or every subsequent dose of nusinersen, the above renewal criteria are not met.

*Permanent invasive ventilation is defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

All requests (including renewal requests) for nusinersen must be completed using the Nusinersen Special Authorization Request Form (ABC 60064)."

2.4 MG / ML (BASE)	**INJECTION**		
00002465663	SPINRAZA	BIO	$ 23600.0000

OBETICHOLIC ACID

"For the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA, where the following criteria are met:

I. A confirmed diagnosis of PBC, defined as:
- Positive antimitochondrial antibodies (AMA); or
- Liver biopsy results consistent with PBC.

AND

II.a. The patient has received ursodeoxycholic acid (UDCA) for a minimum of 12 months and has experienced an inadequate response to UDCA and can benefit from the addition of obeticholic acid. An inadequate response is defined as:
- alkaline phosphatase (ALP) greater than or equal to 1.67 x upper limit of normal (ULN) and/or
- bilirubin > ULN and < 2 x ULN.

OR

II.b. The patient has experienced documented and unmanageable intolerance to UDCA and can benefit from switching therapy to obeticholic acid.

AND

III. Initiated by a gastroenterologist or hepatologist (or an internal medicine specialist with an interest in gastroenterology / hepatology on a case-by-case basis, in geographic areas where access to these specialities is not available).

Initial coverage may be approved for a period of 12 months.

Ongoing coverage may be considered only if the patient continues to benefit from treatment with obeticholic acid as evidenced by:

- A reduction in the ALP level to less than 1.67 x ULN; or
- A 15% reduction in the ALP level compared with values before beginning treatment with obeticholic acid.

Continued coverage may be approved for up to 12 months."

All requests (including renewal requests) for obeticholic acid must be completed using the Obeticholic Acid Special Authorization Request Form (ABC 60065).

5 MG ORAL TABLET				
00002463121	OCALIVA	ICP	$	98.6301
10 MG ORAL TABLET				
00002463148	OCALIVA	ICP	$	98.6301

OCRELIZUMAB

Relapsing Remitting Multiple Sclerosis (RRMS)

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory adult patients (18 years of age or older) with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist, please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Initial coverage may be approved for an initial dose of ocrelizumab 300 mg given by intravenous (IV) infusion, followed 2 weeks later by a second 300 mg dose. A maintenance dose of ocrelizumab 600 mg at 6 months will also be provided in the initial coverage period. Patients will be limited to receiving one dose of ocrelizumab per prescription at their pharmacy.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.
Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for one dose of ocrelizumab 600 mg every 6 months for up to 12 months. Patients may receive one dose of ocrelizumab 600 mg per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

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In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for ocrelizumab for RRMS must be completed using the Dimethyl Fumarate/Glatiramer Acetate /Interferon Beta-1b/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1a for SPMS or RRMS Special Authorization Request Form (ABC 60001).

Primary Progressive Multiple Sclerosis (PPMS)

"Special authorization coverage may be provided for the management of adult patients with early primary progressive multiple sclerosis (PPMS), as defined by disease duration and level of disability in conjunction with imaging features characteristic of inflammatory activity.

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist, please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of PPMS (based on McDonald criteria 2017);

2) The patient must have an Expanded Disability Status Scale (EDSS) score between 3.0 and 6.5;

3) The patient must have a score of at least 2.0 on the Functional Systems scale for the pyramidal system due to lower extremity findings;

4) There are documented imaging features characteristic of inflammatory activity;

5) Disease duration must be less than 15 years for those with an EDSS greater than 5.0, or less than 10 years for those with an EDSS of 5.0 or less.

Initial coverage may be approved for an initial dose of ocrelizumab 300 mg given by intravenous (IV) infusion, followed 2 weeks later by a second 300 mg dose. A maintenance dose of ocrelizumab 600 mg at 6 months will also be provided in the initial coverage period. Patients will be limited to receiving one dose of ocrelizumab per prescription at their pharmacy.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must be assessed between 6 months and 12 months, and every 12 months thereafter, and the request must meet the following criteria:

1) The registered MS Neurologist must confirm a diagnosis of PPMS;

2) A current updated EDSS score must be provided and the patient must not have an EDSS score of 7.0 or above.

Continued coverage may be approved for one dose of ocrelizumab 600 mg every 6 months for up to 12 months. Patients may receive one dose of ocrelizumab 600 mg per prescription at their pharmacy."

All requests (including renewal requests) for ocrelizumab for PPMS must be completed using

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the Ocrelizumab for PPMS Special Authorization Request Form (ABC 60067).

30 MG / ML INJECTION				
00002467224	OCREVUS	HLR	$	815.0000

OCTREOTIDE ACETATE

"For control of symptoms in patients with metastatic carcinoid and vasoactive intestinal peptide-secreting tumors (VIPomas) when prescribed by or in consultation with a Specialist in Internal Medicine, Palliative Care or General Surgery."

"For the treatment of acromegaly when prescribed by or in consultation with a Specialist in Internal Medicine."

"For the treatment of intractable diarrhea which has not responded to less costly therapy [e.g. associated with (secondary to) AIDS, intra-abdominal fistulas, short bowel syndrome]. Treatment for these indications must be prescribed by or in consultation with a Specialist in, Internal Medicine, Palliative Care, or General Surgery."

"Special authorization may be granted for 12 months."

In order to comply with the third criterion, information is required regarding previous medications utilized and the patient's response to therapy.

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

50 MCG / ML (BASE) INJECTION				
00002248639	**OCTREOTIDE ACETATE OMEGA**	**OMG**	$	**1.7465**
00000839191	SANDOSTATIN	NOV	$	5.1460
100 MCG / ML (BASE) INJECTION				
00002248640	**OCTREOTIDE ACETATE OMEGA**	**OMG**	$	**3.2970**
00000839205	SANDOSTATIN	NOV	$	9.7135
200 MCG / ML (BASE) INJECTION				
00002248642	**OCTREOTIDE ACETATE OMEGA**	**OMG**	$	**6.3420**
00002049392	SANDOSTATIN	NOV	$	18.6861
500 MCG / ML (BASE) INJECTION				
00002248641	OCTREOTIDE ACETATE OMEGA	OMG	$	15.4945
10 MG / VIAL (BASE) INJECTION				
00002239323	SANDOSTATIN LAR	NOV	$	1315.7400
20 MG / VIAL (BASE) INJECTION				
00002239324	SANDOSTATIN LAR	NOV	$	1699.8900
30 MG / VIAL (BASE) INJECTION				
00002239325	SANDOSTATIN LAR	NOV	$	2180.9400

OMALIZUMAB

Asthma

"Special authorization coverage may be provided for adults and adolescents (12 years of age and above) with severe persistent asthma who are identified as having severe disease despite optimized standard therapy. Optimized standard therapy defined by a full trial of, and documented compliance with:

- high dose inhaled corticosteroid (budesonide 1600 micrograms per day or fluticasone propionate 1000 micrograms per day or equivalent) for at least twelve (12) months; AND,
- long-acting beta-2 agonist therapy (at least salmeterol 50 micrograms daily or 24 micrograms of formoterol fumarate daily) for at least twelve (12) months; AND,
- Therapeutic trial with systemic corticosteroids (at least 10mg per day prednisolone (or equivalent)) for at least 4 weeks in the previous twelve (12) months, unless contraindicated or not tolerated.

For coverage, the drug must be initiated and monitored by a respirologist or clinical immunologist or allergist and meet the following clinical criteria (Initial Coverage or Continued Coverage, as appropriate). Patients will be limited to receiving a one (1) month supply of omalizumab per prescription at their pharmacy.

INITIAL COVERAGE:
Special authorization requests must meet all of the following criteria for initial approval:

1) Confirmation of severe persistent asthma through recent clinical and physiologic review with exclusion of other obstructive airways processes contributing to symptoms of severe asthma (i.e. psychogenic dyspnea; cardiac dyspnea);

2) Must be a non-smoker;

3) Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing;

4) Baseline IgE level greater than/equal to 30 IU/mL and less than/equal to 700 IU/mL;

5) A weight between 20kg and 150kg;

6) An Asthma Control Questionnaire (ACQ-5) of at least 1.25, on at least two occasions over the past 6 months in a stable state;

7) Must provide documentation:
- Spirometry measurement of FEV1;
- Asthma Quality of Life Questionnaire (AQLQ - Juniper) score;
- Number of exacerbations of asthma within the previous twelve (12) month period that resulted in:
- an emergency room visit or hospitalization;
- physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids;
- chronic use (greater than 50% of the year) of oral corticosteroids;

8) One (1) or more severe exacerbations of asthma requiring a hospital admission or Emergency Room visit within the previous year while on systemic corticosteroids; OR
- One (1) or more severe exacerbations of asthma requiring a hospital admission or Emergency Room visit requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least three (3) days, or parenteral corticosteroids); OR
- Three (3) or more severe exacerbations of asthma within the previous year which required a physician visit and resulted in courses (or chronic use greater than 50% of the year), or increased dose of systemic corticosteroids.

Initial coverage may be approved for twenty-eight (28) weeks of up to 375 mg administered every 2 weeks based on the recommended dose and dosage adjustment outlined in the Health

OMALIZUMAB

Canada approved Product Monograph.

CONTINUED MAINTENANCE TREATMENT:
A patient must be assessed for response to initial coverage of omalizumab with a minimum of twenty-four (24) weeks of therapy with omalizumab, and this assessment must be submitted to Alberta Blue Cross no later than four (4) weeks from the date of assessment.

The assessment must be done by a respirologist or clinical immunologist or allergist or such other clinicians as the Minister may designate. If the following criteria are met, special authorization may be granted for a further twelve (12) month period. Continued coverage may be considered if the following criteria are met at the end of each additional twelve (12) month period:

1) Demonstrated that the patient has an Improvement in FEV1 greater than 12% (and for adults a minimum greater than 200 mL) from initiation of therapy; OR
Unchanged FEV1 with a clinically meaningful Improvement in Asthma Quality of Life Questionnaire score from baseline (greater than/equal to 0.5 mean from baseline); AND
- a decrease in the ACQ-5 of at least 0.5; OR
- a ACQ-5 score of less than/equal to 1.

2) Patients must demonstrate at least a 25% reduction in the number of exacerbations, which required oral corticosteroids from the twelve (12) months prior to initiation of omalizumab that required systemic corticosteroids; OR
For patients that were on chronic (greater than 50% of the year) courses of oral corticosteroids in the twelve (12) months prior to initiation of omalizumab, tapering of oral corticosteroid use by at least 25% from baseline.

3) A reduction in the number of exacerbations that have led to a hospital admission or emergency room visits, compared to the twelve (12) months prior to the commencement of omalizumab."

All requests (including renewal requests) for omalizumab for Asthma must be completed using the Omalizumab for Asthma Special Authorization Request Form (ABC 60020).

Chronic Idiopathic Urticaria

"For the treatment of adults and adolescents (12 years of age and above) with moderate to severe chronic idiopathic urticaria (CIU), defined as having a baseline Urticaria Activity Score over 7 days (UAS7) of greater than or equal to 16, who remain symptomatic (presence of hives and/or associated itching) despite optimum management with available oral therapies. Oral therapies should include a therapeutic trial with H1 antihistamines, unless contraindicated or not tolerated.

For coverage, the drug must be initiated and monitored by a Specialist in Dermatology, Clinical Immunology or Allergy.

Coverage may be approved for a period of 24 weeks at a maximum dose of 300 mg every 4 weeks.
Patients will be limited to receiving a one-month supply of omalizumab per prescription at their pharmacy.
Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Continued coverage of a further 24-week treatment period may be considered if the patient has experienced:
- complete symptom control (i.e., UAS7 of 0) for less than 12 consecutive weeks; OR
- partial symptom control, with a reduction in baseline UAS7 of greater than or equal to 9.5 points.

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Treatment cessation should be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24-week treatment period.

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation should be considered should CIU symptoms reappear."

All requests (including renewal requests) for omalizumab for Chronic Idiopathic Urticaria must be completed using the Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form (ABC 60056).

150 MG / VIAL	**INJECTION**			
00002260565	XOLAIR	NOV	$	628.8400

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

50 MG / SYR (BASE)	INJECTION SYRINGE			
00002354217	INVEGA SUSTENNA (0.5 ML SYR)	JAI	$	311.4300

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

75 MG / SYR (BASE)	INJECTION SYRINGE			
00002354225	INVEGA SUSTENNA (0.75 ML SYR)	JAI	$	467.1800

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

100 MG / SYR (BASE)	INJECTION SYRINGE			
00002354233	INVEGA SUSTENNA (1 ML SYR)	JAI	$	467.1800

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be
completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

150 MG / SYR (BASE)	INJECTION SYRINGE			
00002354241	INVEGA SUSTENNA (1.5 ML SYR)	JAI	$	622.8900

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

175 MG / SYR (BASE)	INJECTION	SYRINGE		
00002455943	INVEGA TRINZA (0.875 ML SYR)	JAI	$	934.2900

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

263 MG / SYR (BASE)	INJECTION	SYRINGE		
00002455986	INVEGA TRINZA (1.315 ML SYR)	JAI	$	1401.5400

PALIPERIDONE PALMITATE

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

350 MG / SYR (BASE)	INJECTION	SYRINGE		
00002455994	INVEGA TRINZA (1.75 ML SYR)	JAI	$	1401.5400

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR

- Is refractory to trials of at least two other antipsychotic therapies.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months."

All requests (including renewal requests) for paliperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

525 MG / SYR (BASE)	INJECTION	SYRINGE		
00002456001	INVEGA TRINZA (2.625 ML SYR)	JAI	$	1868.6700

PEGFILGRASTIM

"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				
00002249790	NEULASTA (0.6 ML SYRINGE)	AMG	$	2504.9700

PEGINTERFERON ALFA-2A

The Special Authorization Criteria outlined below remain part of the Alberta Drug Benefit List to enable patients who initiated therapy with Pegasys for Chronic Hepatitis C prior to December 31, 2017 to complete their course of treatment. No new patients will be approved to initiate Pegasys therapy for the treatment of Chronic Hepatitis C after January 2, 2018.

(Refer to 08:18.20 of the Alberta Drug Benefit List for coverage of peginterferon alfa-2a for the treatment of Chronic Hepatitis B.)

Chronic Hepatitis C

"For the treatment of chronic hepatitis C in adult patients with evidence of active liver disease, who qualify for treatment with Pegasys RBV (peginterferon alfa-2a/ribavirin) but who are intolerant to ribavirin.

All Chronic Hepatitis C Patients Prior to Initiation of Therapy:

- To determine treatment duration and prognosis, HCV genotype testing is required for all patients.
- At least three weeks before anticipated start date of therapy, please submit to Alberta Blue Cross a Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form (ABC 60045), along with appropriate lab results. In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

All Chronic Hepatitis C Patients (with the Exception of Advanced Fibrosis or Cirrhosis Patients):

Prior to initiation of therapy:

- Patients must have a baseline serum sample stored for future viral load testing in the event that the week 12 HCV RNA test is positive.

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients may receive an initial approval for 14 weeks of coverage.

At 12 weeks of treatment:

- HCV RNA testing is required for all patients at the 12th week of treatment.
- If the HCV RNA test is positive, viral load testing is required on the previously stored baseline serum sample, and the 12 week serum sample, for evaluation of continued coverage.

Renewal approval period (for patients meeting criteria):

- Patients who respond to therapy, as measured by a reduction of viral load by at least 2 logs (100 fold) or HCV RNA not detected at 12 weeks, may be approved for an additional 34 weeks of coverage (total 48 weeks).

All Chronic Hepatitis C Patients with Advanced Fibrosis or Cirrhosis:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients with advanced fibrosis or cirrhosis may receive approval for 48 weeks of coverage.

Consideration for therapy in chronic hepatitis C patients who have previously received therapy:

- Consideration for therapy in patients who have previously received therapy may be given for patients who meet at least one of the following criteria:

PEGINTERFERON ALFA-2A

- Advanced fibrosis or cirrhosis.
- Patients who have relapsed following non-pegylated interferon/ribavarin combination therapy."

In order to comply with this criterion: Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of a liver biopsy, or the results of transient elastography. All requests for peginterferon alfa-2a for Chronic Hepatitis C must be completed using the Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form (ABC 60045). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

180 MCG / SYR INJECTION SYRINGE				
00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	$	419.7000

PEGINTERFERON BETA-1A

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage
For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage
1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of peg-interferon beta-1a per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage
For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of peg-interferon beta-1a per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months
In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the

PEGINTERFERON BETA-1A

Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

125 MCG / SYR INJECTION SYRINGE				
00002444399	PLEGRIDY	BIO	$	856.2600

PEGINTERFERON BETA-1A/ PEGINTERFERON BETA-1A

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of peg-interferon beta-1a per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of peg-interferon beta-1a per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months
In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or

PEGINTERFERON BETA-1A/ PEGINTERFERON BETA-1A

2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

63 MCG / SYR * 94 MCG / SYR INJECTION SYRINGE				
00002444402	PLEGRIDY	BIO	$	856.2600

PERAMPANEL

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

2 MG ORAL TABLET				
00002404516	FYCOMPA	EIS	$	9.4500
4 MG ORAL TABLET				
00002404524	FYCOMPA	EIS	$	9.4500
6 MG ORAL TABLET				
00002404532	FYCOMPA	EIS	$	9.4500
8 MG ORAL TABLET				
00002404540	FYCOMPA	EIS	$	9.4500
10 MG ORAL TABLET				
00002404559	FYCOMPA	EIS	$	9.4500
12 MG ORAL TABLET				
00002404567	FYCOMPA	EIS	$	9.4500

PIBRENTASVIR/ GLECAPREVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C infection who
meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist
(except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype (2) 1, 2, 3, 4, 5, 6;
AND
Ill) Laboratory confirmed quantitative HCV RNA value within the last 6 months:
AND
IV) Fibrosis (3) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive, without cirrhosis: 8 weeks
- Treatment-naive, with compensated cirrhosis (4): 12 weeks
- Treatment-experienced (1) genotype 1, 2, 4, 5, or 6, without cirrhosis: 8 weeks
- Treatment-experienced (1) genotype 1, 2, 4, 5, or 6, with compensated cirrhosis (4): 12 weeks
- NS3/4A protease inhibitor treatment-experienced (5) genotype 1, without cirrhosis or with compensated
cirrhosis (4): 12 weeks
- NS5A inhibitor treatment-experienced (6) genotype 1, without cirrhosis or with compensated cirrhosis
(4): 16 weeks
- Treatment-experienced (1) genotype 3, without cirrhosis or with compensated cirrhosis (4): 16 weeks

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent

Notes:
1. Treatment experienced is defined as those who have previously been treated with a regimen containing interferon, peginterferon (P), ribavirin (R), and/or sofosbuvir (e.g. PR, SOF + PR, SOF + R),
but have no prior treatment experience with an NS3/4A protease inhibitor or NS5A inhibitor.
2. HCV genotype testing is optional for treatment naive patients.
3. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography
(FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4
score) either alone or in combination.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. NS3/4A protease inhibitor treatment-experienced is defined as those who have previously been treated
with a regimen containing a non-structural protein 3/4A (NS3/4A) protease inhibitor, but without an NS5A
inhibitor.
6. NS5A inhibitor treatment-experienced is defined as those who have previously been treated with a
regimen containing an NS5A inhibitor, but without an NS3/4A protease inhibitor, such as daclatasavir +
sofosbuvir, ledipasvir/sofosbuvir, or sofosbuvir/velpatasvir.
7. Health care professionals are advised to refer to the product monograph and prescribing guidelines for
appropriate use of the drug product, including use in special populations."

All requests for glecaprevir/pibrentasvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

PIBRENTASVIR/ GLECAPREVIR

40 MG * 100 MG ORAL TABLET

00002467550	MAVIRET	ABV	$	238.0952

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				
00002303442	ACCEL-PIOGLITAZONE	ACP	$	0.3170
30 MG (BASE) ORAL TABLET				
00002303450	ACCEL-PIOGLITAZONE	ACP	$	0.4550
45 MG (BASE) ORAL TABLET				
00002303469	ACCEL-PIOGLITAZONE	ACP	$	0.6900

PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

"For the treatment of:

1) Second-line therapy of intra-abdominal sepsis where there are serious adverse events due to first-line therapy or documented failure of first-line therapy (e.g. ampicillin + gentamicin + metronidazole), as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy or

2) Second-line therapy of severe polymicrobial skin and skin structure infections (e.g. limb threatening diabetic foot) or

3) Therapy of severe ventilator-associated pneumonia where Pseudomonas and Staphylococcus aureus coverage is needed, or

4) Therapy for infections involving multi-resistant Pseudomonas aeruginosa from pulmonary secretions in cystic fibrosis patients, lung transplant patients or patients with bronchiectasis , where there is documented susceptibility to piperacillin/tazobactam sodium, or

5) For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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

2 G / VIAL (BASE) * 250 MG / VIAL (BASE) INJECTION				
00002308444	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**4.1727**
00002362619	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**4.1727**
00002401312	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**4.1727**
00002299623	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**4.1727**
3 G / VIAL (BASE) * 375 MG / VIAL (BASE) INJECTION				
00002308452	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**6.2591**
00002362627	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**6.2591**
00002401320	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**6.2591**
00002299631	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**6.2591**
00002370166	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**6.2591**
4 G / VIAL (BASE) * 500 MG / VIAL (BASE) INJECTION				
00002308460	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**8.3458**
00002362635	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**8.3458**
00002401339	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**8.3458**
00002299658	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**8.3458**
00002370174	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**8.3458**

PIRFENIDONE

"Initial approval criteria:

Adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF):
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.
-All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded.
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.
- Patient is under the care of a physician with experience in IPF.

Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests)

Initial renewal criteria (at 6 months):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 6 months

Second and subsequent renewals (at 12 months and thereafter):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

Patients who have experienced intolerance or failure to pirfenidone or nintedanib will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria."

All requests for pirfenidone must be completed using the Nintedanib/Pirfenidone Special Authorization Request Form (ABC 60051).

267 MG ORAL TABLET				
00002464489	ESBRIET	HLR	$	13.4240
801 MG ORAL TABLET				
00002464500	ESBRIET	HLR	$	40.2720
267 MG ORAL CAPSULE				
00002393751	ESBRIET	HLR	$	13.6251

PLERIXAFOR

"For the treatment of patients with Non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM) undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy, in combination with filgrastim, when prescribed by a designated prescriber."

Coverage may be approved for a maximum of 4 doses (0.24mg/kg given daily) for a single mobilization attempt.

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

Special authorization may be granted for 12 months.

20 MG / ML INJECTION				
00002377225	MOZOBIL	SAV	$	6295.8333

PROPRANOLOL HCL

"For the treatment of proliferating infantile hemangioma requiring systemic therapy and at least one of the following:

- Life- or function-threatening hemangioma, OR
- Ulcerated hemangioma with pain and/or lack of response to simple wound care measures, OR
- Hemangioma with a risk of permanent scarring or disfigurement.

Special authorization may be granted for 12 months.

Continued coverage may be approved for a period of 12 months for patients who are responding to therapy or experience relapse of symptoms after treatment discontinuation."

3.75 MG / ML ORAL SOLUTION				
00002457857	HEMANGIOL	PIE	$	2.2808

QUINAGOLIDE

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

FIRST-LINE DRUG PRODUCT(S): BROMOCRIPTINE

"For the treatment of hyperprolactinemia in patients who are intolerant to or who have failed bromocriptine. 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

0.075 MG ORAL TABLET				
00002223767	NORPROLAC	FEI	$	1.1485
0.15 MG ORAL TABLET				
00002223775	NORPROLAC	FEI	$	1.7177

RALOXIFENE HCL

Osteoporosis:

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

All requests for raloxifene hydrochloride for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form (ABC 60043).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

60 MG ORAL TABLET

00002358840	**ACT RALOXIFENE**	**APH**	$	**0.4583**
00002279215	**APO-RALOXIFENE**	**APX**	$	**0.4583**
00002239028	EVISTA	LIL	$	1.9593

RIBAVIRIN

200 MG ORAL TABLET

00002439212	IBAVYR	PPH	$	11.5373

For use within an Alberta Drug Benefit List (ADBL) funded combination therapy regimen for the treatment of chronic hepatitis C according to specific eligibility criteria corresponding to the regimen in which it is being administered. Use of ribavirin outside of an ADBL hepatitis C funded regimen will not be reimbursed.

(Refer to Section 3 of the Alberta Drug Benefit List for specific eligibility criteria corresponding to the regimen in which ribavirin is being administered for the treatment of Chronic Hepatitis C.)

400 MG ORAL TABLET

00002425890	IBAVYR	PPH	$	23.0746

For use within an Alberta Drug Benefit List (ADBL) funded combination therapy regimen for the treatment of chronic hepatitis C according to specific eligibility criteria corresponding to the regimen in which it is being administered. Use of ribavirin outside of an ADBL hepatitis C funded regimen will not be reimbursed.

(Refer to Section 3 of the Alberta Drug Benefit List for specific eligibility criteria corresponding to the regimen in which ribavirin is being administered for the treatment of Chronic Hepatitis C.)

600 MG ORAL TABLET

00002425904	IBAVYR	PPH	$	34.6119

For use within an Alberta Drug Benefit List (ADBL) funded combination therapy regimen for the treatment of chronic hepatitis C according to specific eligibility criteria corresponding to the regimen in which it is being administered. Use of ribavirin outside of an ADBL hepatitis C funded regimen will not be reimbursed.

(Refer to Section 3 of the Alberta Drug Benefit List for specific eligibility criteria corresponding to the regimen in which ribavirin is being administered for the treatment of Chronic Hepatitis C.)

RIFABUTIN

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

"For susceptible infections when prescribed in consultation with a Specialist in Infectious Diseases.

Special authorization may be granted for 6 months."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

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

150 MG ORAL CAPSULE

00002063786	MYCOBUTIN	PFI	$	5.5288

RIFAXIMIN

"For reducing the risk of recurrent Hepatic Encephalopathy (HE) (i.e. 2 or more episodes), in patients with a diagnosis of cirrhosis of the liver or presence of portal hypertension.
Patients must have tried lactulose and been unable to achieve adequate control of HE recurrence with lactulose alone.
Rifaximin must be used in combination with a maximal tolerated dose of lactulose.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

550 MG ORAL TABLET

00002410702	ZAXINE	SLX	$	7.9968

RILUZOLE

"For use in patients who have probable or definite diagnosis of amyotrophic lateral sclerosis (ALS) as defined by World Federation of Neurology (WFN) criteria who have a vital capacity of >60% predicted and do not have a tracheostomy for invasive ventilation. This drug must be prescribed by a Specialist in Neurology."

"Patients who previously received Rilutek and were not eligible for the Phase IV study can also be considered for coverage if they meet the special authorization criteria."

"Coverage cannot be renewed once the patient has a tracheostomy for the purpose of invasive ventilation."

50 MG ORAL TABLET

00002352583	**APO-RILUZOLE**	**APX**	$	**3.4361**
00002390299	**MYLAN-RILUZOLE**	**MYP**	$	**3.4361**
00002242763	RILUTEK	SAV	$	10.0542

RISEDRONATE SODIUM

Osteoporosis:

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

All requests for risedronate for Osteoporosis must be completed using the Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form (ABC 60043).

The following product(s) are eligible for auto-renewal for the treatment of osteoporosis.

Paget's Disease:

"For the treatment of Paget's disease. Special Authorization for this criteria may be granted to a maximum of 2 months. Renewal requests may be considered following an observation period of at least 2 months."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

5 MG ORAL TABLET				
00002298376	TEVA-RISEDRONATE	TEV	$	1.6729
30 MG ORAL TABLET				
00002298384	TEVA-RISEDRONATE	TEV	$	10.8388

RISPERIDONE

"For the management of the manifestations of schizophrenia and related psychotic disorders in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND who meet at least one of the following criteria:

- Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
- Is refractory to trials of at least two other antipsychotic therapies.

Special Authorization may be granted for six months."

All requests (including renewal requests) for risperidone prolonged release injection must be completed using the Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form (ABC 60024).

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

25 MG / VIAL INJECTION				
00002255707	RISPERDAL CONSTA	JAI	$	169.5900
37.5 MG / VIAL INJECTION				
00002255723	RISPERDAL CONSTA	JAI	$	254.3600
50 MG / VIAL INJECTION				
00002255758	RISPERDAL CONSTA	JAI	$	339.1500

RITUXIMAB

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily); AND
- One anti-tumor necrosis factor (anti-TNF) therapy (e.g., etanercept, infliximab or adalimumab) (minimum 12 week trial).

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

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

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

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

"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 Rituxan for Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA) must be completed using the Rituxan for Granulomatosis with Polyangiitis/Microscopic Polyangiitis Special Authorization Request Form (ABC 60018).

10 MG / ML	**INJECTION**			
00002241927	RITUXAN	HLR	$	48.2308

RIVAROXABAN

NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage

Members of Alberta Government Sponsored Drug Plans who are at-risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following a Reasonable Trial on Warfarin; OR
- Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

At-risk patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Although the ROCKET-AF trial included patients with higher CHADS2 scores (greater than or equal to 2), other landmark studies with the other newer oral anticoagulants demonstrated a therapeutic benefit in patients with a CHADS2 score of 1. Coverage may be considered for an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.

Exclusion from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <30 mL/min) OR
- Greater than or equal to 75 years of age and without Documented Stable Renal Function; OR
- hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR
- prosthetic heart valves.

Definitions:
- Documented Stable Renal Function is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months (i.e. 30-49 mL/min for 15 mg once daily dosing or greater than or equal to 50 mL/Min for 20 mg once daily dosing).
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- Reasonable Trial on Warfarin is defined as at least 2 months of therapy.

OTHER CRITERIA:
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product monograph).
- Patients starting the Drug Product should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

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.

RIVAROXABAN

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

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

OTHER CRITERIA:

The recommended dose of rivaroxaban for patients initiating DVT or PE treatment is 15 mg twice daily for 3 weeks, followed by 20 mg once daily.

Drug plan coverage for rivaroxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, rivaroxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for rivaroxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

15 MG ORAL TABLET

00002378604	XARELTO	BAI	$	2.8700

RIVAROXABAN

NON-VALVULAR ATRIAL FIBRILLATION

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage

Members of Alberta Government Sponsored Drug Plans who are at-risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following a Reasonable Trial on Warfarin; OR
- Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

At-risk patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Although the ROCKET-AF trial included patients with higher CHADS2 scores (greater than or equal to 2), other landmark studies with the other newer oral anticoagulants demonstrated a therapeutic benefit in patients with a CHADS2 score of 1. Coverage may be considered for an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.

Exclusion from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <30 mL/min) OR
- Greater than or equal to 75 years of age and without Documented Stable Renal Function; OR
- hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR
- prosthetic heart valves.

Definitions:
- Documented Stable Renal Function is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months (i.e. 30-49 mL/min for 15 mg once daily dosing or greater than or equal to 50 mL/Min for 20 mg once daily dosing).
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- Reasonable Trial on Warfarin is defined as at least 2 months of therapy.

OTHER CRITERIA:
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product monograph).
- Patients starting the Drug Product should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

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.

RIVAROXABAN

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

VENOUS THROMBOEMBOLIC EVENTS

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

OTHER CRITERIA:

The recommended dose of rivaroxaban for patients initiating DVT or PE treatment is 15 mg twice daily for 3 weeks, followed by 20 mg once daily.

Drug plan coverage for rivaroxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, rivaroxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for rivaroxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

20 MG ORAL TABLET

00002378612	XARELTO	BAI	$	2.8700

RIVASTIGMINE HYDROGEN TARTRATE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Special authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug."

All requests (including renewal requests) for rivastigmine hydrogen tartrate must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 60034).

1.5 MG (BASE) ORAL CAPSULE				
00002336715	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002401614	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324563	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242115	EXELON	NOV	$	2.7725
3 MG (BASE) ORAL CAPSULE				
00002336723	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002401622	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324571	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242116	EXELON	NOV	$	2.7725
4.5 MG (BASE) ORAL CAPSULE				
00002336731	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002401630	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324598	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242117	EXELON	NOV	$	2.7725
6 MG (BASE) ORAL CAPSULE				
00002336758	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002401649	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324601	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242118	EXELON	NOV	$	2.7725
2 MG / ML (BASE) ORAL SOLUTION				
00002245240	EXELON	NOV	$	1.4575

RIZATRIPTAN BENZOATE

(Refer to 28:32.28 of the Alberta Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using rizatriptan benzoate prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

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

5 MG (BASE) ORAL TABLET				
00002393468	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002380455	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429233	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
10 MG (BASE) ORAL TABLET				
00002381702	**ACT RIZATRIPTAN**	**APH**	$	**3.7050**
00002393476	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002441144	**AURO-RIZATRIPTAN**	**AUR**	$	**3.7050**
00002380463	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429241	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
00002379678	**MAR-RIZATRIPTAN**	**MAR**	$	**3.7050**
00002240521	MAXALT	MFC	$	16.5163
5 MG (BASE) ORAL DISINTEGRATING TABLET				
00002465086	**JAMP-RIZATRIPTAN ODT**	**JPC**	$	**3.7050**
00002462788	**MAR-RIZATRIPTAN ODT**	**MAR**	$	**3.7050**
00002379198	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**3.7050**
00002436604	**NAT-RIZATRIPTAN ODT**	**NTP**	$	**3.7050**
00002393360	**PMS-RIZATRIPTAN RDT**	**PMS**	$	**3.7050**
00002442906	**RIZATRIPTAN ODT**	**SNS**	$	**3.7050**
00002446111	**RIZATRIPTAN ODT**	**SIV**	$	**3.7050**
00002351870	**SANDOZ RIZATRIPTAN ODT**	**SDZ**	$	**3.7050**
00002396661	**TEVA-RIZATRIPTAN ODT**	**TEV**	$	**3.7050**
00002240518	MAXALT RPD	MFC	$	16.5163
10 MG (BASE) ORAL DISINTEGRATING TABLET				
00002465094	**JAMP-RIZATRIPTAN ODT**	**JPC**	$	**3.7050**
00002462796	**MAR-RIZATRIPTAN ODT**	**MAR**	$	**3.7050**
00002379201	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**3.7050**
00002436612	**NAT-RIZATRIPTAN ODT**	**NTP**	$	**3.7050**
00002393379	**PMS-RIZATRIPTAN RDT**	**PMS**	$	**3.7050**
00002442914	**RIZATRIPTAN ODT**	**SNS**	$	**3.7050**
00002446138	**RIZATRIPTAN ODT**	**SIV**	$	**3.7050**
00002351889	**SANDOZ RIZATRIPTAN ODT**	**SDZ**	$	**3.7050**
00002396688	**TEVA-RIZATRIPTAN ODT**	**TEV**	$	**3.7050**
00002240519	MAXALT RPD	MFC	$	16.5163

ROSIGLITAZONE MALEATE

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

2 MG (BASE) ORAL TABLET				
00002403366	**ROSIGLITAZONE**	**AAP**	$	**1.0316**
00002241112	AVANDIA	GSK	$	1.4333
4 MG (BASE) ORAL TABLET				
00002403374	**ROSIGLITAZONE**	**AAP**	$	**1.6188**
00002241113	AVANDIA	GSK	$	2.2491
8 MG (BASE) ORAL TABLET				
00002403382	**ROSIGLITAZONE**	**AAP**	$	**2.3150**
00002241114	AVANDIA	GSK	$	3.2161

ROTIGOTINE

"For adjunctive therapy to levodopa for the treatment of patients with advanced stage Parkinson's disease (APD).

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

2 MG/24HR TRANSDERMAL PATCH				
00002403900	NEUPRO	UCB	$	3.5400
4 MG/24HR TRANSDERMAL PATCH				
00002403927	NEUPRO	UCB	$	6.5000
6 MG/24HR TRANSDERMAL PATCH				
00002403935	NEUPRO	UCB	$	7.2700
8 MG/24HR TRANSDERMAL PATCH				
00002403943	NEUPRO	UCB	$	7.2700

RUFINAMIDE

"For the treatment of seizures associated with Lennox-Gastaut Syndrome (LGS) in patients who meet the following criteria:
- are currently taking two or more anti-epileptic drugs (AEDs) without optimal seizure control; AND
- have failed or demonstrated intolerance to adequate trials of both lamotrigine AND topiramate; AND
- therapy must be initiated by a Neurologist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

100 MG ORAL TABLET				
00002369613	BANZEL	EIS	$	0.7182
200 MG ORAL TABLET				
00002369621	BANZEL	EIS	$	1.4364
400 MG ORAL TABLET				
00002369648	BANZEL	EIS	$	3.1298

SACUBITRIL/ VALSARTAN

"For the treatment of heart failure (HF) in patients with the following criteria:

1) reduced left ventricular ejection fraction (LVEF) (< 40%)
And
2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of treatment with:
- a stable dose of an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)
- in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)
And
3) who have Plasma B-type natriuretic peptide (BNP) >= 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) >= 600 pg/mL; or
- if the patient has been hospitalized for HF within the past 12 months and has plasma BNP >= 100 pg/mL or NT-proBNP >= 400 pg/mL levels

For coverage, this drug must be initiated by a Specialist in Cardiology or Internal Medicine, and the initial request must be completed by the Specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

All requests (including renewal requests) for sacubitril+valsartan must be completed using the Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form (ABC 60050).

24.3 MG * 25.7 MG ORAL TABLET				
00002446928	ENTRESTO	NOV	$	3.7060
48.6 MG * 51.4 MG ORAL TABLET				
00002446936	ENTRESTO	NOV	$	3.7060
97.2 MG * 102.8 MG ORAL TABLET				
00002446944	ENTRESTO	NOV	$	3.7060

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

25 MCG / DOSE (BASE)	* 125 MCG / DOSE	INHALATION	METERED DOSE AEROSOL		
00002245126	ADVAIR 125		GSK	$	0.8460

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

25 MCG / DOSE (BASE)	* 250 MCG / DOSE	INHALATION	METERED DOSE AEROSOL		
00002245127	ADVAIR 250		GSK	$	1.2010

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

50 MCG / DOSE (BASE)	* 100 MCG / DOSE	INHALATION	METERED INHALATION POWDER		
00002240835	ADVAIR 100 DISKUS		GSK	$	1.4135

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

50 MCG / DOSE (BASE)	* 250 MCG / DOSE	INHALATION	METERED INHALATION POWDER		
00002240836	ADVAIR 250 DISKUS		GSK	$	1.6920

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

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

ASTHMA

FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)

"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for salmeterol xinafoate + fluticasone propionate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

50 MCG / DOSE (BASE)	* 500 MCG / DOSE	INHALATION	METERED INHALATION POWDER		
00002240837	ADVAIR 500 DISKUS		GSK	$	2.4020

SARILUMAB

Rheumatoid Arthritis

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

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

Initial coverage may be approved for up to 200 mg of sarilumab given subcutaneously every 2 weeks for 12 weeks.
- Patients will be limited to receiving a one-month supply of sarilumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 12 weeks to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one subcutaneous dose of up to 200 mg every 2 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, OR
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal

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requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for sarilumab for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

150 MG / SYR INJECTION SYRINGE				
00002460521	KEVZARA	SAV	$	721.0000
200 MG / SYR INJECTION SYRINGE				
00002460548	KEVZARA	SAV	$	721.0000

SAXAGLIPTIN HCL

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for saxagliptin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

2.5 MG ORAL TABLET				
00002375842	ONGLYZA	AZC	$	2.4910
5 MG (BASE) ORAL TABLET				
00002333554	ONGLYZA	AZC	$	2.9540

SAXAGLIPTIN HCL/ METFORMIN HCL

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for saxagliptin+metformin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

2.5 MG (BASE) * 500 MG ORAL TABLET				
00002389169	KOMBOGLYZE	AZC	$	1.2700
2.5 MG (BASE) * 850 MG ORAL TABLET				
00002389177	KOMBOGLYZE	AZC	$	1.2700
2.5 MG (BASE) * 1,000 MG ORAL TABLET				
00002389185	KOMBOGLYZE	AZC	$	1.2700

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Plaque Psoriasis

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:
- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
- Cyclosporine (6 weeks treatment); AND
- Phototherapy (unless restricted by geographic location)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

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

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

Initial coverage may be approved for 12 weeks as follows:
- Four weekly doses of 300 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8 and 12.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter. Each 300 mg dose is provided as two subcutaneous injections of 150 mg.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of the initial coverage period.
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond seven doses, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial seven doses to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, OR
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 300 mg dose of secukinumab every month for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

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

Psoriatic Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).
Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

Initial coverage may be approved for 16 weeks as follows:
- Four weekly doses of 150 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8, 12 and 16. A dose of 300 mg (given as 2 subcutaneous injections of 150 mg each) may be considered for anti-TNF alpha inadequate responders.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond eight doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial eight doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be considered for one 150 mg (or 300 mg for anti-TNF alpha inadequate responders) dose of secukinumab every month for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to

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therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for secukinumab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Ankylosing Spondylitis

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist"). Initial coverage may be approved for 16 weeks as follows:
- Four weekly doses of 150 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8, 12 and 16.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond eight doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial eight doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be considered for one 150 mg dose of secukinumab every month for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by an RA Specialist every 12 months and is confirmed to be

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continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for secukinumab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

150 MG / ML INJECTION SYRINGE				
00002438070	COSENTYX	NOV	$	831.1100

SILTUXIMAB

"For the treatment of multicentric Castleman's disease (MCD) in patients who are human immunodeficiency virus (HIV) negative and human herpes virus-8 (HHV-8) negative and who have an ECOG performance status of less than or equal to 2.

Initial coverage may be approved for a period of 6 months.

Continued coverage may be approved for a period of 12 months for patients who continue to meet initial coverage criteria.

Coverage for siltuximab will be provided for one intravenous dose of 11 mg/kg every 3 weeks. Patients will be limited to receiving one dose of siltuximab per prescription at their pharmacy."

100 MG / VIAL INJECTION				
00002435128	SYLVANT	JAI	$	697.7000
400 MG / VIAL INJECTION				
00002435136	SYLVANT	JAI	$	2790.8000

SITAGLIPTIN PHOSPHATE MONOHYDRATE

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for sitagliptin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

25 MG ORAL TABLET				
00002388839	JANUVIA	MFC	$	3.0801
50 MG ORAL TABLET				
00002388847	JANUVIA	MFC	$	3.0801
100 MG ORAL TABLET				
00002303922	JANUVIA	MFC	$	3.0801

SITAGLIPTIN PHOSPHATE MONOHYDRATE/ METFORMIN HCL

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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

UP - First-line therapy ineffective
UQ - First-line therapy not tolerated
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for sitagliptin+metformin must be completed using the DPP-4/SGLT2 Inhibitors Special Authorization Request Form (ABC 60012).

50 MG (BASE) * 500 MG ORAL TABLET				
00002333856	JANUMET	MFC	$	1.6691
50 MG (BASE) * 850 MG ORAL TABLET				
00002333864	JANUMET	MFC	$	1.6691
50 MG (BASE) * 1,000 MG ORAL TABLET				
00002333872	JANUMET	MFC	$	1.6691
50 MG (BASE) * 500 MG ORAL EXTENDED-RELEASE TABLET				
00002416786	JANUMET XR	MFC	$	1.6577
50 MG (BASE) * 1,000 MG ORAL EXTENDED-RELEASE TABLET				
00002416794	JANUMET XR	MFC	$	1.6577
100 MG (BASE) * 1,000 MG ORAL EXTENDED-RELEASE TABLET				
00002416808	JANUMET XR	MFC	$	3.3155

SODIUM PHENYLBUTYRATE

"As adjunctive therapy in the chronic management of urea cycle disorders (UCDs) involving deficiencies of carbamoyl phosphate synthetase 1, ornithine transcarbamylase, or argininosuccinate synthetase, in patients with neonatal-onset presentation, and patients with late-onset disease who have a history of hyperammonemic encephalopathy.

For coverage, this drug must be prescribed by or in consultation with a metabolic or genetic physician. The diagnosis must be confirmed by blood, enzymatic, biochemical, or genetic testing.

Special authorization may be granted for 12 months."

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

483 MG / G ORAL GRANULE				
00002436663	PHEBURANE	MDK	$	9.2690

SOFOSBUVIR

"For use as combination therapy with ribavirin or daclatasvir for treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype 2 or genotype 3;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (2) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive or treatment experienced genotype 2, without cirrhosis or with compensated cirrhosis (3): 12 weeks in combination with ribavirin
- Treatment-naive or treatment-experienced genotype 3, without cirrhosis: 12 weeks in combination with daclatasvir
- Treatment-naive or treatment-experienced genotype 3, without cirrhosis or with compensated cirrhosis (3), or with decompensated cirrhosis (4), or post-liver transplant: 24 weeks in combination with ribavirin

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis
- Combination therapy with elbasvir/grazoprevir will not be considered

Notes:
1. Treatment-experienced are those who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor.
2. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
3. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6) and d
4. Decompensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh B or C (i.e. score 7 or above).
5. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG ORAL TABLET

00002418355	SOVALDI	GIL	$	654.7619

SOFOSBUVIR/ LEDIPASVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype 1;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (2) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive, without cirrhosis, recent quantitative hepatitis C viral load less than 6 M IU/mL: 8 weeks or 12 weeks (3)
- Treatment-naive, without cirrhosis, viral load greater than or equal to 6 M IU/mL: 12 weeks
- Treatment-naive, with compensated cirrhosis (4): 12 weeks
- Treatment-experienced, without cirrhosis: 12 weeks
- Treatment-naive or treatment-experienced with decompensated cirrhosis (5): 12 weeks in combination with ribavirin
- Treatment-naive or treatment-experienced liver transplant recipients, without cirrhosis or with compensated cirrhosis (4): 12 weeks in combination with ribavirin
- Treatment-experienced, with compensated cirrhosis (4): 24 weeks

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis

Notes:
1. Treatment-experienced are those who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor.
2. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
3. For this population cohort, evidence has shown that the SVR rates with 8-week and 12-week treatment regimens are similar. Treatment regimens of up to 12 weeks are recognized by Health Canada as an approved treatment option. 12-week treatment regimens may be considered for patients with advanced liver fibrosis.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. Decompensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh B or C (i.e. score 7 or above).
6. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir/ledipasvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG * 90 MG ORAL TABLET

00002432226	HARVONI	GIL	$	797.6190

SOFOSBUVIR/ VELPATASVIR

"For treatment-naive or treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype (2) 1, 2, 3, 4, 5, 6 or mixed genotypes;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (3) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-naive or treatment-experienced, without cirrhosis or with compensated cirrhosis (4): 12 weeks
- Treatment-naive or treatment-experienced, with decompensated cirrhosis (5): 12 weeks in combination with ribavirin

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent
- Retreatment for failure or re-infection in patients who have received an adequate prior course of an HCV direct-acting antiviral drug regimen may be considered on an exceptional case-by-case basis

Notes:
1. Treatment-experienced is defined as those who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor.
2. HCV genotype testing is optional.
3. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. Decompensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh B or C (i.e. score 7 or above).
6. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir/velpatasvir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG * 100 MG ORAL TABLET				
00002456370	EPCLUSA	GIL	$	714.2857

SOFOSBUVIR/ VELPATASVIR/ VOXILAPREVIR

"For treatment-experienced (1) adult patients with chronic hepatitis C (CHC) infection who meet all of the following criteria:
I) Prescribed by or in consultation with a hepatologist, gastroenterologist or infectious disease specialist (except on a case-by-case basis, in geographic areas where access to these specialties is not available);
AND
II) Laboratory confirmed hepatitis C genotype (2) 1, 2, 3, 4, 5, 6 or mixed genotypes and have previously been treated with a CHC antiviral drug regimen containing a non-structural protein 5A (NS5A) inhibitor;
OR
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4 and have previously been treated with a CHC antiviral drug regimen containing sofosbuvir without an NS5A inhibitor;
AND
III) Laboratory confirmed quantitative HCV RNA value within the last 6 months;
AND
IV) Fibrosis (3) stage of F0 or greater (Metavir scale or equivalent).

Duration of therapy reimbursed:
- Treatment-experienced, without cirrhosis or with compensated cirrhosis (4): 12 weeks

Exclusion criteria:
- Patients currently being treated with another HCV antiviral agent

Notes:
1. Treatment-experienced is defined as those who have previously been treated with a CHC antiviral drug regimen.
2. HCV genotype testing is optional for patients previously treated with a CHC antiviral drug regimen containing a non-structural protein 5A (NS5A) inhibitor.
3. Fibrosis score test is optional. Acceptable methods include liver biopsy, transient elastography (FibroScan), fibrotest and serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.
4. Compensated cirrhosis is defined as cirrhosis with Child-Turcotte-Pugh A (i.e. score 5 to 6).
5. Health care professionals are advised to refer to the product monograph and prescribing guidelines for appropriate use of the drug product, including use in special populations."

All requests for sofosbuvir/velpatasvir/voxilaprevir must be completed using the Antivirals for Chronic Hepatitis C Special Authorization Request Form (ABC 60022).

400 MG * 100 MG * 100 MG ORAL TABLET				
00002467542	VOSEVI	GIL	$	714.2857

SOMATROPIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of either a diagnostic insulin tolerance test or a glucagon stimulation test. Growth hormone values less than 3 mcg/litre are indicative of severe growth hormone deficiency.

Special authorization may be granted for 6 months."

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

0.6 MG / SYR INJECTION				
00002401762	GENOTROPIN MINIQUICK	PFI	$	16.7400
0.8 MG / SYR INJECTION				
00002401770	GENOTROPIN MINIQUICK	PFI	$	22.3200
1 MG / SYR INJECTION				
00002401789	GENOTROPIN MINIQUICK	PFI	$	27.9000

SOMATROPIN

1.2 MG / SYR INJECTION				
00002401797	GENOTROPIN MINIQUICK	PFI	$	33.4800
1.4 MG / SYR INJECTION				
00002401800	GENOTROPIN MINIQUICK	PFI	$	39.0600
1.6 MG / SYR INJECTION				
00002401819	GENOTROPIN MINIQUICK	PFI	$	44.6400
1.8 MG / SYR INJECTION				
00002401827	GENOTROPIN MINIQUICK	PFI	$	50.2200
2 MG / SYR INJECTION				
00002401835	GENOTROPIN MINIQUICK	PFI	$	55.8000
5.3 MG / SYR INJECTION				
00002401703	GENOTROPIN GOQUICK	PFI	$	147.8700
12 MG / SYR INJECTION				
00002401711	GENOTROPIN GOQUICK	PFI	$	334.8000

SOMATROPIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of either a diagnostic insulin tolerance test or a glucagon stimulation test. Growth hormone values less than 3 mcg/litre are indicative of severe growth hormone deficiency.

Special authorization may be granted for 6 months."

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

6 MG / VIAL INJECTION				
00002243077	HUMATROPE	LIL	$	280.0200
12 MG / VIAL INJECTION				
00002243078	HUMATROPE	LIL	$	560.0400

SOMATROPIN R-DNA ORIGIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of either a diagnostic insulin tolerance test or a glucagon stimulation test. Growth hormone values less than 3 mcg/litre are indicative of severe growth hormone deficiency.

Special authorization may be granted for 6 months."

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

3.3 MG / VIAL INJECTION				
☒ 00002325063	OMNITROPE	SDZ	$	103.8667
☒ 00002215136	SAIZEN	SRO	$	147.0735
5 MG / VIAL INJECTION				
00002237971	SAIZEN	SRO	$	220.7828
5.83 MG / ML INJECTION				
00002350122	SAIZEN	SRO	$	264.9150
6.7 MG / ML INJECTION				
00002325071	OMNITROPE	SDZ	$	207.7333
8 MG / ML INJECTION				
☒ 00002350130	SAIZEN (1.5 ML)	SRO	$	353.2200
☒ 00002350149	SAIZEN (2.5 ML)	SRO	$	353.2200

STIRIPENTOL

"For use in combination with clobazam and valproate as adjunctive therapy of refractory generalized tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy (Dravet Syndrome), whose seizures are not adequately controlled with clobazam and valproate alone.

This medication must be prescribed in consultation with a Neurologist.

Special authorization may be granted for 6 months."

Each of these products is eligible for auto-renewal.

250 MG ORAL CAPSULE				
00002398958	DIACOMIT	BCF	$	5.8984
500 MG ORAL CAPSULE				
00002398966	DIACOMIT	BCF	$	11.7783
250 MG ORAL POWDER PACKET				
00002398974	DIACOMIT	BCF	$	5.8984

SUMATRIPTAN HEMISULFATE

(Refer to 28:32.28 of the Alberta Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using sumatriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

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

5 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230418	IMITREX	GSK	$	15.6250
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230420	IMITREX	GSK	$	16.0781

SUMATRIPTAN SUCCINATE

(Refer to 28:32.28 of the Alberta Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using sumatriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

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

50 MG (BASE) ORAL TABLET				
00002268388	**APO-SUMATRIPTAN**	**APX**	$	**2.7732**
00002268914	**MYLAN-SUMATRIPTAN**	**MYP**	$	**2.7732**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**2.7732**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**2.7732**
00002286521	**SUMATRIPTAN**	**SNS**	$	**2.7732**
00002385570	**SUMATRIPTAN DF**	**SIV**	$	**2.7732**
00002286823	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**2.7732**
00002212153	IMITREX DF	GSK	$	15.7917
100 MG (BASE) ORAL TABLET				
00002257904	**ACT SUMATRIPTAN**	**APH**	$	**3.0549**
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**3.0549**
00002268922	**MYLAN-SUMATRIPTAN**	**MYP**	$	**3.0549**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**3.0549**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**3.0549**
00002286548	**SUMATRIPTAN**	**SNS**	$	**3.0549**
00002385589	**SUMATRIPTAN DF**	**SIV**	$	**3.0549**
00002239367	**TEVA-SUMATRIPTAN**	**TEV**	$	**3.0549**
00002286831	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**3.0549**
00002212161	IMITREX DF	GSK	$	17.3967
6 MG / SYR (BASE) INJECTION SYRINGE				
00002361698	**TARO-SUMATRIPTAN (0.5 ML)**	**TAR**	$	**34.6200**
00002212188	IMITREX (0.5 ML)	GSK	$	47.1762

TACROLIMUS

"For use in patients 2 to 15 years of age inclusive with atopic dermatitis who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 2 to 15 years of age inclusive with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids."

"For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30 % of body surface area."

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

Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the third criterion, information is also required regarding the area(s) affected. In order to comply with the fourth criterion, information is also required regarding the percentage body surface area affected.

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

All requests for tacrolimus topical ointment must be completed using the Tacrolimus Topical Ointment Special Authorization Request Form (ABC 60047).

0.03 % TOPICAL OINTMENT

00002244149	PROTOPIC	LEO	$	2.2601

"For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30 % of body surface area."

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

Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the first criterion, information is also required regarding the area(s) affected. In order to comply with the second criterion, information is also required regarding the percentage body surface area affected.

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

All requests for tacrolimus topical ointment must be completed using the Tacrolimus Topical Ointment Special Authorization Request Form (ABC 60047).

0.1 % TOPICAL OINTMENT

00002244148	PROTOPIC	LEO	$	2.3993

TEDUGLUTIDE

"Special authorization coverage may be provided for the treatment of adult patients (18 years of age or older) with short bowel syndrome (SBS) if all of the following criteria are met:

- SBS is a result of major intestinal resection (e.g., due to injury, volvulus, vascular disease, cancer, Crohn's Disease), and

- Resection has resulted in dependency on parenteral nutrition (PN) for at least 12 months, and

- PN is required at least three times weekly to meet caloric, fluid or electrolyte needs due to ongoing malabsorption, and

- PN frequency and volume have been stable for at least one month.

For coverage, the drug must be initiated and monitored by a specialist in gastroenterology or an internal medicine specialist with an interest in gastroenterology on a case-by-case basis, in geographic areas where access to this specialty is not available ('Specialist').

Initial coverage may be approved for up to 24 weeks of 0.05 mg/kg/day administered subcutaneously once daily.

- Patients will be limited to receiving a two week supply of teduglutide per prescription at their pharmacy.

For continued coverage beyond 24 weeks, the patient must meet the following criteria:

1) The patient must be assessed by the Specialist between weeks 20 and 24, after initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' as demonstrated by:
- at least a 20% reduction in weekly PN volume from baseline.

Following this assessment, continued coverage may be provided for 0.05 mg/kg/day administered subcutaneously once daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:

1) The patient has been assessed by the Specialist to determine response;

2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:

- confirmation of maintenance of at least a 20% reduction in weekly PN volume from baseline."

5 MG / VIAL INJECTION

00002445727	REVESTIVE	SHB	$	904.0000

TERIFLUNOMIDE

Relapsing Remitting Multiple Sclerosis (RRMS):

Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).

Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of teriflunomide per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of teriflunomide per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the

TERIFLUNOMIDE

patient must meet the following criteria:

1) At least one relapse* per 12 month period; or
2) At least two relapses* during the previous 24 month period.

All requests (including renewal requests) for teriflunomide must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

14 MG ORAL TABLET

00002416328	AUBAGIO	GZM	$	57.7432

TESTOSTERONE

"For use in males for the treatment of congenital and acquired primary and secondary hypogonadism."

"Coverage cannot be considered when used for the treatment of androgen decline in the aging male (ADAM)."

"Special authorization may be granted for 6 months."

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

12.2 MG TRANSDERMAL PATCH

00002239653	ANDRODERM (2.5 MG/DAY)	ALL	$	2.1666

24.3 MG TRANSDERMAL PATCH

00002245972	ANDRODERM (5 MG/DAY)	ALL	$	4.3333

TESTOSTERONE UNDECANOATE

"For use in males for the treatment of congenital and acquired primary and secondary hypogonadism."

"Coverage cannot be considered when used for the treatment of androgen decline in the aging male (ADAM)."

"Special authorization may be granted for 6 months."

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

40 MG ORAL CAPSULE

00002322498	**PMS-TESTOSTERONE**	**PMS**	$	**0.4700**
00002421186	**TARO-TESTOSTERONE**	**TAR**	$	**0.4700**

TETRABENAZINE

"For the treatment of hyperkinetic movement disorders when prescribed by specialists in Neurology, Psychiatry, or Geriatric Medicine.

Special authorization may be granted for 6 months."

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

25 MG ORAL TABLET

00002407590	**APO-TETRABENAZINE**	**APX**	$	**3.3746**
00002402424	**PMS-TETRABENAZINE**	**PMS**	$	**3.3746**
00002410338	**TETRABENAZINE**	**STM**	$	**3.3746**
00002199270	NITOMAN	VCL	$	7.3649

TICAGRELOR

(Refer to 20:12.18 of the Alberta Drug Benefit List for coverage of ticagrelor when prescribed by a specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.)

For the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction, when initiated in hospital in consultation with a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA. Special authorization may be granted for 6 months.*

*Special Authorization is only required when the initiating prescriber is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.

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

90 MG ORAL TABLET

00002368544	BRILINTA	AZC	$	1.5620

TIOTROPIUM BROMIDE MONOHYDRATE/ OLODATEROL HYDROCHLORIDE

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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for tiotropium bromide monohydrate + olodaterol hydrochloride must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

2.5 MCG / DOSE * 2.5 MCG / DOSE INHALATION SOLUTION

00002441888	INSPIOLTO RESPIMAT	BOE	$	1.0576

TOCILIZUMAB

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of
anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the
completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were
deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under
exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 weeks after treatment to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets

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the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal
place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, OR
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal
requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for tocilizumab for Rheumatoid Arthritis must be
completed using the
Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Systemic Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary (Pediatric RA Specialist).

- Coverage may be approved for one dose of 12 mg/kg for patient weight less than 30 kg or 8 mg/kg for patient weight greater than or equal to 30 kg to a maximum of 800 mg, administered every two weeks for 12 weeks.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric RA Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.

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2) The Pediatric RA Specialist must confirm in writing that the patient is a responder as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].

Following this assessment, continued coverage may be approved for one dose of 12 mg/kg for patient weight less than 30 kg or 8 mg/kg for patient weight greater than or equal to 30 kg to a maximum of 800 mg, administered every two weeks, for a maximum of twelve months. After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months by a Pediatric RA Specialist to determine response, AND
2) The Pediatric RA Specialist must confirm in writing that the patient has maintained a response to therapy."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60048).

Polyarticular Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who:
- Have 5 or more active joints (defined by either swelling or limitation of motion plus pain and/or tenderness), AND
- Are refractory to one or more disease modifying anti-rheumatic agents (DMARDs) conventionally used in children (minimum three month trial).

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary (Pediatric Rheumatology Specialist).

- Coverage may be approved for 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks.
- Patients will be limited to receiving a one-month supply of tocilizumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of abatacept) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from abatacept to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient is a responder that meets the following criteria (ACR Pedi 30):
- 30% improvement from baseline in at least three of the following six response

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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 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks, 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 Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

80 MG / VIAL INJECTION

00002350092	ACTEMRA (4 ML)	HLR	$	182.8000

TOCILIZUMAB

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of
anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the
completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were
deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under
exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 weeks after treatment to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets

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the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal
place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, OR
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal
requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for tocilizumab for Rheumatoid Arthritis must be
completed using the
Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Systemic Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary (Pediatric RA Specialist).

- Coverage may be approved for one dose of 12 mg/kg for patient weight less than 30 kg or 8 mg/kg for patient weight greater than or equal to 30 kg to a maximum of 800 mg, administered every two weeks for 12 weeks.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric RA Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.

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2) The Pediatric RA Specialist must confirm in writing that the patient is a responder as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].

Following this assessment, continued coverage may be approved for one dose of 12 mg/kg for patient weight less than 30 kg or 8 mg/kg for patient weight greater than or equal to 30 kg to a maximum of 800 mg, administered every two weeks, for a maximum of twelve months. After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months by a Pediatric RA Specialist to determine response, AND
2) The Pediatric RA Specialist must confirm in writing that the patient has maintained a response to therapy."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60048).

Polyarticular Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who:
- Have 5 or more active joints (defined by either swelling or limitation of motion plus pain and/or tenderness), AND
- Are refractory to one or more disease modifying anti-rheumatic agents (DMARDs) conventionally used in children (minimum three month trial).

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary (Pediatric Rheumatology Specialist).

- Coverage may be approved for 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks.
- Patients will be limited to receiving a one-month supply of tocilizumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of abatacept) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from abatacept to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient is a responder that meets the following criteria (ACR Pedi 30):
- 30% improvement from baseline in at least three of the following six response

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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 10 mg/kg/dose for patients less than 30 kg, or 8 mg/kg/dose for patients 30 kg or greater every 4 weeks, 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 Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for tocilizumab for Polyarticular Juvenile Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

200 MG / VIAL INJECTION

00002350106	ACTEMRA (10 ML)	HLR	$	457.0000

TOCILIZUMAB

Rheumatoid Arthritis:

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of
anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the
completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were
deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under
exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 weeks after treatment to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets

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the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal
place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, OR
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal
requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for tocilizumab for Rheumatoid Arthritis must be
completed using the
Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Systemic Juvenile Idiopathic Arthritis:

"Special authorization coverage may be provided for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older when all of the following conditions are met:
- the patient has a diagnosis of systemic JIA with fever (greater than 38 degrees Celsius) for at least two weeks and at least one of the following: rash of systemic JIA; serositis; lymphadenopathy; hepatomegaly; splenomegaly; AND
- the physician has ruled out other potential etiologies; AND
- the patient is refractory to one or more non-steroidal anti-inflammatory drugs (NSAIDs) and one or more systemic corticosteroids.

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary (Pediatric RA Specialist).

- Coverage may be approved for one dose of 12 mg/kg for patient weight less than 30 kg or 8 mg/kg for patient weight greater than or equal to 30 kg to a maximum of 800 mg, administered every two weeks for 12 weeks.
- Patients will be limited to receiving one month of tocilizumab per prescription at their pharmacy.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric RA Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.

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2) The Pediatric RA Specialist must confirm in writing that the patient is a responder as demonstrated by JIA ACR30 response and/or absence of fever and/or reduction in inflammatory markers [e.g., C-reactive protein (CRP) concentration of less than 15 mg/L or reduction in erythrocyte sedimentation rate (ESR)].

Following this assessment, continued coverage may be approved for one dose of 12 mg/kg for patient weight less than 30 kg or 8 mg/kg for patient weight greater than or equal to 30 kg to a maximum of 800 mg, administered every two weeks, for a maximum of twelve months. After twelve months, in order to be considered for continued coverage, the patient must meet the following criteria:
1) The patient has been re-assessed every 12 months by a Pediatric RA Specialist to determine response, AND
2) The Pediatric RA Specialist must confirm in writing that the patient has maintained a response to therapy."

All requests (including renewal requests) for tocilizumab for Systemic Juvenile Idiopathic Arthritis must be completed using the Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60048).

400 MG / VIAL INJECTION

00002350114	ACTEMRA (20 ML)	HLR	$	914.0000

TOCILIZUMAB

Rheumatoid Arthritis

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

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

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 16 weeks as follows:
- Tocilizumab intravenous infusion: one dose of 4 mg/kg or 8 mg/kg (up to a maximum of 800 mg per dose) of tocilizumab administered at 0, 4, 8, 12 and 16 weeks (total of 5 doses). Patients will be limited to receiving one dose of intravenous tocilizumab per prescription at their pharmacy.
-Tocilizumab subcutaneous injection: for patients weighing less than 100 kg, initial coverage may be approved for one 162 mg dose of tocilizumab administered every other week, up to weekly based on clinical response. For patients weighing 100 kg or more, initial coverage may be approved for one 162 mg dose of tocilizumab administered every week. Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial 16 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 16 weeks, but no longer than 20 weeks after treatment to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].

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It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for a period of 12 months. Coverage for tocilizumab will be provided for one intravenous dose of 4 mg/kg to 8 mg/kg (up to a maximum of 800 mg per dose) every 4 weeks, or one 162 mg subcutaneous dose administered every one to two weeks (based on weight and clinical response). Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, OR
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for tocilizumab for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Giant Cell Arteritis

"Special authorization coverage may be provided for use in combination with glucocorticoids for the treatment of giant cell arteritis (GCA) in adult patients.

For coverage, this drug must be initiated in consultation with a Specialist in Internal Medicine, Rheumatology or Neurology.

Initial coverage may be approved for 12 weeks as follows:
-Coverage may be approved for one 162 mg subcutaneous dose of tocilizumab administered every week.
-As an interim measure, coverage will be provided for additional doses up to week 16, to allow time to determine whether the patient meets criteria for continued coverage below.
-Patients will be limited to receiving a one-month supply of subcutaneous tocilizumab per prescription at their pharmacy.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed after 12 weeks, but no longer than 16 weeks after treatment to determine response; AND
2) The patient must be a `responder' that meets the following criteria:
-Patient has achieved remission which is defined as the absence of flare* AND normalization of C-reactive protein (CRP) to <1 mg/dL.
*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) greater or equal to 30 mm/hr attributable to GCA.

Following this assessment, continued coverage may be approved for one 162 mg subcutaneous dose administered every week for a period of 36 weeks.

Duration of therapy with tocilizumab will be limited to 52 weeks per treatment course. Re-treatment may be considered for patients who experience a disease flare after treatment discontinuation."

TOCILIZUMAB

All requests (including renewal requests) for tocilizumab for Giant Cell Arteritis must be completed using the Tocilizumab for Giant Cell Arteritis Special Authorization Request Form (ABC 60066).

162 MG / SYR INJECTION SYRINGE				
00002424770	ACTEMRA (0.9 ML SYRINGE)	HLR	$	358.9050

TOFACITINIB CITRATE

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for 5 mg twice daily for three months.
- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond three months, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three months to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 5 mg twice daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, or
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent."

All requests (including renewal requests) for tofacitinib for Rheumatoid Arthritis must be completed using the

TOFACITINIB CITRATE

Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

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

TRETINOIN

"For the treatment of severe acne as defined by scarring acne.

Special authorization may be granted for 6 months."

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

0.025 % TOPICAL GEL				
00001926470	VITAMIN A ACID	VCL	$	0.3364
0.05 % TOPICAL GEL				
00001926489	VITAMIN A ACID	VCL	$	0.3364
0.01 % TOPICAL CREAM				
00000657204	STIEVA-A	GSK	$	0.3084
0.025 % TOPICAL CREAM				
00000578576	STIEVA-A	GSK	$	0.3084
0.05 % TOPICAL CREAM				
00000518182	STIEVA-A	GSK	$	0.2060
0.01 % TOPICAL GEL				
00001926462	VITAMIN A ACID	VCL	$	0.3364

TROSPIUM CHLORIDE

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

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA."

"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

20 MG ORAL TABLET				
00002275066	TROSEC	SUN	$	0.7820

UMECLIDINIUM BROMIDE/ VILANTEROL TRIFENATATE

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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

FIRST-LINE DRUG PRODUCT(S): LONG-ACTING BRONCHODILATOR (I.E., LONG-ACTING BETA-2 AGONIST [LABA] OR LONG-ACTING MUSCARINIC ANTAGONIST [LAMA])

"For the long-term maintenance treatment of airflow obstruction in patients with moderate to severe (i.e., FEV1 < 80% predicted) chronic obstructive pulmonary disease (COPD), who have an inadequate response to a long-acting bronchodilator (long-acting beta-2 agonist [LABA] or long-acting muscarinic antagonist [LAMA])."

"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."

"Special authorization may be granted for 24 months."

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

UP - First-line therapy ineffective

All requests for umeclidinium bromide + vilanterol trifenatate must be completed using the Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form (ABC 60025).

62.5 MCG / DOSE (BASE)	* 25 MCG / DOSE (BASE)	INHALATION	METERED INHALATION POWDER		
00002418401	ANORO ELLIPTA		GSK	$	2.8130

USTEKINUMAB

"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:
- 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.

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/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 60030).

USTEKINUMAB

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

VARENICLINE TARTRATE

For subsequent prescriptions, patients may obtain this product via special authorization with the following criteria for coverage:

"For use in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling.

Special authorization coverage may be granted for a maximum of 24 weeks of therapy per year."

This product is not eligible for auto-renewal.

0.5 MG (BASE) ORAL TABLET

00002419882	**APO-VARENICLINE**	**APX**	$	**1.3855**
00002291177	CHAMPIX	PFI	$	1.8437

1 MG (BASE) ORAL TABLET

00002419890	**APO-VARENICLINE**	**APX**	$	**1.3853**
00002291185	CHAMPIX	PFI	$	1.8432

VARENICLINE TARTRATE/ VARENICLINE TARTRATE

For subsequent prescriptions, patients may obtain this product via special authorization with the following criteria for coverage:

"For use in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling.

Special authorization coverage may be granted for a maximum of 24 weeks of therapy per year."

This product is not eligible for auto-renewal.

0.5 MG * 1 MG ORAL TABLET

00002435675	**APO-VARENICLINE (STARTER PACK)**	**APX**	$	**1.3804**
00002298309	CHAMPIX (STARTER PACK)	PFI	$	1.8370

VEDOLIZUMAB

Moderately to Severely Active Crohn's Disease

"Special authorization coverage may be approved for coverage of vedolizumab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease in patients who meet the following criteria:

- vedolizumab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for coverage for the treatment of Moderately to Severely Active Crohn's Disease patients ('Specialist').
- Patients must be 18 years of age or older to be considered for coverage of vedolizumab.
- Patients will be limited to receiving one dose of vedolizumab per prescription at their pharmacy.
- Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) 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.

Prior to initiation of vedolizumab therapy for New Patients:
'New Patients' are patients who have never been treated with vedolizumab by any health care provider.
Moderately to Severely Active Crohn's Disease:
Prior to initiation of vedolizumab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; AND refractory to, or dependent on, glucocorticoids: following at least one tapering dosing schedule of 40 mg/day, tapering by 5 mg each week to 20 mg, then tapering by 2.5 mg each week to zero, or similar.
[Note: Patients who have used the above treatments in combination will not be required to be challenged with individual treatments as monotherapy]

AND
b) Immunosuppressive therapy as follows:
- Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
- 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 3 months; OR
- Methotrexate: minimum or 15 mg/week for a minimum of 3 months.
OR
- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease
- New Patients must meet the criteria above prior to being considered for approval.
- All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:
- Coverage for Induction Dosing may only be approved for New Patients (those who have never

VEDOLIZUMAB

been treated with vedolizumab by any health care provider).
- 'Induction Dosing' means a maximum of one 300 mg dose of vedolizumab per New Patient at 0, 2 and 6 weeks (for a maximum total of three doses).
- New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.

Maintenance Dosing:
'Maintenance Dosing' means one 300 mg dose of vedolizumab per patient every eight (8) weeks for a period of 12 months to:
- New Patients following the completion of Induction Dosing; OR
- Existing Patients, who are patients that are being treated, or have previously been treated, with vedolizumab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:
- The New Patient must be assessed by a Specialist between weeks 10 and 14 after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease; AND
- The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's.

Maintenance Dosing for Existing Patients:
- The patient must be assessed by a Specialist at least 4 to 8 weeks after the day the last dose of vedolizumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's; AND
- these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

Continued Coverage for Maintenance Dosing:
-Continued coverage may be considered for one 300 mg dose of vedolizumab per patient provided no more often than every 8 weeks for a period of 12 months, if the following criteria are met at the end of each 12 month period:

- The New Patient or the Existing Patient must be assessed by a Specialist at least 4 to 6 weeks after the day the last dose of vedolizumab was administered to the patient and prior to the administration of the next dose to obtain a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's; AND
- For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's; OR
- For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score."

All requests (including renewal requests) for vedolizumab for Moderately to Severely Active Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Special Authorization Request Form (ABC 60031).

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks

AND

- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent

VEDOLIZUMAB

i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).
'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.

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for three doses of 300 mg of vedolizumab at 0, 2 and 6 weeks.

- Patients will be limited to receiving a one dose of vedolizumab 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 three doses, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 10 and 12 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 300 mg every 8 weeks for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of vedolizumab therapy."

All requests (including renewal requests) for vedolizumab for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

300 MG / VIAL INJECTION

00002436841	ENTYVIO	TAK	$ 3290.0000

VORICONAZOLE

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or a designated prescriber.)

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

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

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

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.

50 MG ORAL TABLET				
00002399245	**SANDOZ VORICONAZOLE**	**SDZ**	$	**3.1958**
00002396866	**TEVA-VORICONAZOLE**	**TEV**	$	**3.1958**
00002256460	VFEND	PFI	$	13.3516
200 MG ORAL TABLET				
00002399253	**SANDOZ VORICONAZOLE**	**SDZ**	$	**12.7777**
00002396874	**TEVA-VORICONAZOLE**	**TEV**	$	**12.7777**
00002256479	VFEND	PFI	$	53.3843
40 MG / ML ORAL SUSPENSION				
00002279991	VFEND	PFI	$	10.5318
200 MG / VIAL INJECTION				
00002256487	VFEND	PFI	$	160.0204

ZOLEDRONIC ACID

Osteoporosis:

"For the treatment of osteoporosis in patients who have:

A high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture, OR
A moderate 10-year fracture risk (10-20%) and have experienced a prior fragility fracture;

AND

at least one of the following:

1) For whom oral bisphosphonates are contraindicated due to an abnormality of the esophagus which delays esophageal emptying;

OR

2) Who have demonstrated persistent severe gastrointestinal intolerance to a course of therapy with either alendronate or risedronate;

OR

3) Who had an unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for 1 year and evidence of a decline in BMD below pre-treatment baseline level).

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) table.

Special Authorization may be granted for 12 months.

-Patients will be limited to receiving one dose of zoledronic acid per prescription at their pharmacy.

-Coverage cannot be provided for two or more osteoporosis medications (alendronate, denosumab, raloxifene, risedronate, zoledronic acid) when these medications are intended for use as combination therapy.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe.

-Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

-This product is eligible for auto-renewal for the treatment of osteoporosis.

All requests for zoledronic acid for osteoporosis must be completed using the Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form (ABC 60007).

Paget's Disease:

"For the treatment of Paget's disease. Special Authorization for this criterion may be granted for one dose per 12 month period."

"Coverage cannot be provided for two or more medications used in the treatment of

ZOLEDRONIC ACID

Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

0.05 MG / ML INJECTION

00002415100	**TARO-ZOLEDRONIC ACID**	**TAR**	$	**3.3540**
00002422433	**ZOLEDRONIC ACID**	**DRL**	$	**3.3540**
00002269198	ACLASTA	NOV	$	7.0850

"For the treatment of tumor-induced hypercalcemia in patients with documented evidence of intolerance or lack of response to clodronate or pamidronate.

For the prevention of skeletal-related events in patients with metastatic castration-resistant prostate cancer (CRPC) with one or more bony metastases.

Special authorization may be granted for 6 months."

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

0.8 MG / ML INJECTION

00002415186	**TARO-ZOLEDRONIC ACID CONCENTRATE**	**TAR**	$	**38.7856**
00002407639	**ZOLEDRONIC ACID**	**TEV**	$	**38.7856**
00002444739	**ZOLEDRONIC ACID**	**MDA**	$	**38.7856**
00002401606	**ZOLEDRONIC ACID - Z**	**SDZ**	$	**38.7856**
00002422425	**ZOLEDRONIC ACID CONCENTRATE**	**DRL**	$	**38.7856**
00002248296	ZOMETA CONCENTRATE	NOV	$	115.7940

ZOLMITRIPTAN

(Refer to 28:32.28 of the Alberta Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using zolmitriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

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

2.5 MG ORAL TABLET

00002421623	**JAMP-ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002399458	**MAR-ZOLMITRIPTAN**	**MAR**	$	**3.5375**
00002419521	**MINT-ZOLMITRIPTAN**	**MPI**	$	**3.5375**
00002421534	**NAT-ZOLMITRIPTAN**	**NTP**	$	**3.5375**
00002324229	**PMS-ZOLMITRIPTAN**	**PMS**	$	**3.5375**
00002362988	**SANDOZ ZOLMITRIPTAN**	**SDZ**	$	**3.5375**
00002313960	**TEVA-ZOLMITRIPTAN**	**TEV**	$	**3.5375**
00002238660	ZOMIG	AZC	$	14.9600

2.5 MG ORAL DISPERSIBLE TABLET

00002428237	**JAMP-ZOLMITRIPTAN ODT**	**JPC**	$	**1.7532**
00002428474	**SEPTA-ZOLMITRIPTAN-ODT**	**SEP**	$	**1.7532**
00002243045	ZOMIG RAPIMELT	AZC	$	14.9600

5 MG / DOSE NASAL UNIT DOSE SPRAY

00002248993	ZOMIG	AZC	$	14.9600

SECTION 3A

Criteria for Optional Special Authorization of Select Drug Products

CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

The drug products listed in this section may be considered for coverage by optional special authorization for patients covered under Alberta Health-sponsored drug programs. (For Alberta Human Services clients, the optional special authorization criteria for coverage can be found in the Criteria for Optional Special Authorization of Select Drug Products section of the *Alberta Human Services Drug Benefit Supplement*.)

Criteria for Coverage

Wording that appears within quotation marks (“ ”) in this section is the official optional special authorization criteria, as recommended by the Alberta Health Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health. Wording that is not enclosed in quotation marks outlines specific information required to interpret criteria, guidelines for submitting requests and/or information regarding conditions under which coverage cannot be provided.

Role of the Prescribers

In conjunction with the criteria, prescribers have two options by which patients may be eligible for coverage of these select optional special authorization drug products.

1) Prescribers can register to be a *designated prescriber*. Registration allows for patients to receive coverage of select drug products **without special authorization** as long as the prescription is written for one of the criteria for coverage set out in this section. Should a designated prescriber wish to prescribe one of the select drug products outside the coverage criteria, they may do so but must indicate this on the prescription; however, patients will not be eligible for payment under the Alberta government-sponsored program for such prescription and the patient may choose to receive the product at their expense. The registration form may be found on the previous page.

2) Prescribers who choose not to register will be considered *non-designated prescribers*. Such prescribers **will be required to apply for special authorization** on the patient’s behalf.

Registration for Designated Prescriber Status – Select Quinolone Antibiotics

On the reverse is the official *Registration for Designated Prescriber Status – Select Quinolone Antibiotics* (ABC 60041).

- All requests to become a "Registered Designated Prescriber" must be submitted using the *Registration for Designated Prescriber Status – Select Quinolone Antibiotics form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area

  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ALBERTA GOVERNMENT SPONSORED DRUG BENEFIT PROGRAMS
OPTIONAL SPECIAL AUTHORIZATION

REGISTRATION FOR DESIGNATED PRESCRIBER STATUS
for *Alberta Drug Benefit List* Claim Coverage

Select Quinolone Antibiotics
ciprofloxacin, levofloxacin, moxifloxacin

Please complete all sections of this form and return it by fax to Alberta Blue Cross

Registrations will be accepted on an ongoing basis

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	OFFICE PHONE	FAX

OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER
OR PROFESSIONAL REGISTRATION NUMBER

I have reviewed the criteria for coverage of select quinolone products and I agree to abide by and only prescribe in accordance with such criteria as updated from time to time in the Optional Special Authorization section of the *Alberta Drug Benefit List*.

SIGNATURE OF PRESCRIBER (required) _____ **DATE** _____

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-305-9911

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.

CIPROFLOXACIN

"For the treatment of:

1) Respiratory Tract Infections:
-end stage COPD with or without bronchiectasis, where there has been documentation of previous Pseudomonas aeruginosa colonization/infection or
- pneumonic illness in cystic fibrosis; or

2) Genitourinary Tract Infections:
- urinary tract infections,
- prostatitis,
- prophylaxis of urinary tract surgical procedures or
- gonococcal infections; or

3) Skin and Soft Tissue/Bone and Joint Infections:
- malignant/invasive otitis externa,
- bone/joint infections due to gram negative organisms or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. diabetic foot infection, decubitus ulcers; or

4) Gastrointestinal Tract Infections:
- bacterial gastroenteritis where antimicrobial therapy is indicated,
- typhoid fever (enteric fever), or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. intra-abdominal infections; or

5) Other:
- prophylaxis of adult contacts of cases of invasive meningococcal disease,
- therapy/step-down therapy of hospital acquired gram negative infections,
- empiric therapy of febrile neutropenia in combination with other appropriate agents or
- exceptional case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references i.e. AMA CPGs or Bugs and Drugs.
- for use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

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

100 MG / ML	**ORAL**	**SUSPENSION**			
00002237514	CIPRO		BAI	$	0.5750

CIPROFLOXACIN HCL

"For the treatment of:

1) Respiratory Tract Infections:
-end stage COPD with or without bronchiectasis, where there has been documentation of previous Pseudomonas aeruginosa colonization/infection or
- pneumonic illness in cystic fibrosis; or

2) Genitourinary Tract Infections:
- urinary tract infections,
- prostatitis,
- prophylaxis of urinary tract surgical procedures or
- gonococcal infections; or

3) Skin and Soft Tissue/Bone and Joint Infections:
- malignant/invasive otitis externa,
- bone/joint infections due to gram negative organisms or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. diabetic foot infection, decubitus ulcers; or

4) Gastrointestinal Tract Infections:
- bacterial gastroenteritis where antimicrobial therapy is indicated,
- typhoid fever (enteric fever), or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. intra-abdominal infections; or

5) Other:
- prophylaxis of adult contacts of cases of invasive meningococcal disease,
- therapy/step-down therapy of hospital acquired gram negative infections,
- empiric therapy of febrile neutropenia in combination with other appropriate agents or
- exceptional case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references i.e. AMA CPGs or Bugs and Drugs.
- for use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

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

250 MG (BASE) ORAL TABLET

00002247339	**ACT CIPROFLOXACIN**	**APH**	$	**0.4454**
00002381907	**AURO-CIPROFLOXACIN**	**AUR**	$	**0.4454**
00002353318	**CIPROFLOXACIN**	**SNS**	$	**0.4454**
00002386119	**CIPROFLOXACIN**	**SIV**	$	**0.4454**
00002380358	**JAMP-CIPROFLOXACIN**	**JPC**	$	**0.4454**
00002379686	**MAR-CIPROFLOXACIN**	**MAR**	$	**0.4454**
00002423553	**MINT-CIPROFLOX**	**MPI**	$	**0.4454**
00002248437	**PMS-CIPROFLOXACIN**	**PMS**	$	**0.4454**
00002303728	**RAN-CIPROFLOX**	**RAN**	$	**0.4454**
00002248756	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**0.4454**
00002379627	**SEPTA-CIPROFLOXACIN**	**SEP**	$	**0.4454**

CIPROFLOXACIN HCL

500 MG ORAL TABLET

00002247340	ACT CIPROFLOXACIN	APH	$	0.5025
00002381923	AURO-CIPROFLOXACIN	AUR	$	0.5025
00002353326	CIPROFLOXACIN	SNS	$	0.5025
00002386127	CIPROFLOXACIN	SIV	$	0.5025
00002380366	JAMP-CIPROFLOXACIN	JPC	$	0.5025
00002379694	MAR-CIPROFLOXACIN	MAR	$	0.5025
00002423561	MINT-CIPROFLOX	MPI	$	0.5025
00002248438	PMS-CIPROFLOXACIN	PMS	$	0.5025
00002303736	RAN-CIPROFLOX	RAN	$	0.5025
00002248757	SANDOZ CIPROFLOXACIN	SDZ	$	0.5025
00002379635	SEPTA-CIPROFLOXACIN	SEP	$	0.5025

750 MG (BASE) ORAL TABLET

00002247341	ACT CIPROFLOXACIN	APH	$	0.9201
00002229523	APO-CIPROFLOX	APX	$	0.9201
00002380374	JAMP-CIPROFLOXACIN	JPC	$	0.9201
00002379708	MAR-CIPROFLOXACIN	MAR	$	0.9201
00002423588	MINT-CIPROFLOX	MPI	$	0.9201
00002248439	PMS-CIPROFLOXACIN	PMS	$	0.9201
00002303744	RAN-CIPROFLOX	RAN	$	0.9201
00002248758	SANDOZ CIPROFLOXACIN	SDZ	$	0.9201
00002379643	SEPTA-CIPROFLOXACIN	SEP	$	0.9201

LEVOFLOXACIN

250 MG ORAL TABLET

00002315424	**ACT LEVOFLOXACIN**	**APH**	$	**1.2038**
00002284707	**APO-LEVOFLOXACIN**	**APX**	$	**1.2038**
00002298635	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**1.2038**

"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 Levofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 60042).

LEVOFLOXACIN

500 MG ORAL TABLET

00002315432	**ACT LEVOFLOXACIN**	**APH**	$	**1.3718**
00002284715	**APO-LEVOFLOXACIN**	**APX**	$	**1.3718**
00002298643	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**1.3718**

"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 Levofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 60042).

LEVOFLOXACIN

750 MG ORAL TABLET

00002315440	**ACT LEVOFLOXACIN**	**APH**	$	**4.8478**
00002325942	**APO-LEVOFLOXACIN**	**APX**	$	**4.8478**
00002298651	**SANDOZ LEVOFLOXACIN**	**SDZ**	$	**4.8478**

"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 Levofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 60042).

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

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**
00002242965	AVELOX	BAI	$	6.0858

SECTION 4

Rare Diseases Drug Coverage Program

RARE DISEASES DRUG COVERAGE PROGRAM

Selected drug products used in the treatment of rare diseases may be considered for coverage for individuals covered under Alberta government-sponsored drug programs. The Minister of Health makes the final decisions regarding coverage under this Program, and may list a drug product under this section when the Minister considers it in the public interest to do so[1].

RARE DISEASES DRUG COVERAGE

In order to be eligible for the Rare Diseases Drug Coverage Program, an individual must:

- have Alberta government-sponsored drug coverage;
- be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five years unless:
  - the individual is less than five years of age at the date of the application, then the individual's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years;

    OR
  - the individual has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for a drug product listed in this section in the province of origin by a provincial or territorial government sponsored drug plan, and the individual has been registered in the Alberta Health Care Insurance Plan (the individual must provide supporting documentation from the province of origin to prove prior coverage).
- meet the clinical criteria for a rare disease drug product published on the *List*;
- have a *Rare Diseases Drug Coverage* Application form ("Application") submitted on their behalf to Alberta Blue Cross by the individual's "Rare Disease Specialist";
- have the Application reviewed and approved for coverage by the Alberta Rare Diseases Clinical Review Panel ("Review Panel")
- complete the required forms, and consent to and acknowledge that
  - approval for initial and continued coverage is conditional upon clinical outcomes;
  - regular monitoring of the individual's clinical outcomes will be required, and
  - that coverage will be discontinued if there is inadequate response or the individual's condition deteriorates as outlined in the withdrawal criteria established in relation to a specific rare diseases drug product and/or as assessed by the Review Panel.

Contraindications

In addition to meeting the above criteria, the individual must not have the following contraindications:

- Significant illness, not including one of the rare diseases, likely to substantially alter or reduce life expectancy**.**

[1] Section 1 of the ADBL does not apply to the Rare Diseases Drug Coverage Program

Rare Diseases Drugs Eligible for Coverage

Drug products approved by Health Canada for the treatment of Rare Diseases may be considered for coverage in accordance with this section.

Rare Diseases are genetic, lysosomal storage disorders occurring at a rate of less than one per 50,000 for the Canadian population for a specific disease (as determined by Alberta Health).

As of April 1, 2009, drug products for the treatment of the following rare diseases are currently under consideration for coverage:

- Gaucher's disease
- Fabry disease
- MPS-I (Hurler/Hurler Scheie)
- Hunter disease
- Pompe disease

Alberta Rare Diseases Clinical Review Panel

The Alberta Rare Diseases Clinical Review Panel ("Review Panel") is a review panel composed of specialists treating rare diseases and other health professionals with clinical expertise, appointed by the Minister of Health.

The Review Panel's functions include:

- Providing advice to Alberta Health regarding the Rare Diseases Drug Coverage Program;
- Reviewing and applying clinical knowledge and skills to individual applications for Rare Diseases Drug Coverage; and
- Providing advice to the Expert Committee on Drug Evaluation and Therapeutics regarding drug products under consideration for coverage under this section, clinical criteria for rare diseases drug products and identifying appropriate "Rare Disease Specialists".

Process for Rare Diseases Drug Coverage

Participating "Rare Disease Specialists" must complete a Rare Diseases Drug Coverage Application form for each individual. The form must be the one specific to the rare diseases drug product being requested. The completed application may be forwarded to Alberta Blue Cross by mail or by facsimile.

To be considered for Rare Diseases Drug Coverage, the "Rare Disease Specialist" must confirm the individual (or individual's parent/guardian/legal representative) has been provided with information regarding the Rare Diseases Drug Coverage Program and have completed the required forms.

Alberta Blue Cross, in providing administrative support to the Review Panel, receives and screens each application for completeness, then forwards to Alberta Health to confirm that the individual has met the Alberta Health Care Insurance Plan registration requirement (please see above). Once it has been confirmed that the individual meets the Alberta Health Care Insurance Plan registration requirement, Alberta Blue Cross forwards the application to the Review Panel for assessment. Alberta Blue Cross responds to applicants on the Review Panel's behalf. After an application has been assessed by the Review Panel, Alberta Blue Cross notifies the individual's "Rare Disease Specialist" and the individual or individual's parent/guardian/legal representative by letter of the Review Panel's decision. Eligibility will be effective the date coverage is approved by the Review Panel.

Renewals require a new drug product specific Rare Diseases Drug Coverage Application form that is completed by a "Rare Disease Specialist".

To be eligible for Rare Diseases Drug Coverage, prescriptions must be written by a "Rare Disease Specialist" as identified by the eligibility criteria for the drug product. To avoid wastage, prescription quantities are limited to a one-month supply. Extended quantity and vacation supplies are not permitted. Out-of-country claims will only be reimbursed in accordance with standard rules and regulations; individuals should verify with Alberta Blue Cross these rules and regulations prior to obtaining drug products out of the country.

Government will not be responsible for reimbursement of costs associated with wastage or improper storage of rare diseases drug products.

Prior approval must be granted to ensure coverage. Approval is granted for a specific period, to a maximum of 12 months. If continued treatment is necessary, it is the responsibility of the individual or individual's parent/guardian/legal representative and the "Rare Disease Specialist" to re-apply for drug product coverage prior to the expiry date of the authorization period.

00:00

Non-Classified Drugs

00:00 NON-CLASSIFIED DRUGS

00:00.02

(DIABETES SUPPLIES)

DIABETES SUPPLIES

☒ 00000999955	BLOOD GLUCOSE TEST STRIPS	XXX	$	0.0000
☒ 00000999941	BLOOD LETTING LANCET	XXX	$	0.0000
☒ 00000999985	INSULIN PEN NEEDLES	XXX	$	0.0000
☒ 00000999952	INSULIN SYRINGES	XXX	$	0.0000
☒ 00000999957	URINE TEST STRIPS	XXX	$	0.0000

This product is a benefit for patients with diabetes who are currently and regularly using insulin.

Eligible individuals will have coverage to a maximum of $600 per person each benefit year for eligible diabetic supplies purchased from a licensed pharmacy.

04:00

Antihistamine Drugs

04:00 ANTIHISTAMINE DRUGS

04:04.04 FIRST GENERATION ANTIHISTAMINES (ETHANOLAMINE DERIVATIVES)

DIPHENHYDRAMINE HCL

50 MG / ML INJECTION

☒	00000596612	DIPHENHYDRAMINE	SDZ	$	4.0400

04:00 ANTIHISTAMINE DRUGS

04:04.12 FIRST GENERATION ANTIHISTAMINES (PHENOTHIAZINE DERIVATIVES)

TRIMEPRAZINE TARTRATE

2.5 MG (BASE) ORAL TABLET

	00001926306	PANECTYL	ERF	$	0.2974

5 MG (BASE) ORAL TABLET

	00001926292	PANECTYL	ERF	$	0.3649

04:00 ANTIHISTAMINE DRUGS

04:92 OTHER ANTIHISTAMINES

KETOTIFEN FUMARATE

1 MG (BASE) ORAL TABLET

	00000577308	ZADITEN	TEV	$	1.8452

08:00

Anti-Infective Agents

08:00 ANTI-INFECTIVE AGENTS

08:08 ANTHELMINTICS

MEBENDAZOLE

100 MG ORAL CHEWABLE TABLET				
00000556734	VERMOX	JAI	$	5.0300

08:00 ANTI-INFECTIVE AGENTS

08:12.02 ANTIBACTERIALS (AMINOGLYCOSIDES)

GENTAMICIN SULFATE

40 MG / ML (BASE) INJECTION				
☒ 00002242652	GENTAMICIN	SDZ	$	8.9447

TOBRAMYCIN

28 MG INHALATION CAPSULE				
00002365154	TOBI PODHALER	NOV	$	13.4510

TOBRAMYCIN SULFATE

60 MG / ML (BASE) INHALATION SOLUTION				
00002389622	**TEVA-TOBRAMYCIN**	**TEV**	$	**5.4763**
00002443368	**TOBRAMYCIN**	**SDZ**	$	**5.4763**
00002239630	TOBI	NOV	$	10.7608
40 MG / ML (BASE) INJECTION				
☒ 00002420287	JAMP-TOBRAMYCIN	JPC	$	2.7250

08:00 ANTI-INFECTIVE AGENTS

08:12.06.04 ANTIBACTERIALS CEPHALOSPORINS (FIRST GENERATION CEPHALOSPORINS)

CEFADROXIL

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

500 MG ORAL CAPSULE				
00002240774	**APO-CEFADROXIL**	**APX**	$	**0.8421**
00002235134	**TEVA-CEFADROXIL**	**TEV**	$	**0.8421**

CEFAZOLIN SODIUM

This Drug Product is a benefit for use by Home Parenteral Therapy (HPT) programs only.

500 MG / VIAL (BASE) INJECTION				
00002308932	**CEFAZOLIN**	**SDZ**	$	**2.5000**
00002108119	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**2.5000**
1 G / VIAL (BASE) INJECTION				
00002297205	**CEFAZOLIN**	**APX**	$	**3.2308**
00002308959	**CEFAZOLIN**	**SDZ**	$	**3.2308**
00002108127	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**3.2308**

08:00 ANTI-INFECTIVE AGENTS

08:12.06.04 ANTIBACTERIALS
CEPHALOSPORINS
(FIRST GENERATION CEPHALOSPORINS)

CEFAZOLIN SODIUM

10 G / VIAL (BASE) INJECTION				
00002237140	**CEFAZOLIN**	**FKC**	$	**30.1500**
00002297213	**CEFAZOLIN**	**APX**	$	**30.1500**
00002308967	**CEFAZOLIN**	**SDZ**	$	**30.1500**
00002437120	**CEFAZOLIN**	**STM**	$	**30.1500**
00002108135	**STERILE CEFAZOLIN SODIUM**	**TEV**	$	**30.1500**
100 G / G INJECTION				
00002401029	CEFAZOLIN	FKC	$	3.0150

CEPHALEXIN

250 MG ORAL TABLET				
00000768723	**APO-CEPHALEX**	**APX**	$	**0.0866**
00002470578	**AURO-CEPHALEXIN**	**AUR**	$	**0.0866**
00000583413	**TEVA-CEPHALEXIN**	**TEV**	$	**0.0866**
500 MG ORAL TABLET				
00000768715	**APO-CEPHALEX**	**APX**	$	**0.1731**
00002470586	**AURO-CEPHALEXIN**	**AUR**	$	**0.1731**
00000583421	**TEVA-CEPHALEXIN**	**TEV**	$	**0.1731**
250 MG ORAL CAPSULE				
00000342084	TEVA-CEPHALEXIN	TEV	$	0.4028
500 MG ORAL CAPSULE				
00000342114	TEVA-CEPHALEXIN	TEV	$	0.7615
25 MG / ML ORAL SUSPENSION				
00000342106	TEVA-CEPHALEXIN 125	TEV	$	0.2323
50 MG / ML ORAL SUSPENSION				
00000342092	TEVA-CEPHALEXIN 250	TEV	$	0.4468

08:00 ANTI-INFECTIVE AGENTS

08:12.06.08 ANTIBACTERIALS
CEPHALOSPORINS
(SECOND GENERATION CEPHALOSPORINS)

CEFPROZIL

250 MG ORAL TABLET				
00002292998	**APO-CEFPROZIL**	**APX**	$	**0.4332**
00002293528	**RAN-CEFPROZIL**	**RAN**	$	**0.4332**
00002302179	**SANDOZ CEFPROZIL**	**SDZ**	$	**0.4332**
500 MG ORAL TABLET				
00002293536	**RAN-CEFPROZIL**	**RAN**	$	**0.8494**
00002302187	**SANDOZ CEFPROZIL**	**SDZ**	$	**0.8494**

08:00 ANTI-INFECTIVE AGENTS

08:12.06.08 ANTIBACTERIALS
CEPHALOSPORINS
(SECOND GENERATION CEPHALOSPORINS)

CEFUROXIME AXETIL

250 MG (BASE) ORAL TABLET				
00002244393	**APO-CEFUROXIME**	**APX**	$	**0.7237**
00002344823	**AURO-CEFUROXIME**	**AUR**	$	**0.7237**
00002212277	CEFTIN	GSK	$	1.6775
500 MG (BASE) ORAL TABLET				
00002244394	**APO-CEFUROXIME**	**APX**	$	**1.4337**
00002344831	**AURO-CEFUROXIME**	**AUR**	$	**1.4337**
00002212285	CEFTIN	GSK	$	3.3231

08:00 ANTI-INFECTIVE AGENTS

08:12.06.12 ANTIBACTERIALS
CEPHALOSPORINS
(THIRD GENERATION CEPHALOSPORINS)

CEFIXIME

400 MG ORAL TABLET				
00002432773	**AURO-CEFIXIME**	**AUR**	$	**3.0796**
00000868981	SUPRAX	ODN	$	3.0800
20 MG / ML ORAL SUSPENSION				
00000868965	SUPRAX	ODN	$	0.4623

CEFOTAXIME SODIUM

1 G / VIAL (BASE) INJECTION				
00002434091	CEFOTAXIME SODIUM	STM	$	8.7465
2 G / VIAL (BASE) INJECTION				
00002434105	CEFOTAXIME SODIUM	STM	$	17.5198

CEFTAZIDIME

1 G / VIAL INJECTION				
☒ 00002212218	FORTAZ	GSK	$	23.4770
2 G / VIAL INJECTION				
☒ 00002212226	FORTAZ	GSK	$	46.1590
6 G / VIAL INJECTION				
☒ 00002212234	FORTAZ	GSK	$	138.5417

CEFTRIAXONE SODIUM

0.25 G / VIAL (BASE) INJECTION				
00002292866	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$	**3.9500**
00002325594	**CEFTRIAXONE SODIUM FOR INJECTION BP**	**STM**	$	**3.9500**
1 G / VIAL (BASE) INJECTION				
00002292270	**CEFTRIAXONE FOR INJECTION USP**	**SDZ**	$	**12.4900**
00002292874	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$	**12.4900**
00002287633	**CEFTRIAXONE SODIUM FOR INJECTION**	**TEV**	$	**12.4900**
00002325616	**CEFTRIAXONE SODIUM FOR INJECTION BP**	**STM**	$	**12.4900**
2 G / VIAL (BASE) INJECTION				
00002292289	**CEFTRIAXONE FOR INJECTION USP**	**SDZ**	$	**24.1300**
00002292882	**CEFTRIAXONE FOR INJECTION USP**	**APX**	$	**24.1300**
00002325624	**CEFTRIAXONE SODIUM FOR INJECTION BP**	**STM**	$	**24.1300**

08:00 ANTI-INFECTIVE AGENTS

08:12.06.12 ANTIBACTERIALS
CEPHALOSPORINS
(THIRD GENERATION CEPHALOSPORINS)

CEFTRIAXONE SODIUM

10 G / VIAL (BASE)	INJECTION			
00002325632	CEFTRIAXONE SODIUM	STM	$	153.0000

08:00 ANTI-INFECTIVE AGENTS

08:12.07.08 ANTIBACTERIALS
MISCELLANEOUS B-LACTAMS
(CARBAPENEMS)

ERTAPENEM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

1 G / VIAL	INJECTION			
00002247437	INVANZ	MFC	$	54.6344

IMIPENEM/ CILASTATIN SODIUM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

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500 MG / VIAL * 500 MG / VIAL (BASE)	INJECTION			
☒ 00000717282	PRIMAXIN	MFC	$	26.6910

MEROPENEM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

500 MG / VIAL	INJECTION			
☒ 00002378787	MEROPENEM	SDZ	$	9.2225
1 G / VIAL	**INJECTION**			
00002378795	**MEROPENEM**	**SDZ**	$	**18.4450**
00002436507	**MEROPENEM FOR INJECTION USP**	**STM**	$	**18.4450**

08:00 ANTI-INFECTIVE AGENTS

08:12.07.12 ANTIBACTERIALS
MISCELLANEOUS B-LACTAMS
(CEPHAMYCINS)

CEFOXITIN SODIUM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

1 G / VIAL (BASE)	**INJECTION**			
00002291711	**CEFOXITIN**	**APX**	$	**10.6000**
00002128187	**CEFOXITIN SODIUM**	**TEV**	$	**10.6000**
2 G / VIAL (BASE)	**INJECTION**			
00002291738	**CEFOXITIN**	**APX**	$	**21.2500**
00002128195	**CEFOXITIN SODIUM**	**TEV**	$	**21.2500**

08:00 ANTI-INFECTIVE AGENTS

08:12.08 ANTIBACTERIALS
(CHLORAMPHENICOL)

CHLORAMPHENICOL SODIUM SUCCINATE

1 G / VIAL (BASE)	**INJECTION**			
00000312363	CHLOROMYCETIN	ERF	$	20.2029

08:00 ANTI-INFECTIVE AGENTS

08:12.12.04 ANTIBACTERIALS
MACROLIDES
(ERYTHROMYCINS)

ERYTHROMYCIN

250 MG ORAL TABLET				
00000682020	ERYTHRO-BASE	AAP	$	0.1950
333 MG ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000873454	ERYC	PFI	$	0.7361

ERYTHROMYCIN STEARATE

250 MG ORAL TABLET				
00000545678	ERYTHRO-S	AAP	$	0.2205
500 MG ORAL TABLET				
00000688568	ERYTHRO-S	AAP	$	0.5534

08:00 ANTI-INFECTIVE AGENTS

08:12.12.92 ANTIBACTERIALS
MACROLIDES
(OTHER MACROLIDES)

AZITHROMYCIN

250 MG ORAL TABLET

00002415542	**APO-AZITHROMYCIN Z**	**APX**	$	**0.9410**
00002330881	**AZITHROMYCIN**	**SNS**	$	**0.9410**
00002442434	**AZITHROMYCIN**	**SIV**	$	**0.9410**
00002452308	**JAMP-AZITHROMYCIN**	**JPC**	$	**0.9410**
00002452324	**MAR-AZITHROMYCIN**	**MAR**	$	**0.9410**
00002267845	**NOVO-AZITHROMYCIN**	**TEV**	$	**0.9410**
00002261634	**PMS-AZITHROMYCIN**	**PMS**	$	**0.9410**
00002265826	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.9410**
00002212021	ZITHROMAX	PFI	$	5.2318

600 MG ORAL TABLET

00002261642	PMS-AZITHROMYCIN	PMS	$	7.6250

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

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20 MG / ML ORAL SUSPENSION

00002332388	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.3726**
00002223716	ZITHROMAX	PFI	$	1.1310

40 MG / ML ORAL SUSPENSION

00002274574	**GD-AZITHROMYCIN**	**GMD**	$	**0.5280**
00002332396	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.5280**
00002223724	ZITHROMAX	PFI	$	1.6026

CLARITHROMYCIN

250 MG ORAL TABLET

00002442469	**CLARITHROMYCIN**	**SIV**	$	**0.4122**
00002466120	**CLARITHROMYCIN**	**SNS**	$	**0.4122**
00002247573	**PMS-CLARITHROMYCIN**	**PMS**	$	**0.4122**
00002361426	**RAN-CLARITHROMYCIN**	**RAN**	$	**0.4122**
00002266539	**SANDOZ CLARITHROMYCIN**	**SDZ**	$	**0.4122**
00002248804	**TEVA-CLARITHROMYCIN**	**TEV**	$	**0.4122**
00001984853	BIAXIN BID	BGP	$	1.6833

500 MG ORAL TABLET

00002247574	**PMS-CLARITHROMYCIN**	**PMS**	$	**1.6292**
00002266547	**SANDOZ CLARITHROMYCIN**	**SDZ**	$	**1.6292**
00002248805	**TEVA-CLARITHROMYCIN**	**TEV**	$	**1.6292**
00002126710	BIAXIN BID	BGP	$	3.3271

500 MG ORAL EXTENDED-RELEASE TABLET

00002403196	**ACT CLARITHROMYCIN XL**	**APH**	$	**1.2572**
00002413345	**APO-CLARITHROMYCIN XL**	**APX**	$	**1.2572**
00002244756	BIAXIN XL	BGP	$	2.5671

25 MG / ML ORAL SUSPENSION

00002408988	**CLARITHROMYCIN**	**SNS**	$	**0.2047**
00002390442	**TARO-CLARITHROMYCIN**	**TAR**	$	**0.2047**
00002146908	BIAXIN	BGP	$	0.3029

08:00 ANTI-INFECTIVE AGENTS

08:12.12.92 ANTIBACTERIALS
MACROLIDES
(OTHER MACROLIDES)

CLARITHROMYCIN

50 MG / ML ORAL SUSPENSION				
00002408996	**CLARITHROMYCIN**	**SNS**	$	**0.3998**
00002390450	**TARO-CLARITHROMYCIN**	**TAR**	$	**0.3998**
00002244641	BIAXIN	BGP	$	0.5932

08:00 ANTI-INFECTIVE AGENTS

08:12.16.04 ANTIBACTERIALS
PENICILLINS
(NATURAL PENICILLINS)

PENICILLIN G SODIUM

1,000,000 IU / VIAL INJECTION				
00001930672	**PENICILLIN G SODIUM**	**TEV**	$	**2.4000**
00002220261	**PENICILLIN G SODIUM**	**FKC**	$	**2.4000**
5,000,000 IU / VIAL INJECTION				
00000883751	**PENICILLIN G SODIUM**	**TEV**	$	**5.1000**
00002220288	**PENICILLIN G SODIUM**	**FKC**	$	**5.1000**
10,000,000 IU / VIAL INJECTION				
00001930680	**PENICILLIN G SODIUM**	**TEV**	$	**8.9000**
00002220296	**PENICILLIN G SODIUM**	**FKC**	$	**8.9000**

PENICILLIN V POTASSIUM

300 MG ORAL TABLET				
00000642215	PEN-VK	AAP	$	0.1958

08:00 ANTI-INFECTIVE AGENTS

08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE

250 MG (BASE) ORAL CHEWABLE TABLET				
00002036355	NOVAMOXIN	TEV	$	0.7512
250 MG (BASE) ORAL CAPSULE				
00002352710	**AMOXICILLIN**	**SNS**	$	**0.1750**
00002401495	**AMOXICILLIN**	**SIV**	$	**0.1750**
00000628115	**APO-AMOXI**	**APX**	$	**0.1750**
00002388073	**AURO-AMOXICILLIN**	**AUR**	$	**0.1750**
00000406724	**NOVAMOXIN**	**TEV**	$	**0.1750**
500 MG (BASE) ORAL CAPSULE				
00002352729	**AMOXICILLIN**	**SNS**	$	**0.3417**
00002401509	**AMOXICILLIN**	**SIV**	$	**0.3417**
00000628123	**APO-AMOXI**	**APX**	$	**0.3417**
00002388081	**AURO-AMOXICILLIN**	**AUR**	$	**0.3417**
00002238172	**MYLAN-AMOXICILLIN**	**MYP**	$	**0.3417**
00000406716	**NOVAMOXIN**	**TEV**	$	**0.3417**
00002230244	**PMS-AMOXICILLIN**	**PMS**	$	**0.3417**

08:00 ANTI-INFECTIVE AGENTS

08:12.16.08 ANTIBACTERIALS
PENICILLINS
(AMINOPENICILLINS)

AMOXICILLIN TRIHYDRATE

25 MG / ML (BASE) ORAL SUSPENSION				
00000628131	APO-AMOXI	APX	$	0.0352
50 MG / ML (BASE) ORAL SUSPENSION				
00002352753	**AMOXICILLIN**	**SNS**	$	**0.0540**
00002401541	**AMOXICILLIN**	**SIV**	$	**0.0540**
00002352788	**AMOXICILLIN SUGAR-REDUCED**	**SNS**	$	**0.0540**
00000628158	**APO-AMOXI**	**APX**	$	**0.0540**
00000452130	**NOVAMOXIN**	**TEV**	$	**0.0540**
00001934163	**NOVAMOXIN SUGAR-REDUCED**	**TEV**	$	**0.0540**

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM

250 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002243350	APO-AMOXI CLAV	APX	$	0.9375
500 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002243351	**APO-AMOXI CLAV**	**APX**	$	**1.1333**
00001916858	CLAVULIN-500F	GSK	$	1.5420
875 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002245623	**APO-AMOXI CLAV**	**APX**	$	**1.1103**
00002238829	CLAVULIN-875	GSK	$	2.2735
25 MG / ML (BASE) * 6.25 MG / ML (BASE) ORAL SUSPENSION				
00001916882	CLAVULIN-125F	GSK	$	0.0969
40 MG / ML (BASE) * 5.7 MG / ML (BASE) ORAL SUSPENSION				
00002238831	CLAVULIN-200	GSK	$	0.1498
50 MG / ML (BASE) * 12.5 MG / ML (BASE) ORAL SUSPENSION				
00001916874	CLAVULIN-250F	GSK	$	0.2039
80 MG / ML (BASE) * 11.4 MG / ML (BASE) ORAL SUSPENSION				
00002238830	CLAVULIN-400	GSK	$	0.2869

AMPICILLIN

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

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250 MG ORAL CAPSULE				
00000020877	NOVO-AMPICILLIN	TEV	$	0.4223
500 MG ORAL CAPSULE				
00000020885	NOVO-AMPICILLIN	TEV	$	0.8006

AMPICILLIN SODIUM

250 MG / VIAL (BASE) INJECTION				
☒ 00000872644	AMPICILLIN SODIUM	TEV	$	3.1830
500 MG / VIAL (BASE) INJECTION				
☒ 00000872652	AMPICILLIN SODIUM	TEV	$	3.3384
1 G / VIAL (BASE) INJECTION				
☒ 00001933345	AMPICILLIN SODIUM	TEV	$	5.5886
2 G / VIAL (BASE) INJECTION				
☒ 00001933353	AMPICILLIN SODIUM	TEV	$	11.1781

08:00 ANTI-INFECTIVE AGENTS

08:12.16.12 ANTIBACTERIALS
PENICILLINS
(PENICILLINASE-RESISTANT PENICILLINS)

CLOXACILLIN SODIUM

250 MG (BASE) ORAL CAPSULE				
00000337765	NOVO-CLOXIN	TEV	$	0.4713
500 MG (BASE) ORAL CAPSULE				
00000337773	NOVO-CLOXIN	TEV	$	0.8911
25 MG / ML (BASE) ORAL LIQUID				
00000337757	NOVO-CLOXIN	TEV	$	0.1173
500 MG / VIAL (BASE) INJECTION				
00002367408	CLOXACILLIN	STM	$	4.7880
1 G / VIAL (BASE) INJECTION				
00002367416	CLOXACILLIN	STM	$	5.8800
2 G / VIAL (BASE) INJECTION				
00002367424	CLOXACILLIN	STM	$	7.6755

08:00 ANTI-INFECTIVE AGENTS

08:12.16.16 ANTIBACTERIALS
PENICILLINS
(EXTENDED-SPECTRUM PENICILLINS)

PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

2 G / VIAL (BASE) * 250 MG / VIAL (BASE) INJECTION				
00002308444	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**4.1727**
00002362619	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**4.1727**
00002401312	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**4.1727**
00002299623	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**4.1727**
3 G / VIAL (BASE) * 375 MG / VIAL (BASE) INJECTION				
00002308452	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**6.2591**
00002362627	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**6.2591**
00002401320	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**6.2591**
00002299631	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**6.2591**
00002370166	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**6.2591**
4 G / VIAL (BASE) * 500 MG / VIAL (BASE) INJECTION				
00002308460	**PIPERACILLIN AND TAZOBACTAM**	**APX**	$	**8.3458**
00002362635	**PIPERACILLIN AND TAZOBACTAM**	**STM**	$	**8.3458**
00002401339	**PIPERACILLIN AND TAZOBACTAM**	**TGT**	$	**8.3458**
00002299658	**PIPERACILLIN SODIUM/TAZOBACTAM SODIUM**	**SDZ**	$	**8.3458**
00002370174	**PIPERACILLIN/TAZOBACTAM**	**TEV**	$	**8.3458**

08:00 ANTI-INFECTIVE AGENTS

08:12.20 ANTIBACTERIALS (SULFONAMIDES)

SULFAMETHOXAZOLE/ TRIMETHOPRIM

100 MG * 20 MG ORAL TABLET				
00000445266	SULFATRIM	AAP	$	0.0911
400 MG * 80 MG ORAL TABLET				
00000445274	SULFATRIM	AAP	$	0.0482
800 MG * 160 MG ORAL TABLET				
00000445282	SULFATRIM DS	AAP	$	0.1221
40 MG / ML * 8 MG / ML ORAL SUSPENSION				
00000726540	TEVA-TRIMEL	TEV	$	0.1247
80 MG / ML * 16 MG / ML INJECTION				
00000550086	SEPTRA	APC	$	1.5600

SULFASALAZINE

500 MG ORAL TABLET				
00000598461	PMS-SULFASALAZINE	PMS	$	0.2678
500 MG ORAL ENTERIC-COATED TABLET				
00000598488	PMS-SULFASALAZINE	PMS	$	0.4074

08:00 ANTI-INFECTIVE AGENTS

08:12.24 ANTIBACTERIALS (TETRACYCLINES)

DOXYCYCLINE HYCLATE

100 MG (BASE) ORAL TABLET				
00000874256	**APO-DOXY**	**APX**	$	**0.5860**
00002351242	**DOXYCYCLINE**	**SNS**	$	**0.5860**
00002158574	**TEVA-DOXYCYCLINE**	**TEV**	$	**0.5860**
100 MG (BASE) ORAL CAPSULE				
00000740713	**APO-DOXY**	**APX**	$	**0.5860**
00002351234	**DOXYCYCLINE**	**SNS**	$	**0.5860**
00000725250	**TEVA-DOXYCYCLINE**	**TEV**	$	**0.5860**

MINOCYCLINE HCL

50 MG (BASE) ORAL CAPSULE				
00002084090	**APO-MINOCYCLINE**	**APX**	$	**0.1101**
00002230735	**MYLAN-MINOCYCLINE**	**MYP**	$	**0.1101**
00002108143	**NOVO-MINOCYCLINE**	**TEV**	$	**0.1101**
100 MG (BASE) ORAL CAPSULE				
00002084104	**APO-MINOCYCLINE**	**APX**	$	**0.2125**
00002230736	**MYLAN-MINOCYCLINE**	**MYP**	$	**0.2125**
00002108151	**NOVO-MINOCYCLINE**	**TEV**	$	**0.2125**

TETRACYCLINE HCL

250 MG ORAL CAPSULE				
00000580929	TETRACYCLINE	AAP	$	0.0700

08:00 ANTI-INFECTIVE AGENTS

08:12.28 ANTIBACTERIALS
(MISCELLANEOUS ANTIBACTERIALS)

SPIRAMYCIN

750,000 IU ORAL CAPSULE				
00001927825	ROVAMYCINE-250	ODN	$	1.4300
1,500,000 IU ORAL CAPSULE				
00001927817	ROVAMYCINE-500	ODN	$	2.7960

08:00 ANTI-INFECTIVE AGENTS

08:12.28.16 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(GLYCOPEPTIDES)

VANCOMYCIN HCL

125 MG (BASE) ORAL CAPSULE				
00002407744	**JAMP-VANCOMYCIN**	**JPC**	$	**5.1800**
00000800430	**VANCOCIN**	**SLP**	$	**5.1800**
250 MG (BASE) ORAL CAPSULE				
00002407752	**JAMP-VANCOMYCIN**	**JPC**	$	**10.3600**
00000788716	**VANCOCIN**	**SLP**	$	**10.3600**
500 MG / VIAL (BASE) INJECTION				
☒ 00002342855	VANCOMYCIN HCL	STM	$	31.0500
1 G / VIAL (BASE) INJECTION				
☒ 00002342863	VANCOMYCIN HCL	STM	$	58.9900
10 G / VIAL INJECTION				
00002241807	**STERILE VANCOMYCIN HCL**	**FKC**	$	**589.9000**
00002405830	**VANCOMYCIN HCL**	**STM**	$	**589.9000**

RESTRICTED BENEFIT

This Drug Product is a benefit for use by Home Parenteral Therapy (HPT) programs only.

08:00 ANTI-INFECTIVE AGENTS

08:12.28.20 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(LINCOMYCINS)

CLINDAMYCIN HCL

150 MG (BASE) ORAL CAPSULE				
00002245232	**APO-CLINDAMYCIN**	**APX**	$	**0.2217**
00002436906	**AURO-CLINDAMYCIN**	**AUR**	$	**0.2217**
00002241709	**TEVA-CLINDAMYCIN**	**TEV**	$	**0.2217**
300 MG (BASE) ORAL CAPSULE				
00002245233	**APO-CLINDAMYCIN**	**APX**	$	**0.4434**
00002436914	**AURO-CLINDAMYCIN**	**AUR**	$	**0.4434**
00002241710	**TEVA-CLINDAMYCIN**	**TEV**	$	**0.4434**

08:00 ANTI-INFECTIVE AGENTS

08:12.28.20 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(LINCOMYCINS)

CLINDAMYCIN PALMITATE HCL

15 MG / ML (BASE)	ORAL SOLUTION			
00000225851	DALACIN C PALMITATE	PFI	$	0.1893

CLINDAMYCIN PHOSPHATE

150 MG / ML (BASE)	INJECTION			
00002230540	CLINDAMYCIN	SDZ	$	3.6550
00002230535	CLINDAMYCIN (60 & 120 ML)	SDZ	$	3.6550
00000260436	DALACIN C PHOSPHATE	PFI	$	4.4469

08:00 ANTI-INFECTIVE AGENTS

08:12.28.24 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(OXAZOLIDINONES)

LINEZOLID

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

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600 MG	ORAL TABLET			
00002426552	**APO-LINEZOLID**	**APX**	$	**37.0500**
00002422689	**SANDOZ LINEZOLID**	**SDZ**	$	**37.0500**
00002243684	ZYVOXAM	PFI	$	75.7024

08:00 ANTI-INFECTIVE AGENTS

08:12.28.28 ANTIBACTERIALS
MISCELLANEOUS ANTIBACTERIALS
(POLYMYXINS)

COLISTIMETHATE SODIUM

150 MG / VIAL	INJECTION			
☒ 00002244849	COLISTIMETHATE FOR INJECTION	STM	$	33.7397

08:00 ANTI-INFECTIVE AGENTS

08:14.04 ANTIFUNGALS (ALLYLAMINES)

TERBINAFINE HCL

250 MG (BASE) ORAL TABLET

00002254727	**ACT TERBINAFINE**	**APH**	$	**0.7714**
00002239893	**APO-TERBINAFINE**	**APX**	$	**0.7714**
00002320134	**AURO-TERBINAFINE**	**AUR**	$	**0.7714**
00002294273	**PMS-TERBINAFINE**	**PMS**	$	**0.7714**
00002353121	**TERBINAFINE**	**SNS**	$	**0.7714**
00002385279	**TERBINAFINE**	**SIV**	$	**0.7714**
00002240346	**TEVA-TERBINAFINE**	**TEV**	$	**0.7714**
00002031116	LAMISIL	NOV	$	4.3032

08:00 ANTI-INFECTIVE AGENTS

08:14.08 ANTIFUNGALS (AZOLES)

FLUCONAZOLE

50 MG ORAL TABLET

00002281260	**ACT FLUCONAZOLE**	**APH**	$	**1.2904**
00002237370	**APO-FLUCONAZOLE**	**APX**	$	**1.2904**
00002245292	**MYLAN-FLUCONAZOLE**	**MYP**	$	**1.2904**
00002236978	**NOVO-FLUCONAZOLE**	**TEV**	$	**1.2904**
00002245643	**PMS-FLUCONAZOLE**	**PMS**	$	**1.2904**

100 MG ORAL TABLET

00002281279	**ACT FLUCONAZOLE**	**APH**	$	**2.2890**
00002237371	**APO-FLUCONAZOLE**	**APX**	$	**2.2890**
00002245293	**MYLAN-FLUCONAZOLE**	**MYP**	$	**2.2890**
00002236979	**NOVO-FLUCONAZOLE**	**TEV**	$	**2.2890**
00002245644	**PMS-FLUCONAZOLE**	**PMS**	$	**2.2890**

10 MG / ML ORAL SUSPENSION

00002024152	DIFLUCAN	PFI	$	1.1854

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2 MG / ML INJECTION

☒ 00000891835	DIFLUCAN	PFI	$	0.4085

08:00 ANTI-INFECTIVE AGENTS

08:14.08 ANTIFUNGALS (AZOLES)

ITRACONAZOLE

100 MG ORAL CAPSULE

00002462559	**MINT-ITRACONAZOLE**	**MPI**	$	**4.2075**
00002047454	SPORANOX	JAI	$	4.3547

10 MG / ML ORAL SOLUTION

00002231347	SPORANOX	JAI	$	0.8222

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

KETOCONAZOLE

200 MG ORAL TABLET

00002237235	**APO-KETOCONAZOLE**	**APX**	$	**0.9393**
00002231061	**TEVA-KETOCONAZOLE**	**TEV**	$	**0.9393**

VORICONAZOLE

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

50 MG ORAL TABLET

00002399245	**SANDOZ VORICONAZOLE**	**SDZ**	$	**3.1958**
00002396866	**TEVA-VORICONAZOLE**	**TEV**	$	**3.1958**
00002256460	VFEND	PFI	$	13.3516

200 MG ORAL TABLET

00002399253	**SANDOZ VORICONAZOLE**	**SDZ**	$	**12.7777**
00002396874	**TEVA-VORICONAZOLE**	**TEV**	$	**12.7777**
00002256479	VFEND	PFI	$	53.3843

40 MG / ML ORAL SUSPENSION

00002279991	VFEND	PFI	$	10.5318

200 MG / VIAL INJECTION

00002256487	VFEND	PFI	$	160.0204

08:00 ANTI-INFECTIVE AGENTS

08:14.16 ANTIFUNGALS
(ECHINOCANDINS)

CASPOFUNGIN

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

50 MG / VIAL INJECTION				
00002460947	**CASPOFUNGIN**	**MDA**	$	**188.7000**
00002244265	CANCIDAS	MFC	$	222.0000
70 MG / VIAL INJECTION				
00002460955	**CASPOFUNGIN**	**MDA**	$	**188.7000**
00002244266	CANCIDAS	MFC	$	222.0000

08:00 ANTI-INFECTIVE AGENTS

08:14.28 ANTIFUNGALS
(POLYENES)

AMPHOTERICIN B

50 MG / VIAL INJECTION				
☒ 00000029149	FUNGIZONE IV	BMS	$	80.0438

NYSTATIN

100,000 UNIT / ML ORAL SUSPENSION				
☒ 00002433443	JAMP-NYSTATIN	JPC	$	0.0518
00000792667	**PMS-NYSTATIN**	**PMS**	$	**0.0518**
00002194201	**TEVA-NYSTATIN**	**TEV**	$	**0.0518**

08:00 ANTI-INFECTIVE AGENTS

08:16.92 ANTIMYCOBACTERIALS
(MISCELLANEOUS ANTIMYCOBACTERIALS)

DAPSONE

100 MG ORAL TABLET				
00002481227	**MAR-DAPSONE**	**MAR**	$	**1.1952**
00002041510	DAPSONE	NTI	$	1.4061

RIFABUTIN

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or a designated prescriber.)

150 MG ORAL CAPSULE				
00002063786	MYCOBUTIN	PFI	$	5.5288

08:00 ANTI-INFECTIVE AGENTS

08:18.08.20 ANTIVIRALS

ANTIRETROVIRALS

(NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS)

LAMIVUDINE

RESTRICTED BENEFIT - This product is a benefit when initiated by a Specialist in Internal Medicine or a designated prescriber.

100 MG ORAL TABLET

00002393239	**APO-LAMIVUDINE HBV**	**APX**	$	**3.5316**
00002239193	HEPTOVIR	GSK	$	4.9066

TENOFOVIR DISOPROXIL FUMARATE

RESTRICTED BENEFIT - This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber.

300 MG (BASE) ORAL TABLET

00002451980	**APO-TENOFOVIR**	**APX**	$	**4.8884**
00002460173	**AURO-TENOFOVIR**	**AUR**	$	**4.8884**
00002479087	**JAMP-TENOFOVIR**	**JPC**	$	**4.8884**
00002452634	**MYLAN-TENOFOVIR DISOPROXIL**	**MYP**	$	**4.8884**
00002472511	**NAT-TENOFOVIR**	**NTP**	$	**4.8884**
00002453940	**PMS-TENOFOVIR**	**PMS**	$	**4.8884**
00002403889	**TEVA-TENOFOVIR**	**TEV**	$	**4.8884**
00002247128	VIREAD	GIL	$	18.4879

08:00 ANTI-INFECTIVE AGENTS

08:18.20 ANTIVIRALS

(INTERFERONS)

PEGINTERFERON ALFA-2A

RESTRICTED BENEFIT

This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber. (For eligibility for the treatment of chronic hepatitis C refer to Criteria for Special Authorization of Select Drug Products of the List and Criteria for Special Authorization of Select Drug Products of the Alberta Human Services Drug Benefit Supplement for Alberta Human Services clients.)

180 MCG / SYR INJECTION SYRINGE

00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	$	419.7000

08:00 ANTI-INFECTIVE AGENTS

08:18.32 ANTIVIRALS (NUCLEOSIDES AND NUCLEOTIDES)

ACYCLOVIR

200 MG ORAL TABLET				
00002207621	**APO-ACYCLOVIR**	**APX**	$	**0.6397**
00002242784	**MYLAN-ACYCLOVIR**	**MYP**	$	**0.6397**
00002285959	**TEVA-ACYCLOVIR**	**TEV**	$	**0.6397**
400 MG ORAL TABLET				
00002207648	**APO-ACYCLOVIR**	**APX**	$	**1.2700**
00002242463	**MYLAN-ACYCLOVIR**	**MYP**	$	**1.2700**
00002285967	**TEVA-ACYCLOVIR**	**TEV**	$	**1.2700**
800 MG ORAL TABLET				
00002207656	**APO-ACYCLOVIR**	**APX**	$	**1.2673**
00002242464	**MYLAN-ACYCLOVIR**	**MYP**	$	**1.2673**
00002285975	**TEVA-ACYCLOVIR**	**TEV**	$	**1.2673**
40 MG / ML ORAL SUSPENSION				
00000886157	ZOVIRAX	GSK	$	0.2595

ADEFOVIR DIPIVOXIL

RESTRICTED BENEFIT - This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber.

10 MG ORAL TABLET				
00002420333	**APO-ADEFOVIR**	**APX**	$	**18.2518**
00002247823	HEPSERA	GIL	$	23.8405

ENTECAVIR

RESTRICTED BENEFIT - This product is a benefit for the treatment of chronic hepatitis B when prescribed by a Specialist in Internal Medicine or a designated prescriber.

0.5 MG ORAL TABLET				
00002396955	**APO-ENTECAVIR**	**APX**	$	**5.5000**
00002448777	**AURO-ENTECAVIR**	**AUR**	$	**5.5000**
00002467232	**JAMP-ENTECAVIR**	**JPC**	$	**5.5000**
00002430576	**PMS-ENTECAVIR**	**PMS**	$	**5.5000**
00002282224	BARACLUDE	BMS	$	22.6601

GANCICLOVIR SODIUM

500 MG / VIAL (BASE) INJECTION				
00002162695	CYTOVENE	CAG	$	44.5480

08:00 ANTI-INFECTIVE AGENTS

08:18.32 ANTIVIRALS (NUCLEOSIDES AND NUCLEOTIDES)

VALACYCLOVIR

500 MG ORAL TABLET

00002295822	**APO-VALACYCLOVIR (CAPLET)**	**APX**	$	**0.6198**
00002405040	**AURO-VALACYCLOVIR**	**AUR**	$	**0.6198**
00002441454	**JAMP-VALACYCLOVIR**	**JPC**	$	**0.6198**
00002441586	**MAR-VALACYCLOVIR**	**MAR**	$	**0.6198**
00002351579	**MYLAN-VALACYCLOVIR (CAPLET)**	**MYP**	$	**0.6198**
00002298457	**PMS-VALACYCLOVIR (CAPLET)**	**PMS**	$	**0.6198**
00002347091	**SANDOZ VALACYCLOVIR**	**SDZ**	$	**0.6198**
00002357534	**TEVA-VALACYCLOVIR**	**TEV**	$	**0.6198**
00002442000	**VALACYCLOVIR**	**SIV**	$	**0.6198**
00002454645	**VALACYCLOVIR**	**SNS**	$	**0.6198**
00002219492	VALTREX (CAPLET)	GSK	$	3.4436

1,000 MG ORAL TABLET

00002354705	**APO-VALACYCLOVIR (CAPLET)**	**APX**	$	**1.7218**
00002351560	**MYLAN-VALACYCLOVIR (CAPLET)**	**MYP**	$	**1.7218**
00002381230	**PMS-VALACYCLOVIR (CAPLET)**	**PMS**	$	**1.7218**

VALGANCICLOVIR HCL

450 MG (BASE) ORAL TABLET

00002393824	**APO-VALGANCICLOVIR**	**APX**	$	**5.8553**
00002435179	**AURO-VALGANCICLOVIR**	**AUR**	$	**5.8553**
00002413825	**TEVA-VALGANCICLOVIR**	**TEV**	$	**5.8553**
00002245777	VALCYTE	HLR	$	24.7087

50 MG / ML ORAL SUSPENSION

00002306085	VALCYTE	HLR	$	2.7452

08:00 ANTI-INFECTIVE AGENTS

08:30.08 ANTIPROTOZOALS (ANTIMALARIALS)

CHLOROQUINE PHOSPHATE

250 MG ORAL TABLET

00000021261	TEVA-CHLOROQUINE	TEV	$	1.3495

HYDROXYCHLOROQUINE SULFATE

200 MG ORAL TABLET

00002246691	**APO-HYDROXYQUINE**	**APX**	$	**0.2620**
00002424991	**MINT-HYDROXYCHLOROQUINE**	**MPI**	$	**0.2620**
00002017709	PLAQUENIL SULFATE	SAV	$	0.6302

PRIMAQUINE PHOSPHATE

15 MG (BASE) ORAL TABLET

00002017776	PRIMAQUINE PHOSPHATE	SAV	$	0.4397

08:00 ANTI-INFECTIVE AGENTS

08:30.08 ANTIPROTOZOALS (ANTIMALARIALS)

QUININE SULFATE

200 MG ORAL CAPSULE				
00002254514	**APO-QUININE**	**APX**	$	**0.2390**
00002445190	**JAMP-QUININE**	**JPC**	$	**0.2390**
00000021008	**TEVA-QUININE**	**TEV**	$	**0.2390**
300 MG ORAL CAPSULE				
00002254522	**APO-QUININE**	**APX**	$	**0.3750**
00002445204	**JAMP-QUININE**	**JPC**	$	**0.3750**
00000021016	**TEVA-QUININE**	**TEV**	$	**0.3750**

08:00 ANTI-INFECTIVE AGENTS

08:30.92 ANTIPROTOZOALS (MISCELLANEOUS ANTIPROTOZOALS)

ATOVAQUONE

150 MG / ML ORAL SUSPENSION				
00002217422	MEPRON	GSK	$	2.8412

METRONIDAZOLE

250 MG ORAL TABLET				
00000545066	METRONIDAZOLE	AAP	$	0.0635
5 MG / ML INJECTION				
00000870420	**FLAGYL**	**BAX**	$	**0.0269**
00000649074	METRONIDAZOLE	PFI	$	0.1740

08:00 ANTI-INFECTIVE AGENTS

08:36 URINARY ANTI-INFECTIVES

FOSFOMYCIN TROMETHAMINE

3 G (BASE) ORAL POWDER PACKET				
00002473801	**JAMP-FOSFOMYCIN**	**JPC**	$	**14.0250**
00002240335	MONUROL	PAL	$	18.1862

NITROFURANTOIN

50 MG ORAL TABLET				
00000319511	NITROFURANTOIN	AAP	$	0.1781
100 MG ORAL TABLET				
00000312738	NITROFURANTOIN	AAP	$	0.2376
50 MG ORAL CAPSULE (MACROCRYSTALS)				
00002231015	TEVA-NITROFURANTOIN	TEV	$	0.3841
100 MG ORAL CAPSULE (MACROCRYSTALS)				
00002231016	TEVA-NITROFURANTOIN	TEV	$	0.7761
100 MG ORAL CAPSULE (MACROCRYSTALS/MONOHYDRATE)				
00002455676	**PMS-NITROFURANTOIN**	**PMS**	$	**0.5974**
00002063662	MACROBID	ASC	$	0.7983

TRIMETHOPRIM

100 MG ORAL TABLET				
00002243116	TRIMETHOPRIM	AAP	$	0.2736
200 MG ORAL TABLET				
00002243117	TRIMETHOPRIM	AAP	$	0.5623

10:00

Antineoplastic Agents

10:00 ANTINEOPLASTIC AGENTS

10:00

5-FLUOROURACIL/ SALICYLIC ACID

0.5 % * 10 % TOPICAL SOLUTION

00002428946	ACTIKERALL	CIP	$	1.5581

METHOTREXATE

2.5 MG ORAL TABLET

00002182963	**APO-METHOTREXATE**	**APX**	$	**0.6325**
00002170698	**PMS-METHOTREXATE**	**PMS**	$	**0.6325**

10 MG ORAL TABLET

00002182750	METHOTREXATE	PFI	$	2.6505

METHOTREXATE SODIUM

25 MG / ML (BASE) INJECTION

00002099705	**METHOTREXATE SOD.(UNPRESERVED)**	**TEV**	$	**5.6250**
00002182955	**METHOTREXATE SOD.(UNPRESERVED)**	**PFI**	$	**5.6250**

25 MG / ML (BASE) INJECTION

00002398427	**METHOTREXATE (PRESERVED)**	**SDZ**	$	**4.4600**
00002182777	METHOTREXATE SOD. (PRESERVED)	PFI	$	8.4472

17.5 MG / SYR (BASE) INJECTION SYRINGE

00002454769	METOJECT SUBCUTANEOUS	MDX	$	32.0000

20 MG / SYR (BASE) INJECTION SYRINGE

00002454866	METOJECT SUBCUTANEOUS	MDX	$	35.0000

22.5 MG / SYR (BASE) INJECTION SYRINGE

00002454777	METOJECT SUBCUTANEOUS	MDX	$	35.0000

25 MG / SYR (BASE) INJECTION SYRINGE

00002454874	METOJECT SUBCUTANEOUS	MDX	$	39.0000

12:00

Autonomic Drugs

12:00 AUTONOMIC DRUGS

12:04 PARASYMPATHOMIMETIC (CHOLINERGIC) AGENTS

PILOCARPINE HCL

5 MG ORAL TABLET

00002216345	SALAGEN	PFI	$	1.4641

PYRIDOSTIGMINE BROMIDE

60 MG ORAL TABLET

00000869961	MESTINON	VCL	$	0.4880

180 MG ORAL SUSTAINED-RELEASE TABLET

00000869953	MESTINON-SR	VCL	$	1.0861

12:00 AUTONOMIC DRUGS

12:08.08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS / ANTISPASMODICS)

ACLIDINIUM BROMIDE

400 MCG / DOSE INHALATION METERED INHALATION POWDER

00002409720	TUDORZA GENUAIR	AZC	$	0.8850

ATROPINE SULFATE

0.4 MG / ML INJECTION

00000392782	ATROPINE SULFATE	SDZ	$	2.2880

0.6 MG / ML INJECTION

00000392693	ATROPINE SULFATE	SDZ	$	2.4880

GLYCOPYRROLATE

0.2 MG / ML INJECTION

☒ 00002039508	GLYCOPYRROLATE	SDZ	$	3.9780

HYOSCINE BUTYLBROMIDE

10 MG ORAL TABLET

00000363812	BUSCOPAN	SAV	$	0.3368

20 MG / ML INJECTION

00000363839	BUSCOPAN	SAV	$	4.5860

IPRATROPIUM BROMIDE

20 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002247686	ATROVENT HFA	BOE	$	0.1013

250 MCG / ML INHALATION SOLUTION

00002126222	**APO-IPRAVENT**	**APX**	$	**0.3155**
00002231136	**PMS-IPRATROPIUM**	**PMS**	$	**0.3155**

0.03 % NASAL SPRAY

00002239627	PMS-IPRATROPIUM	PMS	$	0.8693

IPRATROPIUM BROMIDE/ SALBUTAMOL SULFATE

0.2 MG / ML * 1 MG / ML (BASE) INHALATION SOLUTION

00002272695	**TEVA-COMBO STERINEBS**	**TEV**	$	**0.5318**
00002231675	COMBIVENT UDV	BOE	$	0.6452

TIOTROPIUM BROMIDE MONOHYDRATE

2.5 MCG / DOSE INHALATION SOLUTION

00002435381	SPIRIVA RESPIMAT	BOE	$	0.9013

18 MCG INHALATION CAPSULE

00002246793	SPIRIVA	BOE	$	1.8027

12:00 AUTONOMIC DRUGS

12:08.08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS / ANTISPASMODICS)

UMECLIDINIUM BROMIDE

62.5 MCG / DOSE INHALATION METERED INHALATION POWDER

00002423596	INCRUSE ELLIPTA	GSK	$	1.6667

12:00 AUTONOMIC DRUGS

12:12.04 SYMPATHOMIMETIC (ADRENERGIC) AGENTS (ALPHA-ADRENERGIC AGONISTS)

MIDODRINE HCL

2.5 MG ORAL TABLET

00002278677	**APO-MIDODRINE**	**APX**	$	**0.2305**
00002473984	**MAR-MIDODRINE**	**MAR**	$	**0.2305**

5 MG ORAL TABLET

00002278685	**APO-MIDODRINE**	**APX**	$	**0.3842**
00002473992	**MAR-MIDODRINE**	**MAR**	$	**0.3842**

12:00 AUTONOMIC DRUGS

12:12.08.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS BETA-ADRENERGIC AGONISTS (SELECTIVE BETA 2-ADRENERGIC AGONISTS)

FORMOTEROL FUMARATE

12 MCG INHALATION CAPSULE

00002230898	FORADIL	NOV	$	0.8520

FORMOTEROL FUMARATE DIHYDRATE

6 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237225	OXEZE TURBUHALER	AZC	$	0.5588

12 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237224	OXEZE TURBUHALER	AZC	$	0.7445

INDACATEROL MALEATE

75 MCG (BASE) INHALATION CAPSULE

00002376938	ONBREZ BREEZHALER	NOV	$	1.5500

ORCIPRENALINE SULFATE

2 MG / ML ORAL SYRUP

00002236783	ORCIPRENALINE	AAP	$	0.0600

SALBUTAMOL

100 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002419858	**SALBUTAMOL HFA**	**SNS**	$	**0.0263**
00002232570	AIROMIR CFC-FREE	VCL	$	0.0269
00002245669	APO-SALVENT CFC FREE	APX	$	0.0273
00002241497	VENTOLIN HFA	GSK	$	0.0300

12:00 AUTONOMIC DRUGS

12:12.08.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS BETA-ADRENERGIC AGONISTS (SELECTIVE BETA 2-ADRENERGIC AGONISTS)

SALBUTAMOL SULFATE

0.5 MG / ML (BASE) INHALATION SOLUTION				
00002208245	PMS-SALBUTAMOL	PMS	$	0.1492
1 MG / ML (BASE) INHALATION SOLUTION				
00002208229	**PMS-SALBUTAMOL**	**PMS**	$	**0.1446**
00001926934	**TEVA-SALBUTAMOL STERINEBS P.F.**	**TEV**	$	**0.1446**
00002213419	VENTOLIN NEBULES P.F.	GSK	$	0.2354
5 MG / ML (BASE) INHALATION SOLUTION				
00002213486	VENTOLIN	GSK	$	0.2350
2 MG / ML (BASE) INHALATION UNIT DOSE SOLUTION				
00002208237	**PMS-SALBUTAMOL POLYNEB**	**PMS**	$	**0.2700**
00002173360	**TEVA-SALBUTAMOL STERINEBS P.F.**	**TEV**	$	**0.2700**
00002213427	VENTOLIN NEBULES P.F.	GSK	$	0.2764

SALMETEROL XINAFOATE

50 MCG / DOSE (BASE) INHALATION METERED INHALATION POWDER				
00002231129	SEREVENT DISKUS	GSK	$	1.0005

TERBUTALINE SULFATE

0.5 MG / DOSE INHALATION METERED INHALATION POWDER				
00000786616	BRICANYL TURBUHALER	AZC	$	0.0821

12:00 AUTONOMIC DRUGS

12:12.12 SYMPATHOMIMETIC (ADRENERGIC) AGENTS (ALPHA- AND BETA-ADRENERGIC AGONISTS)

EPINEPHRINE

0.15 MG / SYR INJECTION SYRINGE				
00000578657	EPIPEN JR	MYS	$	88.5588
0.3 MG / SYR INJECTION SYRINGE				
00000509558	EPIPEN	MYS	$	88.5588

EPINEPHRINE HCL

1 MG / ML INJECTION				
00000155357	ADRENALIN	ERF	$	0.7410

12:00 AUTONOMIC DRUGS

12:16 SYMPATHOLYTIC (ADRENERGIC BLOCKING) AGENTS

DIHYDROERGOTAMINE MESYLATE

4 MG / ML NASAL SPRAY				
00002228947	MIGRANAL	STM	$	14.5775
1 MG / ML INJECTION				
00000027243	DIHYDROERGOTAMINE (DHE)	STM	$	11.7453

12:00 AUTONOMIC DRUGS

12:20.04 SKELETAL MUSCLE RELAXANTS

(CENTRALLY ACTING SKELETAL MUSCLE RELAXANTS)

CYCLOBENZAPRINE HCL

RESTRICTED BENEFIT - Coverage is limited to 126 tablets per plan participant per year as an adjunct to rest and physical therapy for the treatment of acute muscle spasm.

10 MG ORAL TABLET

00002177145	**APO-CYCLOBENZAPRINE**	**APX**	$	**0.1022**
00002348853	**AURO-CYCLOBENZAPRINE**	**AUR**	$	**0.1022**
00002287064	**CYCLOBENZAPRINE**	**SNS**	$	**0.1022**
00002424584	**CYCLOBENZAPRINE**	**SIV**	$	**0.1022**
00002357127	**JAMP-CYCLOBENZAPRINE**	**JPC**	$	**0.1022**
00002212048	**PMS-CYCLOBENZAPRINE**	**PMS**	$	**0.1022**
00002080052	**TEVA-CYCLOBENZAPRINE**	**TEV**	$	**0.1022**

12:00 AUTONOMIC DRUGS

12:20.08 SKELETAL MUSCLE RELAXANTS

(DIRECT-ACTING SKELETAL MUSCLE RELAXANTS)

DANTROLENE SODIUM

25 MG ORAL CAPSULE

00001997602	DANTRIUM	PAL	$	0.4096

12:00 AUTONOMIC DRUGS

12:20.12 SKELETAL MUSCLE RELAXANTS

(GABA-DERIVATIVE SKELETAL MUSCLE RELAXANTS)

BACLOFEN

10 MG ORAL TABLET

00002139332	**APO-BACLOFEN**	**APX**	$	**0.1595**
00002287021	**BACLOFEN**	**SNS**	$	**0.1595**
00002088398	**MYLAN-BACLOFEN**	**MYP**	$	**0.1595**
00002063735	**PMS-BACLOFEN**	**PMS**	$	**0.1595**
00000455881	LIORESAL	NOV	$	0.7382

20 MG ORAL TABLET

00002139391	**APO-BACLOFEN**	**APX**	$	**0.3104**
00002287048	**BACLOFEN**	**SNS**	$	**0.3104**
00002088401	**MYLAN-BACLOFEN**	**MYP**	$	**0.3104**
00002063743	**PMS-BACLOFEN**	**PMS**	$	**0.3104**
00000636576	LIORESAL D.S.	NOV	$	1.4371

0.05 MG / ML INJECTION

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

0.5 MG / ML INJECTION

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

2 MG / ML INJECTION

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

12:00 AUTONOMIC DRUGS

12:92 MISCELLANEOUS AUTONOMIC DRUGS

VARENICLINE TARTRATE

RESTRICTED BENEFIT - This product is a benefit in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling. Coverage will be granted for a total of 12 weeks."

0.5 MG (BASE) ORAL TABLET				
00002419882	**APO-VARENICLINE**	**APX**	$	**1.3855**
00002291177	CHAMPIX	PFI	$	1.8437
1 MG (BASE) ORAL TABLET				
00002419890	**APO-VARENICLINE**	**APX**	$	**1.3853**
00002291185	CHAMPIX	PFI	$	1.8432

VARENICLINE TARTRATE/ VARENICLINE TARTRATE

RESTRICTED BENEFIT - This product is a benefit in patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counseling. Coverage will be granted for a total of 12 weeks.

0.5 MG * 1 MG ORAL TABLET				
00002435675	**APO-VARENICLINE (STARTER PACK)**	**APX**	$	**1.3804**
00002298309	CHAMPIX (STARTER PACK)	PFI	$	1.8370

20:00

Blood Formulation, Coagulation and Thrombosis

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:04.04 ANTIANEMIA DRUGS
(IRON PREPARATIONS)

IRON DEXTRAN COMPLEX

50 MG / ML INJECTION

00002205963	DEXIRON	LPI	$	13.7500

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.08 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(COUMARIN DERIVATIVES)

ACENOCOUMAROL

1 MG ORAL TABLET

00000010383	SINTROM	PAL	$	0.5616

4 MG ORAL TABLET

00000010391	SINTROM	PAL	$	1.7663

WARFARIN SODIUM

1 MG ORAL TABLET

00002242924	**APO-WARFARIN**	**APX**	$	**0.0780**
00002242680	**TARO-WARFARIN**	**TAR**	$	**0.0780**
00001918311	COUMADIN	BMS	$	0.3618

2 MG ORAL TABLET

00002242925	**APO-WARFARIN**	**APX**	$	**0.0825**
00002242681	**TARO-WARFARIN**	**TAR**	$	**0.0825**
00001918338	COUMADIN	BMS	$	0.3828

2.5 MG ORAL TABLET

00002242926	**APO-WARFARIN**	**APX**	$	**0.0660**
00002242682	**TARO-WARFARIN**	**TAR**	$	**0.0660**
00001918346	COUMADIN	BMS	$	0.3065

3 MG ORAL TABLET

00002245618	**APO-WARFARIN**	**APX**	$	**0.1023**
00002242683	**TARO-WARFARIN**	**TAR**	$	**0.1023**
00002240205	COUMADIN	BMS	$	0.4744

4 MG ORAL TABLET

00002242927	**APO-WARFARIN**	**APX**	$	**0.1023**
00002242684	**TARO-WARFARIN**	**TAR**	$	**0.1023**
00002007959	COUMADIN	BMS	$	0.4744

5 MG ORAL TABLET

00002242928	**APO-WARFARIN**	**APX**	$	**0.0662**
00002242685	**TARO-WARFARIN**	**TAR**	$	**0.0662**
00001918354	COUMADIN	BMS	$	0.3070

6 MG ORAL TABLET

00002242686	TARO-WARFARIN	TAR	$	0.3603

7.5 MG ORAL TABLET

00002242697	TARO-WARFARIN	TAR	$	0.3586

10 MG ORAL TABLET

00002242929	**APO-WARFARIN**	**APX**	$	**0.1187**
00002242687	**TARO-WARFARIN**	**TAR**	$	**0.1187**
00001918362	COUMADIN	BMS	$	0.5509

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.16 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(HEPARINS)

DALTEPARIN SODIUM

10,000 IU / ML INJECTION				
00002132664	FRAGMIN	PFI	$	17.2610
25,000 IU / ML INJECTION				
00002231171	FRAGMIN	PFI	$	43.1494
2,500 IU / SYR INJECTION SYRINGE				
00002132621	FRAGMIN (0.2 ML SYRINGE)	PFI	$	5.4656
3,500 IU / SYR INJECTION SYRINGE				
00002430789	FRAGMIN (0.28 ML SYRINGE)	PFI	$	7.6514
5,000 IU / SYR INJECTION SYRINGE				
00002132648	FRAGMIN (0.2 ML SYRINGE)	PFI	$	10.9309
7,500 IU / SYR INJECTION SYRINGE				
00002352648	FRAGMIN (0.3 ML SYRINGE)	PFI	$	16.3960
10,000 IU / SYR INJECTION SYRINGE				
00002352656	FRAGMIN (0.4 ML SYRINGE)	PFI	$	21.8619
12,500 IU / SYR INJECTION SYRINGE				
00002352664	FRAGMIN (0.5 ML SYRINGE)	PFI	$	27.3281
15,000 IU / SYR INJECTION SYRINGE				
00002352672	FRAGMIN (0.6 ML SYRINGE)	PFI	$	32.7941
18,000 IU / SYR INJECTION SYRINGE				
00002352680	FRAGMIN (0.72 ML SYRINGE)	PFI	$	39.3518

ENOXAPARIN SODIUM

100 MG / ML INJECTION				
00002236564	LOVENOX	SAV	$	22.0567
30 MG / SYR INJECTION SYRINGE				
00002012472	LOVENOX (0.3 ML SYRINGE)	SAV	$	6.6170
40 MG / SYR INJECTION SYRINGE				
00002236883	LOVENOX (0.4 ML SYRINGE)	SAV	$	8.8220
60 MG / SYR INJECTION SYRINGE				
00002378426	LOVENOX (0.6 ML SYRINGE)	SAV	$	13.2330
80 MG / SYR INJECTION SYRINGE				
00002378434	LOVENOX (0.8 ML SYRINGE)	SAV	$	17.6450
100 MG / SYR INJECTION SYRINGE				
00002378442	LOVENOX (1 ML SYRINGE)	SAV	$	22.0560
120 MG / SYR INJECTION SYRINGE				
00002242692	LOVENOX (0.8 ML SYRINGE)	SAV	$	26.4670
150 MG / SYR INJECTION SYRINGE				
00002378469	LOVENOX HP (1 ML SYRINGE)	SAV	$	33.0850

HEPARIN SODIUM

1,000 UNIT / ML INJECTION				
00000453811	HEPARIN LEO	LEO	$	0.5283
100 UNIT / ML INJECTION LOCK FLUSH				
00000727520	HEPARIN LEO	LEO	$	0.4493

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.16 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(HEPARINS)

NADROPARIN CALCIUM

9,500 IU / SYR INJECTION SYRINGE				
00002236913	FRAXIPARINE (0.3-1 ML SYR)	APC	$	9.0580
19,000 IU / SYR INJECTION SYRINGE				
00002240114	FRAXIPARINE FORTE (0.6-1 ML SYR)	APC	$	18.1170

TINZAPARIN SODIUM

10,000 IU / ML INJECTION				
00002167840	INNOHEP	LEO	$	18.2435
20,000 IU / ML INJECTION				
00002229515	INNOHEP	LEO	$	37.0572
2,500 IU / SYR INJECTION SYRINGE				
00002229755	INNOHEP (0.25 ML SYRINGE)	LEO	$	4.6008
3,500 IU / SYR INJECTION SYRINGE				
00002358158	INNOHEP (0.35 ML SYRINGE)	LEO	$	6.4365
4,500 IU / SYR INJECTION SYRINGE				
00002358166	INNOHEP (0.45 ML SYRINGE)	LEO	$	8.2774
8,000 IU / SYR INJECTION SYRINGE				
00002429462	INNOHEP (0.4 ML SYRINGE)	LEO	$	15.0328
10,000 IU / SYR INJECTION SYRINGE				
00002231478	INNOHEP (0.5 ML SYRINGE)	LEO	$	18.7793
12,000 IU / SYR INJECTION SYRINGE				
00002429470	INNOHEP (0.6 ML SYRINGE)	LEO	$	22.5492
14,000 IU / SYR INJECTION SYRINGE				
00002358174	INNOHEP (0.7 ML SYRINGE)	LEO	$	26.3074
16,000 IU / SYR INJECTION SYRINGE				
00002429489	INNOHEP (0.8 ML SYRINGE)	LEO	$	30.0656
18,000 IU / SYR INJECTION SYRINGE				
00002358182	INNOHEP (0.9 ML SYRINGE)	LEO	$	33.8185

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.92 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(MISCELLANEOUS ANTICOAGULANTS)

FONDAPARINUX SODIUM

2.5 MG / SYR INJECTION SYRINGE				
00002245531	**ARIXTRA (0.5 ML SYRINGE)**	**APC**	$	**9.8620**
00002406853	**FONDAPARINUX SODIUM (0.5 ML SYRINGE)**	**DRL**	$	**9.8620**
7.5 MG / SYR INJECTION SYRINGE				
00002258056	**ARIXTRA (0.6 ML SYRINGE)**	**APC**	$	**17.5000**
00002406896	FONDAPARINUX SODIUM (0.6 ML SYRINGE)	DRL	$	18.1356

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.04.92 ANTITHROMBOTIC AGENTS
ANTICOAGULANTS
(MISCELLANEOUS ANTICOAGULANTS)

RIVAROXABAN

10 MG ORAL TABLET

00002316986	XARELTO	BAI	$	2.8700

RESTRICTED BENEFIT -This product is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total knee replacement surgery. Coverage is restricted to two 14-day courses of therapy per patient per year.

This product is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total hip replacement surgery. Coverage is restricted to two 35-day courses of therapy per patient per year.

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.18 ANTITHROMBOTIC AGENTS
(PLATELET AGGREGATION INHIBITORS)

CLOPIDOGREL BISULFATE

75 MG (BASE) ORAL TABLET

00002252767	**APO-CLOPIDOGREL**	**APX**	$	**0.2631**
00002416387	**AURO-CLOPIDOGREL**	**AUR**	$	**0.2631**
00002385813	**CLOPIDOGREL**	**SIV**	$	**0.2631**
00002400553	**CLOPIDOGREL**	**SNS**	$	**0.2631**
00002303027	**CO CLOPIDOGREL**	**APH**	$	**0.2631**
00002415550	**JAMP-CLOPIDOGREL**	**JPC**	$	**0.2631**
00002422255	**MAR-CLOPIDOGREL**	**MAR**	$	**0.2631**
00002408910	**MINT-CLOPIDOGREL**	**MPI**	$	**0.2631**
00002348004	**PMS-CLOPIDOGREL**	**PMS**	$	**0.2631**
00002379813	**RAN-CLOPIDOGREL**	**RAN**	$	**0.2631**
00002359316	**SANDOZ CLOPIDOGREL**	**SDZ**	$	**0.2631**
00002293161	**TEVA-CLOPIDOGREL**	**TEV**	$	**0.2631**
00002238682	PLAVIX	SAV	$	2.7125

DIPYRIDAMOLE/ ASA

200 MG * 25 MG ORAL CAPSULE

00002471051	**TARO-DIPYRIDAMOLE/ASA**	**TAR**	$	**0.6656**
00002242119	AGGRENOX	BOE	$	0.9087

TICAGRELOR

RESTRICTED BENEFIT - This product is a benefit for the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction when initiated in hospital and prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the initiating prescriber is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.)

90 MG ORAL TABLET

00002368544	BRILINTA	AZC	$	1.5620

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:12.18 ANTITHROMBOTIC AGENTS (PLATELET AGGREGATION INHIBITORS)

TICLOPIDINE HCL

250 MG ORAL TABLET

00002237701	TICLOPIDINE	AAP	$	1.0935

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:24 HEMORRHEOLOGIC AGENTS

PENTOXIFYLLINE

400 MG ORAL SUSTAINED-RELEASE TABLET

00002230090	PENTOXIFYLLINE SR	AAP	$	0.8042

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:28.16 ANTIHEMORRHAGIC AGENTS (HEMOSTATICS)

TRANEXAMIC ACID

500 MG ORAL TABLET

00002409097	**GD-TRANEXAMIC ACID**	**GMD**	$	**0.5934**
00002401231	**TRANEXAMIC ACID**	**STM**	$	**0.5934**

24:00

Cardiovascular Drugs

24:00 CARDIOVASCULAR DRUGS

24:04.04.04 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS IA ANTIARRHYTHMICS)

DISOPYRAMIDE

100 MG ORAL CAPSULE				
00002224801	RYTHMODAN	SAV	$	0.2950

24:00 CARDIOVASCULAR DRUGS

24:04.04.08 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS IB ANTIARRHYTHMICS)

MEXILETINE HCL

100 MG ORAL CAPSULE				
00002230359	NOVO-MEXILETINE	TEV	$	1.4915
200 MG ORAL CAPSULE				
00002230360	NOVO-MEXILETINE	TEV	$	1.9974

24:00 CARDIOVASCULAR DRUGS

24:04.04.12 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS IC ANTIARRHYTHMICS)

FLECAINIDE ACETATE

50 MG ORAL TABLET				
00002275538	**APO-FLECAINIDE**	**APX**	$	**0.2778**
00002459957	**AURO-FLECAINIDE**	**AUR**	$	**0.2778**
100 MG ORAL TABLET				
00002275546	**APO-FLECAINIDE**	**APX**	$	**0.5558**
00002459965	**AURO-FLECAINIDE**	**AUR**	$	**0.5558**

PROPAFENONE HCL

150 MG ORAL TABLET				
00002243324	**APO-PROPAFENONE**	**APX**	$	**0.2965**
00002457172	**MYLAN-PROPAFENONE**	**MYP**	$	**0.2965**
00000603708	RYTHMOL	BGP	$	1.2264
300 MG ORAL TABLET				
00002243325	**APO-PROPAFENONE**	**APX**	$	**0.5227**
00002457164	**MYLAN-PROPAFENONE**	**MYP**	$	**0.5227**
00000603716	RYTHMOL	BGP	$	2.1617

24:00 CARDIOVASCULAR DRUGS

24:04.04.20 CARDIAC DRUGS
ANTIARRHYTHMIC AGENTS
(CLASS III ANTIARRYTHMICS)

AMIODARONE HCL

100 MG ORAL TABLET				
00002292173	PMS-AMIODARONE	PMS	$	0.8593
200 MG ORAL TABLET				
00002364336	**AMIODARONE**	**SNS**	$	**0.3706**
00002385465	**AMIODARONE**	**SIV**	$	**0.3706**
00002246194	**APO-AMIODARONE**	**APX**	$	**0.3706**
00002242472	**PMS-AMIODARONE**	**PMS**	$	**0.3706**
00002243836	**SANDOZ AMIODARONE**	**SDZ**	$	**0.3706**
00002239835	**TEVA-AMIODARONE**	**TEV**	$	**0.3706**

24:00 CARDIOVASCULAR DRUGS

24:04.08 CARDIAC DRUGS
(CARDIOTONIC AGENTS)

DIGOXIN

0.0625 MG ORAL TABLET				
00002335700	TOLOXIN	PPH	$	0.3018
0.125 MG ORAL TABLET				
00002335719	TOLOXIN	PPH	$	0.3018
0.05 MG / ML ORAL ELIXIR				
00002242320	TOLOXIN PEDIATRIC	PPH	$	1.3111

24:00 CARDIOVASCULAR DRUGS

24:06.04 ANTILIPEMIC AGENTS
(BILE ACID SEQUESTRANTS)

CHOLESTYRAMINE RESIN

4 G ORAL POWDER PACKET				
00002455609	**CHOLESTYRAMINE-ODAN**	**ODN**	$	**0.5275**
00000890960	**OLESTYR LIGHT**	**PMS**	$	**0.5275**
00002210320	**OLESTYR REGULAR**	**PMS**	$	**0.5275**

COLESEVELAM HCL

625 MG ORAL TABLET				
00002373955	LODALIS	VCL	$	1.1622
3.75 G ORAL POWDER PACKET				
00002432463	LODALIS	VCL	$	6.9734

COLESTIPOL HCL

1 G ORAL TABLET				
00002132680	COLESTID	PFI	$	0.2844

24:00 CARDIOVASCULAR DRUGS

24:06.06 ANTILIPEMIC AGENTS (FIBRIC ACID DERIVATIVES)

BEZAFIBRATE

400 MG ORAL SUSTAINED-RELEASE TABLET				
00002453312	**JAMP-BEZAFIBRATE**	**JPC**	$	**1.7460**
00002083523	BEZALIP	ACV	$	2.1638

FENOFIBRATE

100 MG ORAL TABLET				
00002246859	**APO-FENO-SUPER**	**APX**	$	**0.5406**
00002288044	**SANDOZ FENOFIBRATE S**	**SDZ**	$	**0.5406**
67 MG ORAL CAPSULE				
00002243180	APO-FENO-MICRO	APX	$	0.5479
200 MG ORAL CAPSULE				
00002239864	APO-FENO-MICRO	APX	$	0.2722
160 MG ORAL CAPSULE/TABLET				
00002246860	**APO-FENO-SUPER (TABLET)**	**APX**	$	**0.2723**
00002288052	**SANDOZ FENOFIBRATE S (TABLET)**	**SDZ**	$	**0.2723**
00002241602	LIPIDIL SUPRA (TABLET)	BGP	$	1.3362

GEMFIBROZIL

600 MG ORAL TABLET				
00001979582	**APO-GEMFIBROZIL**	**APX**	$	**0.5157**
00002142074	TEVA-GEMFIBROZIL	TEV	$	0.5686
300 MG ORAL CAPSULE				
00001979574	**APO-GEMFIBROZIL**	**APX**	$	**0.1288**
00002241704	TEVA-GEMFIBROZIL	TEV	$	0.1352

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS
(HMG-COA REDUCTASE INHIBITORS)

ATORVASTATIN CALCIUM

10 MG (BASE) ORAL TABLET

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**
00002392933	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.1743**
00002399377	**PMS-ATORVASTATIN**	**PMS**	$	**0.1743**
00002313707	**RAN-ATORVASTATIN**	**RAN**	$	**0.1743**
00002417936	**REDDY-ATORVASTATIN**	**DRL**	$	**0.1743**
00002324946	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.1743**
00002310899	**TEVA-ATORVASTATIN**	**TEV**	$	**0.1743**
00002230711	LIPITOR	PFI	$	1.8223

20 MG (BASE) ORAL TABLET

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**
00002392941	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2179**
00002399385	**PMS-ATORVASTATIN**	**PMS**	$	**0.2179**
00002313715	**RAN-ATORVASTATIN**	**RAN**	$	**0.2179**
00002417944	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2179**
00002324954	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2179**
00002310902	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2179**
00002230713	LIPITOR	PFI	$	2.2779

40 MG (BASE) ORAL TABLET

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**
00002392968	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2342**
00002399393	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002313723	**RAN-ATORVASTATIN**	**RAN**	$	**0.2342**
00002417952	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2342**
00002324962	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2342**
00002310910	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2342**
00002230714	LIPITOR	PFI	$	2.4483

80 MG (BASE) ORAL TABLET

00002295318	**APO-ATORVASTATIN**	**APX**	$	**0.2342**
00002411385	**ATORVASTATIN-80**	**SIV**	$	**0.2342**
00002407280	**AURO-ATORVASTATIN**	**AUR**	$	**0.2342**
00002391082	**JAMP-ATORVASTATIN**	**JPC**	$	**0.2342**
00002454041	**MAR-ATORVASTATIN**	**MAR**	$	**0.2342**
00002392976	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2342**
00002399407	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002313758	**RAN-ATORVASTATIN**	**RAN**	$	**0.2342**
00002417960	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2342**
00002324970	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2342**
00002310929	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2342**
00002243097	LIPITOR	PFI	$	2.4483

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS (HMG-COA REDUCTASE INHIBITORS)

FLUVASTATIN SODIUM

80 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002250527	LESCOL XL	NOV	$	1.5896
20 MG (BASE) ORAL CAPSULE				
00002299224	TEVA-FLUVASTATIN	TEV	$	0.2312
40 MG (BASE) ORAL CAPSULE				
00002299232	TEVA-FLUVASTATIN	TEV	$	0.3579

LOVASTATIN

20 MG ORAL TABLET				
00002220172	**APO-LOVASTATIN**	**APX**	$	**0.4919**
00002248572	**CO LOVASTATIN**	**APH**	$	**0.4919**
00002353229	**LOVASTATIN**	**SNS**	$	**0.4919**
40 MG ORAL TABLET				
00002220180	**APO-LOVASTATIN**	**APX**	$	**0.8985**
00002248573	**CO LOVASTATIN**	**APH**	$	**0.8985**
00002353237	**LOVASTATIN**	**SNS**	$	**0.8985**

PRAVASTATIN SODIUM

10 MG ORAL TABLET				
00002243506	**APO-PRAVASTATIN**	**APX**	$	**0.2916**
00002458977	**AURO-PRAVASTATIN**	**AUR**	$	**0.2916**
00002330954	**JAMP-PRAVASTATIN**	**JPC**	$	**0.2916**
00002432048	**MAR-PRAVASTATIN**	**MAR**	$	**0.2916**
00002317451	**MINT-PRAVASTATIN**	**MPI**	$	**0.2916**
00002247655	**PMS-PRAVASTATIN**	**PMS**	$	**0.2916**
00002356546	**PRAVASTATIN**	**SNS**	$	**0.2916**
00002389703	**PRAVASTATIN**	**SIV**	$	**0.2916**
00002284421	**RAN-PRAVASTATIN**	**RAN**	$	**0.2916**
00002468700	**SANDOZ PRAVASTATIN**	**SDZ**	$	**0.2916**
00002247008	**TEVA-PRAVASTATIN**	**TEV**	$	**0.2916**
20 MG ORAL TABLET				
00002243507	**APO-PRAVASTATIN**	**APX**	$	**0.3440**
00002458985	**AURO-PRAVASTATIN**	**AUR**	$	**0.3440**
00002330962	**JAMP-PRAVASTATIN**	**JPC**	$	**0.3440**
00002432056	**MAR-PRAVASTATIN**	**MAR**	$	**0.3440**
00002317478	**MINT-PRAVASTATIN**	**MPI**	$	**0.3440**
00002247656	**PMS-PRAVASTATIN**	**PMS**	$	**0.3440**
00002356554	**PRAVASTATIN**	**SNS**	$	**0.3440**
00002389738	**PRAVASTATIN**	**SIV**	$	**0.3440**
00002284448	**RAN-PRAVASTATIN**	**RAN**	$	**0.3440**
00002468719	**SANDOZ PRAVASTATIN**	**SDZ**	$	**0.3440**
00002247009	**TEVA-PRAVASTATIN**	**TEV**	$	**0.3440**
00000893757	PRAVACHOL	BMS	$	1.1243

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS
(HMG-COA REDUCTASE INHIBITORS)

PRAVASTATIN SODIUM

40 MG ORAL TABLET

00002243508	**APO-PRAVASTATIN**	**APX**	$	**0.4143**
00002458993	**AURO-PRAVASTATIN**	**AUR**	$	**0.4143**
00002330970	**JAMP-PRAVASTATIN**	**JPC**	$	**0.4143**
00002432064	**MAR-PRAVASTATIN**	**MAR**	$	**0.4143**
00002317486	**MINT-PRAVASTATIN**	**MPI**	$	**0.4143**
00002247657	**PMS-PRAVASTATIN**	**PMS**	$	**0.4143**
00002356562	**PRAVASTATIN**	**SNS**	$	**0.4143**
00002389746	**PRAVASTATIN**	**SIV**	$	**0.4143**
00002284456	**RAN-PRAVASTATIN**	**RAN**	$	**0.4143**
00002468727	**SANDOZ PRAVASTATIN TABLETS**	**SDZ**	$	**0.4143**
00002247010	**TEVA-PRAVASTATIN**	**TEV**	$	**0.4143**
00002222051	PRAVACHOL	BMS	$	1.3543

ROSUVASTATIN CALCIUM

5 MG (BASE) ORAL TABLET

00002339765	**ACT ROSUVASTATIN**	**APH**	$	**0.1284**
00002337975	**APO-ROSUVASTATIN**	**APX**	$	**0.1284**
00002442574	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1284**
00002391252	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1284**
00002413051	**MAR-ROSUVASTATIN**	**MAR**	$	**0.1284**
00002399164	**MED-ROSUVASTATIN**	**GMP**	$	**0.1284**
00002397781	**MINT-ROSUVASTATIN**	**MPI**	$	**0.1284**
00002378523	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1284**
00002382644	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1284**
00002405628	**ROSUVASTATIN**	**SNS**	$	**0.1284**
00002411628	**ROSUVASTATIN-5**	**SIV**	$	**0.1284**
00002338726	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1284**
00002354608	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1284**
00002265540	CRESTOR	AZC	$	1.3210

10 MG (BASE) ORAL TABLET

00002337983	**APO-ROSUVASTATIN**	**APX**	$	**0.1354**
00002442582	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1354**
00002391260	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1354**
00002413078	**MAR-ROSUVASTATIN**	**MAR**	$	**0.1354**
00002399172	**MED-ROSUVASTATIN**	**GMP**	$	**0.1354**
00002397803	**MINT-ROSUVASTATIN**	**MPI**	$	**0.1354**
00002378531	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1354**
00002382652	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1354**
00002405636	**ROSUVASTATIN**	**SNS**	$	**0.1354**
00002411636	**ROSUVASTATIN-10**	**SIV**	$	**0.1354**
00002338734	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1354**
00002354616	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1354**
00002247162	CRESTOR	AZC	$	1.3722

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS (HMG-COA REDUCTASE INHIBITORS)

ROSUVASTATIN CALCIUM

20 MG (BASE) ORAL TABLET

00002337991	**APO-ROSUVASTATIN**	**APX**	$	**0.1692**
00002442590	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1692**
00002391279	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1692**
00002413086	**MAR-ROSUVASTATIN**	**MAR**	$	**0.1692**
00002399180	**MED-ROSUVASTATIN**	**GMP**	$	**0.1692**
00002397811	**MINT-ROSUVASTATIN**	**MPI**	$	**0.1692**
00002378558	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1692**
00002382660	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1692**
00002405644	**ROSUVASTATIN**	**SNS**	$	**0.1692**
00002411644	**ROSUVASTATIN-20**	**SIV**	$	**0.1692**
00002338742	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1692**
00002354624	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1692**
00002247163	CRESTOR	AZC	$	1.7152

40 MG (BASE) ORAL TABLET

00002338009	**APO-ROSUVASTATIN**	**APX**	$	**0.1990**
00002442604	**AURO-ROSUVASTATIN**	**AUR**	$	**0.1990**
00002391287	**JAMP-ROSUVASTATIN**	**JPC**	$	**0.1990**
00002413108	**MAR-ROSUVASTATIN**	**MAR**	$	**0.1990**
00002399199	**MED-ROSUVASTATIN**	**GMP**	$	**0.1990**
00002397838	**MINT-ROSUVASTATIN**	**MPI**	$	**0.1990**
00002378566	**PMS-ROSUVASTATIN**	**PMS**	$	**0.1990**
00002382679	**RAN-ROSUVASTATIN**	**RAN**	$	**0.1990**
00002405652	**ROSUVASTATIN**	**SNS**	$	**0.1990**
00002411652	**ROSUVASTATIN-40**	**SIV**	$	**0.1990**
00002338750	**SANDOZ ROSUVASTATIN**	**SDZ**	$	**0.1990**
00002354632	**TEVA-ROSUVASTATIN**	**TEV**	$	**0.1990**
00002247164	CRESTOR	AZC	$	2.0076

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS
(HMG-COA REDUCTASE INHIBITORS)

SIMVASTATIN

5 MG ORAL TABLET

00002247011	**APO-SIMVASTATIN**	**APX**	$	**0.1023**
00002405148	**AURO-SIMVASTATIN**	**AUR**	$	**0.1023**
00002375591	**JAMP-SIMVASTATIN**	**JPC**	$	**0.1023**
00002375036	**MAR-SIMVASTATIN**	**MAR**	$	**0.1023**
00002372932	**MINT-SIMVASTATIN**	**MPI**	$	**0.1023**
00002246582	**MYLAN-SIMVASTATIN**	**MYP**	$	**0.1023**
00002469979	**PHARMA-SIMVASTATIN**	**PMS**	$	**0.1023**
00002329131	**RAN-SIMVASTATIN**	**RAN**	$	**0.1023**
00002284723	**SIMVASTATIN**	**SNS**	$	**0.1023**
00002386291	**SIMVASTATIN**	**SIV**	$	**0.1023**
00002250144	**TEVA-SIMVASTATIN**	**TEV**	$	**0.1023**

10 MG ORAL TABLET

00002247012	**APO-SIMVASTATIN**	**APX**	$	**0.2023**
00002405156	**AURO-SIMVASTATIN**	**AUR**	$	**0.2023**
00002375605	**JAMP-SIMVASTATIN**	**JPC**	$	**0.2023**
00002375044	**MAR-SIMVASTATIN**	**MAR**	$	**0.2023**
00002372940	**MINT-SIMVASTATIN**	**MPI**	$	**0.2023**
00002246583	**MYLAN-SIMVASTATIN**	**MYP**	$	**0.2023**
00002469987	**PHARMA-SIMVASTATIN**	**PMS**	$	**0.2023**
00002329158	**RAN-SIMVASTATIN**	**RAN**	$	**0.2023**
00002284731	**SIMVASTATIN**	**SNS**	$	**0.2023**
00002386305	**SIMVASTATIN**	**SIV**	$	**0.2023**
00002250152	**TEVA-SIMVASTATIN**	**TEV**	$	**0.2023**
00000884332	ZOCOR	MFC	$	2.2268

20 MG ORAL TABLET

00002247013	**APO-SIMVASTATIN**	**APX**	$	**0.2501**
00002405164	**AURO-SIMVASTATIN**	**AUR**	$	**0.2501**
00002375613	**JAMP-SIMVASTATIN**	**JPC**	$	**0.2501**
00002375052	**MAR-SIMVASTATIN**	**MAR**	$	**0.2501**
00002372959	**MINT-SIMVASTATIN**	**MPI**	$	**0.2501**
00002246737	**MYLAN-SIMVASTATIN**	**MYP**	$	**0.2501**
00002469995	**PHARMA-SIMVASTATIN**	**PMS**	$	**0.2501**
00002329166	**RAN-SIMVASTATIN**	**RAN**	$	**0.2501**
00002284758	**SIMVASTATIN**	**SNS**	$	**0.2501**
00002386313	**SIMVASTATIN**	**SIV**	$	**0.2501**
00002250160	**TEVA-SIMVASTATIN**	**TEV**	$	**0.2501**
00000884340	ZOCOR	MFC	$	2.7521

40 MG ORAL TABLET

00002247014	**APO-SIMVASTATIN**	**APX**	$	**0.2501**
00002405172	**AURO-SIMVASTATIN**	**AUR**	$	**0.2501**
00002375621	**JAMP-SIMVASTATIN**	**JPC**	$	**0.2501**
00002375060	**MAR-SIMVASTATIN**	**MAR**	$	**0.2501**
00002372967	**MINT-SIMVASTATIN**	**MPI**	$	**0.2501**
00002246584	**MYLAN-SIMVASTATIN**	**MYP**	$	**0.2501**
00002470004	**PHARMA-SIMVASTATIN**	**PMS**	$	**0.2501**
00002329174	**RAN-SIMVASTATIN**	**RAN**	$	**0.2501**
00002284766	**SIMVASTATIN**	**SNS**	$	**0.2501**
00002386321	**SIMVASTATIN**	**SIV**	$	**0.2501**
00002250179	**TEVA-SIMVASTATIN**	**TEV**	$	**0.2501**
00000884359	ZOCOR	MFC	$	2.7521

24:00 CARDIOVASCULAR DRUGS

24:06.08 ANTILIPEMIC AGENTS (HMG-COA REDUCTASE INHIBITORS)

SIMVASTATIN

80 MG ORAL TABLET

00002247015	**APO-SIMVASTATIN**	**APX**	$	**0.2501**
00002405180	**AURO-SIMVASTATIN**	**AUR**	$	**0.2501**
00002375648	**JAMP-SIMVASTATIN**	**JPC**	$	**0.2501**
00002375079	**MAR-SIMVASTATIN**	**MAR**	$	**0.2501**
00002372975	**MINT-SIMVASTATIN**	**MPI**	$	**0.2501**
00002246585	**MYLAN-SIMVASTATIN**	**MYP**	$	**0.2501**
00002470012	**PHARMA-SIMVASTATIN**	**PMS**	$	**0.2501**
00002329182	**RAN-SIMVASTATIN**	**RAN**	$	**0.2501**
00002284774	**SIMVASTATIN**	**SNS**	$	**0.2501**
00002386348	**SIMVASTATIN**	**SIV**	$	**0.2501**
00002250187	**TEVA-SIMVASTATIN**	**TEV**	$	**0.2501**

24:00 CARDIOVASCULAR DRUGS

24:08.16 HYPOTENSIVE AGENTS (CENTRAL ALPHA-AGONISTS)

CLONIDINE HCL

0.1 MG ORAL TABLET

00002462192	**MINT-CLONIDINE**	**MPI**	$	**0.1358**
00002046121	**TEVA-CLONIDINE**	**TEV**	$	**0.1358**

0.2 MG ORAL TABLET

00002462206	**MINT-CLONIDINE**	**MPI**	$	**0.2424**
00002046148	**TEVA-CLONIDINE**	**TEV**	$	**0.2424**

METHYLDOPA

125 MG ORAL TABLET

00000360252	METHYLDOPA	AAP	$	0.1055

250 MG ORAL TABLET

00000360260	METHYLDOPA	AAP	$	0.1579

500 MG ORAL TABLET

00000426830	METHYLDOPA	AAP	$	0.2705

24:00 CARDIOVASCULAR DRUGS

24:08.20 HYPOTENSIVE AGENTS (DIRECT VASODILATORS)

HYDRALAZINE HCL

10 MG ORAL TABLET

00000441619	**APO-HYDRALAZINE**	**APX**	$	**0.0355**
00002457865	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0355**
00002468778	**MINT-HYDRALAZINE**	**MPI**	$	**0.0355**

25 MG ORAL TABLET

00000441627	**APO-HYDRALAZINE**	**APX**	$	**0.0609**
00002457873	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0609**
00002468786	**MINT-HYDRALAZINE**	**MPI**	$	**0.0609**

24:00 CARDIOVASCULAR DRUGS

24:08.20 HYPOTENSIVE AGENTS (DIRECT VASODILATORS)

HYDRALAZINE HCL

50 MG ORAL TABLET				
00000441635	**APO-HYDRALAZINE**	**APX**	$	**0.0956**
00002457881	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0956**
00002468794	**MINT-HYDRALAZINE**	**MPI**	$	**0.0956**

MINOXIDIL

2.5 MG ORAL TABLET				
00000514497	LONITEN	PFI	$	0.4694
10 MG ORAL TABLET				
00000514500	LONITEN	PFI	$	1.0346

24:00 CARDIOVASCULAR DRUGS

24:08.24.08 HYPOTENSIVE AGENTS DIURETICS (LOOP DIURETICS)

ETHACRYNIC ACID

25 MG ORAL TABLET				
00002258528	EDECRIN	VCL	$	0.9383

FUROSEMIDE

20 MG ORAL TABLET				
00000396788	**APO-FUROSEMIDE**	**APX**	$	**0.0218**
00002351420	**FUROSEMIDE**	**SNS**	$	**0.0218**
00002466759	**MINT-FUROSEMIDE**	**MPI**	$	**0.0218**
00000337730	**TEVA-FUROSEMIDE**	**TEV**	$	**0.0218**
40 MG ORAL TABLET				
00000362166	**APO-FUROSEMIDE**	**APX**	$	**0.0327**
00002351439	**FUROSEMIDE**	**SNS**	$	**0.0327**
00002466767	**MINT-FUROSEMIDE**	**MPI**	$	**0.0327**
00000337749	**TEVA-FUROSEMIDE**	**TEV**	$	**0.0327**
80 MG ORAL TABLET				
00000707570	**APO-FUROSEMIDE**	**APX**	$	**0.0703**
00002351447	**FUROSEMIDE**	**SNS**	$	**0.0703**
00002466775	**MINT-FUROSEMIDE**	**MPI**	$	**0.0703**
00000765953	**TEVA-FUROSEMIDE**	**TEV**	$	**0.0703**
500 MG ORAL TABLET				
00002224755	LASIX SPECIAL	SAV	$	3.3270
10 MG / ML ORAL SOLUTION				
00002224720	LASIX	SAV	$	0.3229
10 MG / ML INJECTION				
00000527033	**FUROSEMIDE**	**SDZ**	$	**0.8650**
00002382539	**FUROSEMIDE INJECTION SDZ**	**SDZ**	$	**0.8650**

24:00 CARDIOVASCULAR DRUGS

24:08.44.08 HYPOTENSIVE AGENTS
RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS
(ANGIOTENSIN II RECEPTOR ANTAGONISTS)

OLMESARTAN MEDOXOMIL

20 MG ORAL TABLET				
00002442191	**ACT OLMESARTAN**	**APH**	$	**0.3019**
00002453452	**APO-OLMESARTAN**	**APX**	$	**0.3019**
00002443864	**AURO-OLMESARTAN**	**AUR**	$	**0.3019**
00002461641	**JAMP-OLMESARTAN**	**JPC**	$	**0.3019**
00002461307	**PMS-OLMESARTAN**	**PMS**	$	**0.3019**
00002443414	**SANDOZ OLMESARTAN**	**SDZ**	$	**0.3019**
00002318660	OLMETEC	MFC	$	1.1319
40 MG ORAL TABLET				
00002442205	**ACT OLMESARTAN**	**APH**	$	**0.3019**
00002453460	**APO-OLMESARTAN**	**APX**	$	**0.3019**
00002443872	**AURO-OLMESARTAN**	**AUR**	$	**0.3019**
00002461668	**JAMP-OLMESARTAN**	**JPC**	$	**0.3019**
00002461315	**PMS-OLMESARTAN**	**PMS**	$	**0.3019**
00002443422	**SANDOZ OLMESARTAN**	**SDZ**	$	**0.3019**
00002318679	OLMETEC	MFC	$	1.1319

OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE

20 MG * 12.5 MG ORAL TABLET				
00002443112	**ACT OLMESARTAN HCT**	**APH**	$	**0.6038**
00002453606	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.6038**
00002319616	OLMETEC PLUS	MFC	$	1.1319
40 MG * 12.5 MG ORAL TABLET				
00002443120	**ACT OLMESARTAN HCT**	**APH**	$	**0.6038**
00002453614	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.6038**
00002319624	OLMETEC PLUS	MFC	$	1.1319
40 MG * 25 MG ORAL TABLET				
00002443139	**ACT OLMESARTAN HCT**	**APH**	$	**0.6038**
00002453622	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.6038**
00002319632	OLMETEC PLUS	MFC	$	1.1319

24:00 CARDIOVASCULAR DRUGS

24:12.08 VASODILATING AGENTS
(NITRATES AND NITRITES)

ISOSORBIDE DINITRATE

10 MG ORAL TABLET				
00000441686	ISDN	AAP	$	0.0389
30 MG ORAL TABLET				
00000441694	ISDN	AAP	$	0.0913
5 MG ORAL SUBLINGUAL TABLET				
00000670944	ISDN	AAP	$	0.0662

ISOSORBIDE-5-MONONITRATE

60 MG ORAL EXTENDED-RELEASE TABLET				
00002272830	**APO-ISMN**	**APX**	$	**0.3523**
00002301288	**PMS-ISMN**	**PMS**	$	**0.3523**
00002126559	IMDUR	MDA	$	0.7350

24:00 CARDIOVASCULAR DRUGS

24:12.08 VASODILATING AGENTS (NITRATES AND NITRITES)

NITROGLYCERIN

0.3 MG ORAL SUBLINGUAL TABLET				
00000037613	NITROSTAT	PFI	$	0.1537
0.6 MG ORAL SUBLINGUAL TABLET				
00000037621	NITROSTAT	PFI	$	0.1537
0.4 MG / DOSE SUBLINGUAL METERED DOSE SPRAY				
00002243588	**MYLAN-NITRO**	**MYP**	$	**0.0421**
00002238998	**RHO-NITRO PUMPSPRAY**	**SDZ**	$	**0.0421**
00002231441	NITROLINGUAL PUMPSPRAY	SAV	$	0.0762
2 % TOPICAL OINTMENT				
00001926454	NITROL	PAL	$	0.7054
0.2 MG/HR TRANSDERMAL PATCH				
00002407442	**MYLAN-NITRO PATCH**	**MYP**	$	**0.4463**
00001911910	**NITRO-DUR 0.2**	**DRL**	$	**0.4463**
☒ 00002230732	TRINIPATCH 0.2	PAL	$	0.6384
☒ 00002162806	MINITRAN 0.2	VCL	$	0.6523
☒ 00000584223	TRANSDERM-NITRO 0.2	NOV	$	0.7300
0.4 MG/HR TRANSDERMAL PATCH				
00001911902	**NITRO-DUR 0.4**	**DRL**	$	**0.4937**
00002407450	MYLAN-NITRO PATCH	MYP	$	0.4938
☒ 00002230733	TRINIPATCH 0.4	PAL	$	0.7209
☒ 00002163527	MINITRAN 0.4	VCL	$	0.7370
☒ 00000852384	TRANSDERM-NITRO 0.4	NOV	$	0.8240
0.6 MG/HR TRANSDERMAL PATCH				
00001911929	**NITRO-DUR 0.6**	**DRL**	$	**0.4937**
00002407469	MYLAN-NITRO PATCH	MYP	$	0.4938
☒ 00002230734	TRINIPATCH 0.6	PAL	$	0.7209
☒ 00002163535	MINITRAN 0.6	VCL	$	0.7374
☒ 00002046156	TRANSDERM-NITRO 0.6	NOV	$	0.8240
0.8 MG/HR TRANSDERMAL PATCH				
00002407477	**MYLAN-NITRO PATCH**	**MYP**	$	**0.8743**
00002011271	**NITRO-DUR 0.8**	**DRL**	$	**0.8743**

24:00 CARDIOVASCULAR DRUGS

24:12.92 VASODILATING AGENTS (MISCELLANEOUS VASODILATING AGENTS)

ALPROSTADIL

500 MCG / ML INJECTION				
00000559253	PROSTIN VR	PFI	$	268.1784

DIPYRIDAMOLE

25 MG ORAL TABLET				
00000895644	APO-DIPYRIDAMOLE (FC)	APX	$	0.2633
50 MG ORAL TABLET				
00000895652	APO-DIPYRIDAMOLE (FC)	APX	$	0.3685
75 MG ORAL TABLET				
00000895660	APO-DIPYRIDAMOLE (FC)	APX	$	0.4963

24:00 CARDIOVASCULAR DRUGS

24:20 ALPHA-ADRENERGIC BLOCKING AGENTS

DOXAZOSIN MESYLATE

1 MG (BASE) ORAL TABLET				
00002240588	**APO-DOXAZOSIN**	**APX**	$	**0.3437**
00002242728	**TEVA-DOXAZOSIN**	**TEV**	$	**0.3437**
2 MG (BASE) ORAL TABLET				
00002240589	**APO-DOXAZOSIN**	**APX**	$	**0.4123**
00002242729	**TEVA-DOXAZOSIN**	**TEV**	$	**0.4123**
4 MG (BASE) ORAL TABLET				
00002240590	**APO-DOXAZOSIN**	**APX**	$	**0.5361**
00002242730	**TEVA-DOXAZOSIN**	**TEV**	$	**0.5361**

PRAZOSIN HCL

1 MG (BASE) ORAL TABLET				
00000882801	**APO-PRAZO**	**APX**	$	**0.2743**
00001934198	**TEVA-PRAZOSIN**	**TEV**	$	**0.2743**
2 MG (BASE) ORAL TABLET				
00000882828	**APO-PRAZO**	**APX**	$	**0.3725**
00001934201	**TEVA-PRAZOSIN**	**TEV**	$	**0.3725**
5 MG (BASE) ORAL TABLET				
00000882836	**APO-PRAZO**	**APX**	$	**0.5121**
00001934228	**TEVA-PRAZOSIN**	**TEV**	$	**0.5121**

TAMSULOSIN HCL

0.4 MG ORAL EXTENDED-RELEASE TABLET				
00002362406	**APO-TAMSULOSIN CR**	**APX**	$	**0.1500**
00002340208	**SANDOZ TAMSULOSIN CR**	**SDZ**	$	**0.1500**
00002427117	**TAMSULOSIN CR**	**SNS**	$	**0.1500**
00002429667	**TAMSULOSIN CR**	**SIV**	$	**0.1500**
00002368242	**TEVA-TAMSULOSIN CR**	**TEV**	$	**0.1500**
00002270102	FLOMAX CR	BOE	$	0.6627
0.4 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002319217	SANDOZ TAMSULOSIN	SDZ	$	0.1500

TERAZOSIN HCL

1 MG (BASE) ORAL TABLET				
00002234502	**APO-TERAZOSIN**	**APX**	$	**0.1835**
00002243518	**PMS-TERAZOSIN**	**PMS**	$	**0.1835**
00002350475	**TERAZOSIN**	**SNS**	$	**0.1835**
00002230805	**TEVA-TERAZOSIN**	**TEV**	$	**0.1835**
2 MG (BASE) ORAL TABLET				
00002234503	**APO-TERAZOSIN**	**APX**	$	**0.2333**
00002243519	**PMS-TERAZOSIN**	**PMS**	$	**0.2333**
00002350483	**TERAZOSIN**	**SNS**	$	**0.2333**
00002230806	**TEVA-TERAZOSIN**	**TEV**	$	**0.2333**
5 MG (BASE) ORAL TABLET				
00002234504	**APO-TERAZOSIN**	**APX**	$	**0.3168**
00002243520	**PMS-TERAZOSIN**	**PMS**	$	**0.3168**
00002350491	**TERAZOSIN**	**SNS**	$	**0.3168**
00002230807	**TEVA-TERAZOSIN**	**TEV**	$	**0.3168**
10 MG (BASE) ORAL TABLET				
00002234505	**APO-TERAZOSIN**	**APX**	$	**0.4637**
00002243521	**PMS-TERAZOSIN**	**PMS**	$	**0.4637**
00002350505	**TERAZOSIN**	**SNS**	$	**0.4637**
00002230808	**TEVA-TERAZOSIN**	**TEV**	$	**0.4637**

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL HCL

100 MG (BASE) ORAL TABLET				
00002147602	**APO-ACEBUTOLOL**	**APX**	$	**0.0787**
00002204517	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.0787**
200 MG (BASE) ORAL TABLET				
00002147610	**APO-ACEBUTOLOL**	**APX**	$	**0.1177**
00002204525	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.1177**
400 MG (BASE) ORAL TABLET				
00002147629	**APO-ACEBUTOLOL**	**APX**	$	**0.2466**
00002204533	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.2466**

ATENOLOL

25 MG ORAL TABLET				
00002247182	**ATENOLOL**	**SIV**	$	**0.0521**
00002367556	**JAMP-ATENOLOL**	**JPC**	$	**0.0521**
00002371979	**MAR-ATENOLOL**	**MAR**	$	**0.0521**
00002368013	**MINT-ATENOL**	**MPI**	$	**0.0521**
00002246581	**PMS-ATENOLOL**	**PMS**	$	**0.0521**
00002373963	**RAN-ATENOLOL**	**RAN**	$	**0.0521**
00002266660	**TEVA-ATENOLOL**	**TEV**	$	**0.0521**
50 MG ORAL TABLET				
00002255545	**ACT ATENOLOL**	**APH**	$	**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**
00002368641	**SEPTA-ATENOLOL**	**SEP**	$	**0.1107**
00002171791	**TEVA-ATENOLOL**	**TEV**	$	**0.1107**
00002039532	TENORMIN	AZC	$	0.6086
100 MG ORAL TABLET				
00002255553	**ACT ATENOLOL**	**APH**	$	**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**
00002368668	**SEPTA-ATENOLOL**	**SEP**	$	**0.1821**
00002171805	**TEVA-ATENOLOL**	**TEV**	$	**0.1821**
00002039540	TENORMIN	AZC	$	1.0006

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

ATENOLOL/ CHLORTHALIDONE

50 MG * 25 MG ORAL TABLET

00002248763	**APO-ATENIDONE**	**APX**	$	**0.3195**
00002302918	**TEVA-ATENOLTHALIDONE**	**TEV**	$	**0.3195**
00002049961	TENORETIC 50/25	AZC	$	0.7122

100 MG * 25 MG ORAL TABLET

00002248764	**APO-ATENIDONE**	**APX**	$	**0.5236**
00002302926	**TEVA-ATENOLTHALIDONE**	**TEV**	$	**0.5236**
00002049988	TENORETIC 100/25	AZC	$	1.1673

BISOPROLOL FUMARATE

5 MG ORAL TABLET

00002256134	**APO-BISOPROLOL**	**APX**	$	**0.0715**
00002383055	**BISOPROLOL**	**SIV**	$	**0.0715**
00002391589	**BISOPROLOL**	**SNS**	$	**0.0715**
00002247439	**SANDOZ BISOPROLOL**	**SDZ**	$	**0.0715**
00002267470	**TEVA-BISOPROLOL**	**TEV**	$	**0.0715**

10 MG ORAL TABLET

00002256177	**APO-BISOPROLOL**	**APX**	$	**0.1044**
00002383063	**BISOPROLOL**	**SIV**	$	**0.1044**
00002391597	**BISOPROLOL**	**SNS**	$	**0.1044**
00002247440	**SANDOZ BISOPROLOL**	**SDZ**	$	**0.1044**
00002267489	**TEVA-BISOPROLOL**	**TEV**	$	**0.1044**

CARVEDILOL

3.125 MG ORAL TABLET

00002247933	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418495	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248752	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364913	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368897	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245914	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252309	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

6.25 MG ORAL TABLET

00002247934	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418509	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248753	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364921	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368900	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245915	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252317	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

12.5 MG ORAL TABLET

00002247935	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418517	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248754	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364948	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368919	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245916	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252325	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

CARVEDILOL

25 MG ORAL TABLET

00002247936	**APO-CARVEDILOL**	**APX**	$	**0.2431**
00002418525	**AURO-CARVEDILOL**	**AUR**	$	**0.2431**
00002248755	**CARVEDILOL**	**SIV**	$	**0.2431**
00002364956	**CARVEDILOL**	**SNS**	$	**0.2431**
00002368927	**JAMP-CARVEDILOL**	**JPC**	$	**0.2431**
00002245917	**PMS-CARVEDILOL**	**PMS**	$	**0.2431**
00002252333	**TEVA-CARVEDILOL**	**TEV**	$	**0.2431**

LABETALOL HCL

100 MG ORAL TABLET

00002106272	TRANDATE	PAL	$	0.2956

200 MG ORAL TABLET

00002106280	TRANDATE	PAL	$	0.5226

METOPROLOL TARTRATE

25 MG ORAL TABLET

00002246010	**APO-METOPROLOL**	**APX**	$	**0.0643**
00002356813	**JAMP-METOPROLOL-L**	**JPC**	$	**0.0643**
00002248855	**PMS-METOPROLOL-L**	**PMS**	$	**0.0643**

50 MG ORAL TABLET

00000618632	**APO-METOPROLOL**	**APX**	$	**0.0624**
00000749354	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.0624**
00002356821	**JAMP-METOPROLOL-L**	**JPC**	$	**0.0624**
00002350394	**METOPROLOL**	**SNS**	$	**0.0624**
00002442124	**METOPROLOL-L**	**SIV**	$	**0.0624**
00002230803	**PMS-METOPROLOL-L**	**PMS**	$	**0.0624**
00002354187	**SANDOZ METOPROLOL (TYPE L)**	**SDZ**	$	**0.0624**
00000842648	**TEVA-METOPROL**	**TEV**	$	**0.0624**
00000648035	**TEVA-METOPROL (FC)**	**TEV**	$	**0.0624**

100 MG ORAL TABLET

00000618640	**APO-METOPROLOL**	**APX**	$	**0.1250**
00000751170	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.1250**
00002356848	**JAMP-METOPROLOL-L**	**JPC**	$	**0.1250**
00002350408	**METOPROLOL**	**SNS**	$	**0.1250**
00002442132	**METOPROLOL-L**	**SIV**	$	**0.1250**
00002230804	**PMS-METOPROLOL-L**	**PMS**	$	**0.1250**
00002354195	**SANDOZ METOPROLOL (TYPE L)**	**SDZ**	$	**0.1250**
00000842656	**TEVA-METOPROL**	**TEV**	$	**0.1250**
00000648043	**TEVA-METOPROL (FC)**	**TEV**	$	**0.1250**

100 MG ORAL SUSTAINED-RELEASE TABLET

00002285169	**APO-METOPROLOL SR**	**APX**	$	**0.1871**
00002303396	**SANDOZ METOPROLOL SR**	**SDZ**	$	**0.1871**
00000658855	LOPRESOR SR	NOV	$	0.3394

200 MG (BASE) ORAL SUSTAINED-RELEASE TABLET

00002285177	**APO-METOPROLOL SR**	**APX**	$	**0.3396**
00002303418	**SANDOZ METOPROLOL SR**	**SDZ**	$	**0.3396**
00000534560	LOPRESOR SR	NOV	$	0.6162

NADOLOL

40 MG ORAL TABLET

00000782505	NADOL	AAP	$	0.4718

80 MG ORAL TABLET

00000782467	NADOL	AAP	$	0.3879

24:00 CARDIOVASCULAR DRUGS

24:24 BETA-ADRENERGIC BLOCKING AGENTS

NADOLOL

160 MG ORAL TABLET

00000782475	NADOL	AAP	$	1.2594

PROPRANOLOL HCL

10 MG ORAL TABLET

00000496480	TEVA-PROPRANOLOL	TEV	$	0.0631

20 MG ORAL TABLET

00000740675	TEVA-PROPRANOLOL	TEV	$	0.1086

40 MG ORAL TABLET

00000496499	TEVA-PROPRANOLOL	TEV	$	0.1142

80 MG ORAL TABLET

00000496502	TEVA-PROPRANOLOL	TEV	$	0.1805

SOTALOL HCL

80 MG ORAL TABLET

00002210428	**APO-SOTALOL**	**APX**	$	**0.2966**
00002368617	**JAMP-SOTALOL**	**JPC**	$	**0.2966**
00002238326	**PMS-SOTALOL**	**PMS**	$	**0.2966**

160 MG ORAL TABLET

00002167794	**APO-SOTALOL**	**APX**	$	**0.1623**
00002368625	**JAMP-SOTALOL**	**JPC**	$	**0.1623**
00002238327	**PMS-SOTALOL**	**PMS**	$	**0.1623**

24:00 CARDIOVASCULAR DRUGS

24:28.08 CALCIUM-CHANNEL BLOCKING AGENTS (DIHYDROPYRIDINES)

AMLODIPINE BESYLATE

2.5 MG (BASE) ORAL TABLET

00002297477	**ACT AMLODIPINE**	**APH**	$	**0.0767**
00002385783	**AMLODIPINE**	**SIV**	$	**0.0767**
00002419556	**AMLODIPINE BESYLATE**	**AHI**	$	**0.0767**
00002357186	**JAMP-AMLODIPINE**	**JPC**	$	**0.0767**
00002371707	**MAR-AMLODIPINE**	**MAR**	$	**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**
00002280132	**GD-AMLODIPINE**	**GMD**	$	**0.1343**
00002371715	**MAR-AMLODIPINE**	**MAR**	$	**0.1343**
00002362651	**MINT-AMLODIPINE**	**MPI**	$	**0.1343**
00002272113	**MYLAN-AMLODIPINE**	**MYP**	$	**0.1343**
00002469030	**PHARMA-AMLODIPINE**	**PMS**	$	**0.1343**
00002321858	**RAN-AMLODIPINE**	**RAN**	$	**0.1343**
00002284383	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.1343**
00002357712	**SEPTA-AMLODIPINE**	**SEP**	$	**0.1343**
00002250497	**TEVA-AMLODIPINE**	**TEV**	$	**0.1343**
00000878928	NORVASC	PFI	$	1.4064

10 MG (BASE) ORAL TABLET

00002297493	**ACT AMLODIPINE**	**APH**	$	**0.1993**
00002331292	**AMLODIPINE**	**SNS**	$	**0.1993**
00002385805	**AMLODIPINE**	**SIV**	$	**0.1993**
00002429225	**AMLODIPINE**	**JPC**	$	**0.1993**
00002419572	**AMLODIPINE BESYLATE**	**AHI**	$	**0.1993**
00002273381	**APO-AMLODIPINE**	**APX**	$	**0.1993**
00002397080	**AURO-AMLODIPINE**	**AUR**	$	**0.1993**
00002280140	**GD-AMLODIPINE**	**GMD**	$	**0.1993**
00002357208	**JAMP-AMLODIPINE**	**JPC**	$	**0.1993**
00002371723	**MAR-AMLODIPINE**	**MAR**	$	**0.1993**
00002362678	**MINT-AMLODIPINE**	**MPI**	$	**0.1993**
00002272121	**MYLAN-AMLODIPINE**	**MYP**	$	**0.1993**
00002469049	**PHARMA-AMLODIPINE**	**PMS**	$	**0.1993**
00002321866	**RAN-AMLODIPINE**	**RAN**	$	**0.1993**
00002284391	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.1993**
00002357720	**SEPTA-AMLODIPINE**	**SEP**	$	**0.1993**
00002250500	**TEVA-AMLODIPINE**	**TEV**	$	**0.1993**
00000878936	NORVASC	PFI	$	2.0528

24:00 CARDIOVASCULAR DRUGS

24:28.08 CALCIUM-CHANNEL BLOCKING AGENTS (DIHYDROPYRIDINES)

FELODIPINE

2.5 MG ORAL EXTENDED-RELEASE TABLET				
00002452367	**APO-FELODIPINE**	**APX**	$	**0.4050**
00002057778	PLENDIL	AZC	$	0.5520
5 MG ORAL EXTENDED-RELEASE TABLET				
00002452375	**APO-FELODIPINE**	**APX**	$	**0.3565**
00002280264	**SANDOZ FELODIPINE**	**SDZ**	$	**0.3565**
00000851779	PLENDIL	AZC	$	0.7300
10 MG ORAL EXTENDED-RELEASE TABLET				
00002452383	**APO-FELODIPINE**	**APX**	$	**0.5350**
00002280272	**SANDOZ FELODIPINE**	**SDZ**	$	**0.5350**
00000851787	PLENDIL	AZC	$	1.0950

NIFEDIPINE

20 MG ORAL EXTENDED-RELEASE TABLET				
00002237618	ADALAT XL	BAI	$	1.2864
30 MG ORAL EXTENDED-RELEASE TABLET				
00002155907	**ADALAT XL**	**BAI**	$	**0.6171**
00002349167	**MYLAN-NIFEDIPINE EXTENDED RELEASE**	**MYP**	$	**0.6171**
60 MG ORAL EXTENDED-RELEASE TABLET				
00002155990	**ADALAT XL**	**BAI**	$	**0.9374**
00002321149	**MYLAN-NIFEDIPINE EXTENDED RELEASE**	**MYP**	$	**0.9374**
5 MG ORAL CAPSULE				
00000725110	NIFEDIPINE	AAP	$	0.3846
10 MG ORAL CAPSULE				
00000755907	NIFEDIPINE	AAP	$	0.5098

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

30 MG ORAL TABLET				
00000771376	**APO-DILTIAZ**	**APX**	$	**0.1866**
00000862924	**TEVA-DILTIAZEM**	**TEV**	$	**0.1866**
60 MG ORAL TABLET				
00000771384	**APO-DILTIAZ**	**APX**	$	**0.3273**
00000862932	**TEVA-DILTIAZEM**	**TEV**	$	**0.3273**
120 MG ORAL EXTENDED-RELEASE TABLET				
00002256738	TIAZAC XC	VCL	$	0.8910
180 MG ORAL EXTENDED-RELEASE TABLET				
00002256746	TIAZAC XC	VCL	$	1.1839
240 MG ORAL EXTENDED-RELEASE TABLET				
00002256754	TIAZAC XC	VCL	$	1.5736
300 MG ORAL EXTENDED-RELEASE TABLET				
00002256762	TIAZAC XC	VCL	$	1.5705
360 MG ORAL EXTENDED-RELEASE TABLET				
00002256770	TIAZAC XC	VCL	$	1.5712

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

120 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002370611	**ACT DILTIAZEM CD**	**APH**	$	**0.3529**
00002230997	**APO-DILTIAZ CD**	**APX**	$	**0.3529**
00002445999	**DILTIAZEM CD**	**SIV**	$	**0.3529**
00002243338	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.3529**
00002242538	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.3529**
180 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002370638	**ACT DILTIAZEM CD**	**APH**	$	**0.4684**
00002230998	**APO-DILTIAZ CD**	**APX**	$	**0.4684**
00002446006	**DILTIAZEM CD**	**SIV**	$	**0.4684**
00002243339	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.4684**
00002242539	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.4684**
240 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002370646	**ACT DILTIAZEM CD**	**APH**	$	**0.6213**
00002230999	**APO-DILTIAZ CD**	**APX**	$	**0.6213**
00002446014	**DILTIAZEM CD**	**SIV**	$	**0.6213**
00002243340	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.6213**
00002242540	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.6213**
300 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002370654	**ACT DILTIAZEM CD**	**APH**	$	**0.7766**
00002229526	**APO-DILTIAZ CD**	**APX**	$	**0.7766**
00002446022	**DILTIAZEM CD**	**SIV**	$	**0.7766**
00002243341	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.7766**
00002242541	**TEVA-DILTIAZEM CD**	**TEV**	$	**0.7766**
120 MG ORAL EXTENDED-RELEASE CAPSULE				
00002370441	**ACT DILTIAZEM T**	**APH**	$	**0.2133**
00002465353	**MAR-DILTIAZEM T**	**MAR**	$	**0.2133**
00002245918	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.2133**
00002271605	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.2133**
00002231150	TIAZAC	VCL	$	0.9332
180 MG ORAL EXTENDED-RELEASE CAPSULE				
00002370492	**ACT DILTIAZEM T**	**APH**	$	**0.2889**
00002465361	**MAR-DILTIAZEM T**	**MAR**	$	**0.2889**
00002245919	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.2889**
00002271613	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.2889**
00002231151	TIAZAC	VCL	$	1.2578
240 MG ORAL EXTENDED-RELEASE CAPSULE				
00002370506	**ACT DILTIAZEM T**	**APH**	$	**0.3832**
00002465388	**MAR-DILTIAZEM T**	**MAR**	$	**0.3832**
00002245920	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.3832**
00002271621	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.3832**
00002231152	TIAZAC	VCL	$	1.6683
300 MG ORAL EXTENDED-RELEASE CAPSULE				
00002370514	**ACT DILTIAZEM T**	**APH**	$	**0.4719**
00002465396	**MAR-DILTIAZEM T**	**MAR**	$	**0.4719**
00002245921	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.4719**
00002271648	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.4719**
00002231154	TIAZAC	VCL	$	2.0546

24:00 CARDIOVASCULAR DRUGS

24:28.92 CALCIUM-CHANNEL BLOCKING AGENTS (MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS)

DILTIAZEM HCL

360 MG ORAL EXTENDED-RELEASE CAPSULE				
00002370522	**ACT DILTIAZEM T**	**APH**	$	**0.5778**
00002465418	**MAR-DILTIAZEM T**	**MAR**	$	**0.5778**
00002245922	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.5778**
00002271656	**TEVA-DILTIAZEM HCL ER**	**VTC**	$	**0.5778**
00002231155	TIAZAC	VCL	$	2.5157

VERAPAMIL HCL

80 MG ORAL TABLET				
00000782483	**APO-VERAP**	**APX**	$	**0.2735**
00002237921	**MYLAN-VERAPAMIL**	**MYP**	$	**0.2735**
120 MG ORAL TABLET				
00000782491	**APO-VERAP**	**APX**	$	**0.4250**
00002237922	**MYLAN-VERAPAMIL**	**MYP**	$	**0.4250**
120 MG ORAL SUSTAINED-RELEASE TABLET				
00002246893	**APO-VERAP SR**	**APX**	$	**0.5078**
00002210347	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.5078**
00001907123	ISOPTIN SR	BGP	$	1.5019
180 MG ORAL SUSTAINED-RELEASE TABLET				
00002450488	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.5204**
00001934317	ISOPTIN SR	BGP	$	1.6959
240 MG ORAL SUSTAINED-RELEASE TABLET				
00002246895	**APO-VERAP SR**	**APX**	$	**0.5075**
00002450496	**MYLAN-VERAPAMIL SR**	**MYP**	$	**0.5075**
00000742554	ISOPTIN SR	BGP	$	2.2616

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

BENAZEPRIL HCL

5 MG ORAL TABLET				
00002290332	BENAZEPRIL	AAP	$	0.8333
10 MG ORAL TABLET				
00002290340	BENAZEPRIL	AAP	$	0.9870
20 MG ORAL TABLET				
00002273918	BENAZEPRIL	AAP	$	1.1311

CAPTOPRIL

12.5 MG ORAL TABLET				
00001942964	TEVA-CAPTOPRIL	TEV	$	0.1113
25 MG ORAL TABLET				
00001942972	TEVA-CAPTOPRIL	TEV	$	0.1575
50 MG ORAL TABLET				
00001942980	TEVA-CAPTOPRIL	TEV	$	0.2935
100 MG ORAL TABLET				
00001942999	TEVA-CAPTOPRIL	TEV	$	0.5458

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

CILAZAPRIL

1 MG ORAL TABLET

00002291134	**APO-CILAZAPRIL**	**APX**	$	**0.1557**
00002283778	**MYLAN-CILAZAPRIL**	**MYP**	$	**0.1557**

2.5 MG ORAL TABLET

00002291142	**APO-CILAZAPRIL**	**APX**	$	**0.1795**
00002283786	**MYLAN-CILAZAPRIL**	**MYP**	$	**0.1795**
00001911473	INHIBACE	HLR	$	0.8589

5 MG ORAL TABLET

00002291150	**APO-CILAZAPRIL**	**APX**	$	**0.2085**
00002283794	**MYLAN-CILAZAPRIL**	**MYP**	$	**0.2085**
00001911481	INHIBACE	HLR	$	0.9978

CILAZAPRIL/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002284987	**APO-CILAZAPRIL/HCTZ**	**APX**	$	**0.4170**
00002313731	**NOVO-CILAZAPRIL/HCTZ**	**TEV**	$	**0.4170**
00002181479	INHIBACE PLUS	CAG	$	0.9975

ENALAPRIL MALEATE

2.5 MG ORAL TABLET

00002291878	**ACT ENALAPRIL**	**APH**	$	**0.1863**
00002020025	**APO-ENALAPRIL**	**APX**	$	**0.1863**
00002400650	**ENALAPRIL**	**SNS**	$	**0.1863**
00002442957	**ENALAPRIL**	**SIV**	$	**0.1863**
00002300036	**MYLAN-ENALAPRIL**	**MYP**	$	**0.1863**
00002352230	**RAN-ENALAPRIL**	**RAN**	$	**0.1863**
00002299933	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.1863**

5 MG ORAL TABLET

00002291886	**ACT ENALAPRIL**	**APH**	$	**0.2203**
00002019884	**APO-ENALAPRIL**	**APX**	$	**0.2203**
00002400669	**ENALAPRIL**	**SNS**	$	**0.2203**
00002442965	**ENALAPRIL**	**SIV**	$	**0.2203**
00002300044	**MYLAN-ENALAPRIL**	**MYP**	$	**0.2203**
00002352249	**RAN-ENALAPRIL**	**RAN**	$	**0.2203**
00002299941	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.2203**
00000708879	VASOTEC	MFC	$	1.0256

10 MG ORAL TABLET

00002291894	**ACT ENALAPRIL**	**APH**	$	**0.2647**
00002019892	**APO-ENALAPRIL**	**APX**	$	**0.2647**
00002400677	**ENALAPRIL**	**SNS**	$	**0.2647**
00002442973	**ENALAPRIL**	**SIV**	$	**0.2647**
00002300052	**MYLAN-ENALAPRIL**	**MYP**	$	**0.2647**
00002352257	**RAN-ENALAPRIL**	**RAN**	$	**0.2647**
00002299968	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.2647**
00000670901	VASOTEC	MFC	$	1.2325

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

ENALAPRIL MALEATE

20 MG ORAL TABLET

00002291908	**ACT ENALAPRIL**	**APH**	$	**0.3195**
00002019906	**APO-ENALAPRIL**	**APX**	$	**0.3195**
00002400685	**ENALAPRIL**	**SNS**	$	**0.3195**
00002442981	**ENALAPRIL**	**SIV**	$	**0.3195**
00002300060	**MYLAN-ENALAPRIL**	**MYP**	$	**0.3195**
00002352265	**RAN-ENALAPRIL**	**RAN**	$	**0.3195**
00002299976	**SANDOZ ENALAPRIL**	**SDZ**	$	**0.3195**
00000670928	VASOTEC	MFC	$	1.4874

ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002352923	ENALAPRIL MALEATE/HCTZ	AAP	$	0.7673

10 MG * 25 MG ORAL TABLET

00002352931	**ENALAPRIL MALEATE/HCTZ**	**AAP**	$	**1.0741**
00000657298	VASERETIC	MFC	$	1.2696

FOSINOPRIL SODIUM

10 MG ORAL TABLET

00002266008	**APO-FOSINOPRIL**	**APX**	$	**0.2177**
00002459388	**FOSINOPRIL**	**SNS**	$	**0.2177**
00002331004	**JAMP-FOSINOPRIL**	**JPC**	$	**0.2177**
00002247802	**TEVA-FOSINOPRIL**	**TEV**	$	**0.2177**

20 MG ORAL TABLET

00002266016	**APO-FOSINOPRIL**	**APX**	$	**0.2619**
00002459396	**FOSINOPRIL**	**SNS**	$	**0.2619**
00002331012	**JAMP-FOSINOPRIL**	**JPC**	$	**0.2619**
00002247803	**TEVA-FOSINOPRIL**	**TEV**	$	**0.2619**

LISINOPRIL

5 MG ORAL TABLET

00002217481	**APO-LISINOPRIL**	**APX**	$	**0.1347**
00002394472	**AURO-LISINOPRIL**	**AUR**	$	**0.1347**
00002361531	**JAMP-LISINOPRIL**	**JPC**	$	**0.1347**
00002386232	**LISINOPRIL**	**SIV**	$	**0.1347**
00002294230	**RAN-LISINOPRIL**	**RAN**	$	**0.1347**
00002289199	**SANDOZ LISINOPRIL**	**SDZ**	$	**0.1347**
00002285118	**TEVA-LISINOPRIL (TYPE Z)**	**TEV**	$	**0.1347**
00002049333	ZESTRIL	AZC	$	0.5710

10 MG ORAL TABLET

00002217503	**APO-LISINOPRIL**	**APX**	$	**0.1619**
00002394480	**AURO-LISINOPRIL**	**AUR**	$	**0.1619**
00002361558	**JAMP-LISINOPRIL**	**JPC**	$	**0.1619**
00002386240	**LISINOPRIL**	**SIV**	$	**0.1619**
00002294249	**RAN-LISINOPRIL**	**RAN**	$	**0.1619**
00002285088	**TEVA-LISINOPRIL (TYPE P)**	**TEV**	$	**0.1619**
00002285126	**TEVA-LISINOPRIL (TYPE Z)**	**TEV**	$	**0.1619**
00002049376	ZESTRIL	AZC	$	0.6861
00000839396	PRINIVIL	MFC	$	0.7875

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

LISINOPRIL

20 MG ORAL TABLET

00002217511	**APO-LISINOPRIL**	**APX**	$	**0.1945**
00002394499	**AURO-LISINOPRIL**	**AUR**	$	**0.1945**
00002361566	**JAMP-LISINOPRIL**	**JPC**	$	**0.1945**
00002386259	**LISINOPRIL**	**SIV**	$	**0.1945**
00002294257	**RAN-LISINOPRIL**	**RAN**	$	**0.1945**
00002285096	**TEVA-LISINOPRIL (TYPE P)**	**TEV**	$	**0.1945**
00002285134	**TEVA-LISINOPRIL (TYPE Z)**	**TEV**	$	**0.1945**
00002049384	ZESTRIL	AZC	$	0.8241
00000839418	PRINIVIL	MFC	$	0.9469

LISINOPRIL/ HYDROCHLOROTHIAZIDE

10 MG * 12.5 MG ORAL TABLET

00002362945	**LISINOPRIL/HCTZ (TYPE Z)**	**SNS**	$	**0.2083**
00002302365	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.2083**
00002301768	**TEVA-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.2083**
00002103729	ZESTORETIC	AZC	$	0.9286

20 MG * 12.5 MG ORAL TABLET

00002362953	**LISINOPRIL/HCTZ (TYPE Z)**	**SNS**	$	**0.2503**
00002302373	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.2503**
00002301776	**TEVA-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.2503**
00002045737	ZESTORETIC	AZC	$	1.1159

20 MG * 25 MG ORAL TABLET

00002362961	**LISINOPRIL/HCTZ (TYPE Z)**	**SNS**	$	**0.2503**
00002302381	**SANDOZ LISINOPRIL HCT**	**SDZ**	$	**0.2503**
00002301784	**TEVA-LISINOPRIL/HCTZ (TYPE Z)**	**TEV**	$	**0.2503**
00002045729	ZESTORETIC	AZC	$	1.1159

10 MG * 12.5 MG ORAL TABLET

00002302136	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	$	0.4319

PERINDOPRIL ERBUMINE

2 MG ORAL TABLET

00002289261	**APO-PERINDOPRIL**	**APX**	$	**0.1632**
00002459817	**AURO-PERINDOPRIL**	**AUR**	$	**0.1632**
00002470675	**PMS-PERINDOPRIL**	**PMS**	$	**0.1632**
00002470225	**SANDOZ PERINDOPRIL ERBUMINE**	**SDZ**	$	**0.1632**
00002464985	**TEVA-PERINDOPRIL**	**TEV**	$	**0.1632**
00002123274	COVERSYL	SEV	$	0.6960

4 MG ORAL TABLET

00002289288	**APO-PERINDOPRIL**	**APX**	$	**0.2042**
00002459825	**AURO-PERINDOPRIL**	**AUR**	$	**0.2042**
00002470683	**PMS-PERINDOPRIL**	**PMS**	$	**0.2042**
00002470233	**SANDOZ PERINDOPRIL ERBUMINE**	**SDZ**	$	**0.2042**
00002464993	**TEVA-PERINDOPRIL**	**TEV**	$	**0.2042**
00002123282	COVERSYL	SEV	$	0.8714

8 MG ORAL TABLET

00002289296	**APO-PERINDOPRIL**	**APX**	$	**0.2831**
00002459833	**AURO-PERINDOPRIL**	**AUR**	$	**0.2831**
00002470691	**PMS-PERINDOPRIL**	**PMS**	$	**0.2831**
00002470241	**SANDOZ PERINDOPRIL ERBUMINE**	**SDZ**	$	**0.2831**
00002465000	**TEVA-PERINDOPRIL**	**TEV**	$	**0.2831**
00002246624	COVERSYL	SEV	$	1.2201

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

PERINDOPRIL ERBUMINE/ INDAPAMIDE HEMIHYDRATE

4 MG * 1.25 MG ORAL TABLET				
00002470438	**SANDOZ PERINDOPRIL/INDAPAMIDE**	**SDZ**	$	**0.5113**
00002464020	**TEVA-PERINDOPRIL/INDAPAMIDE**	**TEV**	$	**0.5113**
00002246569	COVERSYL PLUS	SEV	$	1.0503
8 MG * 2.5 MG ORAL TABLET				
00002470446	**SANDOZ PERINDOPRIL/INDAPAMIDE HD**	**SDZ**	$	**0.5718**
00002464039	**TEVA-PERINDOPRIL/INDAPAMIDE**	**TEV**	$	**0.5718**
00002321653	COVERSYL PLUS HD	SEV	$	1.2201

QUINAPRIL

5 MG (BASE) ORAL TABLET				
00002248499	**APO-QUINAPRIL**	**APX**	$	**0.2321**
00001947664	ACCUPRIL	PFI	$	0.9742
10 MG (BASE) ORAL TABLET				
00002248500	**APO-QUINAPRIL**	**APX**	$	**0.2321**
00001947672	ACCUPRIL	PFI	$	0.9742
20 MG (BASE) ORAL TABLET				
00002248501	**APO-QUINAPRIL**	**APX**	$	**0.2321**
00001947680	ACCUPRIL	PFI	$	0.9742
40 MG (BASE) ORAL TABLET				
00002248502	**APO-QUINAPRIL**	**APX**	$	**0.2321**
00001947699	ACCUPRIL	PFI	$	0.9742

QUINAPRIL/ HYDROCHLOROTHIAZIDE

10 MG (BASE) * 12.5 MG ORAL TABLET				
00002408767	**APO-QUINAPRIL/HCTZ**	**APX**	$	**0.6865**
00002237367	ACCURETIC 10/12.5	PFI	$	0.9840
20 MG (BASE) * 12.5 MG ORAL TABLET				
00002408775	**APO-QUINAPRIL/HCTZ**	**APX**	$	**0.6865**
00002237368	ACCURETIC 20/12.5	PFI	$	0.9840
20 MG * 25 MG ORAL TABLET				
00002408783	**APO-QUINAPRIL/HCTZ**	**APX**	$	**0.6512**
00002237369	ACCURETIC 20/25	PFI	$	0.9423

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

RAMIPRIL

1.25 MG ORAL CAPSULE/TABLET

00002251515	**APO-RAMIPRIL (CAPSULE)**	**APX**	$	**0.0708**
00002387387	**AURO-RAMIPRIL (CAPSULE)**	**AUR**	$	**0.0708**
00002331101	**JAMP-RAMIPRIL (CAPSULE)**	**JPC**	$	**0.0708**
00002420457	**MAR-RAMIPRIL (CAPSULE)**	**MAR**	$	**0.0708**
00002469057	**PHARMA-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.0708**
00002295369	**PMS-RAMIPRIL (CAPSULE)**	**PMS**	$	**0.0708**
00002308363	**RAMIPRIL (CAPSULE)**	**SIV**	$	**0.0708**
00002310503	**RAN-RAMIPRIL (CAPSULE)**	**RAN**	$	**0.0708**
00002221829	ALTACE (CAPSULE)	VCL	$	0.7692

2.5 MG ORAL CAPSULE/TABLET

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**
00002247917	**PMS-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	$	0.8659

5 MG ORAL CAPSULE/TABLET

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**
00002247918	**PMS-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	$	0.8886

10 MG ORAL CAPSULE/TABLET

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**
00002247919	**PMS-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	$	1.1260

24:00 CARDIOVASCULAR DRUGS

24:32.04 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN-CONVERTING ENZYME INHIBITORS)

RAMIPRIL/ HYDROCHLOROTHIAZIDE

2.5 MG * 12.5 MG ORAL TABLET				
00002449439	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.1495**
00002283131	ALTACE HCT	VCL	$	0.3115
5 MG * 12.5 MG ORAL TABLET				
00002449447	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.2011**
00002283158	ALTACE HCT	VCL	$	0.3990
5 MG * 25 MG ORAL TABLET				
00002449463	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.1915**
00002283174	ALTACE HCT	VCL	$	0.3990
10 MG * 12.5 MG ORAL TABLET				
00002342154	**PMS-RAMIPRIL-HCTZ**	**PMS**	$	**0.1317**
00002449455	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.1317**
00002283166	ALTACE HCT	VCL	$	0.5215
10 MG * 25 MG ORAL TABLET				
00002342170	**PMS-RAMIPRIL-HCTZ**	**PMS**	$	**0.1317**
00002449471	**RAN-RAMIPRIL HCTZ**	**RAN**	$	**0.1317**
00002283182	ALTACE HCT	VCL	$	0.5215

TRANDOLAPRIL

0.5 MG ORAL CAPSULE				
00002471868	**AURO-TRANDOLAPRIL**	**AUR**	$	**0.0698**
00002357755	**PMS-TRANDOLAPRIL**	**PMS**	$	**0.0698**
00002325721	**SANDOZ TRANDOLAPRIL**	**SDZ**	$	**0.0698**
00002415429	**TEVA-TRANDOLAPRIL**	**TEV**	$	**0.0698**
00002231457	MAVIK	BGP	$	0.2790
1 MG ORAL CAPSULE				
00002471876	**AURO-TRANDOLAPRIL**	**AUR**	$	**0.1762**
00002357763	**PMS-TRANDOLAPRIL**	**PMS**	$	**0.1762**
00002325748	**SANDOZ TRANDOLAPRIL**	**SDZ**	$	**0.1762**
00002415437	**TEVA-TRANDOLAPRIL**	**TEV**	$	**0.1762**
00002231459	MAVIK	BGP	$	0.7046
2 MG ORAL CAPSULE				
00002471884	**AURO-TRANDOLAPRIL**	**AUR**	$	**0.2025**
00002357771	**PMS-TRANDOLAPRIL**	**PMS**	$	**0.2025**
00002325756	**SANDOZ TRANDOLAPRIL**	**SDZ**	$	**0.2025**
00002415445	**TEVA-TRANDOLAPRIL**	**TEV**	$	**0.2025**
00002231460	MAVIK	BGP	$	0.8098
4 MG ORAL CAPSULE				
00002471892	**AURO-TRANDOLAPRIL**	**AUR**	$	**0.2498**
00002357798	**PMS-TRANDOLAPRIL**	**PMS**	$	**0.2498**
00002325764	**SANDOZ TRANDOLAPRIL**	**SDZ**	$	**0.2498**
00002415453	**TEVA-TRANDOLAPRIL**	**TEV**	$	**0.2498**
00002239267	MAVIK	BGP	$	0.9990

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

CANDESARTAN CILEXETIL

8 MG ORAL TABLET

00002365359	**APO-CANDESARTAN**	**APX**	$	**0.2281**
00002445794	**AURO-CANDESARTAN**	**AUR**	$	**0.2281**
00002388707	**CANDESARTAN**	**SIV**	$	**0.2281**
00002388928	**CANDESARTAN**	**SNS**	$	**0.2281**
00002379279	**CANDESARTAN CILEXETIL**	**AHI**	$	**0.2281**
00002386518	**JAMP-CANDESARTAN**	**JPC**	$	**0.2281**
00002476916	**MINT-CANDESARTAN**	**MPI**	$	**0.2281**
00002391198	**PMS-CANDESARTAN**	**PMS**	$	**0.2281**
00002380692	**RAN-CANDESARTAN**	**RAN**	$	**0.2281**
00002326965	**SANDOZ CANDESARTAN**	**SDZ**	$	**0.2281**
00002366312	**TEVA-CANDESARTAN**	**TEV**	$	**0.2281**
00002239091	ATACAND	AZC	$	1.2530

16 MG ORAL TABLET

00002365367	**APO-CANDESARTAN**	**APX**	$	**0.2281**
00002388715	**CANDESARTAN**	**SIV**	$	**0.2281**
00002388936	**CANDESARTAN**	**SNS**	$	**0.2281**
00002379287	**CANDESARTAN CILEXETIL**	**AHI**	$	**0.2281**
00002386526	**JAMP-CANDESARTAN**	**JPC**	$	**0.2281**
00002476924	**MINT-CANDESARTAN**	**MPI**	$	**0.2281**
00002391201	**PMS-CANDESARTAN**	**PMS**	$	**0.2281**
00002380706	**RAN-CANDESARTAN**	**RAN**	$	**0.2281**
00002326973	**SANDOZ CANDESARTAN**	**SDZ**	$	**0.2281**
00002366320	**TEVA-CANDESARTAN**	**TEV**	$	**0.2281**
00002239092	ATACAND	AZC	$	1.2530

32 MG ORAL TABLET

00002399105	**APO-CANDESARTAN**	**APX**	$	**0.2281**
00002435845	**CANDESARTAN**	**SNS**	$	**0.2281**
00002379295	**CANDESARTAN CILEXETIL**	**AHI**	$	**0.2281**
00002386534	**JAMP-CANDESARTAN**	**JPC**	$	**0.2281**
00002391228	**PMS-CANDESARTAN**	**PMS**	$	**0.2281**
00002380714	**RAN-CANDESARTAN**	**RAN**	$	**0.2281**
00002417340	**SANDOZ CANDESARTAN**	**SDZ**	$	**0.2281**
00002366339	**TEVA-CANDESARTAN**	**TEV**	$	**0.2281**
00002311658	ATACAND	AZC	$	1.2530

CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE

16 MG * 12.5 MG ORAL TABLET

00002421038	**AURO-CANDESARTAN HCT**	**AUR**	$	**0.2156**
00002394812	**CANDESARTAN HCT**	**SIV**	$	**0.2156**
00002394804	**CANDESARTAN/HCTZ**	**SNS**	$	**0.2156**
00002391295	**PMS-CANDESARTAN HCTZ**	**PMS**	$	**0.2156**
00002327902	**SANDOZ CANDESARTAN PLUS**	**SDZ**	$	**0.2156**
00002395541	**TEVA-CANDESARTAN/HCTZ**	**TEV**	$	**0.2156**
00002244021	ATACAND PLUS	AZC	$	1.2950

32 MG * 12.5 MG ORAL TABLET

00002421046	**AURO-CANDESARTAN HCT**	**AUR**	$	**0.2156**
00002420732	**SANDOZ CANDESARTAN PLUS**	**SDZ**	$	**0.2156**
00002395568	**TEVA-CANDESARTAN/HCTZ**	**TEV**	$	**0.2156**
00002332922	ATACAND PLUS	AZC	$	1.2950

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE

32 MG * 25 MG ORAL TABLET

00002421054	**AURO-CANDESARTAN HCT**	**AUR**	$	**0.3008**
00002420740	**SANDOZ CANDESARTAN PLUS**	**SDZ**	$	**0.3008**
00002332957	ATACAND PLUS	AZC	$	1.2950

EPROSARTAN MESYLATE

400 MG (BASE) ORAL TABLET

00002240432	TEVETEN	BGP	$	0.7550

600 MG (BASE) ORAL TABLET

00002243942	TEVETEN	BGP	$	1.1544

EPROSARTAN MESYLATE/ HYDROCHLOROTHIAZIDE

600 MG * 12.5 MG ORAL TABLET

00002253631	TEVETEN PLUS	BGP	$	1.1544

IRBESARTAN

75 MG ORAL TABLET

00002406098	**AURO-IRBESARTAN**	**AUR**	$	**0.2281**
00002372347	**IRBESARTAN**	**SNS**	$	**0.2281**
00002385287	**IRBESARTAN**	**SIV**	$	**0.2281**
00002418193	**JAMP-IRBESARTAN**	**JPC**	$	**0.2281**
00002422980	**MINT-IRBESARTAN**	**MPI**	$	**0.2281**
00002317060	**PMS-IRBESARTAN**	**PMS**	$	**0.2281**
00002406810	**RAN-IRBESARTAN**	**RAN**	$	**0.2281**
00002328461	**SANDOZ IRBESARTAN**	**SDZ**	$	**0.2281**
00002316390	**TEVA-IRBESARTAN**	**TEV**	$	**0.2281**
00002237923	AVAPRO	SAV	$	1.2671

150 MG ORAL TABLET

00002406101	**AURO-IRBESARTAN**	**AUR**	$	**0.2281**
00002372371	**IRBESARTAN**	**SNS**	$	**0.2281**
00002385295	**IRBESARTAN**	**SIV**	$	**0.2281**
00002418207	**JAMP-IRBESARTAN**	**JPC**	$	**0.2281**
00002422999	**MINT-IRBESARTAN**	**MPI**	$	**0.2281**
00002317079	**PMS-IRBESARTAN**	**PMS**	$	**0.2281**
00002406829	**RAN-IRBESARTAN**	**RAN**	$	**0.2281**
00002328488	**SANDOZ IRBESARTAN**	**SDZ**	$	**0.2281**
00002316404	**TEVA-IRBESARTAN**	**TEV**	$	**0.2281**
00002237924	AVAPRO	SAV	$	1.2671

300 MG ORAL TABLET

00002406128	**AURO-IRBESARTAN**	**AUR**	$	**0.2281**
00002372398	**IRBESARTAN**	**SNS**	$	**0.2281**
00002385309	**IRBESARTAN**	**SIV**	$	**0.2281**
00002418215	**JAMP-IRBESARTAN**	**JPC**	$	**0.2281**
00002423006	**MINT-IRBESARTAN**	**MPI**	$	**0.2281**
00002317087	**PMS-IRBESARTAN**	**PMS**	$	**0.2281**
00002406837	**RAN-IRBESARTAN**	**RAN**	$	**0.2281**
00002328496	**SANDOZ IRBESARTAN**	**SDZ**	$	**0.2281**
00002316412	**TEVA-IRBESARTAN**	**TEV**	$	**0.2281**
00002237925	AVAPRO	SAV	$	1.2671

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

IRBESARTAN/ HYDROCHLOROTHIAZIDE

150 MG * 12.5 MG ORAL TABLET				
00002447878	**AURO-IRBESARTAN HCT**	**AUR**	$	**0.2281**
00002385317	**IRBESARTAN HCT**	**SIV**	$	**0.2281**
00002372886	**IRBESARTAN/HCTZ**	**SNS**	$	**0.2281**
00002418223	**JAMP-IRBESARTAN-HYDROCHLOROTHIAZIDE**	**JPC**	$	**0.2281**
00002392992	**MINT-IRBESARTAN/HCTZ**	**MPI**	$	**0.2281**
00002328518	**PMS-IRBESARTAN-HCTZ**	**PMS**	$	**0.2281**
00002337428	**SANDOZ IRBESARTAN HCT**	**SDZ**	$	**0.2281**
00002330512	**TEVA-IRBESARTAN HCTZ**	**TEV**	$	**0.2281**
00002241818	AVALIDE 150/12.5	SAV	$	1.2671
300 MG * 12.5 MG ORAL TABLET				
00002447886	**AURO-IRBESARTAN HCT**	**AUR**	$	**0.2281**
00002385325	**IRBESARTAN HCT**	**SIV**	$	**0.2281**
00002372894	**IRBESARTAN/HCTZ**	**SNS**	$	**0.2281**
00002418231	**JAMP-IRBESARTAN-HYDROCHLOROTHIAZIDE**	**JPC**	$	**0.2281**
00002393018	**MINT-IRBESARTAN/HCTZ**	**MPI**	$	**0.2281**
00002328526	**PMS-IRBESARTAN-HCTZ**	**PMS**	$	**0.2281**
00002337436	**SANDOZ IRBESARTAN HCT**	**SDZ**	$	**0.2281**
00002330520	**TEVA-IRBESARTAN HCTZ**	**TEV**	$	**0.2281**
00002241819	AVALIDE 300/12.5	SAV	$	1.2671
300 MG * 25 MG ORAL TABLET				
00002447894	**AURO-IRBESARTAN HCT**	**AUR**	$	**0.2184**
00002385333	**IRBESARTAN HCT**	**SIV**	$	**0.2184**
00002372908	**IRBESARTAN/HCTZ**	**SNS**	$	**0.2184**
00002418258	**JAMP-IRBESARTAN-HYDROCHLOROTHIAZIDE**	**JPC**	$	**0.2184**
00002393026	**MINT-IRBESARTAN/HCTZ**	**MPI**	$	**0.2184**
00002328534	**PMS-IRBESARTAN-HCTZ**	**PMS**	$	**0.2184**
00002337444	**SANDOZ IRBESARTAN HCT**	**SDZ**	$	**0.2184**
00002330539	**TEVA-IRBESARTAN HCTZ**	**TEV**	$	**0.2184**

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

LOSARTAN POTASSIUM

25 MG ORAL TABLET

00002379058	**APO-LOSARTAN**	**APX**	$	**0.1616**
00002403323	**AURO-LOSARTAN**	**AUR**	$	**0.1616**
00002445964	**BIO-LOSARTAN**	**BMD**	$	**0.1616**
00002398834	**JAMP-LOSARTAN**	**JPC**	$	**0.1616**
00002388790	**LOSARTAN**	**SIV**	$	**0.1616**
00002405733	**MINT-LOSARTAN**	**MPI**	$	**0.1616**
00002309750	**PMS-LOSARTAN**	**PMS**	$	**0.1616**
00002313332	**SANDOZ LOSARTAN**	**SDZ**	$	**0.1616**
00002424967	**SEPTA-LOSARTAN**	**SEP**	$	**0.1616**
00002380838	**TEVA-LOSARTAN**	**TEV**	$	**0.1616**
00002182815	COZAAR	MFC	$	1.3991

50 MG ORAL TABLET

00002353504	**APO-LOSARTAN**	**APX**	$	**0.1616**
00002403331	**AURO-LOSARTAN**	**AUR**	$	**0.1616**
00002445972	**BIO-LOSARTAN**	**BMD**	$	**0.1616**
00002398842	**JAMP-LOSARTAN**	**JPC**	$	**0.1616**
00002388804	**LOSARTAN**	**SIV**	$	**0.1616**
00002405741	**MINT-LOSARTAN**	**MPI**	$	**0.1616**
00002309769	**PMS-LOSARTAN**	**PMS**	$	**0.1616**
00002313340	**SANDOZ LOSARTAN**	**SDZ**	$	**0.1616**
00002424975	**SEPTA-LOSARTAN**	**SEP**	$	**0.1616**
00002357968	**TEVA-LOSARTAN**	**TEV**	$	**0.1616**
00002182874	COZAAR	MFC	$	1.3991

100 MG ORAL TABLET

00002353512	**APO-LOSARTAN**	**APX**	$	**0.1616**
00002403358	**AURO-LOSARTAN**	**AUR**	$	**0.1616**
00002445980	**BIO-LOSARTAN**	**BMD**	$	**0.1616**
00002398850	**JAMP-LOSARTAN**	**JPC**	$	**0.1616**
00002388812	**LOSARTAN**	**SIV**	$	**0.1616**
00002405768	**MINT-LOSARTAN**	**MPI**	$	**0.1616**
00002309777	**PMS-LOSARTAN**	**PMS**	$	**0.1616**
00002313359	**SANDOZ LOSARTAN**	**SDZ**	$	**0.1616**
00002424983	**SEPTA-LOSARTAN**	**SEP**	$	**0.1616**
00002357976	**TEVA-LOSARTAN**	**TEV**	$	**0.1616**
00002182882	COZAAR	MFC	$	1.3991

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

LOSARTAN POTASSIUM/ HYDROCHLOROTHIAZIDE

50 MG * 12.5 MG ORAL TABLET

00002423642	**AURO-LOSARTAN HCT**	**AUR**	$	**0.3146**
00002408244	**JAMP-LOSARTAN HCTZ**	**JPC**	$	**0.3146**
00002388960	**LOSARTAN/HCT**	**SIV**	$	**0.3146**
00002427648	**LOSARTAN/HCTZ**	**SNS**	$	**0.3146**
00002389657	**MINT-LOSARTAN/HCTZ**	**MPI**	$	**0.3146**
00002392224	**PMS-LOSARTAN-HCTZ**	**PMS**	$	**0.3146**
00002313375	**SANDOZ LOSARTAN HCT**	**SDZ**	$	**0.3146**
00002428539	**SEPTA-LOSARTAN HCTZ**	**SEP**	$	**0.3146**
00002358263	**TEVA-LOSARTAN/HCTZ**	**TEV**	$	**0.3146**
00002230047	HYZAAR	MFC	$	1.3991

100 MG * 12.5 MG ORAL TABLET

00002423650	**AURO-LOSARTAN HCT**	**AUR**	$	**0.3082**
00002388979	**LOSARTAN/HCT**	**SIV**	$	**0.3082**
00002427656	**LOSARTAN/HCTZ**	**SNS**	$	**0.3082**
00002389665	**MINT-LOSARTAN/HCTZ**	**MPI**	$	**0.3082**
00002392232	**PMS-LOSARTAN-HCTZ**	**PMS**	$	**0.3082**
00002362449	**SANDOZ LOSARTAN HCT**	**SDZ**	$	**0.3082**
00002377144	**TEVA-LOSARTAN/HCTZ**	**TEV**	$	**0.3082**
00002297841	HYZAAR	MFC	$	1.3699

100 MG * 25 MG ORAL TABLET

00002423669	**AURO-LOSARTAN HCT**	**AUR**	$	**0.3146**
00002408252	**JAMP-LOSARTAN HCTZ**	**JPC**	$	**0.3146**
00002388987	**LOSARTAN/HCT**	**SIV**	$	**0.3146**
00002427664	**LOSARTAN/HCTZ**	**SNS**	$	**0.3146**
00002389673	**MINT-LOSARTAN/HCTZ DS**	**MPI**	$	**0.3146**
00002392240	**PMS-LOSARTAN-HCTZ**	**PMS**	$	**0.3146**
00002313383	**SANDOZ LOSARTAN HCT DS**	**SDZ**	$	**0.3146**
00002428547	**SEPTA-LOSARTAN HCTZ**	**SEP**	$	**0.3146**
00002377152	**TEVA-LOSARTAN/HCTZ**	**TEV**	$	**0.3146**
00002241007	HYZAAR DS	MFC	$	1.3991

TELMISARTAN

40 MG ORAL TABLET

00002453568	**AURO-TELMISARTAN**	**AUR**	$	**0.2161**
00002375958	**SANDOZ TELMISARTAN**	**SDZ**	$	**0.2161**
00002388944	**TELMISARTAN**	**SNS**	$	**0.2161**
00002390345	**TELMISARTAN**	**SIV**	$	**0.2161**
00002407485	**TELMISARTAN**	**AHI**	$	**0.2161**
00002320177	**TEVA-TELMISARTAN**	**TEV**	$	**0.2161**
00002240769	MICARDIS	BOE	$	1.2474

80 MG ORAL TABLET

00002453576	**AURO-TELMISARTAN**	**AUR**	$	**0.2161**
00002375966	**SANDOZ TELMISARTAN**	**SDZ**	$	**0.2161**
00002388952	**TELMISARTAN**	**SNS**	$	**0.2161**
00002390353	**TELMISARTAN**	**SIV**	$	**0.2161**
00002407493	**TELMISARTAN**	**AHI**	$	**0.2161**
00002320185	**TEVA-TELMISARTAN**	**TEV**	$	**0.2161**
00002240770	MICARDIS	BOE	$	1.2474

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

TELMISARTAN/ AMLODIPINE BESYLATE

40 MG * 5 MG ORAL TABLET				
00002371022	TWYNSTA	BOE	$	0.7296
40 MG * 10 MG ORAL TABLET				
00002371030	TWYNSTA	BOE	$	0.7296
80 MG * 5 MG ORAL TABLET				
00002371049	TWYNSTA	BOE	$	0.7296
80 MG * 10 MG ORAL TABLET				
00002371057	TWYNSTA	BOE	$	0.7296

TELMISARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET				
00002419114	**ACH-TELMISARTAN HCTZ**	**AHI**	$	**0.2098**
00002456389	**AURO-TELMISARTAN HCTZ**	**AUR**	$	**0.2098**
00002393557	**SANDOZ TELMISARTAN HCT**	**SDZ**	$	**0.2098**
00002390302	**TELMISARTAN HCTZ**	**SIV**	$	**0.2098**
00002395355	**TELMISARTAN/HCTZ**	**SNS**	$	**0.2098**
00002330288	**TEVA-TELMISARTAN HCTZ**	**TEV**	$	**0.2098**
00002244344	MICARDIS PLUS	BOE	$	1.2474
80 MG * 25 MG ORAL TABLET				
00002419122	**ACH-TELMISARTAN HCTZ**	**AHI**	$	**0.2098**
00002456397	**AURO-TELMISARTAN HCTZ**	**AUR**	$	**0.2098**
00002393565	**SANDOZ TELMISARTAN HCT**	**SDZ**	$	**0.2098**
00002390310	**TELMISARTAN HCTZ**	**SIV**	$	**0.2098**
00002395363	**TELMISARTAN/HCTZ**	**SNS**	$	**0.2098**
00002379252	**TEVA-TELMISARTAN HCTZ**	**TEV**	$	**0.2098**
00002318709	MICARDIS PLUS	BOE	$	1.2474

VALSARTAN

80 MG ORAL TABLET				
00002371529	**APO-VALSARTAN**	**APX**	$	**0.2159**
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**
00002384531	**VALSARTAN**	**SIV**	$	**0.2159**
00002244781	DIOVAN	NOV	$	1.2832
160 MG ORAL TABLET				
00002371537	**APO-VALSARTAN**	**APX**	$	**0.2159**
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**
00002384558	**VALSARTAN**	**SIV**	$	**0.2159**
00002244782	DIOVAN	NOV	$	1.2825

24:00 CARDIOVASCULAR DRUGS

24:32.08 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (ANGIOTENSIN II RECEPTOR ANTAGONISTS)

VALSARTAN

320 MG ORAL TABLET

00002371545	**APO-VALSARTAN**	**APX**	$	**0.2098**
00002414244	**AURO-VALSARTAN**	**AUR**	$	**0.2098**
00002356775	**SANDOZ VALSARTAN**	**SDZ**	$	**0.2098**
00002356686	**TEVA-VALSARTAN**	**TEV**	$	**0.2098**
00002366975	**VALSARTAN**	**SNS**	$	**0.2098**
00002384566	**VALSARTAN**	**SIV**	$	**0.2098**
00002289504	DIOVAN	NOV	$	1.2357

VALSARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET

00002408112	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2213**
00002356694	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2213**
00002356996	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2213**
00002367009	**VALSARTAN HCT**	**SNS**	$	**0.2213**
00002384736	**VALSARTAN HCT**	**SIV**	$	**0.2213**
00002241900	DIOVAN-HCT	NOV	$	1.2757

160 MG * 12.5 MG ORAL TABLET

00002408120	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2240**
00002356708	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2240**
00002357003	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2240**
00002367017	**VALSARTAN HCT**	**SNS**	$	**0.2240**
00002384744	**VALSARTAN HCT**	**SIV**	$	**0.2240**
00002241901	DIOVAN-HCT	NOV	$	1.2807

160 MG * 25 MG ORAL TABLET

00002408139	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2238**
00002356716	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2238**
00002357011	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2238**
00002367025	**VALSARTAN HCT**	**SNS**	$	**0.2238**
00002384752	**VALSARTAN HCT**	**SIV**	$	**0.2238**
00002246955	DIOVAN-HCT	NOV	$	1.2850

320 MG * 12.5 MG ORAL TABLET

00002408147	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2235**
00002356724	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2235**
00002357038	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2235**
00002367033	**VALSARTAN HCT**	**SNS**	$	**0.2235**
00002308908	DIOVAN-HCT	NOV	$	1.2650

320 MG * 25 MG ORAL TABLET

00002408155	**AURO-VALSARTAN HCT**	**AUR**	$	**0.2231**
00002356732	**SANDOZ VALSARTAN HCT**	**SDZ**	$	**0.2231**
00002357046	**TEVA-VALSARTAN/HCTZ**	**TEV**	$	**0.2231**
00002367041	**VALSARTAN HCT**	**SNS**	$	**0.2231**
00002308916	DIOVAN-HCT	NOV	$	1.2657

24:00 CARDIOVASCULAR DRUGS

24:32.20 RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS (MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONISTS)

HYDROCHLOROTHIAZIDE/ SPIRONOLACTONE

25 MG * 25 MG ORAL TABLET				
00000613231	TEVA-SPIRONOLACTONE/HCTZ	TEV	$	0.1307
50 MG * 50 MG ORAL TABLET				
00000657182	TEVA-SPIRONOLACTONE/HCTZ	TEV	$	0.2765

SPIRONOLACTONE

25 MG ORAL TABLET				
00000613215	TEVA-SPIRONOLACTONE	TEV	$	0.1307
100 MG ORAL TABLET				
00000613223	TEVA-SPIRONOLACTONE	TEV	$	0.2989

28:00

Central Nervous System Agents

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08 ANALGESICS AND ANTIPYRETICS

COMPOUND PRESCRIPTION

TOPICAL

00000999105	COMPD- NSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)-TOPICAL	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999205	COMPD-NSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)-TOPICAL	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04 ANALGESICS AND ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

COMPOUND PRESCRIPTION

TOPICAL

00000999102 COMPOUND-DICLOFENAC (TOPICAL) XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999202 COMPOUND-DICLOFENAC (TOPICAL) XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.24 ANALGESICS AND ANTIPYRETICS NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (SALICYLATES)

BUTALBITAL/ CAFFEINE/ ASA

50 MG * 40 MG * 330 MG ORAL TABLET					
00000608211	TEVA-TECNAL	TEV		$	1.1568
50 MG * 40 MG * 330 MG ORAL CAPSULE					
00000608238	**TEVA-TECNAL**	**TEV**		$	**1.4687**
00000226327	FIORINAL	TRI		$	1.6560

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM

75 MG ORAL SUSTAINED-RELEASE TABLET					
00002162814	**APO-DICLO SR**	**APX**		$	**0.2320**
00002231504	**PMS-DICLOFENAC-SR**	**PMS**		$	**0.2320**
00002261901	**SANDOZ DICLOFENAC SR**	**SDZ**		$	**0.2320**
00002158582	**TEVA-DICLOFENAC SR**	**TEV**		$	**0.2320**
00000782459	VOLTAREN SR	NOV		$	1.2437
100 MG ORAL SUSTAINED-RELEASE TABLET					
00002091194	APO-DICLO SR	APX	***$ 0.3124***	$	0.4048
00002231505	PMS-DICLOFENAC-SR	PMS	***$ 0.3124***	$	0.4048
00002261944	SANDOZ DICLOFENAC SR	SDZ	***$ 0.3124***	$	0.4048
00000590827	VOLTAREN SR	NOV	***$ 0.3124***	$	1.7729

MAC pricing has been applied based on the LCA Price for 4 X 25 mg oral enteric-coated tablets.

25 MG ORAL ENTERIC-COATED TABLET					
00000839175	**APO-DICLO**	**APX**		$	**0.0781**
00002302616	**PMS-DICLOFENAC**	**PMS**		$	**0.0781**
00000808539	**TEVA-DICLOFENAC EC**	**TEV**		$	**0.0781**
50 MG ORAL ENTERIC-COATED TABLET					
00000839183	APO-DICLO	APX	***$ 0.1562***	$	0.2024
00002352397	DICLOFENAC SODIUM	SNS	***$ 0.1562***	$	0.2024
00002302624	PMS-DICLOFENAC	PMS	***$ 0.1562***	$	0.2024
00002261960	SANDOZ DICLOFENAC	SDZ	***$ 0.1562***	$	0.2024
00000808547	TEVA-DICLOFENAC EC	TEV	***$ 0.1562***	$	0.2024
00000514012	VOLTAREN	NOV	***$ 0.1562***	$	0.9554

MAC pricing has been applied based on the LCA Price for 2 x 25 mg oral enteric-coated tablets.

50 MG RECTAL SUPPOSITORY					
00002231506	**PMS-DICLOFENAC**	**PMS**		$	**0.4339**
00002261928	**SANDOZ DICLOFENAC**	**SDZ**		$	**0.4339**
00000632724	VOLTAREN	NOV		$	1.4350
100 MG RECTAL SUPPOSITORY					
00002231508	**PMS-DICLOFENAC**	**PMS**		$	**0.5840**
00002261936	**SANDOZ DICLOFENAC**	**SDZ**		$	**0.5840**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM/ MISOPROSTOL

50 MG * 200 MCG ORAL ENTERIC-COATED TABLET				
00002341689	**GD-DICLOFENAC/MISOPROSTOL 50**	**GMD**	$	**0.3149**
00001917056	ARTHROTEC-50	PFI	$	0.6822
75 MG * 200 MCG ORAL ENTERIC-COATED TABLET				
00002341697	**GD-DICLOFENAC/MISOPROSTOL 75**	**GMD**	$	**0.4286**
00002229837	ARTHROTEC-75	PFI	$	0.9285

ETODOLAC

200 MG ORAL CAPSULE				
00002232317	ETODOLAC	AAP	$	0.7760
300 MG ORAL CAPSULE				
00002232318	ETODOLAC	AAP	$	0.7760

FLOCTAFENINE

200 MG ORAL TABLET				
00002244680	FLOCTAFENINE	AAP	$	0.4348
400 MG ORAL TABLET				
00002244681	FLOCTAFENINE	AAP	$	0.8459

FLURBIPROFEN

50 MG ORAL TABLET				
00001912046	APO-FLURBIPROFEN	APX	$	0.2221
100 MG ORAL TABLET				
00001912038	APO-FLURBIPROFEN	APX	$	0.3039

IBUPROFEN

300 MG ORAL TABLET				
00000441651	APO-IBUPROFEN	APX	$	0.1377
400 MG ORAL TABLET				
00000506052	**APO-IBUPROFEN**	**APX**	$	**0.0936**
00000629340	**NOVO-PROFEN**	**TEV**	$	**0.0936**
600 MG ORAL TABLET				
00000585114	**APO-IBUPROFEN**	**APX**	$	**0.1313**
00000629359	**NOVO-PROFEN**	**TEV**	$	**0.1313**

INDOMETHACIN

25 MG ORAL CAPSULE				
00002461811	**MINT-INDOMETHACIN**	**MPI**	$	**0.1519**
00000337420	**TEVA-INDOMETHACIN**	**TEV**	$	**0.1519**
50 MG ORAL CAPSULE				
00002461536	**MINT-INDOMETHACIN**	**MPI**	$	**0.2469**
00000337439	**TEVA-INDOMETHACIN**	**TEV**	$	**0.2469**
50 MG RECTAL SUPPOSITORY				
00002231799	SANDOZ INDOMETHACIN	SDZ	$	0.9284
100 MG RECTAL SUPPOSITORY				
00002231800	SANDOZ INDOMETHACIN	SDZ	$	0.9356

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

KETOPROFEN

200 MG ORAL SUSTAINED-RELEASE TABLET

00002172577	KETOPROFEN SR	AAP	***$ 1.4210***	$	1.4813

MAC pricing has been applied based on the price for 2 x 100 mg oral enteric-coated tablets.

50 MG ORAL ENTERIC-COATED TABLET

00000790435	KETOPROFEN-E	AAP		$	0.3596

100 MG ORAL ENTERIC-COATED TABLET

00000842664	KETOPROFEN-E	AAP		$	0.7276

50 MG ORAL CAPSULE

00000790427	KETOPROFEN	AAP		$	0.3440

KETOROLAC TROMETHAMINE

10 MG ORAL TABLET

00002229080	**APO-KETOROLAC**	**APX**		$	**0.3546**
00002465124	**MAR-KETOROLAC**	**MAR**		$	**0.3546**
00002162660	TORADOL	AAP		$	0.7241

10 MG / ML INJECTION

00002162644	TORADOL	AMP		$	1.2920

30 MG / ML INJECTION

☒ 00002239944	KETOROLAC TROMETHAMINE	SDZ		$	4.4100

MEFENAMIC ACID

250 MG ORAL CAPSULE

00002229452	MEFENAMIC	AAP		$	0.3990

NABUMETONE

500 MG ORAL TABLET

00002238639	NABUMETONE	AAP		$	0.6130

NAPROXEN

125 MG ORAL TABLET

00000522678	APO-NAPROXEN	APX		$	0.0781

250 MG ORAL TABLET

00000522651	**APO-NAPROXEN**	**APX**		$	**0.1068**
00002350750	**NAPROXEN**	**SNS**		$	**0.1068**
00000565350	**TEVA-NAPROX**	**TEV**		$	**0.1068**

375 MG ORAL TABLET

00000600806	**APO-NAPROXEN**	**APX**		$	**0.1458**
00002350769	**NAPROXEN**	**SNS**		$	**0.1458**
00000627097	**TEVA-NAPROX**	**TEV**		$	**0.1458**

500 MG ORAL TABLET

00000592277	**APO-NAPROXEN**	**APX**		$	**0.2110**
00002350777	**NAPROXEN**	**SNS**		$	**0.2110**
00000589861	**TEVA-NAPROX**	**TEV**		$	**0.2110**

750 MG ORAL SUSTAINED-RELEASE TABLET

00002162466	NAPROSYN SR	AMP	***$ 0.2916***	$	1.4086

MAC pricing has been applied based on the LCA price for 2 x 375 mg oral tablets.

250 MG ORAL ENTERIC-COATED TABLET

00002350785	**NAPROXEN EC**	**SNS**	***$ 0.1068***	$	**0.1068**
00002243312	**TEVA-NAPROX EC**	**TEV**	***$ 0.1068***	$	**0.1068**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

NAPROXEN

250 MG ORAL ENTERIC-COATED TABLET

MAC pricing has been applied based on the LCA price for 1 x 250 mg oral tablet.

375 MG ORAL ENTERIC-COATED TABLET

00002246700	**APO-NAPROXEN EC**	**APX**	***$ 0.1458***	$	**0.1458**
00002350793	**NAPROXEN EC**	**SNS**	***$ 0.1458***	$	**0.1458**
00002243313	**TEVA-NAPROX EC**	**TEV**	***$ 0.1458***	$	**0.1458**
00002162415	NAPROSYN E	AMP	***$ 0.1458***	$	0.5841

MAC pricing has been applied based on the LCA price for 1 x 375 mg oral tablet.

500 MG ORAL ENTERIC-COATED TABLET

00002246701	**APO-NAPROXEN EC**	**APX**	***$ 0.2110***	$	**0.2110**
00002350807	**NAPROXEN EC**	**SNS**	***$ 0.2110***	$	**0.2110**
00002243314	**TEVA-NAPROX EC**	**TEV**	***$ 0.2110***	$	**0.2110**
00002162423	NAPROSYN E	AMP	***$ 0.2110***	$	1.0537

MAC pricing has been applied based on the LCA price for 1 x 500 mg oral tablet.

NAPROXEN SODIUM

275 MG ORAL TABLET

00000784354	**APO-NAPRO-NA**	**APX**	$	**0.3422**
00002351013	**NAPROXEN SODIUM**	**SNS**	$	**0.3422**
00000778389	**TEVA-NAPROX SODIUM**	**TEV**	$	**0.3422**
00002162725	ANAPROX	AMP	$	0.6652

550 MG ORAL TABLET

00001940309	**APO-NAPRO-NA DS**	**APX**	$	**0.6667**
00002351021	**NAPROXEN SODIUM DS**	**SNS**	$	**0.6667**
00002026600	**TEVA-NAPROX SODIUM DS**	**TEV**	$	**0.6667**
00002162717	ANAPROX DS	AMP	$	1.2808

PIROXICAM

10 MG ORAL CAPSULE

00000695718	TEVA-PIROXICAM	TEV	$	0.2324

20 MG ORAL CAPSULE

00000695696	TEVA-PIROXICAM	TEV	$	0.3897

SULINDAC

150 MG ORAL TABLET

00000745588	TEVA-SULINDAC	TEV	$	0.4216

200 MG ORAL TABLET

00000745596	TEVA-SULINDAC	TEV	$	0.5003

TENOXICAM

20 MG ORAL TABLET

00002230661	TENOXICAM	AAP	$	1.1783

TIAPROFENIC ACID

200 MG ORAL TABLET

00002179679	TEVA-TIAPROFENIC ACID	TEV	$	0.5455

300 MG ORAL TABLET

00002179687	TEVA-TIAPROFENIC ACID	TEV	$	0.8070

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

BUTALBITAL/ CODEINE PHOSPHATE/ ASA/ CAFFEINE

50 MG * 15 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608203	**TEVA-TECNAL-C 1/4**	**TEV**	$	**1.5749**
00000176192	FIORINAL-C 1/4	TRI	$	1.7760
50 MG * 30 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608181	**TEVA-TECNAL-C 1/2**	**TEV**	$	**1.9285**
00000176206	FIORINAL-C 1/2	TRI	$	2.1747

CODEINE PHOSPHATE

15 MG ORAL TABLET				
00000593435	TEVA-CODEINE	TEV	$	0.0863
30 MG ORAL TABLET				
00000593451	TEVA-CODEINE	TEV	$	0.1522
30 MG / ML INJECTION				
00000544884	CODEINE PHOSPHATE	SDZ	$	4.1828

CODEINE PHOSPHATE/ ACETAMINOPHEN

30 MG * 300 MG ORAL TABLET				
00000608882	TEVA-EMTEC-30	TEV	$	0.1738
60 MG * 300 MG ORAL TABLET				
00000621463	**TEVA-LENOLTEC NO. 4**	**TEV**	$	**0.1605**
00002163918	TYLENOL NO. 4	JAI	$	0.2444
1.6 MG / ML * 32 MG / ML ORAL ELIXIR				
00000816027	PMS-ACETAMINOPHEN WITH CODEINE	PMS	$	0.1074

RESTRICTED BENEFIT

This Drug Product is a benefit for patients 12 years of age and older

CODEINE PHOSPHATE/ ACETAMINOPHEN/ CAFFEINE

15 MG * 300 MG * 15 MG ORAL TABLET				
00000653241	**TEVA-LENOLTEC NO.2**	**TEV**	$	**0.0847**
00002163934	TYLENOL NO. 2	JAI	$	0.1052
30 MG * 300 MG * 15 MG ORAL TABLET				
00000653276	**TEVA-LENOLTEC NO.3**	**TEV**	$	**0.0889**
00002163926	TYLENOL NO. 3	JAI	$	0.1159

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

COMPOUND PRESCRIPTION

00000999108 COMPOUND NARCOTIC MIXTURES - ORAL AND INJECTION XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999208 COMPOUND NARCOTIC MIXTURES - ORAL AND INJECTION XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

HYDROMORPHONE HCL

1 MG ORAL TABLET				
00002364115	**APO-HYDROMORPHONE**	**APX**	$	**0.0950**
00000705438	**DILAUDID**	**PUR**	$	**0.0950**
00000885444	**PMS-HYDROMORPHONE**	**PMS**	$	**0.0950**
2 MG ORAL TABLET				
00002364123	**APO-HYDROMORPHONE**	**APX**	$	**0.1416**
00000125083	**DILAUDID**	**PUR**	$	**0.1416**
00000885436	**PMS-HYDROMORPHONE**	**PMS**	$	**0.1416**
4 MG ORAL TABLET				
00002364131	**APO-HYDROMORPHONE**	**APX**	$	**0.2240**
00000125121	**DILAUDID**	**PUR**	$	**0.2240**
00000885401	**PMS-HYDROMORPHONE**	**PMS**	$	**0.2240**
8 MG ORAL TABLET				
00002364158	**APO-HYDROMORPHONE**	**APX**	$	**0.3528**
00000786543	**DILAUDID**	**PUR**	$	**0.3528**
00000885428	**PMS-HYDROMORPHONE**	**PMS**	$	**0.3528**
3 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002476614	**APO-HYDROMORPHONE CR**	**APX**	$	**0.6023**
00002125323	**HYDROMORPH CONTIN**	**PUR**	$	**0.6023**
4.5 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002476622	**APO-HYDROMORPHONE CR**	**APX**	$	**0.7275**
00002359502	**HYDROMORPH CONTIN**	**PUR**	$	**0.7275**
6 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002476630	**APO-HYDROMORPHONE CR**	**APX**	$	**0.9030**
00002125331	**HYDROMORPH CONTIN**	**PUR**	$	**0.9030**
9 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002476649	**APO-HYDROMORPHONE CR**	**APX**	$	**1.1925**
00002359510	**HYDROMORPH CONTIN**	**PUR**	$	**1.1925**
12 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002476657	**APO-HYDROMORPHONE CR**	**APX**	$	**1.5653**
00002125366	**HYDROMORPH CONTIN**	**PUR**	$	**1.5653**
18 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002476665	**APO-HYDROMORPHONE CR**	**APX**	$	**2.2590**
00002243562	**HYDROMORPH CONTIN**	**PUR**	$	**2.2590**
24 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002476673	**APO-HYDROMORPHONE CR**	**APX**	$	**2.6138**
00002125382	**HYDROMORPH CONTIN**	**PUR**	$	**2.6138**
30 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125390	HYDROMORPH CONTIN	PUR	$	3.1308
00002476681	**APO-HYDROMORPHONE CR**	**APX**	$	**3.1309**
1 MG / ML ORAL LIQUID				
00001916386	PMS-HYDROMORPHONE	PMS	$	0.0788
2 MG / ML INJECTION				
00002145901	HYDROMORPHONE	SDZ	$	2.0591
10 MG / ML INJECTION				
00002145928	HYDROMORPHONE HP	SDZ	$	4.3460
20 MG / ML INJECTION				
00002145936	HYDROMORPHONE HP 20	SDZ	$	8.9289
50 MG / ML INJECTION				
00002146126	HYDROMORPHONE HP 50	SDZ	$	21.1271

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

MEPERIDINE HCL

50 MG ORAL TABLET				
00002138018	DEMEROL	SAV	$	0.1656
50 MG / ML INJECTION				
00000725765	MEPERIDINE HYDROCHLORIDE	SDZ	$	2.3720

METHADONE HCL

1 MG ORAL TABLET				
00002247698	METADOL	PAL	$	0.1776
5 MG ORAL TABLET				
00002247699	METADOL	PAL	$	0.5916
10 MG ORAL TABLET				
00002247700	METADOL	PAL	$	0.9466
25 MG ORAL TABLET				
00002247701	METADOL	PAL	$	1.7588
1 MG / ML ORAL SOLUTION				
⊠ 00002247374	METADOL-D	PAL	$	0.0563
⊠ 00002247694	METADOL	PAL	$	0.1123
10 MG / ML ORAL LIQUID				
⊠ 00002244290	METADOL-D	PAL	$	0.1500
⊠ 00002394596	METHADOSE	MAL	$	0.1500
⊠ 00002394618	METHADOSE SUGAR FREE	MAL	$	0.1500
⊠ 00002241377	METADOL CONCENTRATE	PAL	$	0.4059

MORPHINE SULFATE

5 MG ORAL TABLET				
00002014203	**MS.IR**	**PUR**	$	**0.1100**
00000594652	STATEX	PAL	$	0.1126
10 MG ORAL TABLET				
00002014211	**MS.IR**	**PUR**	$	**0.1700**
00000594644	STATEX	PAL	$	0.1741
20 MG ORAL TABLET				
00002014238	MS.IR	PUR	$	0.3580
25 MG ORAL TABLET				
00000594636	STATEX	PAL	$	0.2304
30 MG ORAL TABLET				
00002014254	MS.IR	PUR	$	0.4595
50 MG ORAL TABLET				
00000675962	STATEX	PAL	$	0.3533
15 MG ORAL SUSTAINED-RELEASE TABLET				
00002350815	**MORPHINE SR**	**SNS**	$	**0.2317**
00002244790	**SANDOZ MORPHINE SR**	**SDZ**	$	**0.2317**
00002302764	**TEVA-MORPHINE SR**	**TEV**	$	**0.2317**
00002015439	MS CONTIN	PUR	$	0.7460
30 MG ORAL SUSTAINED-RELEASE TABLET				
00002350890	**MORPHINE SR**	**SNS**	$	**0.3500**
00002244791	**SANDOZ MORPHINE SR**	**SDZ**	$	**0.3500**
00002302772	**TEVA-MORPHINE SR**	**TEV**	$	**0.3500**
00002014297	MS CONTIN	PUR	$	1.1280

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE SULFATE

60 MG ORAL SUSTAINED-RELEASE TABLET				
00002350912	**MORPHINE SR**	**SNS**	$	**0.6167**
00002244792	**SANDOZ MORPHINE SR**	**SDZ**	$	**0.6167**
00002302780	**TEVA-MORPHINE SR**	**TEV**	$	**0.6167**
00002014300	MS CONTIN	PUR	$	1.9880
100 MG ORAL SUSTAINED-RELEASE TABLET				
00002478889	**SANDOZ MORPHINE SR**	**SDZ**	$	**1.5395**
00002302799	**TEVA-MORPHINE SR**	**TEV**	$	**1.5395**
00002014319	MS CONTIN	PUR	$	3.0290
200 MG ORAL SUSTAINED-RELEASE TABLET				
00002478897	**SANDOZ MORPHINE SR**	**SDZ**	$	**2.7718**
00002302802	**TEVA-MORPHINE SR**	**TEV**	$	**2.7718**
00002014327	MS CONTIN	PUR	$	5.6350
5 MG ORAL CAPSULE				
00002320398	M-EDIAT	ETP	$	0.1045
10 MG ORAL CAPSULE				
00002320428	M-EDIAT	ETP	$	0.1615
20 MG ORAL CAPSULE				
00002320436	M-EDIAT	ETP	$	0.3268
30 MG ORAL CAPSULE				
00002320444	M-EDIAT	ETP	$	0.4190
10 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019930	M-ESLON	ETP	$	0.3250
15 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177749	M-ESLON	ETP	$	0.3750
30 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019949	M-ESLON	ETP	$	0.5590
60 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019957	M-ESLON	ETP	$	0.9950
100 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019965	M-ESLON	ETP	$	2.1460
200 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177757	M-ESLON	ETP	$	4.2960
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002242163	KADIAN	BGP	$	0.4014
20 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184435	KADIAN	BGP	$	0.7798
50 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184443	KADIAN	BGP	$	1.4335
100 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184451	KADIAN	BGP	$	2.5002
1 MG / ML ORAL SYRUP				
00000591467	STATEX	PAL	$	0.0205
5 MG / ML ORAL SYRUP				
00000591475	STATEX	PAL	$	0.0803
20 MG / ML ORAL DROPS				
00000621935	STATEX	PAL	$	0.5250
50 MG / ML ORAL DROPS				
00000705799	STATEX	PAL	$	0.9979

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE SULFATE

1 MG / ML INJECTION				
00002021048	MORPHINE LP EPIDURAL	SDZ	$	6.7458
10 MG / ML INJECTION				
00000392588	MORPHINE SULFATE	SDZ	$	2.6295
15 MG / ML INJECTION				
00000392561	MORPHINE SULFATE	SDZ	$	2.7870
50 MG / ML INJECTION				
00000617288	MORPHINE HP 50	SDZ	$	7.8944
5 MG RECTAL SUPPOSITORY				
00000632228	STATEX	PAL	$	1.8152
10 MG RECTAL SUPPOSITORY				
00000632201	STATEX	PAL	$	2.0277
20 MG RECTAL SUPPOSITORY				
00000596965	STATEX	PAL	$	2.4143
30 MG RECTAL SUPPOSITORY				
00000639389	STATEX	PAL	$	2.6477

OPIUM/ BELLADONNA

65 MG * 15 MG RECTAL SUPPOSITORY				
00001901869	SANDOZ OPIUM & BELLADONNA	SDZ	$	5.0204

OXYCODONE HCL

5 MG ORAL TABLET				
00002319977	PMS-OXYCODONE	PMS	$	0.1419
00000789739	SUPEUDOL	SDZ	$	0.1434
10 MG ORAL TABLET				
00002319985	**PMS-OXYCODONE**	**PMS**	$	**0.2283**
00000443948	**SUPEUDOL**	**SDZ**	$	**0.2283**
00002240131	OXY-IR	PUR	$	0.4110
20 MG ORAL TABLET				
00002319993	**PMS-OXYCODONE**	**PMS**	$	**0.3965**
00002262983	**SUPEUDOL**	**SDZ**	$	**0.3965**
00002240132	OXY-IR	PUR	$	0.7150
10 MG ORAL CONTROLLED-RELEASE TABLET				
00002372525	OXYNEO	PUR	$	0.9385
15 MG ORAL CONTROLLED-RELEASE TABLET				
00002372533	OXYNEO	PUR	$	1.1340
20 MG ORAL CONTROLLED-RELEASE TABLET				
00002372797	OXYNEO	PUR	$	1.4070
30 MG ORAL CONTROLLED-RELEASE TABLET				
00002372541	OXYNEO	PUR	$	1.8625
40 MG ORAL CONTROLLED-RELEASE TABLET				
00002372568	OXYNEO	PUR	$	2.4300
60 MG ORAL CONTROLLED-RELEASE TABLET				
00002372576	OXYNEO	PUR	$	3.3680
80 MG ORAL CONTROLLED-RELEASE TABLET				
00002372584	OXYNEO	PUR	$	4.5075
10 MG RECTAL SUPPOSITORY				
00000392480	SUPEUDOL	SDZ	$	3.8129
20 MG RECTAL SUPPOSITORY				
00000392472	SUPEUDOL	SDZ	$	5.5042

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.08 ANALGESICS AND ANTIPYRETICS (OPIATE AGONISTS)

OXYCODONE HCL/ ACETAMINOPHEN

5 MG * 325 MG ORAL TABLET

00002324628	**APO-OXYCODONE**	**APX**	$	**0.1285**
00002361361	**OXYCODONE/ACET**	**SNS**	$	**0.1285**
00002307898	**SANDOZ-OXYCODONE ACET**	**SDZ**	$	**0.1285**
00000608165	**TEVA-OXYCOCET**	**TEV**	$	**0.1285**

OXYCODONE HCL/ ASA

5 MG * 325 MG ORAL TABLET

00000608157	TEVA-OXYCODAN	TEV	$	0.4380

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.12 ANALGESICS AND ANTIPYRETICS (OPIATE PARTIAL AGONISTS)

BUPRENORPHINE HCL/ NALOXONE HYDROCHLORIDE DIHYDRATE

2 MG (BASE) * 0.5 MG (BASE) ORAL SUBLINGUAL TABLET

00002453908	**ACT BUPRENORPHINE/NALOXONE**	**APH**	$	**0.6675**
00002424851	**PMS-BUPRENORPHINE/NALOXONE**	**PMS**	$	**0.6675**
00002295695	SUBOXONE	IUK	$	2.7261

8 MG (BASE) * 2 MG (BASE) ORAL SUBLINGUAL TABLET

00002453916	**ACT BUPRENORPHINE/NALOXONE**	**APH**	$	**1.1825**
00002424878	**PMS-BUPRENORPHINE/NALOXONE**	**PMS**	$	**1.1825**
00002295709	SUBOXONE	IUK	$	4.8293

PENTAZOCINE HCL

50 MG (BASE) ORAL TABLET

00002137984	TALWIN	SAV	$	0.4790

PENTAZOCINE LACTATE

30 MG / ML INJECTION

00002241976	TALWIN	HSP	$	12.6816

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:10 OPIATE ANTAGONISTS

NALTREXONE HCL

50 MG ORAL TABLET

00002444275	**APO-NALTREXONE**	**APX**	$	**2.8075**
00002451883	**NALTREXONE HYDROCHLORIDE**	**JPC**	$	**2.8075**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.04 ANTICONVULSANTS (BARBITURATES)

PRIMIDONE

125 MG ORAL TABLET				
00000399310	PRIMIDONE	AAP	$	0.0590
250 MG ORAL TABLET				
00000396761	PRIMIDONE	AAP	$	0.0928

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.08 ANTICONVULSANTS (BENZODIAZEPINES)

CLOBAZAM

10 MG ORAL TABLET				
00002238334	TEVA-CLOBAZAM	TEV	$	0.1270
00002244638	APO-CLOBAZAM	APX	$	0.2197

CLONAZEPAM

0.25 MG ORAL TABLET				
00002179660	PMS-CLONAZEPAM	PMS	$	0.0850
0.5 MG ORAL TABLET				
00002177889	**APO-CLONAZEPAM**	**APX**	$	**0.0418**
00002048701	**PMS-CLONAZEPAM**	**PMS**	$	**0.0418**
00002207818	**PMS-CLONAZEPAM-R**	**PMS**	$	**0.0418**
00000382825	RIVOTRIL	HLR	$	0.2479
1 MG ORAL TABLET				
00002048728	PMS-CLONAZEPAM	PMS	$	0.1487
2 MG ORAL TABLET				
00002177897	**APO-CLONAZEPAM**	**APX**	$	**0.0721**
00002442051	**CLONAZEPAM**	**SIV**	$	**0.0721**
00002048736	**PMS-CLONAZEPAM**	**PMS**	$	**0.0721**
00000382841	RIVOTRIL	HLR	$	0.4274

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.12 ANTICONVULSANTS (HYDANTOINS)

PHENYTOIN

50 MG ORAL CHEWABLE TABLET				
00000023698	DILANTIN INFATABS	PFI	$	0.0879
6 MG / ML ORAL SUSPENSION				
00000023442	DILANTIN-30	PFI	$	0.0484
25 MG / ML ORAL SUSPENSION				
00002250896	**TARO-PHENYTOIN**	**TAR**	$	**0.0428**
00000023450	DILANTIN-125	PFI	$	0.0571

PHENYTOIN SODIUM

30 MG ORAL CAPSULE				
00000022772	DILANTIN	PFI	$	0.1388
100 MG ORAL CAPSULE				
00002460912	**APO-PHENYTOIN SODIUM**	**APX**	$	**0.0665**
00000022780	DILANTIN	PFI	$	0.0892

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.20 ANTICONVULSANTS (SUCCINIMIDES)

ETHOSUXIMIDE

250 MG ORAL CAPSULE				
00000022799	ZARONTIN	ERF	$	0.5000
50 MG / ML ORAL SYRUP				
00000023485	ZARONTIN	ERF	$	0.0702

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS (MISCELLANEOUS ANTICONVULSANTS)

CARBAMAZEPINE

200 MG ORAL TABLET				
00002407515	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.2432**
00000782718	**TEVA-CARBAMAZ**	**TEV**	$	**0.2432**
00000010405	TEGRETOL	NOV	$	0.4267
200 MG ORAL SUSTAINED-RELEASE TABLET				
00002231543	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.0930**
00002261839	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.0930**
00000773611	TEGRETOL CR	NOV	$	0.4302
400 MG ORAL SUSTAINED-RELEASE TABLET				
00002231544	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.1859**
00002261847	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.1859**
00000755583	TEGRETOL CR	NOV	$	0.8605
20 MG / ML ORAL SUSPENSION				
00002367394	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.0693**
00002194333	TEGRETOL	NOV	$	0.0826

DIVALPROEX SODIUM (VALPROIC ACID EQUIV.)

125 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239698	**APO-DIVALPROEX**	**APX**	$	**0.0724**
00002458926	**MYLAN-DIVALPROEX**	**MYP**	$	**0.0724**
00002239701	**NOVO-DIVALPROEX**	**TEV**	$	**0.0724**
00000596418	EPIVAL	BGP	$	0.3055
250 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239699	**APO-DIVALPROEX**	**APX**	$	**0.1301**
00002458934	**MYLAN-DIVALPROEX**	**MYP**	$	**0.1301**
00002239702	**NOVO-DIVALPROEX**	**TEV**	$	**0.1301**
00000596426	EPIVAL	BGP	$	0.5491
500 MG (BASE) ORAL ENTERIC-COATED TABLET				
00002239700	**APO-DIVALPROEX**	**APX**	$	**0.2604**
00002459019	**MYLAN-DIVALPROEX**	**MYP**	$	**0.2604**
00002239703	**NOVO-DIVALPROEX**	**TEV**	$	**0.2604**
00000596434	EPIVAL	BGP	$	1.0990

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS
(MISCELLANEOUS ANTICONVULSANTS)

GABAPENTIN

100 MG ORAL CAPSULE

00002244304	**APO-GABAPENTIN**	**APX**	$	**0.0416**
00002321203	**AURO-GABAPENTIN**	**AUR**	$	**0.0416**
00002246314	**GABAPENTIN**	**SIV**	$	**0.0416**
00002353245	**GABAPENTIN**	**SNS**	$	**0.0416**
00002361469	**JAMP-GABAPENTIN**	**JPC**	$	**0.0416**
00002391473	**MAR-GABAPENTIN**	**MAR**	$	**0.0416**
00002243446	**PMS-GABAPENTIN**	**PMS**	$	**0.0416**
00002244513	**TEVA-GABAPENTIN**	**TEV**	$	**0.0416**
00002084260	NEURONTIN	PFI	$	0.4652

300 MG ORAL CAPSULE

00002244305	**APO-GABAPENTIN**	**APX**	$	**0.1012**
00002321211	**AURO-GABAPENTIN**	**AUR**	$	**0.1012**
00002246315	**GABAPENTIN**	**SIV**	$	**0.1012**
00002353253	**GABAPENTIN**	**SNS**	$	**0.1012**
00002361485	**JAMP-GABAPENTIN**	**JPC**	$	**0.1012**
00002391481	**MAR-GABAPENTIN**	**MAR**	$	**0.1012**
00002243447	**PMS-GABAPENTIN**	**PMS**	$	**0.1012**
00002319063	**RAN-GABAPENTIN**	**RAN**	$	**0.1012**
00002244514	**TEVA-GABAPENTIN**	**TEV**	$	**0.1012**
00002084279	NEURONTIN	PFI	$	1.1127

400 MG ORAL CAPSULE

00002244306	**APO-GABAPENTIN**	**APX**	$	**0.1206**
00002321238	**AURO-GABAPENTIN**	**AUR**	$	**0.1206**
00002246316	**GABAPENTIN**	**SIV**	$	**0.1206**
00002353261	**GABAPENTIN**	**SNS**	$	**0.1206**
00002361493	**JAMP-GABAPENTIN**	**JPC**	$	**0.1206**
00002391503	**MAR-GABAPENTIN**	**MAR**	$	**0.1206**
00002243448	**PMS-GABAPENTIN**	**PMS**	$	**0.1206**
00002244515	**TEVA-GABAPENTIN**	**TEV**	$	**0.1206**
00002084287	NEURONTIN	PFI	$	1.3261

LAMOTRIGINE

25 MG ORAL TABLET

00002245208	**APO-LAMOTRIGINE**	**APX**	$	**0.0698**
00002381354	**AURO-LAMOTRIGINE**	**AUR**	$	**0.0698**
00002343010	**LAMOTRIGINE**	**SNS**	$	**0.0698**
00002428202	**LAMOTRIGINE**	**SIV**	$	**0.0698**
00002265494	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.0698**
00002246897	**PMS-LAMOTRIGINE**	**PMS**	$	**0.0698**
00002142082	LAMICTAL	GSK	$	0.4041

100 MG ORAL TABLET

00002245209	**APO-LAMOTRIGINE**	**APX**	$	**0.2787**
00002381362	**AURO-LAMOTRIGINE**	**AUR**	$	**0.2787**
00002343029	**LAMOTRIGINE**	**SNS**	$	**0.2787**
00002428210	**LAMOTRIGINE**	**SIV**	$	**0.2787**
00002265508	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.2787**
00002246898	**PMS-LAMOTRIGINE**	**PMS**	$	**0.2787**
00002248233	**TEVA-LAMOTRIGINE**	**TEV**	$	**0.2787**
00002142104	LAMICTAL	GSK	$	1.6133

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

LAMOTRIGINE

150 MG ORAL TABLET

00002245210	**APO-LAMOTRIGINE**	**APX**	$	**0.4107**
00002381370	**AURO-LAMOTRIGINE**	**AUR**	$	**0.4107**
00002343037	**LAMOTRIGINE**	**SNS**	$	**0.4107**
00002428229	**LAMOTRIGINE**	**SIV**	$	**0.4107**
00002265516	**MYLAN-LAMOTRIGINE**	**MYP**	$	**0.4107**
00002246899	**PMS-LAMOTRIGINE**	**PMS**	$	**0.4107**
00002248234	**TEVA-LAMOTRIGINE**	**TEV**	$	**0.4107**
00002142112	LAMICTAL	GSK	$	2.3775

5 MG ORAL CHEWABLE TABLET

00002240115	LAMICTAL	GSK	$	0.1723

LEVETIRACETAM

250 MG ORAL TABLET

00002274183	**ACT LEVETIRACETAM**	**APH**	$	**0.3210**
00002285924	**APO-LEVETIRACETAM**	**APX**	$	**0.3210**
00002375249	**AURO-LEVETIRACETAM**	**AUR**	$	**0.3210**
00002403005	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.3210**
00002353342	**LEVETIRACETAM**	**SNS**	$	**0.3210**
00002399776	**LEVETIRACETAM**	**AHI**	$	**0.3210**
00002442531	**LEVETIRACETAM**	**SIV**	$	**0.3210**
00002454653	**LEVETIRACETAM**	**PMS**	$	**0.3210**
00002440202	**NAT-LEVETIRACETAM**	**NTP**	$	**0.3210**
00002461986	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.3210**
00002247027	KEPPRA	UCB	$	1.7252

500 MG ORAL TABLET

00002274191	**ACT LEVETIRACETAM**	**APH**	$	**0.3911**
00002285932	**APO-LEVETIRACETAM**	**APX**	$	**0.3911**
00002375257	**AURO-LEVETIRACETAM**	**AUR**	$	**0.3911**
00002403021	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.3911**
00002353350	**LEVETIRACETAM**	**SNS**	$	**0.3911**
00002399784	**LEVETIRACETAM**	**AHI**	$	**0.3911**
00002442558	**LEVETIRACETAM**	**SIV**	$	**0.3911**
00002454661	**LEVETIRACETAM**	**PMS**	$	**0.3911**
00002440210	**NAT-LEVETIRACETAM**	**NTP**	$	**0.3911**
00002461994	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.3911**
00002247028	KEPPRA	UCB	$	2.1213

750 MG ORAL TABLET

00002274205	**ACT LEVETIRACETAM**	**APH**	$	**0.5416**
00002285940	**APO-LEVETIRACETAM**	**APX**	$	**0.5416**
00002375265	**AURO-LEVETIRACETAM**	**AUR**	$	**0.5416**
00002403048	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.5416**
00002353369	**LEVETIRACETAM**	**SNS**	$	**0.5416**
00002399792	**LEVETIRACETAM**	**AHI**	$	**0.5416**
00002442566	**LEVETIRACETAM**	**SIV**	$	**0.5416**
00002454688	**LEVETIRACETAM**	**PMS**	$	**0.5416**
00002440229	**NAT-LEVETIRACETAM**	**NTP**	$	**0.5416**
00002462001	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.5416**
00002247029	KEPPRA	UCB	$	2.9371

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS

(MISCELLANEOUS ANTICONVULSANTS)

PREGABALIN

25 MG ORAL CAPSULE				
00002394235	**APO-PREGABALIN**	**APX**	$	**0.1481**
00002433869	**AURO-PREGABALIN**	**AUR**	$	**0.1481**
00002435977	**JAMP-PREGABALIN**	**JPC**	$	**0.1481**
00002423804	**MINT-PREGABALIN**	**MPI**	$	**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				
00002394243	**APO-PREGABALIN**	**APX**	$	**0.2324**
00002433877	**AURO-PREGABALIN**	**AUR**	$	**0.2324**
00002435985	**JAMP-PREGABALIN**	**JPC**	$	**0.2324**
00002423812	**MINT-PREGABALIN**	**MPI**	$	**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				
00002394251	**APO-PREGABALIN**	**APX**	$	**0.3007**
00002433885	**AURO-PREGABALIN**	**AUR**	$	**0.3007**
00002435993	**JAMP-PREGABALIN**	**JPC**	$	**0.3007**
00002424185	**MINT-PREGABALIN**	**MPI**	$	**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				
00002394278	**APO-PREGABALIN**	**APX**	$	**0.4145**
00002433907	**AURO-PREGABALIN**	**AUR**	$	**0.4145**
00002436000	**JAMP-PREGABALIN**	**JPC**	$	**0.4145**
00002424207	**MINT-PREGABALIN**	**MPI**	$	**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**
300 MG ORAL CAPSULE				
00002394294	**APO-PREGABALIN**	**APX**	$	**0.4145**
00002359642	**PMS-PREGABALIN**	**PMS**	$	**0.4145**
00002403730	**PREGABALIN**	**SIV**	$	**0.4145**
00002405598	**PREGABALIN**	**SNS**	$	**0.4145**
00002392860	**RAN-PREGABALIN**	**RAN**	$	**0.4145**
00002390868	**SANDOZ PREGABALIN**	**SDZ**	$	**0.4145**
00002361248	**TEVA-PREGABALIN**	**TEV**	$	**0.4145**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS
(MISCELLANEOUS ANTICONVULSANTS)

TOPIRAMATE

25 MG ORAL TABLET				
00002279614	**APO-TOPIRAMATE**	**APX**	$	**0.2433**
00002345803	**AURO-TOPIRAMATE**	**AUR**	$	**0.2433**
00002315645	**MINT-TOPIRAMATE**	**MPI**	$	**0.2433**
00002263351	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.2433**
00002262991	**PMS-TOPIRAMATE**	**PMS**	$	**0.2433**
00002431807	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.2433**
00002248860	**TEVA-TOPIRAMATE**	**TEV**	$	**0.2433**
00002356856	**TOPIRAMATE**	**SNS**	$	**0.2433**
00002389460	**TOPIRAMATE**	**SIV**	$	**0.2433**
00002395738	**TOPIRAMATE**	**AHI**	$	**0.2433**
00002230893	TOPAMAX	JAI	$	1.4110
50 MG ORAL TABLET				
00002312085	PMS-TOPIRAMATE	PMS	$	1.2434
100 MG ORAL TABLET				
00002279630	**APO-TOPIRAMATE**	**APX**	$	**0.4583**
00002345838	**AURO-TOPIRAMATE**	**AUR**	$	**0.4583**
00002315653	**MINT-TOPIRAMATE**	**MPI**	$	**0.4583**
00002263378	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.4583**
00002263009	**PMS-TOPIRAMATE**	**PMS**	$	**0.4583**
00002431815	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.4583**
00002248861	**TEVA-TOPIRAMATE**	**TEV**	$	**0.4583**
00002356864	**TOPIRAMATE**	**SNS**	$	**0.4583**
00002389487	**TOPIRAMATE**	**SIV**	$	**0.4583**
00002395746	**TOPIRAMATE**	**AHI**	$	**0.4583**
00002230894	TOPAMAX	JAI	$	2.6500
200 MG ORAL TABLET				
00002279649	**APO-TOPIRAMATE**	**APX**	$	**0.6748**
00002345846	**AURO-TOPIRAMATE**	**AUR**	$	**0.6748**
00002315661	**MINT-TOPIRAMATE**	**MPI**	$	**0.6748**
00002263386	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.6748**
00002263017	**PMS-TOPIRAMATE**	**PMS**	$	**0.6748**
00002431823	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.6748**
00002248862	**TEVA-TOPIRAMATE**	**TEV**	$	**0.6748**
00002356872	**TOPIRAMATE**	**SNS**	$	**0.6748**
00002395754	**TOPIRAMATE**	**AHI**	$	**0.6748**
00002230896	TOPAMAX	JAI	$	3.9100
15 MG ORAL CAPSULE				
00002239907	TOPAMAX SPRINKLE	JAI	$	1.3200
25 MG ORAL CAPSULE				
00002239908	TOPAMAX SPRINKLE	JAI	$	1.3900

VALPROIC ACID

250 MG ORAL CAPSULE				
00002238048	**APO-VALPROIC**	**APX**	$	**0.2905**
00002230768	**PMS-VALPROIC ACID**	**PMS**	$	**0.2905**
500 MG ORAL ENTERIC-COATED CAPSULE				
00002229628	PMS-VALPROIC ACID E.C.	PMS	$	0.6451
50 MG / ML ORAL SYRUP				
00002238370	**APO-VALPROIC**	**APX**	$	**0.0605**
00002236807	**PMS-VALPROIC ACID**	**PMS**	$	**0.0605**
00000443832	DEPAKENE	BGP	$	0.1201

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 ANTICONVULSANTS
(MISCELLANEOUS ANTICONVULSANTS)

VIGABATRIN

500 MG ORAL TABLET				
00002065819	SABRIL	LUI	$	0.9566
500 MG ORAL POWDER PACKET				
00002068036	SABRIL	LUI	$	0.9566

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.12 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MONOAMINE OXIDASE INHIBITORS)

MOCLOBEMIDE

100 MG ORAL TABLET				
00002232148	MOCLOBEMIDE	AAP	$	0.3482
150 MG ORAL TABLET				
00002232150	MOCLOBEMIDE	AAP	$	0.5042
300 MG ORAL TABLET				
00002240456	MOCLOBEMIDE	AAP	$	1.0399

PHENELZINE SULFATE

15 MG (BASE) ORAL TABLET				
00000476552	NARDIL	ERF	$	0.3810

TRANYLCYPROMINE SULFATE

10 MG (BASE) ORAL TABLET				
00001919598	PARNATE	GSK	$	0.3976

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.16 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(SELECTIVE SEROTONIN- AND NOREPINEPHRINE-REUPTAKE INHIBITORS)

DULOXETINE HYDROCHLORIDE

30 MG (BASE) ORAL DELAYED-RELEASE CAPSULE

00002440423	**APO-DULOXETINE**	**APX**	$	**0.4814**
00002436647	**AURO-DULOXETINE**	**AUR**	$	**0.4814**
00002453630	**DULOXETINE**	**SIV**	$	**0.4814**
00002437082	**DULOXETINE DR**	**TEV**	$	**0.4814**
00002451913	**JAMP-DULOXETINE**	**JPC**	$	**0.4814**
00002446081	**MAR-DULOXETINE**	**MAR**	$	**0.4814**
00002438984	**MINT-DULOXETINE**	**MPI**	$	**0.4814**
00002429446	**PMS-DULOXETINE**	**PMS**	$	**0.4814**
00002438259	**RAN-DULOXETINE**	**RAN**	$	**0.4814**
00002439948	**SANDOZ DULOXETINE**	**SDZ**	$	**0.4814**
00002301482	CYMBALTA	LIL	$	2.0062

60 MG (BASE) ORAL DELAYED-RELEASE CAPSULE

00002440431	**APO-DULOXETINE**	**APX**	$	**0.9769**
00002436655	**AURO-DULOXETINE**	**AUR**	$	**0.9769**
00002453649	**DULOXETINE**	**SIV**	$	**0.9769**
00002437090	**DULOXETINE DR**	**TEV**	$	**0.9769**
00002451921	**JAMP-DULOXETINE**	**JPC**	$	**0.9769**
00002446103	**MAR-DULOXETINE**	**MAR**	$	**0.9769**
00002438992	**MINT-DULOXETINE**	**MPI**	$	**0.9769**
00002429454	**PMS-DULOXETINE**	**PMS**	$	**0.9769**
00002438267	**RAN-DULOXETINE**	**RAN**	$	**0.9769**
00002439956	**SANDOZ DULOXETINE**	**SDZ**	$	**0.9769**
00002301490	CYMBALTA	LIL	$	4.0716

VENLAFAXINE HCL

37.5 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002304317	**ACT VENLAFAXINE XR**	**APH**	$	**0.0913**
00002331683	**APO-VENLAFAXINE XR**	**APX**	$	**0.0913**
00002452839	**AURO-VENLAFAXINE XR**	**AUR**	$	**0.0913**
00002278545	**PMS-VENLAFAXINE XR**	**PMS**	$	**0.0913**
00002380072	**RAN-VENLAFAXINE XR**	**RAN**	$	**0.0913**
00002310317	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**0.0913**
00002275023	**TEVA-VENLAFAXINE XR**	**TEV**	$	**0.0913**
00002354713	**VENLAFAXINE XR**	**SNS**	$	**0.0913**
00002385929	**VENLAFAXINE XR**	**SIV**	$	**0.0913**
00002237279	EFFEXOR XR	PFI	$	0.9864

75 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002331691	**APO-VENLAFAXINE XR**	**APX**	$	**0.1825**
00002452847	**AURO-VENLAFAXINE XR**	**AUR**	$	**0.1825**
00002278553	**PMS-VENLAFAXINE XR**	**PMS**	$	**0.1825**
00002380080	**RAN-VENLAFAXINE XR**	**RAN**	$	**0.1825**
00002310325	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**0.1825**
00002275031	**TEVA-VENLAFAXINE XR**	**TEV**	$	**0.1825**
00002354721	**VENLAFAXINE XR**	**SNS**	$	**0.1825**
00002385937	**VENLAFAXINE XR**	**SIV**	$	**0.1825**
00002237280	EFFEXOR XR	PFI	$	2.0010

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.16 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(SELECTIVE SEROTONIN- AND NOREPINEPHRINE-REUPTAKE INHIBITORS)

VENLAFAXINE HCL

150 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002304333	**ACT VENLAFAXINE XR**	**APH**	$	**0.1927**
00002331705	**APO-VENLAFAXINE XR**	**APX**	$	**0.1927**
00002452855	**AURO-VENLAFAXINE XR**	**AUR**	$	**0.1927**
00002278561	**PMS-VENLAFAXINE XR**	**PMS**	$	**0.1927**
00002380099	**RAN-VENLAFAXINE XR**	**RAN**	$	**0.1927**
00002310333	**SANDOZ VENLAFAXINE XR**	**SDZ**	$	**0.1927**
00002275058	**TEVA-VENLAFAXINE XR**	**TEV**	$	**0.1927**
00002354748	**VENLAFAXINE XR**	**SNS**	$	**0.1927**
00002385945	**VENLAFAXINE XR**	**SIV**	$	**0.1927**
00002237282	EFFEXOR XR	PFI	$	2.1124

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

CITALOPRAM HYDROBROMIDE

10 MG (BASE) ORAL TABLET

00002355248	**ACCEL-CITALOPRAM**	**ACP**	$	**0.0796**
00002387948	**CITALOPRAM**	**SIV**	$	**0.0796**
00002430517	**CITALOPRAM**	**JPC**	$	**0.0796**
00002445719	**CITALOPRAM**	**SNS**	$	**0.0796**
00002371871	**MAR-CITALOPRAM**	**MAR**	$	**0.0796**
00002429691	**MINT-CITALOPRAM**	**MPI**	$	**0.0796**
00002409003	**NAT-CITALOPRAM**	**NTP**	$	**0.0796**
00002270609	**PMS-CITALOPRAM**	**PMS**	$	**0.0796**
00002431629	**SEPTA-CITALOPRAM**	**SEP**	$	**0.0796**
00002312336	**TEVA-CITALOPRAM**	**TEV**	$	**0.0796**

20 MG (BASE) ORAL TABLET

00002355256	**ACCEL-CITALOPRAM**	**ACP**	$	**0.1332**
00002248050	**ACT CITALOPRAM**	**APH**	$	**0.1332**
00002246056	**APO-CITALOPRAM**	**APX**	$	**0.1332**
00002275562	**AURO-CITALOPRAM**	**AUR**	$	**0.1332**
00002459914	**CCP-CITALOPRAM**	**CEL**	$	**0.1332**
00002353660	**CITALOPRAM**	**SNS**	$	**0.1332**
00002387956	**CITALOPRAM**	**SIV**	$	**0.1332**
00002430541	**CITALOPRAM**	**JPC**	$	**0.1332**
00002371898	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429705	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409011	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002248010	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002285622	**RAN-CITALO**	**RAN**	$	**0.1332**
00002248170	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.1332**
00002355272	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293218	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239607	CELEXA	LBC	$	1.4197

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

CITALOPRAM HYDROBROMIDE

30 MG (BASE) ORAL TABLET				
00002296152	CTP 30	SUN	$	0.8961
40 MG (BASE) ORAL TABLET				
00002355264	**ACCEL-CITALOPRAM**	**ACP**	$	**0.1332**
00002248051	**ACT CITALOPRAM**	**APH**	$	**0.1332**
00002246057	**APO-CITALOPRAM**	**APX**	$	**0.1332**
00002275570	**AURO-CITALOPRAM**	**AUR**	$	**0.1332**
00002459922	**CCP-CITALOPRAM**	**CEL**	$	**0.1332**
00002353679	**CITALOPRAM**	**SNS**	$	**0.1332**
00002387964	**CITALOPRAM**	**SIV**	$	**0.1332**
00002430568	**CITALOPRAM**	**JPC**	$	**0.1332**
00002371901	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429713	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409038	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002248011	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002248171	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.1332**
00002355280	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293226	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239608	CELEXA	LBC	$	1.4197

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

ESCITALOPRAM

10 MG ORAL TABLET

00002434652	**ACH-ESCITALOPRAM**	**AHI**	$	**0.3109**
00002295016	**APO-ESCITALOPRAM**	**APX**	$	**0.3109**
00002397358	**AURO-ESCITALOPRAM**	**AUR**	$	**0.3109**
00002429039	**ESCITALOPRAM**	**SIV**	$	**0.3109**
00002430118	**ESCITALOPRAM**	**SNS**	$	**0.3109**
00002429780	**JAMP-ESCITALOPRAM**	**JPC**	$	**0.3109**
00002423480	**MAR-ESCITALOPRAM**	**MAR**	$	**0.3109**
00002407418	**MINT-ESCITALOPRAM**	**MPI**	$	**0.3109**
00002309467	**MYLAN-ESCITALOPRAM**	**MYP**	$	**0.3109**
00002440296	**NAT-ESCITALOPRAM**	**NTP**	$	**0.3109**
00002469243	**PHARMA-ESCITALOPRAM**	**PMS**	$	**0.3109**
00002303949	**PMS-ESCITALOPRAM**	**PMS**	$	**0.3109**
00002385481	**RAN-ESCITALOPRAM**	**RAN**	$	**0.3109**
00002364077	**SANDOZ ESCITALOPRAM**	**SDZ**	$	**0.3109**
00002318180	**TEVA-ESCITALOPRAM**	**TEV**	$	**0.3109**
00002263238	CIPRALEX	LBC	$	1.8330

20 MG ORAL TABLET

00002434660	**ACH-ESCITALOPRAM**	**AHI**	$	**0.3310**
00002295024	**APO-ESCITALOPRAM**	**APX**	$	**0.3310**
00002397374	**AURO-ESCITALOPRAM**	**AUR**	$	**0.3310**
00002429047	**ESCITALOPRAM**	**SIV**	$	**0.3310**
00002430126	**ESCITALOPRAM**	**SNS**	$	**0.3310**
00002429799	**JAMP-ESCITALOPRAM**	**JPC**	$	**0.3310**
00002423502	**MAR-ESCITALOPRAM**	**MAR**	$	**0.3310**
00002407434	**MINT-ESCITALOPRAM**	**MPI**	$	**0.3310**
00002309475	**MYLAN-ESCITALOPRAM**	**MYP**	$	**0.3310**
00002440318	**NAT-ESCITALOPRAM**	**NTP**	$	**0.3310**
00002469251	**PHARMA-ESCITALOPRAM**	**PMS**	$	**0.3310**
00002303965	**PMS-ESCITALOPRAM**	**PMS**	$	**0.3310**
00002385503	**RAN-ESCITALOPRAM**	**RAN**	$	**0.3310**
00002364085	**SANDOZ ESCITALOPRAM**	**SDZ**	$	**0.3310**
00002318202	**TEVA-ESCITALOPRAM**	**TEV**	$	**0.3310**
00002263254	CIPRALEX	LBC	$	1.9569

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

FLUOXETINE HCL

10 MG (BASE) ORAL CAPSULE

00002216353	**APO-FLUOXETINE**	**APX**	$	**0.3404**
00002385627	**AURO-FLUOXETINE**	**AUR**	$	**0.3404**
00002286068	**FLUOXETINE**	**SNS**	$	**0.3404**
00002374447	**FLUOXETINE**	**SIV**	$	**0.3404**
00002393441	**FLUOXETINE BP**	**AHI**	$	**0.3404**
00002401894	**JAMP-FLUOXETINE**	**JPC**	$	**0.3404**
00002380560	**MINT-FLUOXETINE**	**MPI**	$	**0.3404**
00002177579	**PMS-FLUOXETINE**	**PMS**	$	**0.3404**
00002479486	**SANDOZ FLUOXETINE**	**SDZ**	$	**0.3404**
00002216582	**TEVA-FLUOXETINE**	**TEV**	$	**0.3404**
00002018985	PROZAC	LIL	$	1.9522

20 MG (BASE) ORAL CAPSULE

00002216361	**APO-FLUOXETINE**	**APX**	$	**0.3311**
00002385635	**AURO-FLUOXETINE**	**AUR**	$	**0.3311**
00002448432	**BIO-FLUOXETINE**	**BMD**	$	**0.3311**
00002286076	**FLUOXETINE**	**SNS**	$	**0.3311**
00002374455	**FLUOXETINE**	**SIV**	$	**0.3311**
00002383241	**FLUOXETINE BP**	**AHI**	$	**0.3311**
00002386402	**JAMP-FLUOXETINE**	**JPC**	$	**0.3311**
00002380579	**MINT-FLUOXETINE**	**MPI**	$	**0.3311**
00002177587	**PMS-FLUOXETINE**	**PMS**	$	**0.3311**
00002479494	**SANDOZ FLUOXETINE**	**SDZ**	$	**0.3311**
00002216590	**TEVA-FLUOXETINE**	**TEV**	$	**0.3311**
00000636622	PROZAC	LIL	$	1.9522

4 MG / ML (BASE) ORAL LIQUID

00002231328	**APO-FLUOXETINE**	**APX**	$	**0.3084**
00002459361	**ODAN-FLUOXETINE**	**ODN**	$	**0.3084**

FLUVOXAMINE MALEATE

50 MG ORAL TABLET

00002255529	**ACT FLUVOXAMINE**	**APH**	$	**0.2105**
00002231329	**APO-FLUVOXAMINE**	**APX**	$	**0.2105**
00001919342	LUVOX	BGP	$	0.9770

100 MG ORAL TABLET

00002255537	**ACT FLUVOXAMINE**	**APH**	$	**0.3783**
00002231330	**APO-FLUVOXAMINE**	**APX**	$	**0.3783**
00001919369	LUVOX	BGP	$	1.7567

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

PAROXETINE HCL

20 MG (BASE) ORAL TABLET

00002262754	**ACT PAROXETINE**	**APH**	$	**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**
00002431785	**SANDOZ PAROXETINE**	**SDZ**	$	**0.3250**
00002248557	**TEVA-PAROXETINE**	**TEV**	$	**0.3250**
00001940481	PAXIL	GSK	$	1.8814

30 MG (BASE) ORAL TABLET

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**
00002431793	**SANDOZ PAROXETINE**	**SDZ**	$	**0.3453**
00002248558	**TEVA-PAROXETINE**	**TEV**	$	**0.3453**
00001940473	PAXIL	GSK	$	1.9989

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.20 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SELECTIVE-SEROTONIN REUPTAKE INHIBITORS)

SERTRALINE HCL

25 MG (BASE) ORAL CAPSULE				
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	PFI	$	0.8762
50 MG (BASE) ORAL CAPSULE				
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	PFI	$	1.7522
100 MG (BASE) ORAL CAPSULE				
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	PFI	$	1.8637

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.24 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(SEROTONIN MODULATORS)

TRAZODONE HCL

50 MG ORAL TABLET				
00002147637	**APO-TRAZODONE**	**APX**	$	**0.0554**
00001937227	**PMS-TRAZODONE**	**PMS**	$	**0.0554**
00002144263	**TEVA-TRAZODONE**	**TEV**	$	**0.0554**
00002348772	**TRAZODONE**	**SNS**	$	**0.0554**
75 MG ORAL TABLET				
00002237339	PMS-TRAZODONE	PMS	$	0.4422
100 MG ORAL TABLET				
00002147645	**APO-TRAZODONE**	**APX**	$	**0.0989**
00001937235	**PMS-TRAZODONE**	**PMS**	$	**0.0989**
00002144271	**TEVA-TRAZODONE**	**TEV**	$	**0.0989**
00002348780	**TRAZODONE**	**SNS**	$	**0.0989**
150 MG ORAL TABLET				
00002144298	**TEVA-TRAZODONE**	**TEV**	$	**0.1453**
00002348799	**TRAZODONE**	**SNS**	$	**0.1453**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.28 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(TRICYCLICS AND OTHER NOREPINEPHRINE-REUPTAKE INHIBITORS)

AMITRIPTYLINE HCL

10 MG ORAL TABLET				
00002403137	**APO-AMITRIPTYLINE**	**APX**	$	**0.0664**
00000335053	**ELAVIL**	**AAP**	$	**0.0664**
25 MG ORAL TABLET				
00002403145	**APO-AMITRIPTYLINE**	**APX**	$	**0.1211**
00000335061	**ELAVIL**	**AAP**	$	**0.1211**
50 MG ORAL TABLET				
00002403153	**APO-AMITRIPTYLINE**	**APX**	$	**0.2347**
00000335088	**ELAVIL**	**AAP**	$	**0.2347**
75 MG ORAL TABLET				
00002403161	**APO-AMITRIPTYLINE**	**APX**	$	**0.3634**
00000754129	**ELAVIL**	**AAP**	$	**0.3634**

CLOMIPRAMINE HCL

10 MG ORAL TABLET				
00000330566	ANAFRANIL	AAP	$	0.3083
25 MG ORAL TABLET				
00000324019	ANAFRANIL	AAP	$	0.4202
50 MG ORAL TABLET				
00000402591	ANAFRANIL	AAP	$	0.7737

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.28 PSYCHOTHERAPEUTIC AGENTS

ANTIDEPRESSANTS

(TRICYCLICS AND OTHER NOREPINEPHRINE-REUPTAKE INHIBITORS)

DESIPRAMINE HCL

10 MG ORAL TABLET				
00002216248	DESIPRAMINE	AAP	$	0.4056
25 MG ORAL TABLET				
00002216256	DESIPRAMINE	AAP	$	0.4056
50 MG ORAL TABLET				
00002216264	DESIPRAMINE	AAP	$	0.7150
75 MG ORAL TABLET				
00002216272	DESIPRAMINE	AAP	$	0.9507

DOXEPIN HCL

10 MG (BASE) ORAL CAPSULE				
☒ 00002049996	DOXEPIN	AAP	$	0.2567
50 MG (BASE) ORAL CAPSULE				
☒ 00002050013	DOXEPIN	AAP	$	0.5845
100 MG (BASE) ORAL CAPSULE				
☒ 00002050048	DOXEPIN	AAP	$	1.3438

IMIPRAMINE HCL

10 MG ORAL TABLET				
00000360201	IMIPRAMINE	AAP	$	0.1460
25 MG ORAL TABLET				
00000312797	IMIPRAMINE	AAP	$	0.2635
50 MG ORAL TABLET				
00000326852	IMIPRAMINE	AAP	$	0.5142
75 MG ORAL TABLET				
00000644579	IMIPRAMINE	AAP	$	0.6727

NORTRIPTYLINE HCL

10 MG (BASE) ORAL CAPSULE				
00000015229	AVENTYL	AAP	$	0.2632
25 MG (BASE) ORAL CAPSULE				
00000015237	AVENTYL	AAP	$	0.5318

TRIMIPRAMINE MALEATE

12.5 MG (BASE) ORAL TABLET				
00000740799	TRIMIPRAMINE	AAP	$	0.2299
25 MG (BASE) ORAL TABLET				
00000740802	TRIMIPRAMINE	AAP	$	0.2960
50 MG (BASE) ORAL TABLET				
00000740810	TRIMIPRAMINE	AAP	$	0.5795
100 MG (BASE) ORAL TABLET				
00000740829	TRIMIPRAMINE	AAP	$	0.9889
75 MG (BASE) ORAL CAPSULE				
00002070987	TRIMIPRAMINE	AAP	$	0.7800

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.92 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MISCELLANEOUS ANTIDEPRESSANTS)

BUPROPION HCL

100 MG ORAL SUSTAINED-RELEASE TABLET				
00002391562	**BUPROPION SR**	**SNS**	$	**0.1547**
00002275074	**SANDOZ BUPROPION SR**	**SDZ**	$	**0.1547**
150 MG ORAL SUSTAINED-RELEASE TABLET				
00002391570	**BUPROPION SR**	**SNS**	$	**0.2297**
00002275082	**SANDOZ BUPROPION SR**	**SDZ**	$	**0.2297**
00002237825	WELLBUTRIN SR	VCL	$	1.0178
150 MG ORAL EXTENDED-RELEASE TABLET				
00002439654	**ACT BUPROPION XL**	**APH**	$	**0.2926**
00002382075	**MYLAN-BUPROPION XL**	**MYP**	$	**0.2926**
00002275090	WELLBUTRIN XL	VCL	$	0.5883
300 MG ORAL EXTENDED-RELEASE TABLET				
00002439662	**ACT BUPROPION XL**	**APH**	$	**0.5853**
00002382083	**MYLAN-BUPROPION XL**	**MYP**	$	**0.5853**
00002275104	WELLBUTRIN XL	VCL	$	1.1769

L-TRYPTOPHAN

250 MG ORAL TABLET				
00002239326	TRYPTAN	VCL	$	0.4039
500 MG ORAL TABLET				
00002248538	**APO-TRYPTOPHAN**	**APX**	$	**0.3563**
00002240333	**TEVA-TRYPTOPHAN**	**TEV**	$	**0.3563**
00002029456	TRYPTAN	VCL	$	0.8081
750 MG ORAL TABLET				
00002458721	**APO-TRYPTOPHAN**	**APX**	$	**0.9889**
00002239327	TRYPTAN	VCL	$	1.1908
1 G ORAL TABLET				
00002248539	**APO-TRYPTOPHAN**	**APX**	$	**0.7126**
00002237250	**TEVA-TRYPTOPHAN**	**TEV**	$	**0.7126**
00000654531	TRYPTAN	VCL	$	1.6239
500 MG ORAL CAPSULE				
00002248540	**APO-TRYPTOPHAN**	**APX**	$	**0.3563**
00002240334	**TEVA-TRYPTOPHAN**	**TEV**	$	**0.3563**
00000718149	TRYPTAN	VCL	$	0.8081

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.04.92 PSYCHOTHERAPEUTIC AGENTS
ANTIDEPRESSANTS
(MISCELLANEOUS ANTIDEPRESSANTS)

MIRTAZAPINE

15 MG ORAL TABLET				
00002411695	**AURO-MIRTAZAPINE**	**AUR**	$	**0.0974**
00002256096	**MYLAN-MIRTAZAPINE**	**MYP**	$	**0.0974**
00002273942	**PMS-MIRTAZAPINE**	**PMS**	$	**0.0974**
30 MG ORAL TABLET				
00002286629	**APO-MIRTAZAPINE**	**APX**	$	**0.1950**
00002411709	**AURO-MIRTAZAPINE**	**AUR**	$	**0.1950**
00002370689	**MIRTAZAPINE**	**SNS**	$	**0.1950**
00002256118	**MYLAN-MIRTAZAPINE**	**MYP**	$	**0.1950**
00002248762	**PMS-MIRTAZAPINE**	**PMS**	$	**0.1950**
00002250608	**SANDOZ MIRTAZAPINE**	**SDZ**	$	**0.1950**
00002259354	**TEVA-MIRTAZAPINE**	**TEV**	$	**0.1950**
00002243910	REMERON	MFC	$	1.4434
45 MG ORAL TABLET				
00002256126	MYLAN-MIRTAZAPINE	MYP	$	1.1576

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

ARIPIPRAZOLE

2 MG ORAL TABLET				
00002471086	**APO-ARIPIPRAZOLE**	**APX**	$	**0.8092**
00002460025	**AURO-ARIPIPRAZOLE**	**AUR**	$	**0.8092**
00002466635	**PMS-ARIPIPRAZOLE**	**PMS**	$	**0.8092**
00002473658	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**0.8092**
00002464144	**TEVA-ARIPIPRAZOLE**	**TEV**	$	**0.8092**
00002322374	ABILIFY	OTS	$	3.1618

ALBERTA HEALTH RESTRICTED BENEFIT

This Drug Product is a benefit for patients 13 to 17 years of age inclusive.

5 MG ORAL TABLET				
00002471094	**APO-ARIPIPRAZOLE**	**APX**	$	**0.9046**
00002460033	**AURO-ARIPIPRAZOLE**	**AUR**	$	**0.9046**
00002466643	**PMS-ARIPIPRAZOLE**	**PMS**	$	**0.9046**
00002473666	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**0.9046**
00002464152	**TEVA-ARIPIPRAZOLE**	**TEV**	$	**0.9046**
00002322382	ABILIFY	OTS	$	3.5591

ALBERTA HEALTH RESTRICTED BENEFIT

This Drug Product is a benefit for patients 13 to 17 years of age inclusive.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

ARIPIPRAZOLE

10 MG ORAL TABLET				
00002471108	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0754**
00002460041	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0754**
00002466651	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0754**
00002473674	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0754**
00002322390	ABILIFY	OTS	$	4.1016
15 MG ORAL TABLET				
00002471116	**APO-ARIPIPRAZOLE**	**APX**	$	**1.2692**
00002460068	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.2692**
00002466678	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.2692**
00002473682	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.2692**
00002464179	**TEVA-ARIPIPRAZOLE**	**TEV**	$	**1.2692**
00002322404	ABILIFY	OTS	$	4.1016
20 MG ORAL TABLET				
00002471124	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0017**
00002460076	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0017**
00002466686	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0017**
00002473690	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0017**
00002464187	**TEVA-ARIPIPRAZOLE**	**TEV**	$	**1.0017**
00002322412	ABILIFY	OTS	$	4.1016
30 MG ORAL TABLET				
00002471132	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0017**
00002460084	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0017**
00002466694	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0017**
00002473704	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0017**
00002322455	ABILIFY	OTS	$	4.1016

BREXPIPRAZOLE

0.25 MG ORAL TABLET				
00002461749	REXULTI	OTS	$	3.5000
0.5 MG ORAL TABLET				
00002461757	REXULTI	OTS	$	3.5000
1 MG ORAL TABLET				
00002461765	REXULTI	OTS	$	3.5000
2 MG ORAL TABLET				
00002461773	REXULTI	OTS	$	3.5000
3 MG ORAL TABLET				
00002461781	REXULTI	OTS	$	3.5000
4 MG ORAL TABLET				
00002461803	REXULTI	OTS	$	3.5000

CLOZAPINE

25 MG ORAL TABLET				
00002248034	**AA-CLOZAPINE**	**AAP**	$	**0.6594**
00002247243	**GEN-CLOZAPINE**	**MYP**	$	**0.6594**
00000894737	CLOZARIL	HLS	$	0.9420
50 MG ORAL TABLET				
00002305003	GEN-CLOZAPINE	MYP	$	1.3188

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

CLOZAPINE

100 MG ORAL TABLET				
00002248035	**AA-CLOZAPINE**	**AAP**	$	**2.6446**
00002247244	**GEN-CLOZAPINE**	**MYP**	$	**2.6446**
00000894745	CLOZARIL	HLS	$	3.7780
200 MG ORAL TABLET				
00002305011	GEN-CLOZAPINE	MYP	$	5.2892

LURASIDONE HCL

20 MG ORAL TABLET				
00002422050	LATUDA	SUN	$	4.2500
40 MG ORAL TABLET				
00002387751	LATUDA	SUN	$	4.2500
60 MG ORAL TABLET				
00002413361	LATUDA	SUN	$	4.2500
80 MG ORAL TABLET				
00002387778	LATUDA	SUN	$	4.2500
120 MG ORAL TABLET				
00002387786	LATUDA	SUN	$	4.2500

OLANZAPINE

2.5 MG ORAL TABLET				
00002281791	**APO-OLANZAPINE**	**APX**	$	**0.1772**
00002417243	**JAMP OLANZAPINE FC**	**JPC**	$	**0.1772**
00002372819	**OLANZAPINE**	**SNS**	$	**0.1772**
00002385864	**OLANZAPINE**	**SIV**	$	**0.1772**
00002303116	**PMS-OLANZAPINE**	**PMS**	$	**0.1772**
00002310341	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.1772**
00002276712	**TEVA-OLANZAPINE**	**TEV**	$	**0.1772**
00002229250	ZYPREXA	LIL	$	1.8894
5 MG ORAL TABLET				
00002281805	**APO-OLANZAPINE**	**APX**	$	**0.3544**
00002417251	**JAMP OLANZAPINE FC**	**JPC**	$	**0.3544**
00002372827	**OLANZAPINE**	**SNS**	$	**0.3544**
00002385872	**OLANZAPINE**	**SIV**	$	**0.3544**
00002303159	**PMS-OLANZAPINE**	**PMS**	$	**0.3544**
00002310368	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.3544**
00002276720	**TEVA-OLANZAPINE**	**TEV**	$	**0.3544**
00002229269	ZYPREXA	LIL	$	3.7791
7.5 MG ORAL TABLET				
00002281813	**APO-OLANZAPINE**	**APX**	$	**0.5316**
00002417278	**JAMP OLANZAPINE FC**	**JPC**	$	**0.5316**
00002372835	**OLANZAPINE**	**SNS**	$	**0.5316**
00002385880	**OLANZAPINE**	**SIV**	$	**0.5316**
00002303167	**PMS-OLANZAPINE**	**PMS**	$	**0.5316**
00002310376	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.5316**
00002276739	**TEVA-OLANZAPINE**	**TEV**	$	**0.5316**
00002229277	ZYPREXA	LIL	$	5.6685

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

OLANZAPINE

10 MG (BASE) ORAL TABLET

00002281821	**APO-OLANZAPINE**	**APX**	$	**0.7088**
00002417286	**JAMP OLANZAPINE FC**	**JPC**	$	**0.7088**
00002372843	**OLANZAPINE**	**SNS**	$	**0.7088**
00002385899	**OLANZAPINE**	**SIV**	$	**0.7088**
00002303175	**PMS-OLANZAPINE**	**PMS**	$	**0.7088**
00002310384	**SANDOZ OLANZAPINE**	**SDZ**	$	**0.7088**
00002276747	**TEVA-OLANZAPINE**	**TEV**	$	**0.7088**
00002229285	ZYPREXA	LIL	$	7.5582

15 MG ORAL TABLET

00002281848	**APO-OLANZAPINE**	**APX**	$	**1.0631**
00002417294	**JAMP OLANZAPINE FC**	**JPC**	$	**1.0631**
00002372851	**OLANZAPINE**	**SNS**	$	**1.0631**
00002385902	**OLANZAPINE**	**SIV**	$	**1.0631**
00002303183	**PMS-OLANZAPINE**	**PMS**	$	**1.0631**
00002310392	**SANDOZ OLANZAPINE**	**SDZ**	$	**1.0631**
00002276755	**TEVA-OLANZAPINE**	**TEV**	$	**1.0631**
00002238850	ZYPREXA	LIL	$	11.3373

5 MG ORAL DISINTEGRATING TABLET

00002327562	**ACT OLANZAPINE ODT**	**TEV**	$	**0.3574**
00002360616	**APO-OLANZAPINE ODT**	**APX**	$	**0.3574**
00002448726	**AURO-OLANZAPINE ODT**	**AUR**	$	**0.3574**
00002406624	**JAMP-OLANZAPINE ODT**	**JPC**	$	**0.3574**
00002389088	**MAR-OLANZAPINE ODT**	**MAR**	$	**0.3574**
00002436965	**MINT-OLANZAPINE ODT**	**MPI**	$	**0.3574**
00002343665	**OLANZAPINE ODT**	**SIV**	$	**0.3574**
00002352974	**OLANZAPINE ODT**	**SNS**	$	**0.3574**
00002303191	**PMS-OLANZAPINE ODT**	**PMS**	$	**0.3574**
00002414090	**RAN-OLANZAPINE ODT**	**RAN**	$	**0.3574**
00002327775	**SANDOZ OLANZAPINE ODT**	**SDZ**	$	**0.3574**
00002243086	ZYPREXA ZYDIS	LIL	$	3.7583

10 MG (BASE) ORAL DISINTEGRATING TABLET

00002327570	**ACT OLANZAPINE ODT**	**TEV**	$	**0.7143**
00002360624	**APO-OLANZAPINE ODT**	**APX**	$	**0.7143**
00002448734	**AURO-OLANZAPINE ODT**	**AUR**	$	**0.7143**
00002406632	**JAMP-OLANZAPINE ODT**	**JPC**	$	**0.7143**
00002389096	**MAR-OLANZAPINE ODT**	**MAR**	$	**0.7143**
00002436973	**MINT-OLANZAPINE ODT**	**MPI**	$	**0.7143**
00002343673	**OLANZAPINE ODT**	**SIV**	$	**0.7143**
00002352982	**OLANZAPINE ODT**	**SNS**	$	**0.7143**
00002303205	**PMS-OLANZAPINE ODT**	**PMS**	$	**0.7143**
00002414104	**RAN-OLANZAPINE ODT**	**RAN**	$	**0.7143**
00002327783	**SANDOZ OLANZAPINE ODT**	**SDZ**	$	**0.7143**
00002243087	ZYPREXA ZYDIS	LIL	$	7.5098

PALIPERIDONE

3 MG ORAL EXTENDED-RELEASE TABLET

00002300273	INVEGA	JAI	$	3.8660

6 MG ORAL EXTENDED-RELEASE TABLET

00002300281	INVEGA	JAI	$	5.7833

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

PALIPERIDONE

9 MG ORAL EXTENDED-RELEASE TABLET

00002300303	INVEGA	JAI	$	7.7080

QUETIAPINE FUMARATE

25 MG (BASE) ORAL TABLET

00002316080	**ACT QUETIAPINE**	**APH**	$	**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**
00002313995	**SANDOZ QUETIAPINE**	**SDZ**	$	**0.0494**
00002236951	SEROQUEL	AZC	$	0.5195

50 MG (BASE) ORAL TABLET

00002361892	PMS-QUETIAPINE	PMS	$	0.5778

100 MG (BASE) ORAL TABLET

00002316099	**ACT QUETIAPINE**	**APH**	$	**0.1318**
00002313928	**APO-QUETIAPINE**	**APX**	$	**0.1318**
00002390213	**AURO-QUETIAPINE**	**AUR**	$	**0.1318**
00002447207	**BIO-QUETIAPINE**	**BMD**	$	**0.1318**
00002330423	**JAMP-QUETIAPINE**	**JPC**	$	**0.1318**
00002399830	**MAR-QUETIAPINE**	**MAR**	$	**0.1318**
00002438011	**MINT-QUETIAPINE**	**MPI**	$	**0.1318**
00002439166	**NAT-QUETIAPINE**	**NTP**	$	**0.1318**
00002296578	**PMS-QUETIAPINE**	**PMS**	$	**0.1318**
00002317907	**QUETIAPINE**	**SIV**	$	**0.1318**
00002353172	**QUETIAPINE**	**SNS**	$	**0.1318**
00002387808	**QUETIAPINE**	**AHI**	$	**0.1318**
00002397102	**RAN-QUETIAPINE**	**RAN**	$	**0.1318**
00002314002	**SANDOZ QUETIAPINE**	**SDZ**	$	**0.1318**
00002236952	SEROQUEL	AZC	$	1.3860

150 MG (BASE) ORAL TABLET

00002439174	**NAT-QUETIAPINE**	**NTP**	$	**1.0195**
00002284251	**TEVA-QUETIAPINE**	**TEV**	$	**1.0195**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

QUETIAPINE FUMARATE

200 MG (BASE) ORAL TABLET

00002316110	**ACT QUETIAPINE**	**APH**	$	**0.2647**
00002313936	**APO-QUETIAPINE**	**APX**	$	**0.2647**
00002390248	**AURO-QUETIAPINE**	**AUR**	$	**0.2647**
00002447223	**BIO-QUETIAPINE**	**BMD**	$	**0.2647**
00002330458	**JAMP-QUETIAPINE**	**JPC**	$	**0.2647**
00002399849	**MAR-QUETIAPINE**	**MAR**	$	**0.2647**
00002438046	**MINT-QUETIAPINE**	**MPI**	$	**0.2647**
00002439182	**NAT-QUETIAPINE**	**NTP**	$	**0.2647**
00002296594	**PMS-QUETIAPINE**	**PMS**	$	**0.2647**
00002317923	**QUETIAPINE**	**SIV**	$	**0.2647**
00002353199	**QUETIAPINE**	**SNS**	$	**0.2647**
00002387824	**QUETIAPINE**	**AHI**	$	**0.2647**
00002397110	**RAN-QUETIAPINE**	**RAN**	$	**0.2647**
00002314010	**SANDOZ QUETIAPINE**	**SDZ**	$	**0.2647**
00002236953	SEROQUEL	AZC	$	2.7830

300 MG (BASE) ORAL TABLET

00002316129	**ACT QUETIAPINE**	**APH**	$	**0.3863**
00002313944	**APO-QUETIAPINE**	**APX**	$	**0.3863**
00002390256	**AURO-QUETIAPINE**	**AUR**	$	**0.3863**
00002447258	**BIO-QUETIAPINE**	**BMD**	$	**0.3863**
00002330466	**JAMP-QUETIAPINE**	**JPC**	$	**0.3863**
00002399857	**MAR-QUETIAPINE**	**MAR**	$	**0.3863**
00002438054	**MINT-QUETIAPINE**	**MPI**	$	**0.3863**
00002439190	**NAT-QUETIAPINE**	**NTP**	$	**0.3863**
00002296608	**PMS-QUETIAPINE**	**PMS**	$	**0.3863**
00002317931	**QUETIAPINE**	**SIV**	$	**0.3863**
00002353202	**QUETIAPINE**	**SNS**	$	**0.3863**
00002387832	**QUETIAPINE**	**AHI**	$	**0.3863**
00002397129	**RAN-QUETIAPINE**	**RAN**	$	**0.3863**
00002314029	**SANDOZ QUETIAPINE**	**SDZ**	$	**0.3863**
00002244107	SEROQUEL	AZC	$	4.0610

50 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002457229	**APO-QUETIAPINE XR**	**APX**	$	**0.2501**
00002417359	**QUETIAPINE XR**	**SIV**	$	**0.2501**
00002407671	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.2501**
00002395444	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.2501**
00002300184	SEROQUEL XR	AZC	$	1.0003

150 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002457237	**APO-QUETIAPINE XR**	**APX**	$	**0.4926**
00002417367	**QUETIAPINE XR**	**SIV**	$	**0.4926**
00002407698	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.4926**
00002395452	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.4926**
00002321513	SEROQUEL XR	AZC	$	1.9701

200 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002457245	**APO-QUETIAPINE XR**	**APX**	$	**0.6661**
00002417375	**QUETIAPINE XR**	**SIV**	$	**0.6661**
00002407701	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.6661**
00002395460	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.6661**
00002300192	SEROQUEL XR	AZC	$	2.6641

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

QUETIAPINE FUMARATE

300 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002457253	**APO-QUETIAPINE XR**	**APX**	$	**0.9776**
00002417383	**QUETIAPINE XR**	**SIV**	$	**0.9776**
00002407728	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**0.9776**
00002395479	**TEVA-QUETIAPINE XR**	**TEV**	$	**0.9776**
00002300206	SEROQUEL XR	AZC	$	3.9101

400 MG (BASE) ORAL EXTENDED-RELEASE TABLET

00002457261	**APO-QUETIAPINE XR**	**APX**	$	**1.3270**
00002417391	**QUETIAPINE XR**	**SIV**	$	**1.3270**
00002407736	**SANDOZ QUETIAPINE XRT**	**SDZ**	$	**1.3270**
00002395487	**TEVA-QUETIAPINE XR**	**TEV**	$	**1.3270**
00002300214	SEROQUEL XR	AZC	$	5.3080

RISPERIDONE

0.25 MG ORAL TABLET

00002282119	**APO-RISPERIDONE**	**APX**	$	**0.1036**
00002359529	**JAMP-RISPERIDONE**	**JPC**	$	**0.1036**
00002371766	**MAR-RISPERIDONE**	**MAR**	$	**0.1036**
00002359790	**MINT-RISPERIDON**	**MPI**	$	**0.1036**
00002252007	**PMS-RISPERIDONE**	**PMS**	$	**0.1036**
00002328305	**RAN-RISPERIDONE**	**RAN**	$	**0.1036**
00002356880	**RISPERIDONE**	**SNS**	$	**0.1036**
00002303655	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.1036**
00002282690	**TEVA-RISPERIDONE**	**TEV**	$	**0.1036**
00002240551	RISPERDAL	JAI	$	0.5539

0.5 MG ORAL TABLET

00002282127	**APO-RISPERIDONE**	**APX**	$	**0.1735**
00002359537	**JAMP-RISPERIDONE**	**JPC**	$	**0.1735**
00002371774	**MAR-RISPERIDONE**	**MAR**	$	**0.1735**
00002359804	**MINT-RISPERIDON**	**MPI**	$	**0.1735**
00002252015	**PMS-RISPERIDONE**	**PMS**	$	**0.1735**
00002328313	**RAN-RISPERIDONE**	**RAN**	$	**0.1735**
00002356899	**RISPERIDONE**	**SNS**	$	**0.1735**
00002303663	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.1735**
00002264188	**TEVA-RISPERIDONE**	**TEV**	$	**0.1735**
00002240552	RISPERDAL	JAI	$	0.9280

1 MG ORAL TABLET

00002282135	**APO-RISPERIDONE**	**APX**	$	**0.2397**
00002359545	**JAMP-RISPERIDONE**	**JPC**	$	**0.2397**
00002371782	**MAR-RISPERIDONE**	**MAR**	$	**0.2397**
00002359812	**MINT-RISPERIDON**	**MPI**	$	**0.2397**
00002252023	**PMS-RISPERIDONE**	**PMS**	$	**0.2397**
00002328321	**RAN-RISPERIDONE**	**RAN**	$	**0.2397**
00002356902	**RISPERIDONE**	**SNS**	$	**0.2397**
00002279800	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.2397**
00002264196	**TEVA-RISPERIDONE**	**TEV**	$	**0.2397**
00002025280	RISPERDAL	JAI	$	1.2815

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

RISPERIDONE

2 MG ORAL TABLET				
00002282143	**APO-RISPERIDONE**	**APX**	$	**0.4795**
00002359553	**JAMP-RISPERIDONE**	**JPC**	$	**0.4795**
00002371790	**MAR-RISPERIDONE**	**MAR**	$	**0.4795**
00002359820	**MINT-RISPERIDON**	**MPI**	$	**0.4795**
00002252031	**PMS-RISPERIDONE**	**PMS**	$	**0.4795**
00002328348	**RAN-RISPERIDONE**	**RAN**	$	**0.4795**
00002356910	**RISPERIDONE**	**SNS**	$	**0.4795**
00002279819	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.4795**
00002264218	**TEVA-RISPERIDONE**	**TEV**	$	**0.4795**
00002025299	RISPERDAL	JAI	$	2.5588
3 MG ORAL TABLET				
00002282151	**APO-RISPERIDONE**	**APX**	$	**0.7180**
00002359561	**JAMP-RISPERIDONE**	**JPC**	$	**0.7180**
00002371804	**MAR-RISPERIDONE**	**MAR**	$	**0.7180**
00002359839	**MINT-RISPERIDON**	**MPI**	$	**0.7180**
00002252058	**PMS-RISPERIDONE**	**PMS**	$	**0.7180**
00002328364	**RAN-RISPERIDONE**	**RAN**	$	**0.7180**
00002356929	**RISPERIDONE**	**SNS**	$	**0.7180**
00002279827	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.7180**
00002264226	**TEVA-RISPERIDONE**	**TEV**	$	**0.7180**
00002025302	RISPERDAL	JAI	$	3.8380
4 MG ORAL TABLET				
00002282178	**APO-RISPERIDONE**	**APX**	$	**0.9574**
00002359588	**JAMP-RISPERIDONE**	**JPC**	$	**0.9574**
00002371812	**MAR-RISPERIDONE**	**MAR**	$	**0.9574**
00002359847	**MINT-RISPERIDON**	**MPI**	$	**0.9574**
00002252066	**PMS-RISPERIDONE**	**PMS**	$	**0.9574**
00002328372	**RAN-RISPERIDONE**	**RAN**	$	**0.9574**
00002356937	**RISPERIDONE**	**SNS**	$	**0.9574**
00002279835	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.9574**
00002264234	**TEVA-RISPERIDONE**	**TEV**	$	**0.9574**
00002025310	RISPERDAL	JAI	$	5.1185
0.5 MG ORAL DISINTEGRATING TABLET				
00002413485	MYLAN-RISPERIDONE ODT	MYP	$	0.5588
1 MG ORAL DISINTEGRATING TABLET				
00002413493	MYLAN-RISPERIDONE ODT	MYP	$	0.5150
2 MG ORAL DISINTEGRATING TABLET				
00002413507	MYLAN-RISPERIDONE ODT	MYP	$	1.0187
3 MG ORAL DISINTEGRATING TABLET				
00002413515	MYLAN-RISPERIDONE ODT	MYP	$	1.5275
4 MG ORAL DISINTEGRATING TABLET				
00002413523	MYLAN-RISPERIDONE ODT	MYP	$	2.0425

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

RISPERIDONE TARTRATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 years of age and older for the management of the manifestations of schizophrenia and related psychotic disorders, as well as in severe dementia for the short-term symptomatic management of inappropriate behavior due to aggression and/or psychosis.

1 MG / ML (BASE) ORAL SOLUTION				
00002454319	**JAMP-RISPERIDONE**	**JPC**	$	**0.4895**
00002279266	**PMS-RISPERIDONE**	**PMS**	$	**0.4895**
00002236950	RISPERDAL	JAI	$	1.4118

ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE

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

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.08 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(BUTYROPHENONES)

HALOPERIDOL

0.5 MG ORAL TABLET				
00000363685	TEVA-HALOPERIDOL	TEV	$	0.1362
1 MG ORAL TABLET				
00000363677	TEVA-HALOPERIDOL	TEV	$	0.2046
2 MG ORAL TABLET				
00000363669	TEVA-HALOPERIDOL	TEV	$	0.3058
5 MG ORAL TABLET				
00000363650	TEVA-HALOPERIDOL	TEV	$	0.4877
10 MG ORAL TABLET				
00000713449	TEVA-HALOPERIDOL	TEV	$	0.7095
20 MG ORAL TABLET				
00000768820	TEVA-HALOPERIDOL	TEV	$	1.3047
5 MG / ML INJECTION				
00000808652	HALOPERIDOL	SDZ	$	5.0715

HALOPERIDOL DECANOATE

100 MG / ML (BASE) INJECTION				
00002130300	HALOPERIDOL LA	SDZ	$	18.6142

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.24 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (PHENOTHIAZINES)

CHLORPROMAZINE HCL

25 MG (BASE) ORAL TABLET				
00000232823	TEVA-CHLORPROMAZINE	TEV	$	0.2454
50 MG (BASE) ORAL TABLET				
00000232807	TEVA-CHLORPROMAZINE	TEV	$	0.2808
100 MG (BASE) ORAL TABLET				
00000232831	TEVA-CHLORPROMAZINE	TEV	$	0.7475

FLUPHENAZINE DECANOATE

100 MG / ML INJECTION				
00000755575	MODECATE CONCENTRATE	BMS	$	29.7800

FLUPHENAZINE HCL

1 MG ORAL TABLET				
00000405345	FLUPHENAZINE	AAP	$	0.1868
2 MG ORAL TABLET				
00000410632	FLUPHENAZINE	AAP	$	0.2401
5 MG ORAL TABLET				
00000405361	FLUPHENAZINE	AAP	$	0.3924

METHOTRIMEPRAZINE HCL

25 MG / ML (BASE) INJECTION				
00001927698	NOZINAN	SAV	$	3.6810

METHOTRIMEPRAZINE MALEATE

2 MG (BASE) ORAL TABLET				
00002238403	METHOPRAZINE	AAP	$	0.0731
5 MG (BASE) ORAL TABLET				
00002238404	METHOPRAZINE	AAP	$	0.1057
25 MG (BASE) ORAL TABLET				
00002238405	METHOPRAZINE	AAP	$	0.2718
50 MG (BASE) ORAL TABLET				
00002238406	METHOPRAZINE	AAP	$	0.4113

PERICIAZINE

5 MG ORAL CAPSULE				
00001926780	NEULEPTIL	ERF	$	0.2067
10 MG ORAL CAPSULE				
00001926772	NEULEPTIL	ERF	$	0.3367
10 MG / ML ORAL DROPS				
00001926756	NEULEPTIL	ERF	$	0.4079

PERPHENAZINE

2 MG ORAL TABLET				
00000335134	PERPHENAZINE	AAP	$	0.0668
4 MG ORAL TABLET				
00000335126	PERPHENAZINE	AAP	$	0.0808
8 MG ORAL TABLET				
00000335118	PERPHENAZINE	AAP	$	0.0888
16 MG ORAL TABLET				
00000335096	PERPHENAZINE	AAP	$	0.1359

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.24 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (PHENOTHIAZINES)

TRIFLUOPERAZINE HCL

1 MG (BASE) ORAL TABLET				
00000345539	TRIFLUOPERAZINE	AAP	$	0.1430
2 MG (BASE) ORAL TABLET				
00000312754	TRIFLUOPERAZINE	AAP	$	0.1875
5 MG (BASE) ORAL TABLET				
00000312746	TRIFLUOPERAZINE	AAP	$	0.2483
10 MG (BASE) ORAL TABLET				
00000326836	TRIFLUOPERAZINE	AAP	$	0.2976
20 MG (BASE) ORAL TABLET				
00000595942	TRIFLUOPERAZINE	AAP	$	0.5951

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.32 PSYCHOTHERAPEUTIC AGENTS ANTIPSYCHOTICS (THIOXANTHENES)

FLUPENTIXOL DECANOATE

20 MG / ML INJECTION				
00002156032	FLUANXOL DEPOT	LBC	$	7.6610
100 MG / ML INJECTION				
00002156040	FLUANXOL DEPOT	LBC	$	38.3049

FLUPENTIXOL DIHYDROCHLORIDE

0.5 MG ORAL TABLET				
00002156008	FLUANXOL	LBC	$	0.2647
3 MG ORAL TABLET				
00002156016	FLUANXOL	LBC	$	0.5716

ZUCLOPENTHIXOL ACETATE

50 MG / ML INJECTION				
00002230405	CLOPIXOL ACUPHASE	LBC	$	15.8998

ZUCLOPENTHIXOL DECANOATE

200 MG / ML INJECTION				
00002230406	CLOPIXOL DEPOT	LBC	$	15.8998

ZUCLOPENTHIXOL DIHYDROCHLORIDE

10 MG (BASE) ORAL TABLET				
00002230402	CLOPIXOL	LBC	$	0.4089
25 MG (BASE) ORAL TABLET				
00002230403	CLOPIXOL	LBC	$	1.0221

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.92 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(MISCELLANEOUS ANTIPSYCHOTICS)

LOXAPINE SUCCINATE

2.5 MG (BASE) ORAL TABLET				
00002242868	XYLAC	PPH	$	0.2215
10 MG (BASE) ORAL TABLET				
00002230838	XYLAC	PPH	$	0.3456
25 MG (BASE) ORAL TABLET				
00002230839	XYLAC	PPH	$	0.5359

PIMOZIDE

2 MG ORAL TABLET				
00002245432	PIMOZIDE	AAP	$	0.3297
4 MG ORAL TABLET				
00000313823	**ORAP**	**PPH**	$	**0.4811**
00002245433	PIMOZIDE	AAP	$	0.5022

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:20.04 ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS
(AMPHETAMINES)

DEXTROAMPHETAMINE SULFATE

5 MG ORAL TABLET				
00002443236	**DEXTROAMPHETAMINE**	**AAP**	$	**0.5081**
00001924516	DEXEDRINE	PAL	$	0.6347
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002448319	**ACT DEXTROAMPHETAMINE SR**	**APH**	$	**0.8096**
00001924559	DEXEDRINE	PAL	$	0.9105
15 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002448327	**ACT DEXTROAMPHETAMINE SR**	**APH**	$	**0.9898**
00001924567	DEXEDRINE	PAL	$	1.1131

LISDEXAMFETAMINE DIMESYLATE

RESTRICTED BENEFIT - For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older.

20 MG ORAL CAPSULE				
00002347156	VYVANSE	SHB	$	2.8058
30 MG ORAL CAPSULE				
00002322951	VYVANSE	SHB	$	3.3560
40 MG ORAL CAPSULE				
00002347164	VYVANSE	SHB	$	3.9060
50 MG ORAL CAPSULE				
00002322978	VYVANSE	SHB	$	4.4562
60 MG ORAL CAPSULE				
00002347172	VYVANSE	SHB	$	5.0063

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:20.92 ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS
(MISCELLANEOUS ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS)

METHYLPHENIDATE HCL

5 MG ORAL TABLET					
☒	00002273950	APO-METHYLPHENIDATE	APX	$	0.0947
☒	00002234749	PMS-METHYLPHENIDATE	PMS	$	0.0947
10 MG ORAL TABLET					
	00002249324	**APO-METHYLPHENIDATE**	**APX**	$	**0.0816**
	00000584991	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.0816**
	00000005606	RITALIN	NOV	$	0.3876
20 MG ORAL TABLET					
	00002249332	**APO-METHYLPHENIDATE**	**APX**	$	**0.2326**
	00000585009	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.2326**
	00000005614	RITALIN	NOV	$	0.6773
20 MG ORAL EXTENDED-RELEASE TABLET					
	00002266687	**APO-METHYLPHENIDATE SR**	**APX**	$	**0.2820**
	00002320312	**SANDOZ METHYLPHENIDATE**	**SDZ**	$	**0.2820**
	00000632775	RITALIN SR	NOV	$	0.6801
10 MG ORAL CONTROLLED-RELEASE CAPSULE					
	00002277166	BIPHENTIN	PUR	$	0.7460

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

15 MG ORAL CONTROLLED-RELEASE CAPSULE					
	00002277131	BIPHENTIN	PUR	$	1.0675

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

20 MG ORAL CONTROLLED-RELEASE CAPSULE					
	00002277158	BIPHENTIN	PUR	$	1.3800

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

30 MG ORAL CONTROLLED-RELEASE CAPSULE					
	00002277174	BIPHENTIN	PUR	$	1.8930

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

40 MG ORAL CONTROLLED-RELEASE CAPSULE					
	00002277182	BIPHENTIN	PUR	$	2.4130

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

50 MG ORAL CONTROLLED-RELEASE CAPSULE					
	00002277190	BIPHENTIN	PUR	$	2.9260

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

60 MG ORAL CONTROLLED-RELEASE CAPSULE					
	00002277204	BIPHENTIN	PUR	$	3.4050

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:20.92 ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS
(MISCELLANEOUS ANOREXIGENIC AGENTS & RESPIRATORY AND CEREBRAL STIMULANTS)

METHYLPHENIDATE HCL

80 MG ORAL CONTROLLED-RELEASE CAPSULE

00002277212	BIPHENTIN	PUR	$	4.4930

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.04 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS
(BARBITURATES)

PHENOBARBITAL

15 MG ORAL TABLET

00000178799	PHENOBARB	PPH	$	0.1394

30 MG ORAL TABLET

00000178802	PHENOBARB	PPH	$	0.1580

60 MG ORAL TABLET

00000178810	PHENOBARB	PPH	$	0.2142

100 MG ORAL TABLET

00000178829	PHENOBARB	PPH	$	0.3078

5 MG / ML ORAL ELIXIR

00000645575	PHENOBARB	PPH	$	0.1489

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS
(BENZODIAZEPINES)

ALPRAZOLAM

0.25 MG ORAL TABLET

00002349191	**ALPRAZOLAM**	**SNS**	$	**0.0609**
00000865397	**APO-ALPRAZ**	**APX**	$	**0.0609**
00002400111	**JAMP-ALPRAZOLAM**	**JPC**	$	**0.0609**
00001913484	**TEVA-ALPRAZOL**	**TEV**	$	**0.0609**

0.5 MG ORAL TABLET

00002349205	**ALPRAZOLAM**	**SNS**	$	**0.0728**
00000865400	**APO-ALPRAZ**	**APX**	$	**0.0728**
00002400138	**JAMP-ALPRAZOLAM**	**JPC**	$	**0.0728**
00001913492	**TEVA-ALPRAZOL**	**TEV**	$	**0.0728**

BROMAZEPAM

1.5 MG ORAL TABLET

00002177153	APO-BROMAZEPAM	APX	$	0.1028

3 MG ORAL TABLET

00002177161	**APO-BROMAZEPAM**	**APX**	$	**0.0776**
00002230584	**TEVA-BROMAZEPAM**	**TEV**	$	**0.0776**

6 MG ORAL TABLET

00002177188	**APO-BROMAZEPAM**	**APX**	$	**0.1134**
00002230585	**TEVA-BROMAZEPAM**	**TEV**	$	**0.1134**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BENZODIAZEPINES)

CHLORDIAZEPOXIDE HCL

5 MG ORAL CAPSULE				
00000522724	CHLORDIAZEPOXIDE	AAP	$	0.0725
10 MG ORAL CAPSULE				
00000522988	CHLORDIAZEPOXIDE	AAP	$	0.1141
25 MG ORAL CAPSULE				
00000522996	CHLORDIAZEPOXIDE	AAP	$	0.1769

CHLORDIAZEPOXIDE HCL/ CLIDINIUM BROMIDE

5 MG * 2.5 MG ORAL CAPSULE				
00000618454	**CHLORAX**	**AAP**	$	**0.2451**
00000115630	LIBRAX	VCL	$	0.3405

CLORAZEPATE DIPOTASSIUM

3.75 MG ORAL CAPSULE				
00000860689	CLORAZEPATE	AAP	$	0.1575
7.5 MG ORAL CAPSULE				
00000860700	CLORAZEPATE	AAP	$	0.2054
15 MG ORAL CAPSULE				
00000860697	CLORAZEPATE	AAP	$	0.4112

DIAZEPAM

2 MG ORAL TABLET				
00000405329	APO-DIAZEPAM	APX	$	0.0508
5 MG ORAL TABLET				
00000362158	APO-DIAZEPAM	APX	$	0.0650
10 MG ORAL TABLET				
00000405337	APO-DIAZEPAM	APX	$	0.0867
5 MG / ML INJECTION				
00000399728	DIAZEPAM	SDZ	$	1.6745

FLURAZEPAM HCL

15 MG ORAL CAPSULE				
00000521698	FLURAZEPAM	AAP	$	0.1219
30 MG ORAL CAPSULE				
00000521701	FLURAZEPAM	AAP	$	0.1426

LORAZEPAM

0.5 MG ORAL TABLET				
00000655740	**APO-LORAZEPAM**	**APX**	$	**0.0359**
00000711101	**TEVA-LORAZEPAM**	**TEV**	$	**0.0359**
00002041413	ATIVAN	PFI	$	0.0401
1 MG ORAL TABLET				
00000655759	**APO-LORAZEPAM**	**APX**	$	**0.0447**
00002351080	**LORAZEPAM**	**SNS**	$	**0.0447**
00000728195	**PMS-LORAZEPAM**	**PMS**	$	**0.0447**
00000637742	**TEVA-LORAZEPAM**	**TEV**	$	**0.0447**
00002041421	ATIVAN	PFI	$	0.0499
2 MG ORAL TABLET				
00000655767	**APO-LORAZEPAM**	**APX**	$	**0.0699**
00002351099	**LORAZEPAM**	**SNS**	$	**0.0699**
00000728209	**PMS-LORAZEPAM**	**PMS**	$	**0.0699**
00000637750	**TEVA-LORAZEPAM**	**TEV**	$	**0.0699**
00002041448	ATIVAN	PFI	$	0.0782

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.08 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (BENZODIAZEPINES)

LORAZEPAM

0.5 MG ORAL SUBLINGUAL TABLET

00002410745	**LORAZEPAM**	**AAP**	$	**0.0875**
00002041456	ATIVAN	PFI	$	0.1218

1 MG ORAL SUBLINGUAL TABLET

00002410753	**LORAZEPAM**	**AAP**	$	**0.1100**
00002041464	ATIVAN	PFI	$	0.1534

2 MG ORAL SUBLINGUAL TABLET

00002410761	**LORAZEPAM**	**AAP**	$	**0.1711**
00002041472	ATIVAN	PFI	$	0.2383

MIDAZOLAM HCL

5 MG / ML (BASE) INJECTION

00002240286	MIDAZOLAM	SDZ	$	4.1000

NITRAZEPAM

5 MG ORAL TABLET

00000511528	MOGADON	AAP	$	0.1604

10 MG ORAL TABLET

00000511536	MOGADON	AAP	$	0.2400

OXAZEPAM

10 MG ORAL TABLET

00000402680	APO-OXAZEPAM	APX	$	0.0420

15 MG ORAL TABLET

00000402745	APO-OXAZEPAM	APX	$	0.0660

30 MG ORAL TABLET

00000402737	APO-OXAZEPAM	APX	$	0.0900

TEMAZEPAM

15 MG ORAL CAPSULE

00000604453	RESTORIL	AAP	$	0.2163

30 MG ORAL CAPSULE

00000604461	RESTORIL	AAP	$	0.2617

TRIAZOLAM

0.25 MG ORAL TABLET

00000808571	TRIAZO	AAP	$	0.2669

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.92 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS (MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS)

BUSPIRONE HCL

10 MG ORAL TABLET

00002211076	**APO-BUSPIRONE**	**APX**	$	**0.3517**
00002231492	**NOVO-BUSPIRONE**	**TEV**	$	**0.3517**
00002230942	**PMS-BUSPIRONE**	**PMS**	$	**0.3517**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:24.92 ANXIOLYTICS, SEDATIVES, AND HYPNOTICS

(MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS)

HYDROXYZINE HCL

10 MG ORAL CAPSULE				
00000646059	HYDROXYZINE	AAP	$	0.1143
25 MG ORAL CAPSULE				
00000738832	**NOVO-HYDROXYZIN**	**TEV**	$	**0.1425**
00000646024	HYDROXYZINE	AAP	$	0.1459
50 MG ORAL CAPSULE				
00000738840	**NOVO-HYDROXYZIN**	**TEV**	$	**0.2068**
00000646016	HYDROXYZINE	AAP	$	0.2118
2 MG / ML ORAL SYRUP				
00000024694	ATARAX	ERF	$	0.0568

ZOPICLONE

5 MG ORAL TABLET				
00002245077	**APO-ZOPICLONE**	**APX**	$	**0.0990**
00002406969	**JAMP-ZOPICLONE**	**JPC**	$	**0.0990**
00002386771	**MAR-ZOPICLONE**	**MAR**	$	**0.0990**
00002391716	**MINT-ZOPICLONE**	**MPI**	$	**0.0990**
00002243426	**PMS-ZOPICLONE**	**PMS**	$	**0.0990**
00002267918	**RAN-ZOPICLONE**	**RAN**	$	**0.0990**
00002246534	**RATIO-ZOPICLONE**	**TEV**	$	**0.0990**
00002257572	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.0990**
00002386909	**SEPTA-ZOPICLONE**	**SEP**	$	**0.0990**
00002344122	**ZOPICLONE**	**SNS**	$	**0.0990**
00002385821	**ZOPICLONE**	**SIV**	$	**0.0990**
00002216167	IMOVANE	SAV	$	1.0589
7.5 MG ORAL TABLET				
00002218313	**APO-ZOPICLONE**	**APX**	$	**0.1250**
00002406977	**JAMP-ZOPICLONE**	**JPC**	$	**0.1250**
00002386798	**MAR-ZOPICLONE**	**MAR**	$	**0.1250**
00002391724	**MINT-ZOPICLONE**	**MPI**	$	**0.1250**
00002240606	**PMS-ZOPICLONE**	**PMS**	$	**0.1250**
00002267926	**RAN-ZOPICLONE**	**RAN**	$	**0.1250**
00002242481	**RATIO-ZOPICLONE**	**TEV**	$	**0.1250**
00002008203	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.1250**
00002386917	**SEPTA-ZOPICLONE**	**SEP**	$	**0.1250**
00002282445	**ZOPICLONE**	**SNS**	$	**0.1250**
00002385848	**ZOPICLONE**	**SIV**	$	**0.1250**
00001926799	IMOVANE	SAV	$	1.3370

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:28 ANTIMANIC AGENTS

LITHIUM CARBONATE

150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0667**
00002216132	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0667**
00000461733	CARBOLITH	VCL	$	0.1292
150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0667**
00002013231	LITHANE	ERF	$	0.1117

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:28 ANTIMANIC AGENTS

LITHIUM CARBONATE

300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0657**
00002216140	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0657**
00000236683	CARBOLITH	VCL	$	0.1004
300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0657**
00000406775	LITHANE	ERF	$	0.1113
600 MG ORAL CAPSULE				
00002216159	PMS-LITHIUM CARBONATE	PMS	$	0.1988

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS

(SELECTIVE SEROTONIN AGONISTS)

ALMOTRIPTAN MALATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older, and Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

6.25 MG (BASE) ORAL TABLET				
00002405792	**APO-ALMOTRIPTAN**	**APX**	$	**7.0433**
00002398435	**MYLAN-ALMOTRIPTAN**	**MYP**	$	**7.0433**
12.5 MG (BASE) ORAL TABLET				
00002466821	**ALMOTRIPTAN**	**SNS**	$	**2.3478**
00002405806	**APO-ALMOTRIPTAN**	**APX**	$	**2.3478**
00002398443	**MYLAN-ALMOTRIPTAN**	**MYP**	$	**2.3478**
00002405334	**SANDOZ ALMOTRIPTAN**	**SDZ**	$	**2.3478**

NARATRIPTAN HCL

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

1 MG (BASE) ORAL TABLET				
00002314290	**TEVA-NARATRIPTAN**	**TEV**	$	**11.9041**
00002237820	AMERGE	GSK	$	14.7667
2.5 MG (BASE) ORAL TABLET				
00002322323	**SANDOZ NARATRIPTAN**	**SDZ**	$	**6.1436**
00002314304	**TEVA-NARATRIPTAN**	**TEV**	$	**6.1436**
00002237821	AMERGE	GSK	$	15.5646

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS (SELECTIVE SEROTONIN AGONISTS)

RIZATRIPTAN BENZOATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

5 MG (BASE) ORAL TABLET				
00002393468	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002380455	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429233	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
10 MG (BASE) ORAL TABLET				
00002381702	**ACT RIZATRIPTAN**	**APH**	$	**3.7050**
00002393476	**APO-RIZATRIPTAN**	**APX**	$	**3.7050**
00002441144	**AURO-RIZATRIPTAN**	**AUR**	$	**3.7050**
00002380463	**JAMP-RIZATRIPTAN**	**JPC**	$	**3.7050**
00002429241	**JAMP-RIZATRIPTAN IR**	**JPC**	$	**3.7050**
00002379678	**MAR-RIZATRIPTAN**	**MAR**	$	**3.7050**
00002240521	MAXALT	MFC	$	16.5163
5 MG (BASE) ORAL DISINTEGRATING TABLET				
00002465086	**JAMP-RIZATRIPTAN ODT**	**JPC**	$	**3.7050**
00002462788	**MAR-RIZATRIPTAN ODT**	**MAR**	$	**3.7050**
00002379198	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**3.7050**
00002436604	**NAT-RIZATRIPTAN ODT**	**NTP**	$	**3.7050**
00002393360	**PMS-RIZATRIPTAN RDT**	**PMS**	$	**3.7050**
00002442906	**RIZATRIPTAN ODT**	**SNS**	$	**3.7050**
00002446111	**RIZATRIPTAN ODT**	**SIV**	$	**3.7050**
00002351870	**SANDOZ RIZATRIPTAN ODT**	**SDZ**	$	**3.7050**
00002396661	**TEVA-RIZATRIPTAN ODT**	**TEV**	$	**3.7050**
00002240518	MAXALT RPD	MFC	$	16.5163
10 MG (BASE) ORAL DISINTEGRATING TABLET				
00002465094	**JAMP-RIZATRIPTAN ODT**	**JPC**	$	**3.7050**
00002462796	**MAR-RIZATRIPTAN ODT**	**MAR**	$	**3.7050**
00002379201	**MYLAN-RIZATRIPTAN ODT**	**MYP**	$	**3.7050**
00002436612	**NAT-RIZATRIPTAN ODT**	**NTP**	$	**3.7050**
00002393379	**PMS-RIZATRIPTAN RDT**	**PMS**	$	**3.7050**
00002442914	**RIZATRIPTAN ODT**	**SNS**	$	**3.7050**
00002446138	**RIZATRIPTAN ODT**	**SIV**	$	**3.7050**
00002351889	**SANDOZ RIZATRIPTAN ODT**	**SDZ**	$	**3.7050**
00002396688	**TEVA-RIZATRIPTAN ODT**	**TEV**	$	**3.7050**
00002240519	MAXALT RPD	MFC	$	16.5163

SUMATRIPTAN HEMISULFATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

5 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230418	IMITREX	GSK	$	15.6250
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230420	IMITREX	GSK	$	16.0781

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.28 ANTIMIGRAINE AGENTS (SELECTIVE SEROTONIN AGONISTS)

SUMATRIPTAN SUCCINATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older, and Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

50 MG (BASE) ORAL TABLET				
00002268388	**APO-SUMATRIPTAN**	**APX**	$	**2.7732**
00002268914	**MYLAN-SUMATRIPTAN**	**MYP**	$	**2.7732**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**2.7732**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**2.7732**
00002286521	**SUMATRIPTAN**	**SNS**	$	**2.7732**
00002385570	**SUMATRIPTAN DF**	**SIV**	$	**2.7732**
00002286823	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**2.7732**
00002212153	IMITREX DF	GSK	$	15.7917
100 MG (BASE) ORAL TABLET				
00002257904	**ACT SUMATRIPTAN**	**APH**	$	**3.0549**
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**3.0549**
00002268922	**MYLAN-SUMATRIPTAN**	**MYP**	$	**3.0549**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**3.0549**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**3.0549**
00002286548	**SUMATRIPTAN**	**SNS**	$	**3.0549**
00002385589	**SUMATRIPTAN DF**	**SIV**	$	**3.0549**
00002239367	**TEVA-SUMATRIPTAN**	**TEV**	$	**3.0549**
00002286831	**TEVA-SUMATRIPTAN DF**	**TEV**	$	**3.0549**
00002212161	IMITREX DF	GSK	$	17.3967
6 MG / SYR (BASE) INJECTION SYRINGE				
00002361698	**TARO-SUMATRIPTAN (0.5 ML)**	**TAR**	$	**34.6200**
00002212188	IMITREX (0.5 ML)	GSK	$	47.1762

ZOLMITRIPTAN

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

2.5 MG ORAL TABLET				
00002421623	**JAMP-ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002399458	**MAR-ZOLMITRIPTAN**	**MAR**	$	**3.5375**
00002419521	**MINT-ZOLMITRIPTAN**	**MPI**	$	**3.5375**
00002421534	**NAT-ZOLMITRIPTAN**	**NTP**	$	**3.5375**
00002324229	**PMS-ZOLMITRIPTAN**	**PMS**	$	**3.5375**
00002362988	**SANDOZ ZOLMITRIPTAN**	**SDZ**	$	**3.5375**
00002313960	**TEVA-ZOLMITRIPTAN**	**TEV**	$	**3.5375**
00002238660	ZOMIG	AZC	$	14.9600
2.5 MG ORAL DISPERSIBLE TABLET				
00002428237	**JAMP-ZOLMITRIPTAN ODT**	**JPC**	$	**1.7532**
00002428474	**SEPTA-ZOLMITRIPTAN-ODT**	**SEP**	$	**1.7532**
00002243045	ZOMIG RAPIMELT	AZC	$	14.9600
5 MG / DOSE NASAL UNIT DOSE SPRAY				
00002248993	ZOMIG	AZC	$	14.9600

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:32.92 ANTIMIGRAINE AGENTS
(MISCELLANEOUS ANTIMIGRAINE AGENTS)

PIZOTIFEN MALATE

0.5 MG (BASE) ORAL TABLET				
00000329320	SANDOMIGRAN	PAL	$	0.4127
1 MG (BASE) ORAL TABLET				
00000511552	SANDOMIGRAN DS	PAL	$	0.7103

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.04 ANTIPARKINSONIAN AGENTS
(ADAMANTANES)

AMANTADINE HCL

100 MG ORAL CAPSULE				
00001990403	PDP-AMANTADINE HYDROCHLORIDE	PPH	$	0.6120
10 MG / ML ORAL SYRUP				
00002022826	PDP-AMANTADINE HYDROCHLORIDE	PPH	$	0.1223

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.08 ANTIPARKINSONIAN AGENTS
(ANTICHOLINERGIC AGENTS)

BENZTROPINE MESYLATE

1 MG ORAL TABLET				
00000706531	PDP-BENZTROPINE	PPH	$	0.0522
1 MG / ML INJECTION				
00002238903	BENZTROPINE OMEGA	OMG	$	10.5000

ETHOPROPAZINE HCL

50 MG (BASE) ORAL TABLET				
00001927744	PARSITAN	ERF	$	0.2284

TRIHEXYPHENIDYL HCL

2 MG ORAL TABLET				
00000545058	TRIHEXYPHENIDYL	AAP	$	0.0384
5 MG ORAL TABLET				
00000545074	TRIHEXYPHENIDYL	AAP	$	0.0695

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.12 ANTIPARKINSONIAN AGENTS
(CATECHOL-O-METHYLTRANSFERASE (COMT) INHIBITORS)

ENTACAPONE

200 MG ORAL TABLET				
00002380005	**SANDOZ ENTACAPONE**	**SDZ**	$	**0.4010**
00002375559	**TEVA-ENTACAPONE**	**TEV**	$	**0.4010**
00002243763	COMTAN	NOV	$	1.6685

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.16 ANTIPARKINSONIAN AGENTS (DOPAMINE PRECURSORS)

LEVODOPA/ BENSERAZIDE HCL

50 MG * 12.5 MG (BASE) ORAL CAPSULE				
00000522597	PROLOPA 50-12.5	HLR	$	0.3197
100 MG * 25 MG (BASE) ORAL CAPSULE				
00000386464	PROLOPA 100-25	HLR	$	0.5265
200 MG * 50 MG (BASE) ORAL CAPSULE				
00000386472	PROLOPA 200-50	HLR	$	0.8839

LEVODOPA/ CARBIDOPA

100 MG * 10 MG ORAL TABLET				
00002195933	**APO-LEVOCARB**	**APX**	$	**0.1479**
00002457954	**MINT-LEVOCARB**	**MPI**	$	**0.1479**
00002244494	**TEVA-LEVOCARBIDOPA**	**TEV**	$	**0.1479**
100 MG * 25 MG ORAL TABLET				
00002195941	**APO-LEVOCARB**	**APX**	$	**0.2209**
00002457962	**MINT-LEVOCARB**	**MPI**	$	**0.2209**
00002244495	**TEVA-LEVOCARBIDOPA**	**TEV**	$	**0.2209**
00000513997	SINEMET 100/25	MFC	$	0.7273
250 MG * 25 MG ORAL TABLET				
00002195968	**APO-LEVOCARB**	**APX**	$	**0.2466**
00002457970	**MINT-LEVOCARB**	**MPI**	$	**0.2466**
00002244496	**TEVA-LEVOCARBIDOPA**	**TEV**	$	**0.2466**
00000328219	SINEMET 250/25	MFC	$	0.8119
100 MG * 25 MG ORAL SUSTAINED-RELEASE TABLET				
00002272873	**APO-LEVOCARB CR**	**APX**	$	**0.3857**
00002028786	SINEMET CR 100/25	MFC	$	0.7888
200 MG * 50 MG ORAL SUSTAINED-RELEASE TABLET				
00002245211	**APO-LEVOCARB CR**	**APX**	$	**0.7115**
00000870935	SINEMET CR 200/50	MFC	$	1.4550

LEVODOPA/ CARBIDOPA/ ENTACAPONE

50 MG * 12.5 MG * 200 MG ORAL TABLET				
00002305933	STALEVO	NOV	$	1.7061
75 MG * 18.75 MG * 200 MG ORAL TABLET				
00002337827	STALEVO	NOV	$	1.7061
100 MG * 25 MG * 200 MG ORAL TABLET				
00002305941	STALEVO	NOV	$	1.7061
125 MG * 31.25 MG * 200 MG ORAL TABLET				
00002337835	STALEVO	NOV	$	1.7061
150 MG * 37.5 MG * 200 MG ORAL TABLET				
00002305968	STALEVO	NOV	$	1.7061

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.20.04 ANTIPARKINSONIAN AGENTS
DOPAMINE RECEPTOR AGONISTS
(ERGOT-DERIVATIVE-DOPAMINE RECEPTOR AGONISTS)

BROMOCRIPTINE MESYLATE

2.5 MG (BASE) ORAL TABLET				
00002087324	BROMOCRIPTINE	AAP	$	1.0433
5 MG (BASE) ORAL CAPSULE				
00002230454	BROMOCRIPTINE	AAP	$	1.5617

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.20.08 ANTIPARKINSONIAN AGENTS
DOPAMINE RECEPTOR AGONISTS
(NONERGOT-DERIVATIVE DOPAMINE RECEPTOR AGONISTS)

PRAMIPEXOLE DIHYDROCHLORIDE

0.25 MG ORAL TABLET				
00002297302	**ACT PRAMIPEXOLE**	**APH**	$	**0.1950**
00002292378	**APO-PRAMIPEXOLE**	**APX**	$	**0.1950**
00002424061	**AURO-PRAMIPEXOLE**	**AUR**	$	**0.1950**
00002290111	**PMS-PRAMIPEXOLE**	**PMS**	$	**0.1950**
00002309122	**PRAMIPEXOLE**	**SIV**	$	**0.1950**
00002315262	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**0.1950**
00002237145	MIRAPEX	BOE	$	1.1594
1 MG ORAL TABLET				
00002297329	**ACT PRAMIPEXOLE**	**APH**	$	**0.3901**
00002292394	**APO-PRAMIPEXOLE**	**APX**	$	**0.3901**
00002424096	**AURO-PRAMIPEXOLE**	**AUR**	$	**0.3901**
00002290146	**PMS-PRAMIPEXOLE**	**PMS**	$	**0.3901**
00002309149	**PRAMIPEXOLE**	**SIV**	$	**0.3901**
00002315289	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**0.3901**
1.5 MG ORAL TABLET				
00002297337	**ACT PRAMIPEXOLE**	**APH**	$	**0.3901**
00002292408	**APO-PRAMIPEXOLE**	**APX**	$	**0.3901**
00002424118	**AURO-PRAMIPEXOLE**	**AUR**	$	**0.3901**
00002290154	**PMS-PRAMIPEXOLE**	**PMS**	$	**0.3901**
00002309157	**PRAMIPEXOLE**	**SIV**	$	**0.3901**
00002315297	**SANDOZ PRAMIPEXOLE**	**SDZ**	$	**0.3901**

ROPINIROLE HCL

0.25 MG (BASE) ORAL TABLET				
00002316846	**ACT ROPINIROLE**	**APH**	$	**0.0709**
00002352338	**JAMP-ROPINIROLE**	**JPC**	$	**0.0709**
00002314037	**RAN-ROPINIROLE**	**RAN**	$	**0.0709**
00002353040	**ROPINIROLE**	**SNS**	$	**0.0709**
1 MG (BASE) ORAL TABLET				
00002316854	**ACT ROPINIROLE**	**APH**	$	**0.2838**
00002352346	**JAMP-ROPINIROLE**	**JPC**	$	**0.2838**
00002314053	**RAN-ROPINIROLE**	**RAN**	$	**0.2838**
00002353059	**ROPINIROLE**	**SNS**	$	**0.2838**
2 MG (BASE) ORAL TABLET				
00002316862	**ACT ROPINIROLE**	**APH**	$	**0.3122**
00002352354	**JAMP-ROPINIROLE**	**JPC**	$	**0.3122**
00002314061	**RAN-ROPINIROLE**	**RAN**	$	**0.3122**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.20.08 ANTIPARKINSONIAN AGENTS
DOPAMINE RECEPTOR AGONISTS
(NONERGOT-DERIVATIVE DOPAMINE RECEPTOR AGONISTS)

ROPINIROLE HCL

5 MG (BASE) ORAL TABLET

00002316870	**ACT ROPINIROLE**	**APH**	$	**0.8596**
00002352362	**JAMP-ROPINIROLE**	**JPC**	$	**0.8596**
00002314088	**RAN-ROPINIROLE**	**RAN**	$	**0.8596**

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:36.32 ANTIPARKINSONIAN AGENTS
(MONOAMINE OXIDASE B INHIBITORS)

SELEGILINE HCL

5 MG ORAL TABLET

00002230641	**APO-SELEGILINE**	**APX**	$	**0.5021**
00002068087	**NOVO-SELEGILINE**	**TEV**	$	**0.5021**

34:00

Dental Agents

34:00 DENTAL AGENTS

34:00

SODIUM FLUORIDE

2.21 MG ORAL CHEWABLE TABLET

00000575569	FLUOR-A-DAY	PMS	$	0.0880

36:00

Diagnostic Agents

36:00 DIAGNOSTIC AGENTS

36:60 THYROID FUNCTION

THYROTROPIN ALFA

0.9 MG / VIAL INJECTION

00002246016	THYROGEN	GZM	$	871.2950

40:00

Electrolytic, Caloric, and Water Balance

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:10 AMMONIA DETOXICANTS

LACTULOSE

667 MG / ML ORAL SYRUP

00002295881	**JAMP-LACTULOSE**	**JPC**	$	**0.0145**
00002412268	**LACTULOSE**	**SNS**	$	**0.0145**
00000703486	**PMS-LACTULOSE**	**PMS**	$	**0.0145**
00002469391	**PMS-LACTULOSE-PHARMA**	**PMS**	$	**0.0145**
00000854409	**RATIO-LACTULOSE**	**TEV**	$	**0.0145**
00002331551	**TEVA-LACTULOSE**	**TEV**	$	**0.0145**

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:12 REPLACEMENT PREPARATIONS

MAGNESIUM GLUCOHEPTONATE

100 MG / ML ORAL SOLUTION

☒ 00080004109	MAGNESIUM-ODAN	ODN	$	0.0199
☒ 00000026697	ROUGIER MAGNESIUM	TEV	$	0.0200

MAGNESIUM GLUCONATE

500 MG ORAL TABLET

☒ 00080009539	JAMP MAGNESIUM GLUCONATE	JPC	$	0.1088
☒ 00000555126	MAGLUCATE	PPH	$	0.1183

POTASSIUM BICARBONATE

975 MG (BASE) ORAL EFFERVESCENT TABLET

00080033602	JAMP-K EFFERVESCENT (25 MEQ)	JPC	$	0.4760

POTASSIUM CHLORIDE (K+)

8 MEQ ORAL SUSTAINED-RELEASE TABLET

☒ 00002246734	EURO-K	SDZ	***$ 0.0450***	$	0.0450
☒ 00080013005	JAMP-K 8	JPC	***$ 0.0450***	$	0.0450

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release tablet.

8 MEQ ORAL EXTENDED-RELEASE CAPSULE

00080062704	JAMP-POTASSIUM CHLORIDE ER	JPC	***$ 0.0822***	$	0.0822

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release capsules.

8 MEQ ORAL SUSTAINED-RELEASE CAPSULE

00002042304	MICRO-K EXTENCAPS	PAL	***$ 0.0822***	$	0.0995

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release capsules.

20 MEQ ORAL TABLET/SUSTAINED-RELEASE TABLET

☒ 00002242261	EURO-K 20	SDZ	***$ 0.1995***	$	0.1995
☒ 00080013007	JAMP-K 20	JPC	***$ 0.1995***	$	0.1995
☒ 00080004415	ODAN K-20	ODN	***$ 0.1995***	$	0.1995

MAC pricing has been applied based on the lowest unit cost for an 20 mEq (K+) oral tablet and / or sustained-release tablet.

POTASSIUM CHLORIDE (K+)(CL-)

1.33 MEQ / ML ORAL LIQUID

00080024835	JAMP POTASSIUM CHLORIDE	JPC	***$ 0.0360***	$	0.0360

MAC pricing has been applied based on the lowest unit cost for the 1.33 mEq / ml Oral Liquid

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:12 REPLACEMENT PREPARATIONS

POTASSIUM CITRATE (K+)

25 MEQ ORAL EFFERVESCENT TABLET

00002085992	K-LYTE	WSP	$	0.5600

SODIUM ACID PHOSPHATE/ SODIUM BICARBONATE/ POTASSIUM BICARBONATE

500 MG (BASE) * 469 MG (BASE) * 123 MG (BASE) ORAL EFFERVESCENT TABLET

00080047562	JAMP-SODIUM PHOSPHATE	JPC	$	1.4010

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:18.18 ION-REMOVING AGENTS (POTASSIUM-REMOVING AGENTS)

CALCIUM POLYSTYRENE SULPHONATE

ORAL POWDER

00002017741	RESONIUM CALCIUM	SAV	$	0.3865

SODIUM POLYSTYRENE SULFONATE

250 MG / ML ORAL SUSPENSION

00000769541	SOLYSTAT	PPH	$	0.1566

ORAL POWDER

00002026961	**KAYEXALATE**	**SAV**	$	**0.1851**
00000755338	SOLYSTAT	PPH	$	0.2001

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.16 DIURETICS (POTASSIUM-SPARING DIURETICS)

AMILORIDE HCL

5 MG ORAL TABLET

00002249510	MIDAMOR	AAP	$	0.2897

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.20 DIURETICS (THIAZIDE DIURETICS)

HYDROCHLOROTHIAZIDE

12.5 MG ORAL TABLET

☒ 00002327856	APO-HYDRO	APX	$	0.0322
☒ 00002274086	PMS-HYDROCHLOROTHIAZIDE	PMS	$	0.0322

25 MG ORAL TABLET

00000326844	**APO-HYDRO**	**APX**	$	**0.0157**
00002360594	**HYDROCHLOROTHIAZIDE**	**SNS**	$	**0.0157**
00000021474	**TEVA-HYDRAZIDE**	**TEV**	$	**0.0157**

50 MG ORAL TABLET

00000312800	**APO-HYDRO**	**APX**	$	**0.0217**
00002360608	**HYDROCHLOROTHIAZIDE**	**SNS**	$	**0.0217**
00000021482	**TEVA-HYDRAZIDE**	**TEV**	$	**0.0217**

100 MG ORAL TABLET

00000644552	APO-HYDRO	APX	$	0.1232

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.20 DIURETICS

(THIAZIDE DIURETICS)

HYDROCHLOROTHIAZIDE/ AMILORIDE HCL

50 MG * 5 MG ORAL TABLET

00000784400	APO-AMILZIDE	APX	$	0.0838

HYDROCHLOROTHIAZIDE/ TRIAMTERENE

25 MG * 50 MG ORAL TABLET

00000441775	**APO-TRIAZIDE**	**APX**	$	**0.0608**
00000532657	**TEVA-TRIAMTERENE/HCTZ**	**TEV**	$	**0.0608**

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.24 DIURETICS

(THIAZIDE-LIKE DIURETICS)

CHLORTHALIDONE

50 MG ORAL TABLET

00000360279	CHLORTHALIDONE	AAP	$	0.1325

INDAPAMIDE HEMIHYDRATE

1.25 MG (BASE) ORAL TABLET

00002245246	**APO-INDAPAMIDE**	**APX**	$	**0.0745**
00002373904	**JAMP-INDAPAMIDE**	**JPC**	$	**0.0745**
00002240067	**MYLAN-INDAPAMIDE**	**MYP**	$	**0.0745**

2.5 MG (BASE) ORAL TABLET

00002223678	**APO-INDAPAMIDE**	**APX**	$	**0.1182**
00002373912	**JAMP-INDAPAMIDE**	**JPC**	$	**0.1182**
00002153483	**MYLAN-INDAPAMIDE**	**MYP**	$	**0.1182**
00000564966	LOZIDE	SEV	$	0.4990

METOLAZONE

2.5 MG ORAL TABLET

00000888400	ZAROXOLYN	SAV	$	0.2136

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:40 URICOSURIC AGENTS

SULFINPYRAZONE

200 MG ORAL TABLET

00000441767	SULFINPYRAZONE	AAP	$	0.3121

48:00

Respiratory Tract Agents

48:00 RESPIRATORY TRACT AGENTS

48:10.24 ANTI-INFLAMMATORY AGENTS (LEUKOTRIENE MODIFIERS)

MONTELUKAST SODIUM

10 MG (BASE) ORAL TABLET

00002374609	**APO-MONTELUKAST**	**APX**	$	**0.4231**
00002401274	**AURO-MONTELUKAST**	**AUR**	$	**0.4231**
00002391422	**JAMP-MONTELUKAST**	**JPC**	$	**0.4231**
00002399997	**MAR-MONTELUKAST**	**MAR**	$	**0.4231**
00002408643	**MINT-MONTELUKAST**	**MPI**	$	**0.4231**
00002379333	**MONTELUKAST**	**SNS**	$	**0.4231**
00002382474	**MONTELUKAST**	**SIV**	$	**0.4231**
00002379236	**MONTELUKAST SODIUM**	**AHI**	$	**0.4231**
00002373947	**PMS-MONTELUKAST FC**	**PMS**	$	**0.4231**
00002389517	**RAN-MONTELUKAST**	**RAN**	$	**0.4231**
00002328593	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.4231**
00002355523	**TEVA-MONTELUKAST**	**TEV**	$	**0.4231**
00002238217	SINGULAIR	MFC	$	2.4823

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility for Alberta Human Services clients.)

4 MG (BASE) ORAL CHEWABLE TABLET

00002377608	**APO-MONTELUKAST**	**APX**	$	**0.2758**
00002442353	**JAMP-MONTELUKAST**	**JPC**	$	**0.2758**
00002399865	**MAR-MONTELUKAST**	**MAR**	$	**0.2758**
00002408627	**MINT-MONTELUKAST**	**MPI**	$	**0.2758**
00002379317	**MONTELUKAST**	**SNS**	$	**0.2758**
00002382458	**MONTELUKAST**	**SIV**	$	**0.2758**
00002354977	**PMS-MONTELUKAST**	**PMS**	$	**0.2758**
00002330385	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.2758**
00002355507	**TEVA-MONTELUKAST**	**TEV**	$	**0.2758**
00002243602	SINGULAIR	MFC	$	1.5264

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

5 MG (BASE) ORAL CHEWABLE TABLET

00002377616	**APO-MONTELUKAST**	**APX**	$	**0.3082**
00002442361	**JAMP-MONTELUKAST**	**JPC**	$	**0.3082**
00002399873	**MAR-MONTELUKAST**	**MAR**	$	**0.3082**
00002408635	**MINT-MONTELUKAST**	**MPI**	$	**0.3082**
00002379325	**MONTELUKAST**	**SNS**	$	**0.3082**
00002382466	**MONTELUKAST**	**SIV**	$	**0.3082**
00002354985	**PMS-MONTELUKAST**	**PMS**	$	**0.3082**
00002330393	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.3082**
00002355515	**TEVA-MONTELUKAST**	**TEV**	$	**0.3082**
00002238216	SINGULAIR	MFC	$	1.6902

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility for Alberta Human Services clients.)

48:00 RESPIRATORY TRACT AGENTS

48:10.24 ANTI-INFLAMMATORY AGENTS (LEUKOTRIENE MODIFIERS)

MONTELUKAST SODIUM

4 MG (BASE) ORAL GRANULE

00002358611	**SANDOZ MONTELUKAST**	**SDZ**	$	**1.3139**
00002247997	SINGULAIR	MFC	$	1.5264

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

48:00 RESPIRATORY TRACT AGENTS

48:10.32 ANTI-INFLAMMATORY AGENTS (MAST-CELL STABILIZERS)

SODIUM CROMOGLYCATE

100 MG ORAL CAPSULE

00000500895	NALCROM	SAV	$	1.5755

1 % INHALATION SOLUTION

00002046113	PMS-SODIUM CROMOGLYCATE	PMS	$	0.9836

48:00 RESPIRATORY TRACT AGENTS

48:12.08 BRONCHODILATORS (ANTICHOLINERGIC AGENTS)

GLYCOPYRRONIUM BROMIDE

50 MCG INHALATION CAPSULE

00002394936	SEEBRI BREEZHALER	NOV	$	1.7700

48:00 RESPIRATORY TRACT AGENTS

48:24 MUCOLYTIC AGENTS

ACETYLCYSTEINE

20 % INHALATION SOLUTION

☒ 00002243098	ACETYLCYSTEINE	SDZ	$	0.7000

52:00

Eye, Ear, Nose and Throat (EENT) Preparations

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:04.04 ANTI-INFECTIVES (ANTIBACTERIALS)

CIPROFLOXACIN HCL

0.3 % (BASE) OPHTHALMIC SOLUTION				
00002387131	**SANDOZ CIPROFLOXACIN**	**SDZ**	$	**1.7600**
00001945270	CILOXAN	NOV	$	2.2240

ERYTHROMYCIN

0.5 % OPHTHALMIC OINTMENT				
☒ 00001912755	PDP-ERYTHROMYCIN	PPH	$	4.0686

OFLOXACIN

0.3 % OPHTHALMIC SOLUTION				
00002143291	OCUFLOX	ALL	$	2.6410

TOBRAMYCIN

0.3 % OPHTHALMIC SOLUTION				
00002241755	**SANDOZ TOBRAMYCIN**	**SDZ**	$	**1.3620**
00000513962	TOBREX	NOV	$	1.8580
0.3 % OPHTHALMIC OINTMENT				
00000614254	TOBREX	NOV	$	2.6343

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:04.20 ANTI-INFECTIVES (ANTIVIRALS)

TRIFLURIDINE

1 % OPHTHALMIC SOLUTION				
00000687456	VIROPTIC	VCL	$	3.4539

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08 ANTI-INFLAMMATORY AGENTS (CORTICOSTEROIDS)

BECLOMETHASONE DIPROPIONATE

50 MCG / DOSE NASAL METERED DOSE SPRAY				
00002238796	**APO-BECLOMETHASONE**	**APX**	$	**0.0613**
00002172712	**MYLAN-BECLO AQ.**	**MYP**	$	**0.0613**

BUDESONIDE

100 MCG / DOSE NASAL METERED DOSE AEROSOL				
00002035324	RHINOCORT TURBUHALER	AZC	$	0.1252
100 MCG / DOSE NASAL METERED DOSE SPRAY				
00002230648	MYLAN-BUDESONIDE AQ	MYP	$	0.1006

CIPROFLOXACIN HCL/ DEXAMETHASONE

0.3 % * 0.1 % OTIC SUSPENSION				
00002252716	CIPRODEX	NOV	$	3.7693

DEXAMETHASONE

0.1 % OPHTHALMIC SUSPENSION				
00000042560	MAXIDEX	NOV	$	1.7180
0.1 % OPHTHALMIC OINTMENT				
00000042579	MAXIDEX	NOV	$	2.6600

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08 ANTI-INFLAMMATORY AGENTS (CORTICOSTEROIDS)

FLUOROMETHOLONE

0.1 % OPHTHALMIC SUSPENSION

00000432814	SANDOZ FLUOROMETHOLONE	SDZ	$	1.7880

FLUOROMETHOLONE ACETATE

0.1 % OPHTHALMIC SUSPENSION

00000756784	FLAREX	NOV	$	1.9920

FLUTICASONE FUROATE

100 MCG / DOSE INHALATION METERED INHALATION POWDER

00002446561	ARNUITY ELLIPTA	GSK	$	1.3063

200 MCG / DOSE INHALATION METERED INHALATION POWDER

00002446588	ARNUITY ELLIPTA	GSK	$	2.6127

MOMETASONE FUROATE

50 MCG / DOSE NASAL METERED DOSE SPRAY

00002403587	**APO-MOMETASONE**	**APX**	$	**0.0752**
00002449811	**SANDOZ MOMETASONE**	**SDZ**	$	**0.0752**
00002475863	**TEVA-MOMETASONE**	**TEV**	$	**0.0752**
00002238465	NASONEX	MFC	$	0.2125

PREDNISOLONE ACETATE

0.12 % OPHTHALMIC SUSPENSION

00000299405	PRED MILD	ALL	$	1.8881

1 % OPHTHALMIC SUSPENSION

00001916203	**SANDOZ PREDNISOLONE ACETATE**	**SDZ**	$	**1.9400**
00000700401	**TEVA-PREDNISOLONE**	**TEV**	$	**1.9400**
00000301175	PRED FORTE	ALL	$	5.2880

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08.00 ANTI-INFLAMMATORY AGENTS CORTICOSTEROIDS (COMBINATION ANTI-INFECTIVE/CORTICOSTEROID AGENTS)

DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN

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

00002224623	SOFRACORT	SAV	$	2.0575

DEXAMETHASONE/ NEOMYCIN SULFATE/ POLYMYXIN B SULFATE

1 MG / ML * 3.5 MG / ML (BASE) * 6,000 UNIT / ML OPHTHALMIC SUSPENSION

00000042676	MAXITROL	NOV	$	2.1220

1 MG / G * 3.5 MG / G (BASE) * 6,000 UNIT / G OPHTHALMIC OINTMENT

00000358177	MAXITROL	NOV	$	2.9600

DEXAMETHASONE/ TOBRAMYCIN

0.1 % * 0.3 % OPHTHALMIC SUSPENSION

00000778907	TOBRADEX	NOV	$	2.1720

0.1 % * 0.3 % OPHTHALMIC OINTMENT

00000778915	TOBRADEX	NOV	$	3.2057

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.08.00 ANTI-INFLAMMATORY AGENTS
CORTICOSTEROIDS
(COMBINATION ANTI-INFECTIVE/CORTICOSTEROID AGENTS)

FLUMETHASONE PIVALATE/ CLIOQUINOL

0.02 % * 1 % OTIC SOLUTION

00000074454	LOCACORTEN VIOFORM	PAL	$	1.6331

PREDNISOLONE ACETATE/ SULFACETAMIDE SODIUM

0.2 % * 10 % OPHTHALMIC SUSPENSION

00000807788	BLEPHAMIDE	ALL	$	2.8405

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:08.20 ANTI-INFLAMMATORY AGENTS
(NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM

0.1 % OPHTHALMIC SOLUTION

00002441020	**APO-DICLOFENAC OPHTHALMIC**	**APX**	$	**1.7710**
00002454807	**SANDOZ DICLOFENAC OPHTHA**	**SDZ**	$	**1.7710**
00001940414	VOLTAREN OPHTHA	NOV	$	2.6860

KETOROLAC TROMETHAMINE

0.45 % OPHTHALMIC SOLUTION

00002369362	ACUVAIL	ALL	$	0.6466

0.5 % OPHTHALMIC SOLUTION

00002245821	**KETOROLAC**	**AAP**	$	**2.7585**
00001968300	ACULAR	ALL	$	3.6490

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:16 LOCAL ANESTHETICS

LIDOCAINE HCL

2 % ORAL LIQUID

00001968823	**LIDODAN VISCOUS**	**ODN**	$	**0.0551**
00000001686	XYLOCAINE VISCOUS	APC	$	0.1076

PROPARACAINE HCL

0.5 % OPHTHALMIC SOLUTION

00000035076	ALCAINE	ALC	$	0.8514

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:24 MYDRIATICS

ATROPINE SULFATE

1 % OPHTHALMIC SOLUTION

☒	00000035017	ISOPTO ATROPINE	ALC	$	0.7320

CYCLOPENTOLATE HCL

1 % OPHTHALMIC SOLUTION

00000252506	CYCLOGYL	ALC	$	1.0060

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:28 MOUTHWASHES AND GARGLES

BENZYDAMINE HCL

0.15 % ORAL RINSE

00002463105	**ODAN-BENZYDAMINE**	**ODN**	$	**0.0384**
00002239537	**PMS-BENZYDAMINE**	**PMS**	$	**0.0384**

COMPOUND PRESCRIPTION

ORAL

00000999209	COMPD-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT 0.12%)	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

ORAL

00000999109	COMPD-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT .12%)	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:32 VASOCONSTRICTORS

EPINEPHRINE HCL

1 MG / ML TOPICAL SOLUTION

00000155365	ADRENALIN	ERF	$	0.6085

PHENYLEPHRINE HCL

2.5 % OPHTHALMIC SOLUTION

00000465763	MYDFRIN	ALC	$	1.2100

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.04 ANTIGLAUCOMA AGENTS (ALPHA-ADRENERGIC AGONISTS)

BRIMONIDINE TARTRATE

0.2 % OPHTHALMIC SOLUTION

00002260077	**APO-BRIMONIDINE**	**APX**	$	**1.1550**
00002305429	**SANDOZ BRIMONIDINE**	**SDZ**	$	**1.1550**
00002236876	ALPHAGAN	ALL	$	3.6169

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.08 ANTIGLAUCOMA AGENTS (BETA-ADRENERGIC AGENTS)

BETAXOLOL HCL

0.25 % (BASE) OPHTHALMIC SUSPENSION

00001908448	BETOPTIC S	NOV	$	2.4520

LEVOBUNOLOL HCL

0.5 % OPHTHALMIC SOLUTION

00000637661	BETAGAN	ALL	$	3.5505

TIMOLOL MALEATE

0.25 % (BASE) OPHTHALMIC SOLUTION

00002166712	SANDOZ TIMOLOL MALEATE	SDZ	$	0.9678

0.5 % (BASE) OPHTHALMIC SOLUTION

00000755834	**APO-TIMOP**	**APX**	$	**1.2140**
00002166720	**SANDOZ TIMOLOL MALEATE**	**SDZ**	$	**1.2140**
00000451207	TIMOPTIC	PUR	$	4.0360

0.25 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION

00002171880	TIMOPTIC-XE	PUR	$	4.3080

0.5 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION

00002171899	TIMOPTIC-XE	PUR	$	5.1520

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.12 ANTIGLAUCOMA AGENTS (CARBONIC ANHYDRASE INHIBITORS)

ACETAZOLAMIDE

250 MG ORAL TABLET

00000545015	ACETAZOLAMIDE	AAP	$	0.1320

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.12 ANTIGLAUCOMA AGENTS (CARBONIC ANHYDRASE INHIBITORS)

BRINZOLAMIDE

1 % OPHTHALMIC SUSPENSION

00002238873	AZOPT	NOV	$	3.4820

DORZOLAMIDE HCL

2 % (BASE) OPHTHALMIC SOLUTION

00002316307	**SANDOZ DORZOLAMIDE**	**SDZ**	$	**3.1622**
00002216205	TRUSOPT	PUR	$	4.2840
☒ 00002269090	TRUSOPT (PRESERVATIVE-FREE)	PUR	$	4.2900

METHAZOLAMIDE

50 MG ORAL TABLET

00002245882	METHAZOLAMIDE	AAP	$	0.5136

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.20 ANTIGLAUCOMA AGENTS (MIOTICS)

PILOCARPINE HCL

2 % OPHTHALMIC SOLUTION

00000000868	ISOPTO CARPINE	NOV	$	0.2720

4 % OPHTHALMIC SOLUTION

00000000884	ISOPTO CARPINE	NOV	$	0.3080

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.28 ANTIGLAUCOMA AGENTS (PROSTAGLANDIN ANALOGS)

BIMATOPROST

OPHTHALMIC SOLUTION

00002429063	**VISTITAN 0.03%**	**SDZ**	$	**9.1936**
00002324997	LUMIGAN RC 0.01%	ALL	$	11.8871

LATANOPROST

0.005 % OPHTHALMIC SOLUTION

00002296527	**APO-LATANOPROST**	**APX**	$	**3.6320**
00002254786	**CO LATANOPROST**	**APH**	$	**3.6320**
00002373041	**GD-LATANOPROST**	**GMD**	$	**3.6320**
00002426935	**MED-LATANOPROST**	**GMP**	$	**3.6320**
00002367335	**SANDOZ LATANOPROST**	**SDZ**	$	**3.6320**
00002231493	XALATAN	PFI	$	12.1528

TRAVOPROST

0.003 % OPHTHALMIC SOLUTION

00002457997	IZBA	NOV	$	3.9400

0.004 % OPHTHALMIC SOLUTION

00002415739	**APO-TRAVOPROST Z**	**APX**	$	**4.0264**
00002413167	**SANDOZ TRAVOPROST**	**SDZ**	$	**4.0264**
00002412063	**TEVA-TRAVOPROST Z**	**TEV**	$	**4.0264**
00002318008	TRAVATAN Z	NOV	$	11.6960

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:40.92 ANTIGLAUCOMA AGENTS
(MISCELLANEOUS ANTIGLAUCOMA AGENTS)

BRIMONIDINE TARTRATE/ TIMOLOL MALEATE

0.2 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002248347	COMBIGAN	ALL	$	4.4087

BRINZOLAMIDE/ BRIMONIDINE TARTRATE

1 % * 0.2 % OPHTHALMIC SUSPENSION

00002435411	SIMBRINZA	NOV	$	4.6810

BRINZOLAMIDE/ TIMOLOL MALEATE

1 % * 0.5 % (BASE) OPHTHALMIC SUSPENSION

00002331624	AZARGA	NOV	$	4.5440

DORZOLAMIDE HCL/ TIMOLOL MALEATE

2 % (BASE) * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002404389	**ACT DORZOTIMOLOL**	**APH**	$	**1.9887**
00002299615	**APO-DORZO-TIMOP**	**APX**	$	**1.9887**
00002437686	**MED-DORZOLAMIDE-TIMOLOL**	**GMP**	$	**1.9887**
00002443090	**MINT-DORZOLAMIDE/TIMOLOL**	**MPI**	$	**1.9887**
00002344351	**SANDOZ DORZOLAMIDE/ TIMOLOL**	**SDZ**	$	**1.9887**
☒ 00002258692	COSOPT PRESERVATIVE-FREE	PUR	$	2.6250
00002240113	COSOPT	PUR	$	6.4900

LATANOPROST/ TIMOLOL MALEATE

0.005 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002436256	**ACT LATANOPROST/TIMOLOL**	**APH**	$	**4.4268**
00002373068	**GD-LATANOPROST/TIMOLOL**	**GMD**	$	**4.4268**
00002394685	**SANDOZ LATANOPROST/TIMOLOL**	**SDZ**	$	**4.4268**
00002246619	XALACOM	PFI	$	13.7543

TRAVOPROST/ TIMOLOL MALEATE

0.004 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002415305	**APO-TRAVOPROST-TIMOP**	**APX**	$	**8.8425**
00002278251	DUOTRAV PQ	NOV	$	11.7900

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

AFLIBERCEPT

RESTRICTED BENEFIT

This Drug Product is a benefit to a member of an Alberta Government Sponsored Drug Plan when the Drug Product is prescribed by a registered prescriber and pursuant to the following criteria:

"For the treatment of neovascular (wet) age-related macular degeneration (AMD) if all of the following apply to the eye to be treated:

- The best corrected visual acuity (BCVA) is between 6/12 (20/40) and 6/96 (20/320); and
- There is active disease activity (choroidal neovascularization) and no permanent structural damage to the central fovea; and
- There is evidence of recent (< three (3) months) presumed disease progression (blood vessel growth, as indicated by fluoroscein angiography, optical coherence tomography (OCT) or recent visual acuity changes); and
- No concurrent verteporfin PDT treatment; and
- The injection will be administered by a qualified ophthalmologist with experience in intravitreal injections.

Treatment with anti-VEGF agents should be continued only in patients who maintain adequate response to therapy.

The anti-VEGF agent should be discontinued if any of the following occur:
- Reduction in BCVA in the treated eye to less than fifteen (15) letters (absolute) on two (2) consecutive visits in the treated eye, attributed to AMD in the absence of other pathology; or
- Reduction in BCVA of thirty (30) letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect or adverse event or both; or
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three (3) consecutive visits.

The interval between the doses should be no less than 1 month.

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent."

"For the treatment of diabetic macular edema (DME), in patients with severe visual impairment as defined by:

Best-Corrected Visual Acuity (using the Early Treatment Diabetic Retinopathy Study visual acuity test) of seventy-eight (78) to twenty-four (24) letters and a central retinal thickness greater than or equal to three hundred (300) micrometres meeting all of the following criteria:
- clinically significant diabetic macular edema for whom laser photocoagulation is also indicated, and
- a hemoglobin A1c of less than or equal to 12%.

Coverage will not be provided to patients who have failed to respond to a previous anti-VEGF agent."

"For the treatment of visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (BRVO).

Aflibercept is administered by intravitreal injection once every month. The interval between doses should not be shorter than one month. The treatment interval may be extended up to 3 months based on visual and anatomic outcomes. Prescribers are advised to periodically assess the need for continued therapy.

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

AFLIBERCEPT

Clinical trial experience of a monthly dosing regimen of 2 mg aflibercept beyond 6 months in the CRVO and BRVO indications is limited. The dosing regimen of once every 4 weeks changed, at 24 weeks, to a regimen that allowed for extension of the treatment based on visual and anatomic outcomes in the CRVO clinical trials and to once every 8 weeks in the BRVO clinical trial.

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent."

2 MG / VIAL INJECTION

00002415992	EYLEA	BAI	$ 1418.0000

APRACLONIDINE HCL

0.5 % OPHTHALMIC SOLUTION

00002076306	IOPIDINE	NOV	$ 4.9880

OCRIPLASMIN

0.5 MG / VIAL INJECTION

00002410818	JETREA	ONV	$ 4068.5000

RESTRICTED BENEFIT

For the treatment of symptomatic vitreomacular adhesion (VMA) if the following clinical criteria and conditions are met:

Clinical Criteria:
- Diagnosis of VMA should be confirmed through optical coherence tomography
- Patient does not have any of the following: large diameter macular holes (> 400 micrometre), high myopia (> 8 dioptre spherical correction or axial length > 28 millimetre), aphakia, history of retinal detachment, lens zonule instability, recent ocular surgery or intraocular injection (including laser therapy), proliferative diabetic retinopathy, ischemic retinopathies, retinal vein occlusions, exudative age-related macular degeneration, or vitreous hemorrhage.

Conditions:
- For coverage this drug must be prescribed by an ophthalmologist who is registered with Alberta Blue Cross as a Registered Prescriber. To register to become a Registered Prescriber please complete the Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs - Jetrea Form.
- Treatment with ocriplasmin should be limited to a single injection per eye (i.e., retreatments are not covered).

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

RANIBIZUMAB

This Drug Product is a benefit to a member of an Alberta Government Sponsored Drug Plan when the Drug Product is prescribed by a registered prescriber and pursuant to the following criteria:

"For the treatment of visual impairment due to macular edema secondary to retinal vein occlusion (RVO).

Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on ranibizumab treatment. Thereafter patients should be monitored monthly for visual acuity.

Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to macular edema secondary to RVO and continued until stable visual acuity is reached again for three consecutive monthly assessments."

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent.

"For the treatment of diabetic macular edema (DME), in patients with severe visual impairment as defined by:

Best-Corrected Visual Acuity (using the Early Treatment Diabetic Retinopathy Study visual acuity test) of seventy-eight (78) to twenty-four (24) letters and a central retinal thickness greater than or equal to three hundred (300) micrometres meeting all of the following criteria:
- clinically significant diabetic macular edema for whom laser photocoagulation is also indicated, and
- a hemoglobin A1c of less than or equal to 11%."

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent.

"For the treatment of neovascular (wet) age-related macular degeneration (AMD) in anti-vascular endothelial growth factor (anti-VEGF) treatment naive patients if all of the following apply to the eye to be treated:

- The best corrected visual acuity (BCVA) is between 6/12 (20/40) and 6/96 (20/320); and
- There is active disease activity (choroidal neovascularization) and no permanent structural damage to the central fovea; and
- There is evidence of recent (< three (3) months) presumed disease progression (blood vessel growth, as indicated by fluoroscein angiography, optical coherence tomography (OCT) or recent visual acuity changes); and
- No concurrent verteporfin PDT treatment; and
- The injection will be administered by a qualified ophthalmologist with experience in intravitreal injections.

Treatment with anti-VEGF agents should be continued only in patients who maintain adequate response to therapy.

The anti-VEGF agent should be discontinued if any of the following occur:
- Reduction in BCVA in the treated eye to less than fifteen (15) letters (absolute) on two (2) consecutive visits in the treated eye, attributed to AMD in the absence of other pathology; or
- Reduction in BCVA of thirty (30) letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect or adverse event or both; or
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three (3) consecutive visits."

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:92 MISCELLANEOUS EENT DRUGS

RANIBIZUMAB

The interval between the doses should be no less than 1 month.

Coverage will not be provided for patients who have failed to respond to a previous anti-VEGF agent.

2.3 MG / VIAL INJECTION

00002296810	LUCENTIS	NOV	$ 1575.0000

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

56:00

Gastrointestinal Drugs

56:00 GASTROINTESTINAL DRUGS

56:08 ANTIDIARRHEA AGENTS

DIPHENOXYLATE HCL/ ATROPINE SULFATE

2.5 MG * 0.025 MG ORAL TABLET

00000036323	LOMOTIL	PFI	$	0.5113

56:00 GASTROINTESTINAL DRUGS

56:14 CHOLELITHOLYTIC AGENTS

URSODIOL

250 MG ORAL TABLET

00002472392	**JAMP-URSODIOL**	**JPC**	$	**0.3818**
00002273497	**PMS-URSODIOL C**	**PMS**	$	**0.3818**
00002426900	**URSODIOL TABLETS USP**	**GLM**	$	**0.3818**
00002238984	URSO	AXC	$	1.5300

500 MG ORAL TABLET

00002472406	**JAMP-URSODIOL**	**JPC**	$	**0.7242**
00002273500	**PMS-URSODIOL C**	**PMS**	$	**0.7242**
00002426919	**URSODIOL TABLETS USP**	**GLM**	$	**0.7242**
00002245894	URSO DS	AXC	$	2.9019

56:00 GASTROINTESTINAL DRUGS

56:16 DIGESTANTS

LIPASE/ AMYLASE/ PROTEASE

10,440 UNIT * 56,400 UNIT * 57,100 UNIT ORAL TABLET

00002230019	VIOKACE	AXC	$	0.2586

20,880 UNIT * 113,400 UNIT * 112,500 UNIT ORAL TABLET

00002241933	VIOKACE	AXC	$	0.3967

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE

00000263818	COTAZYM	MFC	$	0.2025

4,000 UNIT * 12,000 UNIT * 12,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789445	PANCREASE MT 4	JAI	$	0.5953

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000502790	COTAZYM ECS 8	MFC	$	0.3655

10,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789437	PANCREASE MT 10	JAI	$	1.4881

10,000 UNIT * 33,200 UNIT * 37,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00002200104	CREON 10 MINIMICROSPHERES	BGP	$	0.2723

16,000 UNIT * 48,000 UNIT * 48,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789429	PANCREASE MT 16	JAI	$	2.3807

20,000 UNIT * 55,000 UNIT * 55,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000821373	COTAZYM ECS 20	MFC	$	0.9582

25,000 UNIT * 74,000 UNIT * 62,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00001985205	CREON 25 MINIMICROSPHERES	BGP	$	0.8507

56:00 GASTROINTESTINAL DRUGS

56:22.08 ANTIEMETICS (ANTIHISTAMINES)

DIMENHYDRINATE

10 MG / ML INJECTION				
00000392731	DIMENHYDRINATE I.V.	SDZ	$	0.9807
50 MG / ML INJECTION				
00000392537	DIMENHYDRINATE I.M.	SDZ	$	1.4490

PROCHLORPERAZINE

5 MG ORAL TABLET				
00000886440	PROCHLORAZINE	AAP	$	0.1769
10 MG ORAL TABLET				
00000886432	PROCHLORAZINE	AAP	$	0.2160
10 MG RECTAL SUPPOSITORY				
00000789720	SANDOZ PROCHLORPERAZINE	SDZ	$	1.8200

56:00 GASTROINTESTINAL DRUGS

56:22.20 ANTIEMETICS (5-HT3 RECEPTOR ANTAGONISTS)

GRANISETRON HCL

1 MG (BASE) ORAL TABLET				
00002308894	**APO-GRANISETRON**	**APX**	$	**9.0000**
00002452359	**NAT-GRANISETRON**	**NTP**	$	**9.0000**

ONDANSETRON

4 MG ORAL DISINTEGRATING TABLET/FILM				
00002389983	**ONDISSOLVE ODF**	**TAK**	$	**3.2720**
00002444674	**SANDOZ ONDANSETRON ODT**	**SDZ**	$	**3.2720**
00002239372	ZOFRAN ODT	NOV	$	14.0040
8 MG ORAL DISINTEGRATING TABLET/FILM				
00002389991	**ONDISSOLVE ODF**	**TAK**	$	**4.9930**
00002444682	**SANDOZ ONDANSETRON ODT**	**SDZ**	$	**4.9930**
00002239373	ZOFRAN ODT	NOV	$	21.3690

56:00 GASTROINTESTINAL DRUGS

56:22.20 ANTIEMETICS

(5-HT3 RECEPTOR ANTAGONISTS)

ONDANSETRON HCL DIHYDRATE

4 MG (BASE) ORAL TABLET				
00002288184	**APO-ONDANSETRON**	**APX**	$	**3.2720**
00002458810	**CCP-ONDANSETRON**	**CEL**	$	**3.2720**
00002296349	**CO ONDANSETRON**	**APH**	$	**3.2720**
00002313685	**JAMP-ONDANSETRON**	**JPC**	$	**3.2720**
00002371731	**MAR-ONDANSETRON**	**MAR**	$	**3.2720**
00002305259	**MINT-ONDANSETRON**	**MPI**	$	**3.2720**
00002297868	**MYLAN-ONDANSETRON**	**MYP**	$	**3.2720**
00002417839	**NAT-ONDANSETRON**	**NTP**	$	**3.2720**
00002421402	**ONDANSETRON**	**SNS**	$	**3.2720**
00002258188	**PMS-ONDANSETRON**	**PMS**	$	**3.2720**
00002274310	**SANDOZ ONDANSETRON**	**SDZ**	$	**3.2720**
00002376091	**SEPTA-ONDANSETRON**	**SEP**	$	**3.2720**
00002213567	ZOFRAN	NOV	$	14.5480
8 MG (BASE) ORAL TABLET				
00002288192	**APO-ONDANSETRON**	**APX**	$	**4.9930**
00002458802	**CCP-ONDANSETRON**	**CEL**	$	**4.9930**
00002296357	**CO ONDANSETRON**	**APH**	$	**4.9930**
00002313693	**JAMP-ONDANSETRON**	**JPC**	$	**4.9930**
00002371758	**MAR-ONDANSETRON**	**MAR**	$	**4.9930**
00002305267	**MINT-ONDANSETRON**	**MPI**	$	**4.9930**
00002297876	**MYLAN-ONDANSETRON**	**MYP**	$	**4.9930**
00002417847	**NAT-ONDANSETRON**	**NTP**	$	**4.9930**
00002421410	**ONDANSETRON**	**SNS**	$	**4.9930**
00002258196	**PMS-ONDANSETRON**	**PMS**	$	**4.9930**
00002274329	**SANDOZ ONDANSETRON**	**SDZ**	$	**4.9930**
00002376105	**SEPTA-ONDANSETRON**	**SEP**	$	**4.9930**
00002213575	ZOFRAN	NOV	$	22.2030
0.8 MG / ML (BASE) ORAL SOLUTION				
00002291967	ONDANSETRON	AAP	$	1.6641
00002229639	ZOFRAN	NOV	$	2.1872
2 MG / ML (BASE) INJECTION				
00002420414	**JAMP-ONDANSETRON (PRESERVATIVE FREE)**	**JPC**	$	**3.4552**
00002390019	**ONDANSETRON (PRESERVATIVE FREE)**	**MYP**	$	**3.4552**
00002279428	**ONDANSETRON (UNPRESERVED)**	**SDZ**	$	**3.4552**
00002464578	**ONDANSETRON INJECTION USP**	**STM**	$	**3.4552**
00002213745	ZOFRAN	NOV	$	10.7200
2 MG / ML (BASE) INJECTION				
00002420422	**JAMP-ONDANSETRON (WITH PRESERVATIVE)**	**JPC**	$	**3.4552**
00002279436	**ONDANSETRON (PRESERVED)**	**SDZ**	$	**3.4552**
00002390051	**ONDANSETRON (WITH PRESERVATIVE)**	**MYP**	$	**3.4552**
00002274418	**ONDANSETRON HYDROCHLORIDE DIHYDRATE (PRESERVED)**	**SDZ**	$	**3.4552**

56:00 GASTROINTESTINAL DRUGS

56:22.92 ANTIEMETICS
(MISCELLANEOUS ANTIEMETICS)

APREPITANT

RESTRICTED BENEFIT - This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates).

80 MG ORAL CAPSULE

00002298791	EMEND	MFC	$	33.0788

APREPITANT/ APREPITANT

RESTRICTED BENEFIT - This drug product must be prescribed by the Directors of Alberta Health Services - Cancer Care "Cancer Centres" (or their designates).

80 MG * 125 MG ORAL CAPSULE

00002298813	EMEND TRI-PACK	MFC	$	33.0788

DOXYLAMINE SUCCINATE/ PYRIDOXINE HCL

10 MG * 10 MG ORAL SUSTAINED-RELEASE TABLET

00002413248	**APO-DOXYLAMINE/B6**	**APX**	$	**0.6402**
00002406187	**PMS-DOXYLAMINE-PYRIDOXINE**	**PMS**	$	**0.6402**
00000609129	DICLECTIN	DUI	$	1.2803

NABILONE

0.5 MG ORAL CAPSULE

00002393581	ACT NABILONE	APH	$	0.8477
00002380900	PMS-NABILONE	PMS	$	0.8477
00002384884	TEVA-NABILONE	TEV	$	0.8477
00002256193	CESAMET	VCL	$	3.4605

1 MG ORAL CAPSULE

00002393603	ACT NABILONE	APH	$	1.6953
00002380919	PMS-NABILONE	PMS	$	1.6953
00002384892	TEVA-NABILONE	TEV	$	1.6953
00000548375	CESAMET	VCL	$	6.9208

56:00 GASTROINTESTINAL DRUGS

56:28.12 ANTIULCER AGENTS AND ACID SUPPRESSANTS
(HISTAMINE H2-ANTAGONISTS)

CIMETIDINE

200 MG ORAL TABLET

00000584215	CIMETIDINE	AAP	$	0.3284

300 MG ORAL TABLET

00000487872	CIMETIDINE	AAP	$	0.3423

FAMOTIDINE

20 MG ORAL TABLET

00002351102	**FAMOTIDINE**	**SNS**	$	**0.2657**
00002022133	**TEVA-FAMOTIDINE**	**TEV**	$	**0.2657**

40 MG ORAL TABLET

00002351110	**FAMOTIDINE**	**SNS**	$	**0.4833**
00002022141	**TEVA-FAMOTIDINE**	**TEV**	$	**0.4833**

NIZATIDINE

150 MG ORAL CAPSULE

00000778338	AXID	PPH	$	1.1759

56:00 GASTROINTESTINAL DRUGS

56:28.12 ANTIULCER AGENTS AND ACID SUPPRESSANTS (HISTAMINE H2-ANTAGONISTS)

RANITIDINE HCL

150 MG (BASE) ORAL TABLET				
00002248570	**ACT RANITIDINE**	**APH**	$	**0.1197**
00000733059	**APO-RANITIDINE**	**APX**	$	**0.1197**
00002463717	**JAMP-RANITIDINE**	**JPC**	$	**0.1197**
00002443708	**MAR-RANITIDINE**	**MAR**	$	**0.1197**
00002242453	**PMS-RANITIDINE**	**PMS**	$	**0.1197**
00002336480	**RAN-RANITIDINE**	**RAN**	$	**0.1197**
00002353016	**RANITIDINE**	**SNS**	$	**0.1197**
00002385953	**RANITIDINE**	**SIV**	$	**0.1197**
00002243229	**SANDOZ RANITIDINE**	**SDZ**	$	**0.1197**
300 MG (BASE) ORAL TABLET				
00002248571	**ACT RANITIDINE**	**APH**	$	**0.2253**
00000733067	**APO-RANITIDINE**	**APX**	$	**0.2253**
00002463725	**JAMP-RANITIDINE**	**JPC**	$	**0.2253**
00002443716	**MAR-RANITIDINE**	**MAR**	$	**0.2253**
00002242454	**PMS-RANITIDINE**	**PMS**	$	**0.2253**
00002336502	**RAN-RANITIDINE**	**RAN**	$	**0.2253**
00002353024	**RANITIDINE**	**SNS**	$	**0.2253**
00002385961	**RANITIDINE**	**SIV**	$	**0.2253**
00002243230	**SANDOZ RANITIDINE**	**SDZ**	$	**0.2253**
15 MG / ML (BASE) ORAL SOLUTION				
00002280833	APO-RANITIDINE	APX	$	0.1480
25 MG / ML (BASE) INJECTION				
00002256711	**RANITIDINE**	**SDZ**	$	**1.3975**
00002212366	ZANTAC	GSK	$	1.4210

56:00 GASTROINTESTINAL DRUGS

56:28.28 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROSTAGLANDINS)

MISOPROSTOL

100 MCG ORAL TABLET				
00002244022	MISOPROSTOL	AAP	$	0.2756
200 MCG ORAL TABLET				
00002244023	MISOPROSTOL	AAP	$	0.4589

56:00 GASTROINTESTINAL DRUGS

56:28.32 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTECTANTS)

SUCRALFATE

1 G ORAL TABLET				
00002045702	**TEVA-SUCRALFATE**	**TEV**	$	**0.1443**
00002100622	SULCRATE	AXC	$	0.6376
200 MG / ML ORAL SUSPENSION				
00002103567	SULCRATE SUSPENSION PLUS	AXC	$	0.1146

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

LANSOPRAZOLE

15 MG ORAL DELAYED-RELEASE CAPSULE

00002293811	APO-LANSOPRAZOLE	APX	***$ 0.0669***	$ 0.5000
00002357682	LANSOPRAZOLE	SNS	***$ 0.0669***	$ 0.5000
00002385767	LANSOPRAZOLE	SIV	***$ 0.0669***	$ 0.5000
00002433001	LANSOPRAZOLE	PMS	***$ 0.0669***	$ 0.5000
00002353830	MYLAN-LANSOPRAZOLE	MYP	***$ 0.0669***	$ 0.5000
00002402610	RAN-LANSOPRAZOLE	RAN	***$ 0.0669***	$ 0.5000
00002385643	SANDOZ LANSOPRAZOLE	SDZ	***$ 0.0669***	$ 0.5000
00002280515	TEVA-LANSOPRAZOLE	TEV	***$ 0.0669***	$ 0.5000
00002165503	PREVACID	BGP	***$ 0.0669***	$ 2.0840

MAC pricing will be applied based on the LCA Price for Rabeprazole Sodium 1 X 10 mg enteric-coated tablet.

30 MG ORAL DELAYED-RELEASE CAPSULE

00002293838	APO-LANSOPRAZOLE	APX	***$ 0.1875***	$ 0.5000
00002357690	LANSOPRAZOLE	SNS	***$ 0.1875***	$ 0.5000
00002410389	LANSOPRAZOLE	SIV	***$ 0.1875***	$ 0.5000
00002433028	LANSOPRAZOLE	PMS	***$ 0.1875***	$ 0.5000
00002353849	MYLAN-LANSOPRAZOLE	MYP	***$ 0.1875***	$ 0.5000
00002402629	RAN-LANSOPRAZOLE	RAN	***$ 0.1875***	$ 0.5000
00002385651	SANDOZ LANSOPRAZOLE	SDZ	***$ 0.1875***	$ 0.5000
00002280523	TEVA-LANSOPRAZOLE	TEV	***$ 0.1875***	$ 0.5000
00002165511	PREVACID	BGP	***$ 0.1875***	$ 2.0840

MAC pricing will be applied based on the LCA Price for Pantoprazole Magnesium 1 X 40 mg enteric-coated tablet.

LANSOPRAZOLE/ AMOXICILLIN TRIHYDRATE/ CLARITHROMYCIN

30 MG * 500 MG (BASE) * 500 MG ORAL TABLET/CAPSULE

00002470780	**APO-LANSOPRAZOLE-AMOXICILLIN-CLARITHROMYCIN**	**APX**	**$ 67.9125**
00002238525	HP-PAC (KIT)	BGP	$ 92.7117

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

OMEPRAZOLE

10 MG ORAL CAPSULE/SUSTAINED-RELEASE TABLET

00002296438	SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAPSULE)	SDZ	***$ 0.0669***	$	0.8166
00002295407	TEVA-OMEPRAZOLE (DELAYED-RELEASE TABLET)	TEV	***$ 0.0669***	$	0.8166
00002230737	LOSEC (SUSTAINED-RELEASE TABLET)	AZC	***$ 0.0669***	$	1.8940

MAC pricing will be applied based on the LCA Price for Rabeprazole Sodium 1 X 10 mg enteric-coated tablet.

20 MG ORAL CAPSULE/SUSTAINED-RELEASE TABLET

00002245058	APO-OMEPRAZOLE (DELAYED-RELEASE CAPSULE)	APX	***$ 0.1875***	$	0.2287
00002420198	JAMP-OMEPRAZOLE DR (DELAYED-RELEASE TABLET)	JPC	***$ 0.1875***	$	0.2287
00002439549	NAT-OMEPRAZOLE DR (DELAYED-RELEASE TABLET)	NTP	***$ 0.1875***	$	0.2287
00002348691	OMEPRAZOLE (DELAYED-RELEASE CAPSULE)	SNS	***$ 0.1875***	$	0.2287
00002416549	OMEPRAZOLE (DELAYED-RELEASE TABLET)	AHI	***$ 0.1875***	$	0.2287
00002411857	OMEPRAZOLE-20 (DELAYED-RELEASE CAPSULE)	SIV	***$ 0.1875***	$	0.2287
00002320851	PMS-OMEPRAZOLE (SUSTAINED-RELEASE CAP)	PMS	***$ 0.1875***	$	0.2287
00002310260	PMS-OMEPRAZOLE DR (DELAYED-RELEASE TAB)	PMS	***$ 0.1875***	$	0.2287
00002296446	SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAP)	SDZ	***$ 0.1875***	$	0.2287
00002295415	TEVA-OMEPRAZOLE (DELAYED-RELEASE TABLET)	TEV	***$ 0.1875***	$	0.2287
00000846503	LOSEC (SUSTAINED-RELEASE CAPSULE)	AZC	***$ 0.1875***	$	1.1320
00002190915	LOSEC (SUSTAINED-RELEASE TABLET)	AZC	***$ 0.1875***	$	2.3820

MAC pricing will be applied based on the LCA Price for Pantoprazole Magnesium 1 X 40 mg enteric-coated tablet.

PANTOPRAZOLE MAGNESIUM

40 MG ORAL ENTERIC-COATED TABLET

00002408570	**MYLAN-PANTOPRAZOLE T**	**MYP**	$	**0.1875**
00002441853	**PANTOPRAZOLE MAGNESIUM**	**ALH**	$	**0.1875**
00002466147	**PANTOPRAZOLE T**	**SNS**	$	**0.1875**
00002440628	**TEVA-PANTOPRAZOLE MAGNESIUM**	**TEV**	$	**0.1875**
00002267233	TECTA	TAK	$	0.7500

56:00 GASTROINTESTINAL DRUGS

56:28.36 ANTIULCER AGENTS AND ACID SUPPRESSANTS (PROTON-PUMP INHIBITORS)

PANTOPRAZOLE SODIUM

40 MG ORAL ENTERIC-COATED TABLET

00002292920	APO-PANTOPRAZOLE	APX	***$ 0.1875***	$ 0.2016
00002415208	AURO-PANTOPRAZOLE	AUR	***$ 0.1875***	$ 0.2016
00002357054	JAMP-PANTOPRAZOLE	JPC	***$ 0.1875***	$ 0.2016
00002416565	MAR-PANTOPRAZOLE	MAR	***$ 0.1875***	$ 0.2016
00002417448	MINT-PANTOPRAZOLE	MPI	***$ 0.1875***	$ 0.2016
00002370808	PANTOPRAZOLE	SNS	***$ 0.1875***	$ 0.2016
00002437945	PANTOPRAZOLE	PMS	***$ 0.1875***	$ 0.2016
00002428180	PANTOPRAZOLE-40	SIV	***$ 0.1875***	$ 0.2016
00002307871	PMS-PANTOPRAZOLE	PMS	***$ 0.1875***	$ 0.2016
00002305046	RAN-PANTOPRAZOLE	RAN	***$ 0.1875***	$ 0.2016
00002301083	SANDOZ PANTOPRAZOLE	SDZ	***$ 0.1875***	$ 0.2016
00002285487	TEVA-PANTOPRAZOLE	TEV	***$ 0.1875***	$ 0.2016
00002229453	PANTOLOC	TAK	***$ 0.1875***	$ 2.0803

MAC pricing will be applied based on the LCA Price for Pantoprazole Magnesium 1 X 40 mg enteric-coated tablet.

RABEPRAZOLE SODIUM

10 MG ORAL ENTERIC-COATED TABLET

00002345579	**APO-RABEPRAZOLE**	**APX**	$	**0.0669**
00002310805	**PMS-RABEPRAZOLE EC**	**PMS**	$	**0.0669**
00002385449	**RABEPRAZOLE**	**SIV**	$	**0.0669**
00002356511	**RABEPRAZOLE EC**	**SNS**	$	**0.0669**
00002298074	**RAN-RABEPRAZOLE**	**RAN**	$	**0.0669**
00002314177	**SANDOZ RABEPRAZOLE**	**SDZ**	$	**0.0669**
00002296632	**TEVA-RABEPRAZOLE**	**TEV**	$	**0.0669**
00002243796	PARIET	JAI	$	0.8535

20 MG ORAL ENTERIC-COATED TABLET

00002310813	**PMS-RABEPRAZOLE EC**	**PMS**	$	**0.1338**
00002385457	**RABEPRAZOLE**	**SIV**	$	**0.1338**
00002356538	**RABEPRAZOLE EC**	**SNS**	$	**0.1338**
00002298082	**RAN-RABEPRAZOLE**	**RAN**	$	**0.1338**
00002314185	**SANDOZ RABEPRAZOLE**	**SDZ**	$	**0.1338**
00002296640	**TEVA-RABEPRAZOLE**	**TEV**	$	**0.1338**
00002243797	PARIET	JAI	$	1.7072

56:00 GASTROINTESTINAL DRUGS

56:32 PROKINETIC AGENTS

DOMPERIDONE MALEATE

10 MG (BASE) ORAL TABLET

00002103613	**APO-DOMPERIDONE**	**APX**	$	**0.0428**
00002238341	**DOMPERIDONE**	**SIV**	$	**0.0428**
00002350440	**DOMPERIDONE**	**SNS**	$	**0.0428**
00002369206	**JAMP-DOMPERIDONE**	**JPC**	$	**0.0428**
00002403870	**MAR-DOMPERIDONE**	**MAR**	$	**0.0428**
00002236466	**PMS-DOMPERIDONE**	**PMS**	$	**0.0428**
00002268078	**RAN-DOMPERIDONE**	**RAN**	$	**0.0428**
00001912070	**TEVA-DOMPERIDONE**	**TEV**	$	**0.0428**

56:00 GASTROINTESTINAL DRUGS

56:32 PROKINETIC AGENTS

METOCLOPRAMIDE HCL

5 MG ORAL TABLET				
00002230431	METONIA	PPH	$	0.0676
1 MG / ML ORAL LIQUID				
00002230433	METONIA	PPH	$	0.0578
5 MG / ML INJECTION				
00002185431	METOCLOPRAMIDE HYDROCHLORIDE	SDZ	$	3.3925

56:00 GASTROINTESTINAL DRUGS

56:36 ANTI-INFLAMMATORY AGENTS

MESALAZINE

1.2 G ORAL DELAYED AND EXTENDED-RELEASE TABLET				
00002297558	MEZAVANT	SHB	$	1.6910
500 MG ORAL EXTENDED-RELEASE TABLET				
00002099683	PENTASA	FEI	$	0.5939
1 G ORAL EXTENDED-RELEASE TABLET				
00002399466	PENTASA	FEI	$	1.1860
400 MG ORAL ENTERIC-COATED TABLET				
☒ 00002171929	NOVO-5 ASA	TEV	$	0.4996
☒ 00001997580	ASACOL	ASC	$	0.5648
500 MG ORAL ENTERIC-COATED TABLET				
00002112787	SALOFALK	AXC	$	0.5937
800 MG ORAL ENTERIC-COATED TABLET				
00002267217	ASACOL 800	ASC	$	1.1400
500 MG RECTAL SUPPOSITORY				
00002112760	SALOFALK	AXC	$	1.3612
1 G RECTAL SUPPOSITORY				
00002153564	PENTASA	FEI	$	1.7325
00002474018	MEZERA	AVP	$	1.8000
1,000 MG RECTAL SUPPOSITORY				
00002242146	SALOFALK	AXC	$	1.9926
1 G / ENM RECTAL ENEMA				
00002153521	PENTASA (1G/100ML)	FEI	$	4.0072
2 G / ENM RECTAL ENEMA				
00002112795	SALOFALK (2G/60G)	AXC	$	4.3571
4 G / ENM RECTAL ENEMA				
☒ 00002153556	PENTASA (4G/100 ML)	FEI	$	4.8303
☒ 00002112809	SALOFALK (4G/60G)	AXC	$	7.3998

OLSALAZINE SODIUM

250 MG ORAL CAPSULE				
00002063808	DIPENTUM	ATH	$	0.5850

56:00 GASTROINTESTINAL DRUGS

56:92 MISCELLANEOUS GI DRUGS

PINAVERIUM BROMIDE

50 MG ORAL TABLET				
00002469677	**APO-PINAVERIUM**	**APX**	$	**0.3066**
00001950592	DICETEL	BGP	$	0.3681
100 MG ORAL TABLET				
00002469685	**APO-PINAVERIUM**	**APX**	$	**0.5346**
00002230684	DICETEL	BGP	$	0.6419

TRIMEBUTINE MALEATE

100 MG ORAL TABLET				
00002245663	TRIMEBUTINE	AAP	$	0.2869
200 MG ORAL TABLET				
00002245664	TRIMEBUTINE	AAP	$	0.6275

60:00

Gold Compounds

60:00 GOLD COMPOUNDS

60:00

AURANOFIN

3 MG ORAL CAPSULE

00001916823	RIDAURA	XPI	$	6.2138

GOLD SODIUM THIOMALATE

10 MG / ML INJECTION

00001927620	MYOCHRYSINE	SAV	$	13.1000

50 MG / ML INJECTION

00001927604	MYOCHRYSINE	SAV	$	24.7800

64:00

Heavy Metal Antagonists

64:00 HEAVY METAL ANTAGONISTS

64:00

DEFEROXAMINE MESYLATE

500 MG / VIAL INJECTION

00002241600	**DEFEROXAMINE MESYLATE**	**PFI**	$	**5.1980**
00001981242	DESFERAL	NOV	$	15.4390

2 G / VIAL INJECTION

00002247022	DEFEROXAMINE MESYLATE	PFI	$	20.8896

PENICILLAMINE

250 MG ORAL CAPSULE

00000016055	CUPRIMINE	VCL	$	3.7502

68:00

Hormones and Synthetic Substitutes

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:00

COMPOUND PRESCRIPTION

00000999111	COMPOUND HORMONES (ESTROGEN PROGEST TESTOSTERONE)	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999212	COMPOUND HORMONES (ESTROGEN PROGEST TESTOSTERONE)	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

BECLOMETHASONE DIPROPIONATE

50 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002242029	QVAR CFC-FREE	VCL	$	0.1646
100 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002242030	QVAR CFC-FREE	VCL	$	0.3158

BETAMETHASONE SODIUM PHOSPHATE/ BETAMETHASONE ACETATE

3 MG / ML (BASE) * 3 MG / ML INJECTION				
00000028096	CELESTONE SOLUSPAN	MFC	$	13.5700

BUDESONIDE

100 MCG / DOSE INHALATION METERED INHALATION POWDER				
00000852074	PULMICORT TURBUHALER	AZC	$	0.1623
200 MCG / DOSE INHALATION METERED INHALATION POWDER				
00000851752	PULMICORT TURBUHALER	AZC	$	0.3319
400 MCG / DOSE INHALATION METERED INHALATION POWDER				
00000851760	PULMICORT TURBUHALER	AZC	$	0.4845
0.125 MG / ML INHALATION SUSPENSION				
00002465949	**TEVA-BUDESONIDE**	**TEV**	$	**0.1714**
00002229099	PULMICORT NEBUAMP	AZC	$	0.2310
0.25 MG / ML INHALATION SUSPENSION				
00001978918	PULMICORT NEBUAMP	AZC	$	0.4630
0.5 MG / ML INHALATION SUSPENSION				
00002465957	**TEVA-BUDESONIDE**	**TEV**	$	**0.6839**
00001978926	PULMICORT NEBUAMP	AZC	$	0.9235

CICLESONIDE

100 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002285606	ALVESCO	AZC	$	0.3885
200 MCG / DOSE INHALATION METERED DOSE AEROSOL				
00002285614	ALVESCO	AZC	$	0.6425

CORTISONE ACETATE

25 MG ORAL TABLET				
00000280437	CORTISONE ACETATE	VCL	$	0.3545

DEXAMETHASONE

0.5 MG ORAL TABLET				
00002261081	**APO-DEXAMETHASONE**	**APX**	$	**0.1564**
00001964976	**PMS-DEXAMETHASONE**	**PMS**	$	**0.1564**
0.75 MG ORAL TABLET				
00001964968	PMS-DEXAMETHASONE	PMS	$	0.6783
2 MG ORAL TABLET				
00002279363	PMS-DEXAMETHASONE	PMS	$	0.5267
4 MG ORAL TABLET				
00002250055	**APO-DEXAMETHASONE**	**APX**	$	**0.3046**
00001964070	**PMS-DEXAMETHASONE**	**PMS**	$	**0.3046**

DEXAMETHASONE SODIUM PHOSPHATE

4 MG / ML (BASE) INJECTION				
00000664227	**DEXAMETHASONE SODIUM PHOSPHATE**	**SDZ**	$	**1.6900**
00001977547	**DEXAMETHASONE SODIUM PHOSPHATE**	**STM**	$	**1.6900**
10 MG / ML (BASE) INJECTION				
00000783900	PMS-DEXAMETHASONE SODIUM PHOSP	PMS	$	1.2830
00000874582	DEXAMETHASONE SODIUM PHOSPHATE	SDZ	$	4.5600

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

FLUDROCORTISONE ACETATE

0.1 MG ORAL TABLET

00002086026	FLORINEF	PAL	$	0.2725

FLUTICASONE PROPIONATE

50 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002244291	FLOVENT HFA	GSK	$	0.2078

125 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002244292	FLOVENT HFA	GSK	$	0.3583

250 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002244293	FLOVENT HFA	GSK	$	0.7167

250 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237246	FLOVENT DISKUS	GSK	$	0.7167

500 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237247	FLOVENT DISKUS	GSK	$	1.1148

HYDROCORTISONE

10 MG ORAL TABLET

00000030910	CORTEF	PFI	$	0.2077

20 MG ORAL TABLET

00000030929	CORTEF	PFI	$	0.3747

HYDROCORTISONE SODIUM SUCCINATE

100 MG / VIAL (BASE) INJECTION

00000030600	SOLU-CORTEF	PFI	$	4.1472

250 MG / VIAL (BASE) INJECTION

00000030619	SOLU-CORTEF	PFI	$	7.1975

500 MG / VIAL (BASE) INJECTION

00000030627	SOLU-CORTEF	PFI	$	10.8794

1 G / VIAL (BASE) INJECTION

00000030635	SOLU-CORTEF	PFI	$	18.2312

METHYLPREDNISOLONE

4 MG ORAL TABLET

00000030988	MEDROL	PFI	$	0.4725

16 MG ORAL TABLET

00000036129	MEDROL	PFI	$	1.3615

METHYLPREDNISOLONE ACETATE

20 MG / ML INJECTION

00001934325	DEPO-MEDROL	PFI	$	2.7597

40 MG / ML INJECTION

00000030759	DEPO-MEDROL	PFI	$	6.1911

80 MG / ML INJECTION

00000030767	DEPO-MEDROL	PFI	$	11.9659

40 MG / ML INJECTION

00001934333	DEPO-MEDROL (PRESERVED)	PFI	$	5.9361

80 MG / ML INJECTION

00001934341	DEPO-MEDROL (PRESERVED)	PFI	$	9.1546

METHYLPREDNISOLONE ACETATE/ LIDOCAINE HCL

40 MG / ML * 10 MG / ML INJECTION

00000260428	DEPO-MEDROL WITH LIDOCAINE	PFI	$	6.8505

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

METHYLPREDNISOLONE SODIUM SUCCINATE

40 MG / VIAL (BASE) INJECTION				
00002231893	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**4.7801**
00002367947	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	7.0167
125 MG / VIAL (BASE) INJECTION				
00002231894	**METHYLPREDNISOLONE SOD SUCCINATE**	**TEV**	$	**10.4010**
00002367955	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	16.6594
500 MG / VIAL (BASE) INJECTION				
00002231895	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**24.6960**
00000030678	SOLU-MEDROL	PFI	$	40.9317
00002367963	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	41.7511
1 G / VIAL (BASE) INJECTION				
00002241229	**METHYLPREDNISOLONE SOD SUCCIN.**	**TEV**	$	**37.9336**
00000036137	SOLU-MEDROL	PFI	$	62.7302
00002367971	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	PFI	$	63.9987

MOMETASONE FUROATE

100 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002438690	ASMANEX TWISTHALER	MFC	$	1.2323

RESTRICTED BENEFIT - This Drug Product is a benefit for patients up to 11 years of age inclusive.

200 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002243595	ASMANEX TWISTHALER	MFC	$	0.6284
400 MCG / DOSE INHALATION METERED INHALATION POWDER				
00002243596	ASMANEX TWISTHALER	MFC	$	1.2567

PREDNISOLONE SODIUM PHOSPHATE

1 MG / ML (BASE) ORAL LIQUID				
00002245532	**PMS-PREDNISOLONE**	**PMS**	$	**0.1189**
00002230619	PEDIAPRED	SAV	$	0.1399

PREDNISONE

1 MG ORAL TABLET				
00000271373	WINPRED	AAP	$	0.1121
5 MG ORAL TABLET				
00000312770	APO-PREDNISONE	APX	$	0.0401
50 MG ORAL TABLET				
00000550957	APO-PREDNISONE	APX	$	0.1735

TRIAMCINOLONE ACETONIDE

10 MG / ML INJECTION				
00001999761	KENALOG-10	WSD	$	3.5800
40 MG / ML INJECTION				
00001977563	**TRIAMCINOLONE ACETONIDE USP**	**STM**	$	**5.7750**
00001999869	KENALOG-40	WSD	$	8.3166

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:08 ANDROGENS

DANAZOL

50 MG ORAL CAPSULE				
00002018144	CYCLOMEN	SAV	$	0.9983
100 MG ORAL CAPSULE				
00002018152	CYCLOMEN	SAV	$	1.4816
200 MG ORAL CAPSULE				
00002018160	CYCLOMEN	SAV	$	2.3676

TESTOSTERONE CYPIONATE

100 MG / ML INJECTION				
00000030783	DEPO-TESTOSTERONE CYPIONATE	PFI	$	4.4681

TESTOSTERONE ENANTHATE

200 MG / ML INJECTION				
00000029246	DELATESTRYL	VCL	$	10.3825

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

DESOGESTREL/ ETHINYL ESTRADIOL

0.15 MG * 0.03 MG ORAL TABLET				
00002317192	**APRI 21**	**TEV**	$	**0.3700**
00002396491	**FREYA 21**	**MYP**	$	**0.3700**
00002410249	**MIRVALA 21**	**APX**	$	**0.3700**
00002042487	MARVELON (21 DAY)	MFC	$	0.6942
0.15 MG * 0.03 MG ORAL TABLET				
00002317206	**APRI 28**	**TEV**	$	**0.2775**
00002396610	**FREYA 28**	**MYP**	$	**0.2775**
00002410257	**MIRVALA 28**	**APX**	$	**0.2775**
00002042479	MARVELON (28 DAY)	MFC	$	0.5207

DESOGESTREL/ ETHINYL ESTRADIOL/ DESOGESTREL/ ETHINYL ESTRADIOL/ DESOGESTREL/ ETHINYL ESTRADIOL

0.1 MG * 0.025 MG * 0.125 MG * 0.025 MG * 0.15 MG * 0.025 MG ORAL TABLET				
00002272903	LINESSA 21	APC	$	0.6762
0.1 MG * 0.025 MG * 0.125 MG * 0.025 MG * 0.15 MG * 0.025 MG ORAL TABLET				
00002257238	LINESSA 28	APC	$	0.5072

DROSPIRENONE/ ETHINYL ESTRADIOL

3 MG * 0.03 MG ORAL TABLET				
00002261723	YASMIN 21	BAI	$	0.5924
3 MG * 0.03 MG ORAL TABLET				
00002261731	YASMIN 28	BAI	$	0.4443

ETHYNODIOL DIACETATE/ ETHINYL ESTRADIOL

2 MG * 30 MCG ORAL TABLET				
00000469327	DEMULEN 30 (21 DAY)	PFI	$	0.7136
2 MG * 30 MCG ORAL TABLET				
00000471526	DEMULEN 30 (28 DAY)	PFI	$	0.5725

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

LEVONORGESTREL

1.5 MG ORAL TABLET				
00002433532	**BACKUP PLAN ONESTEP**	**APX**	$	**8.6000**
00002293854	PLAN B	TEP	$	17.2000
19.5 MG INTRAUTERINE INSERT				
00002459523	KYLEENA	BAI	$	326.0600
52 MG INTRAUTERINE INSERT				
00002243005	MIRENA SYSTEM	BAI	$	348.4500

LEVONORGESTREL/ ETHINYL ESTRADIOL

100 MCG * 20 MCG ORAL TABLET				
00002387875	**ALYSENA 21**	**APX**	$	**0.3629**
00002298538	**AVIANE 21**	**TEV**	$	**0.3629**
00002236974	ALESSE (21 DAY)	PFI	$	0.7470
150 MCG * 30 MCG ORAL TABLET				
00002387085	**OVIMA 21**	**APX**	$	**0.3467**
00002295946	**PORTIA 21**	**TEV**	$	**0.3467**
100 MCG * 20 MCG ORAL TABLET				
00002387883	**ALYSENA 28**	**APX**	$	**0.2721**
00002298546	**AVIANE 28**	**TEV**	$	**0.2721**
00002236975	ALESSE (28 DAY)	PFI	$	0.5604
150 MCG * 30 MCG ORAL TABLET				
00002387093	**OVIMA 28**	**APX**	$	**0.2600**
00002295954	**PORTIA 28**	**TEV**	$	**0.2600**

LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL

50 MCG * 30 MCG * 75 MCG * 40 MCG * 125 MCG * 30 MCG ORAL TABLET				
00000707600	TRIQUILAR (21 DAY)	BAI	$	0.7500
50 MCG * 30 MCG * 75 MCG * 40 MCG * 125 MCG * 30 MCG ORAL TABLET				
00000707503	TRIQUILAR (28 DAY)	BAI	$	0.5625

NORETHINDRONE

0.35 MG ORAL TABLET				
00002441306	**JENCYCLA (28 DAY)**	**LPC**	$	**0.3925**
00002410303	**MOVISSE (28 DAY)**	**MYP**	$	**0.3925**
00000037605	MICRONOR (28 DAY)	JAI	$	0.9536

NORETHINDRONE ACETATE/ ETHINYL ESTRADIOL

1 MG * 20 MCG ORAL TABLET				
00000315966	MINESTRIN 1/20 (21 DAY)	ASC	$	0.6460
1.5 MG * 0.03 MG ORAL TABLET				
00000297143	LOESTRIN 1.5/30 (21 DAY)	ASC	$	0.6460
1 MG * 20 MCG ORAL TABLET				
00000343838	MINESTRIN 1/20 (28 DAY)	ASC	$	0.4845
1.5 MG * 0.03 MG ORAL TABLET				
00000353027	LOESTRIN 1.5/30 (28 DAY)	ASC	$	0.4845

NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET				
00002187108	SYNPHASIC (21 DAY)	PFI	$	0.5946
0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET				
00002187116	SYNPHASIC (28 DAY)	PFI	$	0.4460

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

NORGESTIMATE/ ETHINYL ESTRADIOL

0.25 MG * 0.035 MG ORAL TABLET				
00001968440	CYCLEN (21 DAY)	JAI	$	1.2715
0.25 MG * 0.035 MG ORAL TABLET				
00001992872	CYCLEN (28 DAY)	JAI	$	0.9536

NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL

0.18 MG * 0.025 MG * 0.215 MG * 0.025 MG * 0.25 MG * 0.025 MG ORAL TABLET				
00002258587	TRI-CYCLEN LO 28	JAI	$	0.5518
0.18 MG * 0.035 MG * 0.215 MG * 0.035 MG * 0.25 MG * 0.035 MG ORAL TABLET				
00002028700	TRI-CYCLEN (21 DAY)	JAI	$	1.2715
0.18 MG * 0.025 MG * 0.215 MG * 0.025 MG * 0.25 MG * 0.025 MG ORAL TABLET				
00002258560	TRI-CYCLEN LO 21	JAI	$	0.7358
0.18 MG * 0.035 MG * 0.215 MG * 0.035 MG * 0.25 MG * 0.035 MG ORAL TABLET				
00002029421	TRI-CYCLEN (28 DAY)	JAI	$	0.9536

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.04 ESTROGENS AND ANTIESTROGENS (ESTROGENS)

CONJUGATED ESTROGENS

0.3 MG ORAL SUSTAINED-RELEASE TABLET				
00002414678	PREMARIN	PFI	$	0.3382
0.625 MG ORAL SUSTAINED-RELEASE TABLET				
00002414686	PREMARIN	PFI	$	0.3382
1.25 MG ORAL SUSTAINED-RELEASE TABLET				
00002414694	PREMARIN	PFI	$	0.3382
0.625 MG / G VAGINAL CREAM				
00002043440	PREMARIN	PFI	$	0.7154

ESTRADIOL-17B

0.5 MG ORAL TABLET				
00002449048	**LUPIN-ESTRADIOL**	**LPC**	$	**0.1199**
00002225190	ESTRACE	ACE	$	0.1401
1 MG ORAL TABLET				
00002449056	**LUPIN-ESTRADIOL**	**LPC**	$	**0.2313**
00002148587	ESTRACE	ACE	$	0.2709
2 MG ORAL TABLET				
00002449064	**LUPIN-ESTRADIOL**	**LPC**	$	**0.4083**
00002148595	ESTRACE	ACE	$	0.4782
0.06 % TRANSDERMAL GEL				
00002238704	ESTROGEL	MFC	$	0.3401
0.1 % TRANSDERMAL GEL				
☒ 00002424924	DIVIGEL (0.25 MG PACK)	SLP	$	0.7971
☒ 00002424835	DIVIGEL (0.5 MG PACK)	SLP	$	0.7971
☒ 00002424843	DIVIGEL (1 MG PACK)	SLP	$	0.7971
25 MCG/DAY TRANSDERMAL PATCH				
☒ 00002245676	ESTRADOT 25 (0.39 MG/PTH)	NOV	$	2.8562
☒ 00002243722	OESCLIM 25 (5 MG/PTH)	SLP	$	2.9053
☒ 00002247499	CLIMARA 25 (2 MG/PTH)	BAI	$	5.1600
37.5 MCG/DAY TRANSDERMAL PATCH				
00002243999	ESTRADOT 37.5 (0.585 MG/PTH)	NOV	$	2.8750

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16.04 ESTROGENS AND ANTIESTROGENS (ESTROGENS)

ESTRADIOL-17B

50 MCG/DAY TRANSDERMAL PATCH				
00002246967	**SANDOZ ESTRADIOL DERM 50 (4 MG/PTH)**	**SDZ**	$	**2.5331**
☒ 00002243724	OESCLIM 50 (10 MG/PTH)	SLP	$	2.9145
00002244000	ESTRADOT 50 (0.78 MG/PTH)	NOV	$	3.0662
☒ 00002231509	CLIMARA 50 (3.9 MG/PTH)	BAI	$	5.5118
75 MCG/DAY TRANSDERMAL PATCH				
00002246968	**SANDOZ ESTRADIOL DERM 75 (6 MG/PTH)**	**SDZ**	$	**2.7169**
00002244001	ESTRADOT 75 (1.17 MG/PTH)	NOV	$	3.2875
☒ 00002247500	CLIMARA 75 (5.7 MG/PTH)	BAI	$	5.8764
100 MCG/DAY TRANSDERMAL PATCH				
00002246969	**SANDOZ ESTRADIOL DERM 100 (8 MG/PTH)**	**SDZ**	$	**2.8744**
00002244002	ESTRADOT 100 (1.56 MG/PTH)	NOV	$	3.4737
10 MCG VAGINAL TABLET				
00002325462	VAGIFEM	NNA	$	4.1505
2 MG VAGINAL SLOW-RELEASE RING				
00002168898	ESTRING	PAL	$	72.2002

NORETHINDRONE ACETATE/ ESTRADIOL-17B

140 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH				
00002241835	ESTALIS (2.7*.62 MG/PTH)	NOV	$	3.4012
250 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH				
00002241837	ESTALIS (4.8*.51 MG/PTH)	NOV	$	3.4012

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.02 ANTIDIABETIC AGENTS (ALPHA-GLUCOSIDASE INHIBITORS)

ACARBOSE

50 MG ORAL TABLET				
00002190885	GLUCOBAY	BAI	$	0.2695
100 MG ORAL TABLET				
00002190893	GLUCOBAY	BAI	$	0.3733

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.04 ANTIDIABETIC AGENTS (BIGUANIDES)

METFORMIN HCL

500 MG ORAL TABLET

00002257726	**ACT METFORMIN**	**APH**	$	**0.0247**
00002167786	**APO-METFORMIN**	**APX**	$	**0.0247**
00002438275	**AURO-METFORMIN**	**AUR**	$	**0.0247**
00002380196	**JAMP-METFORMIN**	**JPC**	$	**0.0247**
00002353377	**METFORMIN**	**SNS**	$	**0.0247**
00002385341	**METFORMIN FC**	**SIV**	$	**0.0247**
00002388766	**MINT-METFORMIN**	**MPI**	$	**0.0247**
00002223562	**PMS-METFORMIN**	**PMS**	$	**0.0247**
00002269031	**RAN-METFORMIN**	**RAN**	$	**0.0247**
00002242974	**RATIO-METFORMIN HYDROCHLORIDE**	**TEV**	$	**0.0247**
00002246820	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.0247**
00002379767	**SEPTA-METFORMIN**	**SEP**	$	**0.0247**
00002099233	GLUCOPHAGE	SAV	$	0.2716

850 MG ORAL TABLET

00002257734	**ACT METFORMIN**	**APH**	$	**0.0339**
00002229785	**APO-METFORMIN**	**APX**	$	**0.0339**
00002438283	**AURO-METFORMIN**	**AUR**	$	**0.0339**
00002380218	**JAMP-METFORMIN**	**JPC**	$	**0.0339**
00002353385	**METFORMIN**	**SNS**	$	**0.0339**
00002385368	**METFORMIN FC**	**SIV**	$	**0.0339**
00002388774	**MINT-METFORMIN**	**MPI**	$	**0.0339**
00002242589	**PMS-METFORMIN**	**PMS**	$	**0.0339**
00002269058	**RAN-METFORMIN**	**RAN**	$	**0.0339**
00002242931	**RATIO-METFORMIN HYDROCHLORIDE**	**TEV**	$	**0.0339**
00002246821	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.0339**
00002379775	**SEPTA-METFORMIN**	**SEP**	$	**0.0339**
00002162849	GLUCOPHAGE	SAV	$	0.3673

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN ASPART

100 UNIT / ML INJECTION

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

INSULIN DEGLUDEC

100 UNIT / ML INJECTION

00002467879	TRESIBA FLEXTOUCH PEN	NNA	$	7.4333

200 UNIT / ML INJECTION

00002467887	TRESIBA FLEXTOUCH PEN	NNA	$	14.8666

INSULIN DETEMIR

100 UNIT / ML INJECTION

☒ 00002271842	LEVEMIR CARTRIDGE	NNA	$	7.2006
☒ 00002412829	LEVEMIR FLEXTOUCH	NNA	$	7.4333

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN GLARGINE

100 UNIT / ML INJECTION

☒ 00002444844	BASAGLAR CARTRIDGE	LIL	$	4.6425
☒ 00002444852	BASAGLAR KWIKPEN	LIL	$	4.6425
☒ 00002461528	BASAGLAR KWIKPEN (80 UNIT)	LIL	$	4.6425
☒ 00002245689	LANTUS	SAV	$	6.1690
☒ 00002251930	LANTUS CARTRIDGE	SAV	$	6.1900
☒ 00002294338	LANTUS PEN	SAV	$	6.1900

INSULIN GLULISINE (RDNA ORIGIN)

100 UNIT / ML INJECTION

☒ 00002279460	APIDRA	SAV	$	2.6580
☒ 00002279479	APIDRA CARTRIDGE	SAV	$	3.5100
☒ 00002294346	APIDRA PEN	SAV	$	3.5433

INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

100 UNIT / ML INJECTION

☒ 00000587737	HUMULIN N	LIL	$	2.3800
☒ 00002024225	NOVOLIN GE NPH	NNA	$	2.4360
☒ 00001959239	HUMULIN N CARTRIDGE	LIL	$	3.1146
☒ 00002403447	HUMULIN N KWIKPEN	LIL	$	3.1146
☒ 00002024268	NOVOLIN GE NPH CARTRIDGE	NNA	$	3.1926

INSULIN HUMAN BIOSYNTHETIC (REGULAR)

100 UNIT / ML INJECTION

☒ 00000586714	HUMULIN R	LIL	$	2.3800
☒ 00002024233	NOVOLIN GE TORONTO	NNA	$	2.3820
☒ 00001959220	HUMULIN R CARTRIDGE	LIL	$	3.1146
☒ 00002024284	NOVOLIN GE TORONTO CARTRIDGE	NNA	$	3.1180

INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

30 UNIT / ML * 70 UNIT / ML INJECTION

☒ 00000795879	HUMULIN 30/70	LIL	$	2.3800
☒ 00002024217	NOVOLIN GE 30/70	NNA	$	2.4480
☒ 00002025248	NOVOLIN GE 30/70 CARTRIDGE	NNA	$	3.0853
☒ 00001959212	HUMULIN 30/70 CARTRIDGE	LIL	$	3.1146

40 UNIT / ML * 60 UNIT / ML INJECTION

00002024314	NOVOLIN GE 40/60 CARTRIDGE	NNA	$	3.1073

50 UNIT / ML * 50 UNIT / ML INJECTION

00002024322	NOVOLIN GE 50/50 CARTRIDGE	NNA	$	3.1073

INSULIN LISPRO

100 UNIT / ML INJECTION

☒ 00002229704	HUMALOG	LIL	$	2.9155
☒ 00002403412	HUMALOG KWIKPEN	LIL	$	3.8394
☒ 00002229705	HUMALOG CARTRIDGE	LIL	$	3.8912

200 UNIT / ML INJECTION

00002439611	HUMALOG KWIKPEN	LIL	$	7.1467

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN LISPRO/ INSULIN LISPRO PROTAMINE

25 % * 75 % INJECTION					
☒	00002403420	HUMALOG MIX 25 KWIKPEN	LIL	$	3.8846
☒	00002240294	HUMALOG MIX 25 CARTRIDGE	LIL	$	3.9353
50 % * 50 % INJECTION					
☒	00002403439	HUMALOG MIX 50 KWIKPEN	LIL	$	3.8200
☒	00002240297	HUMALOG MIX 50 CARTRIDGE	LIL	$	3.8540

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.16 ANTIDIABETIC AGENTS (MEGLITINIDES)

REPAGLINIDE

0.5 MG ORAL TABLET					
	00002321475	**ACT REPAGLINIDE**	**APH**	$	**0.0808**
	00002424258	**AURO-REPAGLINIDE**	**AUR**	$	**0.0808**
	00002357453	**SANDOZ REPAGLINIDE**	**SDZ**	$	**0.0808**
	00002239924	GLUCONORM	NNA	$	0.3365
1 MG ORAL TABLET					
	00002321483	**ACT REPAGLINIDE**	**APH**	$	**0.0840**
	00002424266	**AURO-REPAGLINIDE**	**AUR**	$	**0.0840**
	00002357461	**SANDOZ REPAGLINIDE**	**SDZ**	$	**0.0840**
	00002239925	GLUCONORM	NNA	$	0.3498
2 MG ORAL TABLET					
	00002321491	**ACT REPAGLINIDE**	**APH**	$	**0.0873**
	00002424274	**AURO-REPAGLINIDE**	**AUR**	$	**0.0873**
	00002357488	**SANDOZ REPAGLINIDE**	**SDZ**	$	**0.0873**
	00002239926	GLUCONORM	NNA	$	0.3634

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.20 ANTIDIABETIC AGENTS (SULFONYLUREAS)

GLICLAZIDE

80 MG ORAL TABLET					
	00002245247	**APO-GLICLAZIDE**	**APX**	$	**0.0931**
	00002287072	**GLICLAZIDE**	**SNS**	$	**0.0931**
	00002238103	**TEVA-GLICLAZIDE**	**TEV**	$	**0.0931**
	00000765996	DIAMICRON	SEV	$	0.3814
30 MG ORAL SUSTAINED-RELEASE TABLET					
	00002297795	**APO-GLICLAZIDE MR**	**APX**	$	**0.0931**
	00002423286	**MINT-GLICLAZIDE MR**	**MPI**	$	**0.0931**
	00002438658	**MYLAN-GLICLAZIDE MR**	**MYP**	$	**0.0931**
	00002463571	**RAN-GLICLAZIDE MR**	**RAN**	$	**0.0931**
	00002461323	**SANDOZ GLICLAZIDE MR**	**SDZ**	$	**0.0931**
	00002242987	DIAMICRON MR	SEV	$	0.1438

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20.20 ANTIDIABETIC AGENTS (SULFONYLUREAS)

GLICLAZIDE

60 MG ORAL SUSTAINED-RELEASE TABLET

00002407124	**APO-GLICLAZIDE MR**	**APX**	$	**0.0632**
00002423294	**MINT-GLICLAZIDE MR**	**MPI**	$	**0.0632**
00002439328	**RAN-GLICLAZIDE MR**	**RAN**	$	**0.0632**
00002461331	**SANDOZ GLICLAZIDE MR**	**SDZ**	$	**0.0632**
00002356422	DIAMICRON MR	SEV	$	0.2589

GLYBURIDE

2.5 MG ORAL TABLET

00001913654	**APO-GLYBURIDE**	**APX**	$	**0.0321**
00002350459	**GLYBURIDE**	**SNS**	$	**0.0321**
00001913670	**TEVA-GLYBURIDE**	**TEV**	$	**0.0321**
00002224550	DIABETA	SAV	$	0.1466

5 MG ORAL TABLET

00001913662	**APO-GLYBURIDE**	**APX**	$	**0.0573**
00002350467	**GLYBURIDE**	**SNS**	$	**0.0573**
00001913689	**TEVA-GLYBURIDE**	**TEV**	$	**0.0573**
00002224569	DIABETA	SAV	$	0.2636

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:22.12 ANTIHYPOGLYCEMIC AGENTS (GLYCOGENOLYTIC AGENTS)

GLUCAGON, RDNA ORIGIN

1 MG / VIAL INJECTION

☒ 00002333619	GLUCAGEN	NPA	$	84.4086
☒ 00002333627	GLUCAGEN HYPOKIT	NPA	$	84.4086
☒ 00002243297	GLUCAGON	LIL	$	89.9767

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:24 PARATHYROID

SYNTHETIC CALCITONIN SALMON (SALCATONIN)

200 IU / ML INJECTION

00001926691	CALCIMAR	SAV	$	30.4800

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:28 PITUITARY

DESMOPRESSIN ACETATE

0.1 MG ORAL TABLET

00002284030	**DESMOPRESSIN**	**AAP**	$	**0.6609**
00000824305	DDAVP	FEI	$	1.3336

0.2 MG ORAL TABLET

00002284049	**DESMOPRESSIN**	**AAP**	$	**1.3216**
00000824143	DDAVP	FEI	$	2.6670

10 MCG / DOSE NASAL METERED DOSE SPRAY

00002242465	**DESMOPRESSIN**	**AAP**	$	**1.5222**
00000836362	DDAVP	FEI	$	1.9796

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:28 PITUITARY

DESMOPRESSIN ACETATE

150 MCG / DOSE NASAL METERED DOSE SPRAY				
00002237860	OCTOSTIM	FEI	$	16.0463
0.1 MG / ML NASAL SOLUTION				
00000402516	DDAVP	FEI	$	1.9796
4 MCG / ML INJECTION				
00000873993	DDAVP	FEI	$	10.7059

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:32 PROGESTINS

MEDROXYPROGESTERONE ACETATE

2.5 MG ORAL TABLET				
00002244726	**APO-MEDROXY**	**APX**	$	**0.0416**
00002221284	**TEVA-MEDROXYPROGESTERONE**	**TEV**	$	**0.0416**
5 MG ORAL TABLET				
00002244727	**APO-MEDROXY**	**APX**	$	**0.0823**
00002221292	**TEVA-MEDROXYPROGESTERONE**	**TEV**	$	**0.0823**
10 MG ORAL TABLET				
00002277298	**APO-MEDROXY**	**APX**	$	**0.1670**
00002221306	**TEVA-MEDROXYPROGESTERONE**	**TEV**	$	**0.1670**
100 MG ORAL TABLET				
00002267640	APO-MEDROXY	APX	$	1.2057
150 MG / ML INJECTION				
00000585092	DEPO-PROVERA	PFI	$	30.4800

PROGESTERONE

"Due to the high prevalence of peanut allergies within the population, Alberta Health has chosen to highlight the fact that Teva-Progesterone 100 mg capsules contain peanut oil, while the Brand Name drug product Prometrium does not. Please note that the Expert Committee does not regularly review possible allergens within drug products listed in the Alberta Drug Benefit List (ADBL) and it remains the responsibility of the prescribing physician and dispensing pharmacist to review all patient allergies."

100 MG ORAL CAPSULE				
00002166704	**PROMETRIUM**	**MFC**	$	**1.1330**
00002439913	**TEVA-PROGESTERONE (PEANUT OIL)**	**TEV**	$	**1.1330**
50 MG / ML INJECTION				
00001977652	PROGESTERONE	CYT	$	6.2089

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.04 THYROID AND ANTITHYROID AGENTS (THYROID AGENTS)

DESICCATED THYROID

30 MG ORAL TABLET				
00000023949	THYROID	ERF	$	0.3500
60 MG ORAL TABLET				
00000023957	THYROID	ERF	$	0.6000
125 MG ORAL TABLET				
00000023965	THYROID	ERF	$	1.0800

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.04 THYROID AND ANTITHYROID AGENTS (THYROID AGENTS)

LEVOTHYROXINE SODIUM

0.025 MG ORAL TABLET				
00002172062	SYNTHROID	BGP	$	0.0966
0.05 MG ORAL TABLET				
00002213192	**ELTROXIN**	**APC**	$	**0.0317**
00002172070	SYNTHROID	BGP	$	0.0663
0.075 MG ORAL TABLET				
00002172089	SYNTHROID	BGP	$	0.1044
0.088 MG ORAL TABLET				
00002172097	SYNTHROID	BGP	$	0.1044
0.1 MG ORAL TABLET				
00002213206	**ELTROXIN**	**APC**	$	**0.0390**
00002172100	SYNTHROID	BGP	$	0.0817
0.112 MG ORAL TABLET				
00002171228	SYNTHROID	BGP	$	0.1101
0.125 MG ORAL TABLET				
00002172119	SYNTHROID	BGP	$	0.1114
0.137 MG ORAL TABLET				
00002233852	SYNTHROID	BGP	$	0.1882
0.15 MG ORAL TABLET				
00002213214	**ELTROXIN**	**APC**	$	**0.0433**
00002172127	SYNTHROID	BGP	$	0.0876
0.175 MG ORAL TABLET				
00002172135	SYNTHROID	BGP	$	0.1196
0.2 MG ORAL TABLET				
00002213222	**ELTROXIN**	**APC**	$	**0.0458**
00002172143	SYNTHROID	BGP	$	0.0934
0.3 MG ORAL TABLET				
00002172151	SYNTHROID	BGP	$	0.1288

LIOTHYRONINE SODIUM

5 MCG (BASE) ORAL TABLET				
00001919458	CYTOMEL	PFI	$	1.3632
25 MCG (BASE) ORAL TABLET				
00001919466	CYTOMEL	PFI	$	1.4818

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36.08 THYROID AND ANTITHYROID AGENTS (ANTITHYROID AGENTS)

PROPYLTHIOURACIL

50 MG ORAL TABLET				
00000010200	PROPYL-THYRACIL	PAL	$	0.2384
100 MG ORAL TABLET				
00000010219	PROPYL-THYRACIL	PAL	$	0.3732

THIAMAZOLE

5 MG ORAL TABLET				
00002480107	**MAR-METHIMAZOLE**	**MAR**	$	**0.2297**
00000015741	TAPAZOLE	PAL	$	0.2763

80:00

Serums, Toxoids and Vaccines

80:00 SERUMS, TOXOIDS, AND VACCINES

80:04 SERUMS

ALLERGY SERUM

INJECTION

00000999981	ALLERGY SERUM	XXX	$	0.0000

80:00 SERUMS, TOXOIDS, AND VACCINES

80:12 VACCINES

HEPATITIS B VACCINE (RECOMBINANT)

20 MCG / ML INJECTION

00001919431	ENGERIX-B	GSK	$	23.0600

84:00

Skin and Mucous Membrane Agents

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:00

COMPOUND PRESCRIPTION

TOPICAL

00000999119	COMPOUND - RETINOIC ACID (TRETINOIN) (TOPICAL)	XXX	$	0.0000
00000999112	MISCELLANEOUS TOPICAL COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999219	COMPOUND - RETINOIC ACID (TRETINOIN) (TOPICAL)	XXX	$	0.0000
00000999213	MISCELLANEOUS TOPICAL COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04 ANTI-INFECTIVES

COMPOUND PRESCRIPTION

TOPICAL

00000999103 COMPOUND-ANTI-INFECTIVE (TOPICAL) XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999203 COMPOUND-ANTI-INFECTIVE (TOPICAL) XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.04 ANTI-INFECTIVES (ANTIBACTERIALS)

FUSIDIC ACID

2 % TOPICAL CREAM				
00000586668	FUCIDIN	LEO	$	0.6759

METRONIDAZOLE

1 % TOPICAL CREAM				
00002156091	NORITATE	VCL	$	0.6152
1 % TOPICAL GEL				
00002297809	METROGEL	GAL	$	0.6860
10 % VAGINAL CREAM				
00001926861	FLAGYL	SAV	$	0.2558

METRONIDAZOLE/ NYSTATIN

500 MG * 100,000 UNIT VAGINAL OVULE				
00001926829	FLAGYSTATIN	SAV	$	3.4440

MUPIROCIN

2 % TOPICAL OINTMENT				
00002279983	TARO-MUPIROCIN	TAR	$	0.4775

SODIUM FUSIDATE

2 % TOPICAL OINTMENT				
00000586676	FUCIDIN	LEO	$	0.6759

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.04 ANTI-INFECTIVES ANTIFUNGALS (ALLYLAMINES)

TERBINAFINE HCL

1 % TOPICAL CREAM				
00002031094	LAMISIL	NOV	$	0.5480
1 % TOPICAL SOLUTION				
00002238703	LAMISIL	NOV	$	0.5560

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.08 ANTI-INFECTIVES ANTIFUNGALS (AZOLES)

KETOCONAZOLE

2 % TOPICAL CREAM				
00002245662	KETODERM	TPT	$	0.3888

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.20 ANTI-INFECTIVES
ANTIFUNGALS
(HYDROXYPYRIDONES)

CICLOPIROX OLAMINE

1 % TOPICAL CREAM

00002221802	LOPROX	VCL	$	0.3144

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.92 ANTI-INFECTIVES
(MISCELLANEOUS LOCAL ANTI-INFECTIVES)

SILVER SULFADIAZINE

1 % TOPICAL CREAM

00000323098	FLAMAZINE	SNE	$	0.2048

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

AMCINONIDE

0.1 % TOPICAL CREAM

00002246714	TARO-AMCINONIDE	TAR	$	0.2253

BECLOMETHASONE DIPROPIONATE

250 MCG / G TOPICAL CREAM

00002089602	PROPADERM	VCL	$	0.4596

BETAMETHASONE DIPROPIONATE

0.05 % (BASE) TOPICAL CREAM

00000804991	**TEVA-TOPISONE**	**TEV**	$	**0.2046**
00000323071	DIPROSONE	MFC	$	0.2091

0.05 % (BASE) TOPICAL GLYCOL CREAM

00000688622	**DIPROLENE GLYCOL**	**MFC**	$	**0.5186**
00000849650	**TEVA-TOPILENE**	**TEV**	$	**0.5186**

0.05 % (BASE) TOPICAL OINTMENT

00000805009	**TEVA-TOPISONE**	**TEV**	$	**0.2186**
00000344923	DIPROSONE	MFC	$	0.2197

0.05 % (BASE) TOPICAL GLYCOL OINTMENT

00000629367	**DIPROLENE GLYCOL**	**MFC**	$	**0.5186**
00000849669	**TEVA-TOPILENE**	**TEV**	$	**0.5186**

0.05 % (BASE) TOPICAL LOTION

00000417246	**DIPROSONE**	**MFC**	$	**0.2022**
00000809187	TEVA-TOPISONE	TEV	$	0.2079

0.05 % (BASE) TOPICAL GLYCOL LOTION

00001927914	TEVA-TOPILENE	TEV	$	0.2832

BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID

0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT

00000578436	DIPROSALIC	MFC	$	0.9084

0.5 MG / ML (BASE) * 20 MG / ML TOPICAL LOTION

00000578428	**DIPROSALIC**	**MFC**	$	**0.4512**
00002245688	RATIO-TOPISALIC	TEV	$	0.4582

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

BETAMETHASONE SODIUM PHOSPHATE

5 MG / ENM (BASE) RECTAL ENEMA				
00002060884	BETNESOL (5MG/100ML)	PAL	$	10.6292

BETAMETHASONE VALERATE

0.05 % (BASE) TOPICAL CREAM				
00000716618	**BETADERM MILD**	**TAR**	$	**0.0596**
00000535427	**TEVA-ECTOSONE MILD**	**TEV**	$	**0.0596**
0.1 % (BASE) TOPICAL CREAM				
00000716626	**BETADERM REGULAR**	**TAR**	$	**0.0889**
00000535435	**TEVA-ECTOSONE REGULAR**	**TEV**	$	**0.0889**
0.05 % (BASE) TOPICAL OINTMENT				
00000716642	BETADERM MILD	TAR	$	0.0694
0.1 % (BASE) TOPICAL OINTMENT				
00000716650	BETADERM REGULAR	TAR	$	0.1034
0.05 % (BASE) TOPICAL LOTION				
00000653209	TEVA-ECTOSONE MILD	TEV	$	0.2846
0.1 % (BASE) TOPICAL LOTION				
00000750050	TEVA-ECTOSONE REGULAR	TEV	$	0.3529
0.1 % (BASE) SCALP LOTION				
00000653217	TEVA-ECTOSONE SCALP	TEV	$	0.0853

BUDESONIDE

2.3 MG / ENM RECTAL ENEMA				
00002052431	ENTOCORT (115 ML)	TPG	$	8.8900

CLOBETASOL 17-PROPIONATE

0.05 % TOPICAL CREAM				
00002024187	**MYLAN-CLOBETASOL**	**MYP**	$	**0.2279**
00002245523	**TARO-CLOBETASOL**	**TAR**	$	**0.2279**
00001910272	**TEVA-CLOBETASOL**	**TEV**	$	**0.2279**
00002213265	DERMOVATE	TPT	$	0.9116
0.05 % TOPICAL OINTMENT				
00002026767	**MYLAN-CLOBETASOL**	**MYP**	$	**0.2279**
00002245524	**TARO-CLOBETASOL**	**TAR**	$	**0.2279**
00001910280	**TEVA-CLOBETASOL**	**TEV**	$	**0.2279**
00002213273	DERMOVATE	TPT	$	0.9116
0.05 % SCALP LOTION				
00002216213	**MYLAN-CLOBETASOL**	**MYP**	$	**0.1990**
00002245522	**TARO-CLOBETASOL**	**TAR**	$	**0.1990**
00001910299	**TEVA-CLOBETASOL**	**TEV**	$	**0.1990**
00002213281	DERMOVATE	TPT	$	0.7312

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

COMPOUND PRESCRIPTION

TOPICAL

00000999107 COMPOUND-CORTICOSTEROIDS - TOPICAL XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

TOPICAL

00000999207 COMPOUND-CORTICOSTEROIDS - TOPICAL XXX $ 0.0000

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To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

DESONIDE

0.05 % TOPICAL CREAM

00002229315 PDP-DESONIDE PPH $ 0.3757

0.05 % TOPICAL OINTMENT

00002229323 PDP-DESONIDE PPH $ 0.3742

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

DESOXIMETASONE

0.05 % TOPICAL CREAM				
00002221918	TOPICORT MILD	VCL	$	0.5129
0.25 % TOPICAL CREAM				
00002221896	TOPICORT	VCL	$	0.7181

FLUOCINONIDE

0.05 % TOPICAL CREAM				
☒ 00000716863	LYDERM	TPT	$	0.2498
☒ 00002161923	LIDEX	VCL	$	0.2550
0.05 % TOPICAL EMOLLIENT CREAM				
☒ 00000598933	TIAMOL	TPT	$	0.2079
☒ 00002163152	LIDEMOL	VCL	$	0.2122
0.05 % TOPICAL OINTMENT				
☒ 00002236996	LYDERM	TPT	$	0.3153
☒ 00002161966	LIDEX	VCL	$	0.3229
0.05 % TOPICAL GEL				
☒ 00002236997	LYDERM	TPT	$	0.3232
☒ 00002161974	LIDEX	VCL	$	0.3298

HALOBETASOL PROPIONATE

0.05 % TOPICAL CREAM				
00001962701	ULTRAVATE	VCL	$	0.9766

HYDROCORTISONE

1 % TOPICAL OCCLUSIVE CREAM				
00000804533	PREVEX HC	GSK	$	0.2703
0.5 % TOPICAL OINTMENT				
00000716685	CORTODERM MILD	TAR	$	0.1720
1 % TOPICAL OINTMENT				
00000716693	CORTODERM REGULAR	TAR	$	0.0542
1 % TOPICAL LOTION				
00080057191	JAMP-HYDROCORTISONE	JPC	$	0.1191
100 MG / ENM RECTAL ENEMA				
00002112736	CORTENEMA (100MG/60ML)	AXC	$	7.6483

HYDROCORTISONE 17-VALERATE

0.2 % TOPICAL CREAM				
00002242984	HYDROVAL	TPT	$	0.1667
0.2 % TOPICAL OINTMENT				
00002242985	HYDROVAL	TPT	$	0.1667

HYDROCORTISONE ACETATE

0.5 % TOPICAL CREAM				
00000716820	HYDERM	TAR	$	0.1909
1 % TOPICAL CREAM				
00000716839	HYDERM	TAR	$	0.0533
1 % TOPICAL LOTION				
00000681997	DERMAFLEX HC	PAL	$	0.1023
10 % RECTAL FOAM				
00000579335	CORTIFOAM	PAL	$	6.7758

HYDROCORTISONE ACETATE/ PRAMOXINE HCL

1 % * 1 % RECTAL FOAM				
00000363014	PROCTOFOAM-HC	DUI	$	1.3839

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

HYDROCORTISONE ACETATE/ PRAMOXINE HCL/ ZINC SULFATE

10 MG * 20 MG * 10 MG RECTAL SUPPOSITORY

00002242797	**SANDOZ ANUZINC HC PLUS**	**SDZ**	$	**0.7825**
00002240851	PROCTODAN-HC	ODN	$	0.8216
00000476242	ANUGESIC-HC	MCL	$	1.3650

0.5 % * 1 % * 0.5 % RECTAL OINTMENT

00002234466	**PROCTODAN-HC**	**ODN**	$	**0.7314**
00000505781	ANUGESIC-HC	MCL	$	0.9100

HYDROCORTISONE ACETATE/ UREA

1 % * 10 % TOPICAL CREAM

00000681989	DERMAFLEX HC	PAL	$	0.1819

HYDROCORTISONE ACETATE/ ZINC SULFATE

10 MG * 10 MG RECTAL SUPPOSITORY

00002236399	**ANODAN-HC**	**ODN**	$	**0.6124**
00000476285	ANUSOL-HC	CHD	$	1.1183

0.5 % * 0.5 % RECTAL OINTMENT

00002128446	**ANODAN-HC**	**ODN**	$	**0.3850**
00002387239	**JAMPZINC-HC**	**JPC**	$	**0.3850**
00002247691	**SANDOZ ANUZINC HC**	**SDZ**	$	**0.3850**
00000505773	ANUSOL-HC	CHD	$	0.7827

MOMETASONE FUROATE

0.1 % TOPICAL CREAM

00002367157	**TARO-MOMETASONE**	**TAR**	$	**0.5708**
00000851744	ELOCOM	MFC	$	0.7098

0.1 % TOPICAL OINTMENT

00002248130	**TEVA-MOMETASONE**	**TEV**	$	**0.6013**
00000851736	ELOCOM	MFC	$	0.6384

0.1 % TOPICAL LOTION

00002266385	**TARO-MOMETASONE**	**TAR**	$	**0.3788**
00000871095	ELOCOM	MFC	$	0.4759

TRIAMCINOLONE ACETONIDE

0.1 % TOPICAL CREAM

00000716960	**TRIADERM REGULAR**	**TAR**	$	**0.1024**
00002194058	ARISTOCORT R	VCL	$	0.1401

0.5 % TOPICAL CREAM

00002194066	ARISTOCORT C	VCL	$	1.2352

0.1 % TOPICAL OINTMENT

00002194031	ARISTOCORT R	VCL	$	0.1404

0.1 % DENTAL PASTE

00001964054	ORACORT	TAR	$	1.4707

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06.00 ANTI-INFLAMMATORY AGENTS

(COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS)

BETAMETHASONE DIPROPIONATE/ CLOTRIMAZOLE

0.05 % (BASE) * 1 % TOPICAL CREAM

00000611174	LOTRIDERM	MFC	$	0.8106

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06.00 ANTI-INFLAMMATORY AGENTS

(COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS)

COMPOUND PRESCRIPTION

00000999110	COMBINATION ANTI-INFECTIVE /CORTICOSTEROID	XXX	$	0.0000

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To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999211	COMBINATION ANTI-INFECTIVE/CORTICOSTEROID	XXX	$	0.0000

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- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

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84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06.00 ANTI-INFLAMMATORY AGENTS

(COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS)

HYDROCORTISONE/ CINCHOCAINE HCL/ FRAMYCETIN SULFATE/ ESCULIN

5 MG * 5 MG * 10 MG * 10 MG RECTAL SUPPOSITORY

00002247882	**PROCTOL**	**ODN**	$	**0.6000**
00002242528	**SANDOZ PROCTOMYXIN HC**	**SDZ**	$	**0.6000**
00002226391	**TEVA-PROCTOSONE**	**TEV**	$	**0.6000**

5 MG / G * 5 MG / G * 10 MG / G * 10 MG / G RECTAL OINTMENT

00002247322	**PROCTOL**	**ODN**	$	**0.4000**
00002242527	**SANDOZ PROCTOMYXIN HC**	**SDZ**	$	**0.4000**
00002226383	**TEVA-PROCTOSONE**	**TEV**	$	**0.4000**
00002223252	PROCTOSEDYL	AXC	$	0.8641

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:08 ANTIPRURITICS AND LOCAL ANESTHETICS

LIDOCAINE

5 % TOPICAL OINTMENT

00002083795	**LIDODAN**	**ODN**	$	**0.2800**
00000001961	XYLOCAINE	APC	$	0.3286

LIDOCAINE HCL

2 % TOPICAL JELLY

☒ 00002143879	LIDODAN	ODN	$	0.3625
☒ 00000001694	XYLOCAINE JELLY	APC	$	0.5367

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:28 KERATOLYTIC AGENTS

COMPOUND PRESCRIPTION

TOPICAL

00000999104 COMPOUND- SALICYLIC ACID (TOPICAL) XXX $ 0.0000

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TOPICAL

00000999204 COMPOUND- SALICYLIC ACID (TOPICAL) XXX $ 0.0000

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84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:92 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

5-FLUOROURACIL

50 MG / G TOPICAL CREAM

00000330582 EFUDEX VCL $ 0.9006

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:92 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ACITRETIN

10 MG ORAL CAPSULE

00002468840	**MINT-ACITRETIN**	**MPI**	$	**1.2965**
00002466074	**TARO-ACITRETIN**	**TAR**	$	**1.2965**
00002070847	SORIATANE	ACV	$	2.3069

25 MG ORAL CAPSULE

00002468859	**MINT-ACITRETIN**	**MPI**	$	**2.2770**
00002466082	**TARO-ACITRETIN**	**TAR**	$	**2.2770**
00002070863	SORIATANE	ACV	$	4.0510

AZELAIC ACID

15 % TOPICAL GEL

00002270811	FINACEA	BAI	$	0.6066

CALCIPOTRIOL

50 MCG / G TOPICAL OINTMENT

00001976133	DOVONEX	LEO	$	0.7837

CALCIPOTRIOL MONOHYDRATE/ BETAMETHASONE DIPROPIONATE

50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL OINTMENT

00002244126	DOVOBET	LEO	$	1.5477

50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL GEL

00002319012	DOVOBET	LEO	$	1.5210

50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL FOAM

00002457393	ENSTILAR	LEO	$	1.5746

COLLAGENASE

250 UNIT / G TOPICAL OINTMENT

00002063670	SANTYL	SNE	$	3.0330

ISOTRETINOIN

10 MG ORAL CAPSULE

00002257955	**CLARUS**	**MYP**	$	**0.9313**
00000582344	ACCUTANE	HLR	$	0.9547

40 MG ORAL CAPSULE

00002257963	**CLARUS**	**MYP**	$	**1.9003**
00000582352	ACCUTANE	HLR	$	1.9480

TAZAROTENE

0.05 % TOPICAL GEL

00002230784	TAZORAC	ALL	$	1.3886

0.1 % TOPICAL GEL

00002230785	TAZORAC	ALL	$	1.3886

86:00

Smooth Muscle Relaxants

86:00 SMOOTH MUSCLE RELAXANTS

86:12 GENITOURINARY SMOOTH MUSCLE RELAXANTS

OXYBUTYNIN CHLORIDE

2.5 MG ORAL TABLET

00002240549	PMS-OXYBUTYNIN	PMS	$	0.1736

5 MG ORAL TABLET

00002163543	**APO-OXYBUTYNIN**	**APX**	$	**0.0986**
00002350238	**OXYBUTYNIN**	**SNS**	$	**0.0986**
00002240550	**PMS-OXYBUTYNIN**	**PMS**	$	**0.0986**
00002230394	**TEVA-OXYBUTYNIN**	**TEV**	$	**0.0986**

1 MG / ML ORAL SYRUP

00002223376	PMS-OXYBUTYNIN	PMS	$	0.1632

PROPIVERINE HYDROCHLORIDE

5 MG ORAL TABLET

00002460289	MICTORYL PEDIATRIC	DUI	$	0.3700

This Drug Product is a restricted benefit for symptomatic treatment of urinary incontinence and/or increased urinary frequency and urgency in pediatric patients from 5-18 years old with overactive bladder.

SOLIFENACIN SUCCINATE

5 MG ORAL TABLET

00002423375	**APO-SOLIFENACIN**	**APX**	$	**0.3041**
00002446375	**AURO-SOLIFENACIN**	**AUR**	$	**0.3041**
00002424339	**JAMP-SOLIFENACIN**	**JPC**	$	**0.3041**
00002428911	**MED-SOLIFENACIN**	**GMP**	$	**0.3041**
00002443171	**MINT-SOLIFENACIN**	**MPI**	$	**0.3041**
00002417723	**PMS-SOLIFENACIN**	**PMS**	$	**0.3041**
00002437988	**RAN-SOLIFENACIN**	**RAN**	$	**0.3041**
00002399032	**SANDOZ SOLIFENACIN**	**SDZ**	$	**0.3041**
00002458241	**SOLIFENACIN**	**SNS**	$	**0.3041**
00002448335	**SOLIFENACIN SUCCINATE**	**MDA**	$	**0.3041**
00002397900	**TEVA-SOLIFENACIN**	**TEV**	$	**0.3041**
00002277263	VESICARE	ASP	$	1.5135

10 MG ORAL TABLET

00002423383	**APO-SOLIFENACIN**	**APX**	$	**0.3041**
00002446383	**AURO-SOLIFENACIN**	**AUR**	$	**0.3041**
00002424347	**JAMP-SOLIFENACIN**	**JPC**	$	**0.3041**
00002428938	**MED-SOLIFENACIN**	**GMP**	$	**0.3041**
00002443198	**MINT-SOLIFENACIN**	**MPI**	$	**0.3041**
00002417731	**PMS-SOLIFENACIN**	**PMS**	$	**0.3041**
00002437996	**RAN-SOLIFENACIN**	**RAN**	$	**0.3041**
00002399040	**SANDOZ SOLIFENACIN**	**SDZ**	$	**0.3041**
00002458268	**SOLIFENACIN**	**SNS**	$	**0.3041**
00002448343	**SOLIFENACIN SUCCINATE**	**MDA**	$	**0.3041**
00002397919	**TEVA-SOLIFENACIN**	**TEV**	$	**0.3041**
00002277271	VESICARE	ASP	$	1.5135

86:00 SMOOTH MUSCLE RELAXANTS

86:12 GENITOURINARY SMOOTH MUSCLE RELAXANTS

TOLTERODINE L-TARTRATE

2 MG ORAL EXTENDED-RELEASE CAPSULE				
00002404184	**MYLAN-TOLTERODINE ER**	**MYP**	$	**0.4911**
00002413140	**SANDOZ TOLTERODINE LA**	**SDZ**	$	**0.4911**
00002412195	**TEVA-TOLTERODINE LA**	**TEV**	$	**0.4911**
00002244612	DETROL LA	PFI	$	2.0433
4 MG ORAL EXTENDED-RELEASE CAPSULE				
00002404192	**MYLAN-TOLTERODINE ER**	**MYP**	$	**0.4911**
00002413159	**SANDOZ TOLTERODINE LA**	**SDZ**	$	**0.4911**
00002412209	**TEVA-TOLTERODINE LA**	**TEV**	$	**0.4911**
00002244613	DETROL LA	PFI	$	2.0433

86:00 SMOOTH MUSCLE RELAXANTS

86:16 RESPIRATORY SMOOTH MUSCLE RELAXANTS

AMINOPHYLLINE

25 MG / ML INJECTION				
00000497193	AMINOPHYLLINE	HSP	$	0.4600

OXTRIPHYLLINE/ GUAIFENESIN

20 MG / ML * 10 MG / ML ORAL ELIXIR				
00000476374	CHOLEDYL EXPECTORANT	ERF	$	0.0807

THEOPHYLLINE

100 MG ORAL SUSTAINED-RELEASE TABLET				
00000692689	APO-THEO LA	APX	$	0.1624
200 MG ORAL SUSTAINED-RELEASE TABLET				
00000692697	APO-THEO LA	APX	$	0.1805
300 MG ORAL SUSTAINED-RELEASE TABLET				
00000692700	APO-THEO LA	APX	$	0.2186
400 MG ORAL SUSTAINED-RELEASE TABLET				
00002014165	UNIPHYL	PUR	$	0.5030
600 MG ORAL SUSTAINED-RELEASE TABLET				
00002014181	UNIPHYL	PUR	$	0.6090
5.3 MG / ML ORAL LIQUID				
00001966219	THEOLAIR	VCL	$	0.0278

88:00

Vitamins

88:00 VITAMINS

88:08 VITAMIN B COMPLEX

CYANOCOBALAMIN

1,000 MCG / ML INJECTION

00001987003	**CYANOCOBALAMIN**	**STM**	$	**0.3063**
00002413795	**CYANOCOBALAMIN**	**MYP**	$	**0.3063**
00002420147	**JAMP-CYANOCOBALAMIN**	**JPC**	$	**0.3063**
00000521515	**VITAMIN B12**	**SDZ**	$	**0.3063**

FOLIC ACID

5 MG ORAL TABLET

☒ 00002285673	EURO FOLIC	SDZ	$	0.0198
☒ 00002366061	JAMP-FOLIC ACID	JPC	$	0.0198
☒ 00000426849	FOLIC ACID	AAP	$	0.0404

5 MG / ML INJECTION

☒ 00000816086	FOLIC ACID	SDZ	$	3.9500

THIAMINE HCL

100 MG / ML INJECTION

00002193221	THIAMIJECT	OMG	$	1.1880

88:00 VITAMINS

88:16 VITAMIN D

ALFACALCIDOL

0.25 MCG ORAL CAPSULE

00000474517	ONE-ALPHA	LEO	$	0.4735

1 MCG ORAL CAPSULE

00000474525	ONE-ALPHA	LEO	$	1.4172

2 MCG / ML ORAL DROPS

00002240329	ONE-ALPHA	LEO	$	5.4146

2 MCG / ML INJECTION

00002242502	ONE-ALPHA	LEO	$	17.3640

CALCITRIOL

0.25 MCG ORAL CAPSULE

00002431637	**CALCITRIOL-ODAN**	**ODN**	$	**0.6960**
00000481823	ROCALTROL	HLR	$	0.7071

0.5 MCG ORAL CAPSULE

00002431645	**CALCITRIOL-ODAN**	**ODN**	$	**1.1069**
00000481815	ROCALTROL	HLR	$	1.1246

1 MCG / ML INJECTION

00002399334	CALCITRIOL	STM	$	9.4337

88:00 VITAMINS

88:24 VITAMIN K ACTIVITY

PHYTONADIONE

2 MG / ML INJECTION

00000781878	VITAMIN K1 PEDIATRIC	SDZ	$	10.5900

10 MG / ML INJECTION

00000804312	VITAMIN K1	SDZ	$	6.0000

88:00 VITAMINS

88:28 MULTIVITAMIN PREPARATIONS

PIPRADROL HCL/ THIAMINE HCL/ RIBOFLAVIN/ PYRIDOXINE HCL/ NIACINAMIDE (NICOTINAMIDE)/ CHOLINE/ INOSITOL

0.04 MG / ML * 0.22 MG / ML * 0.11 MG / ML * 0.04 MG / ML * 1.11 MG / ML * 2.22 MG / ML * 2.22 MG / ML
ORAL LIQUID

00002103052	ALERTONIC	ODN	$	0.0915

92:00

Miscellaneous Therapeutic Agents

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

ALENDRONATE SODIUM

70 MG ORAL TABLET

00002299712	**ALENDRONATE**	**SIV**	$	**2.1014**
00002352966	**ALENDRONATE**	**SNS**	$	**2.1014**
00002381494	**ALENDRONATE SODIUM**	**AHI**	$	**2.1014**
00002248730	**APO-ALENDRONATE**	**APX**	$	**2.1014**
00002388553	**AURO-ALENDRONATE**	**AUR**	$	**2.1014**
00002385031	**JAMP-ALENDRONATE**	**JPC**	$	**2.1014**
00002394871	**MINT-ALENDRONATE**	**MPI**	$	**2.1014**
00002284006	**PMS-ALENDRONATE-FC**	**PMS**	$	**2.1014**
00002288109	**SANDOZ ALENDRONATE**	**SDZ**	$	**2.1014**
00002261715	**TEVA-ALENDRONATE**	**TEV**	$	**2.1014**
00002245329	FOSAMAX	MFC	$	11.0114

ALENDRONATE SODIUM/ VITAMIN D3

70 MG * 5,600 UNIT ORAL TABLET

00002454475	**APO-ALENDRONATE/VITAMIN D3**	**APX**	$	**1.2174**
00002429160	**SANDOZ ALENDRONATE/CHOLECALCIFEROL**	**SDZ**	$	**1.2174**
00002403641	**TEVA-ALENDRONATE/CHOLECALCIFEROL**	**TEV**	$	**1.2174**
00002314940	FOSAVANCE	MFC	$	4.8970

ALLOPURINOL

100 MG ORAL TABLET

00002402769	**APO-ALLOPURINOL**	**APX**	$	**0.0780**
00002396327	**MAR-ALLOPURINOL**	**MAR**	$	**0.0780**
00000402818	**ZYLOPRIM**	**AAP**	$	**0.0780**

200 MG ORAL TABLET

00002402777	**APO-ALLOPURINOL**	**APX**	$	**0.1300**
00002396335	**MAR-ALLOPURINOL**	**MAR**	$	**0.1300**
00000479799	**ZYLOPRIM**	**AAP**	$	**0.1300**

300 MG ORAL TABLET

00002402785	**APO-ALLOPURINOL**	**APX**	$	**0.2125**
00002396343	**MAR-ALLOPURINOL**	**MAR**	$	**0.2125**
00000402796	**ZYLOPRIM**	**AAP**	$	**0.2125**

AZATHIOPRINE

50 MG ORAL TABLET

00002242907	**APO-AZATHIOPRINE**	**APX**	$	**0.2405**
00002236819	**TEVA-AZATHIOPRINE**	**TEV**	$	**0.2405**
00000004596	IMURAN	APC	$	1.0927

BETAHISTINE DIHYDROCHLORIDE

8 MG ORAL TABLET

00002449145	AURO-BETAHISTINE	AUR	$	0.1273

16 MG ORAL TABLET

00002449153	**AURO-BETAHISTINE**	**AUR**	$	**0.1106**
00002466449	**BETAHISTINE**	**SNS**	$	**0.1106**
00002330210	**PMS-BETAHISTINE**	**PMS**	$	**0.1106**
00002280191	**TEVA-BETAHISTINE**	**TEV**	$	**0.1106**
00002243878	SERC	BGP	$	0.4864

CLODRONATE DISODIUM

400 MG ORAL CAPSULE

00002245828	CLASTEON	SUN	$	1.2374

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

CLONIDINE HCL

0.025 MG ORAL TABLET

00002304163	TEVA-CLONIDINE	TEV	$	0.2713

COLCHICINE

0.6 MG ORAL TABLET

00000572349	**COLCHICINE**	**ODN**	$	**0.2565**
00002373823	**JAMP-COLCHICINE**	**JPC**	$	**0.2565**
00002402181	**PMS-COLCHICINE**	**PMS**	$	**0.2565**

COMPOUND PRESCRIPTION

INJECTION

00000999114	MISCELLANEOUS INJECTABLE COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

INJECTION

00000999215	MISCELLANEOUS INJECTABLE COMPOUND	XXX	$	0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

COMPOUND PRESCRIPTION

00000999999 MISCELLANEOUS COMPOUND XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

00000999216 MISCELLANEOUS COMPOUND XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

COMPOUND PRESCRIPTION

ORAL

00000999214 MISCELLANEOUS ORAL COMPOUND XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been procured from a licensed compound and repackaging pharmacy and dispensed by a licensed community pharmacy.

ORAL

00000999113 MISCELLANEOUS ORAL COMPOUND XXX $ 0.0000

To determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

In order for a compound to be eligible:

- the compounded prescription must contain in therapeutic dosage; one or more drug(s) identified as allowable Drug Benefits; or one or more chemical entities; and

- the compounded prescription must not duplicate a manufactured drug product, whether the drug product is or is not identified as an allowable Drug Benefit; and

- the compounded prescription must not include a chemical entitiy or drug product, with the exception of diluents or bases, specifically identified as not an allowable Drug Benefit.

To be used when the compound has been prepared and dispensed by a licensed community pharmacy.

DIMETHYL SULFOXIDE

50 % BLADDER IRRIGATION SOLUTION

00000493392 RIMSO-50 MYP $ 1.7000

ETIDRONATE DISODIUM/ CALCIUM CARBONATE

400 MG * 500 MG ORAL TABLET

00002263866 ACT ETIDROCAL APH $ 0.3332

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

FLUNARIZINE HCL

5 MG (BASE) ORAL CAPSULE

00002246082	FLUNARIZINE	AAP	$	0.7682

LEUCOVORIN CALCIUM

5 MG (BASE) ORAL TABLET

00002170493	LEDERLE LEUCOVORIN CALCIUM	PFI	$	7.2466

10 MG / ML INJECTION

00002087316	LEUCOVORIN CALCIUM	TEV	$	13.7886

NAFARELIN ACETATE

2 MG / ML (BASE) NASAL SOLUTION

00002188783	SYNAREL	PFI	$	48.8851

PAMIDRONATE DISODIUM

For the products within the following three groupings, pricing has been established on a per millilitre basis.

3 MG / ML INJECTION

00002244550	PAMIDRONATE DISODIUM	PFI	$	3.0317

6 MG / ML INJECTION

00002244551	PAMIDRONATE DISODIUM	PFI	$	9.0366

9 MG / ML INJECTION

00002244552	PAMIDRONATE DISODIUM	PFI	$	9.0953

PENTOSAN POLYSULFATE SODIUM

100 MG ORAL CAPSULE

00002029448	ELMIRON	JAI	$	2.1600

RISEDRONATE SODIUM

35 MG ORAL TABLET

00002353687	**APO-RISEDRONATE**	**APX**	$	**1.9787**
00002406306	**AURO-RISEDRONATE**	**AUR**	$	**1.9787**
00002368552	**JAMP-RISEDRONATE**	**JPC**	$	**1.9787**
00002302209	**PMS-RISEDRONATE**	**PMS**	$	**1.9787**
00002370255	**RISEDRONATE**	**SNS**	$	**1.9787**
00002411407	**RISEDRONATE-35**	**SIV**	$	**1.9787**
00002327295	**SANDOZ RISEDRONATE**	**SDZ**	$	**1.9787**
00002298392	**TEVA-RISEDRONATE**	**TEV**	$	**1.9787**
00002246896	ACTONEL	ASC	$	11.4233

ULIPRISTAL ACETATE

RESTRICTED BENEFIT - "This product is a benefit for patients for the treatment of moderate to severe signs and symptoms of uterine fibroids in adult women of reproductive age who are eligible for surgery, under the following conditions:
- the duration of treatment will not exceed three months, per patient, per lifetime AND
- the patient is under the care of a physician experienced in the management of gynecological conditions such as uterine fibroids."

5 MG ORAL TABLET

00002408163	FIBRISTAL	ASC	$	11.4600

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:08 5 ALFA REDUCTASE INHIBITORS

DUTASTERIDE

0.5 MG ORAL CAPSULE

00002412691	**ACT DUTASTERIDE**	**APH**	$	**0.3027**
00002404206	**APO-DUTASTERIDE**	**APX**	$	**0.3027**
00002469308	**AURO-DUTASTERIDE**	**AUR**	$	**0.3027**
00002429012	**DUTASTERIDE**	**SIV**	$	**0.3027**
00002443058	**DUTASTERIDE**	**SNS**	$	**0.3027**
00002416298	**MED-DUTASTERIDE**	**GMP**	$	**0.3027**
00002428873	**MINT-DUTASTERIDE**	**MPI**	$	**0.3027**
00002393220	**PMS-DUTASTERIDE**	**PMS**	$	**0.3027**
00002424444	**SANDOZ DUTASTERIDE**	**SDZ**	$	**0.3027**
00002408287	**TEVA-DUTASTERIDE**	**TEV**	$	**0.3027**
00002247813	AVODART	GSK	$	1.6819

FINASTERIDE

5 MG ORAL TABLET

00002365383	**APO-FINASTERIDE**	**APX**	$	**0.4138**
00002405814	**AURO-FINASTERIDE**	**AUR**	$	**0.4138**
00002355043	**FINASTERIDE**	**AHI**	$	**0.4138**
00002445077	**FINASTERIDE**	**SNS**	$	**0.4138**
00002447541	**FINASTERIDE**	**SIV**	$	**0.4138**
00002357224	**JAMP-FINASTERIDE**	**JPC**	$	**0.4138**
00002389878	**MINT-FINASTERIDE**	**MPI**	$	**0.4138**
00002310112	**PMS-FINASTERIDE**	**PMS**	$	**0.4138**
00002322579	**SANDOZ FINASTERIDE**	**SDZ**	$	**0.4138**
00002348500	**TEVA-FINASTERIDE**	**TEV**	$	**0.4138**
00002010909	PROSCAR	MFC	$	2.0816

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:36 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

LEFLUNOMIDE

RESTRICTED BENEFIT - This product is a benefit for the treatment of rheumatoid arthritis when the initial prescription is prescribed by a Specialist in Rheumatology or Internal Medicine.

10 MG ORAL TABLET

00002256495	**APO-LEFLUNOMIDE**	**APX**	$	**2.6433**
00002351668	**LEFLUNOMIDE**	**SNS**	$	**2.6433**
00002283964	**SANDOZ LEFLUNOMIDE**	**SDZ**	$	**2.6433**
00002261251	**TEVA-LEFLUNOMIDE**	**TEV**	$	**2.6433**
00002241888	ARAVA	SAV	$	11.0677

20 MG ORAL TABLET

00002256509	**APO-LEFLUNOMIDE**	**APX**	$	**2.6433**
00002351676	**LEFLUNOMIDE**	**SNS**	$	**2.6433**
00002283972	**SANDOZ LEFLUNOMIDE**	**SDZ**	$	**2.6433**
00002261278	**TEVA-LEFLUNOMIDE**	**TEV**	$	**2.6433**
00002241889	ARAVA	SAV	$	11.0680

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:92 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

ABOBOTULINUMTOXINA

300 IU / VIAL INJECTION

00002460203	DYSPORT THERAPEUTIC	ISP	$ 385.5600

500 IU / VIAL INJECTION

00002456117	DYSPORT THERAPEUTIC	ISP	$ 642.6000

BOTULINUMTOXINA(150KD), FREE FROM COMPLEXING PROTEIN

50 UNIT / VIAL INJECTION

00002371081	XEOMIN	MPC	$ 165.0000

100 UNIT / VIAL INJECTION

00002324032	XEOMIN	MPC	$ 330.0000

ONABOTULINUMTOXINA

INJECTION

00001981501	BOTOX (50/100/200 UNITS/VIAL)	ALL	$ 3.5700

94:00

Devices

94:00 DEVICES

94:00

AEROSOL HOLDING CHAMBER

RESTRICTED BENEFIT - Coverage is limited to one aerosol holding chamber per plan participant per year.

DEVICE

00000990095	OPTICHAMBER ADVANTAGE II (CHAMBER ONLY)	RNA	$	15.6000
00000999399	OPTICHAMBER DIAMOND (CHAMBER ONLY)	RNA	$	17.2000
00000990080	VORTEX	KGH	$	19.4977
00000990091	AEROCHAMBER PLUS FLOW-VU W/ MOUTHPIECE	TMI	$	23.5500
00000990100	AEROCHAMBER PLUS FLOW-VU YOUTH W/ MOUTHPIECE	TMI	$	23.5500
00000990101	INSPIRA CHAMBER WITH MOUTHPIECE	LPC	$	23.5500

AEROSOL HOLDING CHAMBER/MASK

RESTRICTED BENEFIT - Coverage is limited to one of each size (infant, pediatric, adult) aerosol holding chamber mask or chamber w/ mask per plan participant per year.

INFANT DEVICE

00000990015	VORTEX TODDLER/INFANT MASK DEVICE	KGH	$	13.0047
00000990096	OPTICHAMBER ADVANTAGE II (WITH SMALL MASK)	RNA	$	26.8000
00000999398	OPTICHAMBER DIAMOND (WITH SMALL MASK)	RNA	$	29.4000
00000990092	AEROCHAMBER PLUS FLOW-VU W/ SMALL MASK	TMI	$	37.6700
00000990103	INSPIRA CHAMBER W/ SM INSPIRAMASK/SOOTHERMASK DEV	LPC	$	37.6700

PEDIATRIC DEVICE

00000990016	VORTEX CHILD/PEDIATRIC MASK DEVICE	KGH	$	13.0047
00000990097	OPTICHAMBER ADVANTAGE II (WITH MEDIUM MASK)	RNA	$	26.8000
00000999397	OPTICHAMBER DIAMOND (WITH MEDIUM MASK)	RNA	$	29.4000
00000990093	AEROCHAMBER PLUS FLOW-VU W/ MEDIUM MASK	TMI	$	37.6700
00000990102	INSPIRA CHAMBER W/ MED INSPIRAMASK/SOOTHERMASK DEV	LPC	$	37.6700

ADULT DEVICE

00000990098	OPTICHAMBER ADVANTAGE II (WITH LARGE MASK)	RNA	$	29.6000
00000999396	OPTICHAMBER DIAMOND (WITH LARGE MASK)	RNA	$	32.4000
00000990109	AEROCHAMBER PLUS FLOW-VU W/ ADULT SMALL MASK	TMI	$	39.8600
00000990094	AEROCHAMBER PLUS FLOW-VU W/ LARGE MASK	TMI	$	39.8600

Appendices

Abbreviations

Pharmaceutical Manufacturers

Appendix 1
Abbreviations

ASA ..... acetylsalicylic acid
COMPD ..... compound
DEV..... device
ENM..... enema
FC..... film coated
G..... gram(s)
HCL..... hydrochloride

HR..... per hour
IU ..... international unit(s)
MCG..... microgram
MED..... medium
MEQ..... milliequivalent

MG ..... milligram
ML..... millilitre
PTH..... patch
SM..... small
SYR..... syringe

W..... with
%..... percent

Appendix 2
Pharmaceutical Manufacturers

A
AAP AA Pharma Inc.
ABV Abbvie Corporation
ACE Acerus Pharmaceuticals Corporation
ACP Accel Pharma Inc.
ACV Actavis
AHI Accord Healthcare Inc.
ALC Alcon Canada Inc.
ALH Altius Healthcare Inc.
ALL Allergan Inc.
AMG Amgen Inc.
AMP Atnahs Pharma/Methapharm Inc.
APC Aspen Pharmacare Canada Inc.
APG Alexion Pharma GMBH
APH Actavis Pharma Company
APP Apopharma Inc.
APX Apotex Inc.
ASC Actavis Specialty Pharmaceuticals Co.
ASP Astellas Pharma Canada Inc.
ATH Atnahs Pharma UK Limited
AUR Auro Pharma Inc.
AVP Avir Pharma Inc.
AXC Aptalis Pharma Canada Inc.
AZC AstraZeneca Canada Inc.

B
BAI Bayer Inc.
BAX Baxter Corporation
BCF Biocodex SA
BGP BGP Pharma ULC
BIO Biogen Idec Canada Inc
BMD Biomed Pharma
BMS Bristol-Myers Squibb
BOE Boehringer Ingelheim (Canada) Ltd.
BVM Swedish Orphan Biovitrum (SOBI) Canada Inc.

C
CAG Cheplapharm Arzneimittel GMBH Germany
CEL Cellchem Pharmaceuticals Inc.
CHD Church & Dwight Canada
CHH Celltrion Healthcare/Hospira Healthcare
CIP Cipher Pharmaceuticals Inc.
CUB Cubist Pharmaceuticals, Inc.
CYC Cycle Pharmaceuticals Ltd.
CYT Cytex Pharmaceuticals Inc.

D
DRL Dr. Reddy's Laboratories Inc.
DUI Duchesnay Inc.

E
EIS Eisai Limited
ERF ERFA Canada 2012 Inc.
ETP Ethypharm Inc.

F
FEI Ferring Inc.
FKC Fresenius Kabi Canada

G
GAL Galderma Canada Inc.
GIL Gilead Sciences Inc.
GLM Glenmark Phamaceuticals Canada Inc.
GMD Genmed, a Division of Pfizer Canada Inc.
GMP Generic Medical Partners Inc.
GSK GlaxoSmithKline
GZM Genzyme, a Division of Sanofi-Aventis CA.

H
HLR Hoffman-La Roche Limited
HLS HLS Therapeutics Inc.
HSP Hospira Healthcare Corporation

I
ICP Intercept Pharmaceuticals Inc.
ISP Ipsen Biopharm Limited
IUK Indivior UK Limited

J
JAI Janssen Inc.
JPC Jamp Pharma Corporation

K
KGH Kego Healthcare

L
LBC Lundbeck Canada Inc.
LEO Leo Pharma Inc.
LIL Eli Lilly Canada Inc.
LPC Lupin Pharma Canada Limited
LPI Luitpold Pharmaceuticals, Inc.
LUI Lundbeck Inc.

M
MAL Mallinckrodt Canada ULC.
MAR Marcan Pharmaceuticals Inc
MCL McNeil Consumer Healthcare
MDA MDA Inc.
MDK Medunik Canada
MDX Medexus Inc.
MEN MendeliKabs Inc.
MFC Merck Canada Inc.

Appendix 2
Pharmaceutical Manufacturers

M

MJO Mead Johnson Nutrition (Canada) Co.
MPC Merz Pharma Canada Ltd.
MPI Mint Pharmaceuticals Inc.
MYP Mylan Pharmaceuticals ULC
MYS Mylan Specialty LP/Pfizer Canada Inc.

N

NNA Novo Nordisk Canada Inc.
NOV Novartis Pharmaceuticals Canada Inc.
NPA Novo Nordisk Canada/Paladin Labs
NTI Jacobus Pharmaceuticals Company Inc.
NTP Natco Pharma (Canada) Inc.
NUN Nutricia North America

O

ODN Odan Laboratories Ltd.
OMG Omega Laboratories Limited
ONV Oxurion N.V.
OTS Otsuka Pharmaceutical Co. Ltd.

P

PAL Paladin Labs Inc.
PFI Pfizer Canada Inc.
PIE Pierre Fabre Dermo-Cosmetique Canada Inc.
PMS Pharmascience Inc.
PPH Pendopharm Inc.
PUR Purdue Pharma

R

RAN Ranbaxy Pharmaceuticals Canada Inc.
RAP HZNP Canada Limited
RNA Respironics NJ Inc – Auto Control Med Inc.

S

SAV Sanofi-Aventis
SDZ Sandoz Canada Inc.
SEP Septa Pharmaceuticals Inc.
SEV Servier Canada Inc.
SGM Leadiant Biosciences, Inc.
SHB Shire Pharma Canada ULC
SIV Sivem Pharmaceuticals ULC
SLP Searchlight Pharma Inc.
SLX Salix Pharmaceuticals Inc.
SNE Smith & Nephew Inc.
SNS Sanis Health Inc.
SOT Shire Orphan Therapies Inc.
SRO EMD Serono Canada Inc.
SSB Samsung Bioepis Co., Ltd
STM SteriMax Inc.
SUN Sunovion Pharmaceutical Inc.

T

TAK Takeda Canada, Inc.
TAR Taro Pharmaceuticals Inc.
TEP Teva Branded Pharmaceutical Products / Paladin Labs Inc.
TEV Teva Canada Limited
TGT Teligent Canada, Inc.
TMI Trudell Medical International
TMP Teva Canada Ltd/Teva Canada Innovation G.P. S.E.N.C
TPG Tillotts Pharma GMBH
TPT Taropharma, a division of Taro Pharmaceuticals Inc.
TRI Tribute Pharmaceuticals Canada Ltd
TSA Tersera Canada Inc.

U

UCB UCB Pharma Canada Inc.

V

VCL Bausch Health
VER Vertex Pharmaceuticals (Canada) Inc
VTC Valeant Canada Ltd./Teva Canada Ltd.

W

WSD Westwood Squibb (Division of Bristol-Myers Squibb Canada)
WSP Wellspring Pharmaceutical Canada Corp.

X

XPI Xediton Pharmaceuticals Inc.
XXX Miscellaneous Manufacturers

Indices

Alphabetical List of
Pharmaceutical Products

Numerical List by
Drug Identification Number

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

NUMERIC

A

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

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