

Alberta Drug Benefit List

Effective April 1, 2019



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Administered by Alberta Blue Cross
on behalf of Alberta Health.

The Drug Benefit List (DBL) is a list of drugs for which coverage may be provided to program participants. The DBL is not intended to be, and must not be used as a diagnostic or prescribing tool. Inclusion of a drug on the DBL does not mean or imply that the drug is fit or effective for any specific purpose. Prescribing professionals must always use their professional judgment and should refer to product monographs and any applicable practice guidelines when prescribing drugs. The product monograph contains information that may be required for the safe and effective use of the product.

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Contents only: **\$36.75** (\$35.00 + \$1.75 G.S.T.)

A cheque or money order must accompany the request for copies.

Table of Contents

PART 1

SECTION 1—POLICIES AND GUIDELINES

Introduction

Acknowledgments	1.1
Eligibility	1.1
Additional Notes Regarding Application of the <i>List</i>	1.1
Legend	1.3
Example of Drug Product Listings.....	1.4
Drug Reviews.....	1.5
Alberta Health Expert Committee on Drug Evaluation and Therapeutics	1.7

Submissions for Drug Reviews

Submissions for Drug Reviews	1.8
Criteria for Listing Drug Products.....	1.10
Interchangeable Drug Products – Additional Criteria.....	1.12
Interchangeable Drug Products – Additional Criteria Appendices.....	1.17
Review of Benefit Status (ROBS) Criteria.....	1.22
Submission Requirements	1.23
Non-Innovator Policy.....	1.39
Supply Shortages.....	1.41
Units of Issue for Pricing	1.43
Policy for Administering Interchangeability Challenges	1.44
Your Comments are Important to Us	1.46

Restricted Benefits

Restricted Benefits	1.47
Products Designated as Restricted Benefits	1.47
Limited Restricted Benefits	1.50

Special Authorization Guidelines

Special Authorization Policy.....	1.51
Special Authorization Procedures	1A.1
Special Authorization Forms	1A.2
Prescriber Registration Forms	1A.6
<i>Drug Special Authorization Request Form</i>	1A.7
<i>Donepezil/Galantamine/Rivastigmine Special Authorization Request Form</i>	1A.9
<i>Darbepoetin/Epoetin Special Authorization Request Form</i>	1A.11
<i>Abatacept/Adalimumab/Anakinra/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/ Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form</i>	1A.14
<i>Ezetimibe Special Authorization Request Form</i>	1A.16
<i>Peginterferon Alfa-2a for Chronic Hepatitis C Special Authorization Request Form</i>	1A.18
<i>Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form</i>	1A.20
<i>Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form</i>	1A.22
<i>Select Quinolones Special Authorization Request Form</i>	1A.24
<i>Alendronate/Raloxifene/Risedronate for Osteoporosis Special Authorization Request Form</i>	1A.27

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

Table of Contents, continued

<i>Celecoxib Special Authorization Request Form</i>	1A.29
<i>Filgrastim/Pegfilgrastim/Plerixafor Special Authorization Request Form</i>	1A.31
<i>Fentanyl Special Authorization Request Form</i>	1A.34
<i>Adalimumab/Etanercept/Infliximab/Ixekizumab/Secukinumab/Ustekinumab for Plaque Psoriasis Special Authorization Request Form</i>	1A.36
<i>Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form</i>	1A.38
<i>Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form</i>	1A.40
<i>Rituximab for Rheumatoid Arthritis Special Authorization Request Form</i>	1A.42
<i>Imiquimod Special Authorization Request Form</i>	1A.44
<i>Aripiprazole/Paliperidone/Risperidone Prolonged Release Injection Special Authorization Request Form</i>	1A.46
<i>Abatacept for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form</i>	1A.49
<i>Montelukast/Zafirlukast Special Authorization Request Form</i>	1A.51
<i>Febuxostat Special Authorization Request Form</i>	1A.53
<i>Denosumab/Zoledronic Acid for Osteoporosis Special Authorization Request Form</i>	1A.55
<i>Omalizumab for Asthma Special Authorization Request Form</i>	1A.57
<i>Eculizumab Special Authorization Request Form</i>	1A.59
<i>Eculizumab Consent Form</i>	1A.64
<i>Rituximab for Granulomatosis with Polyangiitis/Microscopic Polyangiitis Special Authorization Request Form</i>	1A.66
<i>Tocilizumab for Systemic Juvenile Idiopathic Arthritis Special Authorization Request Form</i>	1A.68
<i>DPP-4/SGLT2 Inhibitors Special Authorization Request Form</i>	1A.70
<i>Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form</i>	1A.73
<i>Tacrolimus Topical Ointment Special Authorization Request Form</i>	1A.75
<i>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</i>	1A.78
<i>Alemtuzumab/Fingolimod/Natalizumab for Multiple Sclerosis Special Authorization Request Form</i>	1A.80
<i>Ivacaftor Special Authorization Request Form</i>	1A.82
<i>Adalimumab/Golimumab/Infliximab/Vedolizumab for Ulcerative Colitis Special Authorization Request Form</i>	1A.84
<i>Antivirals for Chronic Hepatitis C Special Authorization Request Form</i>	1A.86
<i>Proton-Pump Inhibitors Pricing Authorization Request Form</i>	1A.88
<i>Nintedanib/Pirfenidone Special Authorization Request Form</i>	1A.91
<i>Deferiprone Special Authorization Request Form</i>	1A.94
<i>Long-Acting Fixed-Dose Combination Products for Asthma/COPD Special Authorization Request Form</i>	1A.96
<i>Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form</i>	1A.99
<i>Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form</i>	1A.102
<i>Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form</i>	1A.104
<i>Mepolizumab Special Authorization Request Form</i>	1A.107
<i>Alirocumab/Evolocumab for HeFH Special Authorization Request Form</i>	1A.109
<i>Fidaxomicin Special Authorization Request Form</i>	1A.111
<i>Asfotase Alfa Special Authorization Request Form</i>	1A.113
<i>Asfotase Alfa Consent Form</i>	1A.118
<i>Tocilizumab for Giant Cell Arteritis Special Authorization Request Form</i>	1A.120
<i>Nusinersen Special Authorization Request Form</i>	1A.122
<i>Obeticholic Acid Special Authorization Request Form</i>	1A.124

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

Table of Contents, continued

<i>Ocrelizumab for PPMS Special Authorization Request Form</i>	1A.127
<i>Registration for MS Neurologist Status Form</i>	1A.129
<i>Application for Registered Prescriber Status for Restricted Benefit Claim Coverage under Alberta Government Sponsored Drug Benefit Programs – Jetrea Form</i>	1A.131

SECTION 2—PRICE POLICY

Definitions	2.1
Alberta Price Confirmation (APC) for Non-Fixed Price, Fixed Price and Pan-Canadian Select Molecule	
Price Initiative Drug Products.....	2.3
Interim APC.....	2.6
Fixed Pricing Rules	2.7
Non-Fixed Pricing Rules	2.8
Exceptions.....	2.8
Price Reductions	2.10
Minister's Authority.....	2.10
Least Cost Alternative (LCA) Price Policy.....	2.13
Maximum Allowable (MAC) Price Policy.....	2.14
Transitional Period Price Policy	2.15

SECTION 3—CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

Special Authorization Policy.....	3.1
Criteria for Coverage.....	3.3

SECTION 3A— CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

Criteria for Coverage.....	3A
Role of the Prescribers.....	3A
<i>Registration for Designated Prescriber Status for Alberta Drug Benefit List Claim Coverage – Select Quinolone Antibiotics Form</i>	3A.1

SECTION 4—RARE DISEASES DRUG COVERAGE PROGRAM

Rare Diseases Drug Coverage	4.1
Contraindications	4.1
Rare Diseases Drugs Eligible for Coverage	4.2
Alberta Rare Diseases Clinical Review Panel	4.2
Process for Rare Diseases Drug Coverage.....	4.2

PART 2

PHARMACOLOGIC–THERAPEUTIC CLASSIFICATION OF DRUGS

00:00	Non-Classified Drugs.....	1
04:00	Antihistamine Drugs	3
08:00	Anti-Infective Agents.....	5

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

Table of Contents, continued

10:00	Antineoplastic Agents	25
12:00	Autonomic Drugs	27
20:00	Blood Formulation, Coagulation and Thrombosis	33
24:00	Cardiovascular Drugs	39
28:00	Central Nervous System Agents	75
34:00	Dental Agents	129
36:00	Diagnostic Agents.....	131
40:00	Electrolytic, Caloric, and Water Balance	133
48:00	Respiratory Tract Agents.....	137
52:00	Eye, Ear, Nose and Throat (EENT) Preparations	139
56:00	Gastrointestinal Drugs	151
60:00	Gold Compounds.....	161
64:00	Heavy Metal Antagonists.....	163
68:00	Hormones and Synthetic Substitutes	165
80:00	Serums, Toxoids and Vaccines	179
84:00	Skin and Mucous Membrane Agents	181
86:00	Smooth Muscle Relaxants.....	193
88:00	Vitamins	195
92:00	Miscellaneous Therapeutic Agents	197
94:00	Devices	205
 APPENDICES		
	Appendix 1 Abbreviations.....	214
	Appendix 2 Pharmaceutical Manufacturers.....	215
 INDICES		
	Index 1 Alphabetical List of Pharmaceutical Products	217
	Index 2 Numerical List by Drug Identification Number	252

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.

ALBERTA DRUG BENEFIT LIST

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.

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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.

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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

10 APX \$ 0.9375 12

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08:08 ANALGESICS AND ANTIPYRETICS
(OPIATE AGONISTS)

OXYCODONE HCL
10 MG ORAL TABLET

00002319985 PMS-OXYCODONE
00000443948 SUPEUDOL
00002240131 OXY-IR

PMS \$ 0.2283 14
SDZ \$ 0.2283
PUR \$ 0.4110

1 28:00 CENTRAL NERVOUS SYSTEM AGENTS

2 28:08:04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

3 DICLOFENAC SODIUM

4 5 100 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)	13 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

7 8 0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT

00000578436	DIPROSALIC	9 MFC	\$	0.9084
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FLUOCINONIDE
0.05 % TOPICAL EMOLLIENT CREAM

6	00000598933	TIAMOL	VCL	\$	0.2079
	000002163152	LIDEMOL	TPT	\$	0.2122 11

48:00 RESPIRATORY TRACT AGENTS

48:10.24 ANTI-INFLAMMATORY AGENTS
(LEUKOTRIENE MODIFIERS)

APREPITANT

15 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.

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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 Expert Committee on Drug Evaluation and Therapeutics

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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.

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ALBERTA DRUG BENEFIT LIST

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.

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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;

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ALBERTA DRUG BENEFIT LIST

- 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.

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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 II, 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.

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ALBERTA DRUG BENEFIT LIST

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 not mean the Drug Product will automatically be designated as interchangeable.**

Expedited Reviews

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:

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ALBERTA DRUG BENEFIT LIST

- 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:**

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ALBERTA DRUG BENEFIT LIST

- 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.

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- 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.

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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 C_{max} 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 C_{min} of the test to reference formulation should also be between 80.0 and 125.0%.

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ALBERTA DRUG BENEFIT LIST
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) measurable 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.

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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.

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ALBERTA DRUG BENEFIT LIST
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.

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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.

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

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

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ALBERTA DRUG BENEFIT LIST

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.

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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

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ALBERTA DRUG BENEFIT LIST

- 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.

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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)

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

ALBERTA DRUG BENEFIT LIST

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.

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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

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ALBERTA DRUG BENEFIT LIST

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.

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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.

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ALBERTA DRUG BENEFIT LIST

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

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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

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ALBERTA DRUG BENEFIT LIST

(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.

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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.

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ALBERTA DRUG BENEFIT LIST

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;

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ALBERTA DRUG BENEFIT LIST

- 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.

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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.

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ALBERTA DRUG BENEFIT LIST

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

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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.

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Units of Issue for Pricing

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

Dosage Form	Unit of Issue Priced in <i>ADBL</i>
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 nebulas
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

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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

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

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

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ALBERTA DRUG BENEFIT LIST

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

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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

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ALBERTA DRUG BENEFIT LIST

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

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ALBERTA DRUG BENEFIT LIST

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

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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.

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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

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ALBERTA DRUG BENEFIT LIST

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.

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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.

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ALBERTA DRUG BENEFIT LIST

- *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.

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ALBERTA DRUG BENEFIT LIST

- *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 acclidinium bromide + formoterol fumarate dihydrate, budesonide + formoterol fumarate dihydrate, fluticasone furoate + vilanterol trifenate, indacaterol maleate + glycopyrronium bromide, salmeterol xinafoate + fluticasone propionate, tiotropium bromide + olodaterol hydrochloride or umeclidinium bromide + vilanterol trifenate 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.

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ALBERTA DRUG BENEFIT LIST

- *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.

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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.

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

PATIENT INFORMATION				COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			PHONE		FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
<input type="checkbox"/> NEW <input type="checkbox"/> 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.

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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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
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 <input type="checkbox"/> Donepezil (e.g. Aricept) <input type="checkbox"/> Galantamine (e.g. Reminyl ER) <input type="checkbox"/> Rivastigmine (e.g. Exelon)	Please confirm the diagnosis for which this drug is requested For the treatment of <input type="checkbox"/> Dementia of the Alzheimer's Type <input type="checkbox"/> other (please specify) _____
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Please provide a current MMSE or InterRAI-Cognitive Performance Scale score* and the date the exam was administered

MMSE score _____	InterRAI-Cognitive Performance Scale score _____
Date of exam _____	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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
CITY, PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED
POSTAL CODE			

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 <u>not</u> apply to epoetin 30,000 or 40,000 IU/syringe strengths)	
<input type="checkbox"/> anemia of chronic renal failure <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
NEW patients a) Provide <u>pre-treatment</u> hemoglobin level (g/L) _____ b) Is the hemoglobin level falling? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patients currently on darbepoetin or epoetin Provide <u>current</u> hemoglobin level (g/L) _____
Please provide the current iron status: Transferrin saturation is >20% <input type="checkbox"/> Yes <input type="checkbox"/> No	

CHEMOTHERAPY-INDUCED ANEMIA (includes epoetin 30,000 and 40,000 IU/syringe strengths)	
Please specify the type of cancer _____ <input type="checkbox"/> other (please specify) _____	For the treatment of anemia Please indicate if the anemia is chemotherapy-induced <input type="checkbox"/> Yes <input type="checkbox"/> No, please specify _____
Please provide the patient's hemoglobin level (g/L) _____	Please specify the reason why blood transfusions are not an option <input type="checkbox"/> Transfusion reactions in the past <input type="checkbox"/> Difficulty cross-matching the patient <input type="checkbox"/> Iron overload <input type="checkbox"/> Other, please specify: _____

ANEMIA IN AZT-TREATED/HIV INFECTED PATIENTS (does <u>not</u> apply to darbepoetin or epoetin 30,000 or 40,000 IU/syringe strengths)	
<input type="checkbox"/> anemia in AZT-treated/HIV infected patients <input type="checkbox"/> 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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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

Criteria for coverage

<p>DARBEPOETIN</p> <p>“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.</p> <p>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.”</p> <p>“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.”</p> <p>In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.</p> <p>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.</p> <p>For the second criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.</p> <p>The following product(s) are eligible for auto-renewal for the indication of the treatment of anemia of chronic renal failure.</p>
<p>EPOETIN (ALL strengths except 30,000 and 40,000 IU/syringe)</p> <p>“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.</p> <p>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.”</p> <p>“For the treatment of anemia in AZT-treated/HIV infected patients. Special authorization will be granted for twelve months.”</p> <p>“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.”</p> <p>In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.</p> <p>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.</p> <p>For the third criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.</p> <p>The following product(s) are eligible for auto-renewal for the indication of treatment of anemia of chronic renal failure.</p>
<p>EPOETIN 30,000 and 40,000 IU/syringe strengths</p> <p>“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.”</p> <p>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.</p> <p>Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on therapy.</p>



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.

**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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			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	Current weight (kg)	Dosage
<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Actemra <input type="checkbox"/> *Enbrel <input type="checkbox"/> *Inflectra <input type="checkbox"/> Orencia <input type="checkbox"/> Simponi <input type="checkbox"/> *Brenzys <input type="checkbox"/> *Erelzi <input type="checkbox"/> Kevzara <input type="checkbox"/> *Remicade <input type="checkbox"/> Xeljanz <input type="checkbox"/> Cimzia <input type="checkbox"/> Humira <input type="checkbox"/> Kineret <input type="checkbox"/> *Renflexis		
<p>*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.</p>			Frequency

*Pre-treatment scores	Current scores
DAS28 Score ____ Date _____	DAS28 Score ____ OR <input type="checkbox"/> ACR20 (renewals only) Date _____
HAQ Score ____ 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	For Abatacept ONLY Will the patient be maintained on methotrexate or another DMARD in combination with Abatacept? <input type="checkbox"/> YES <input type="checkbox"/> 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

<input type="checkbox"/> Abatacept _____	<input type="checkbox"/> Infliximab _____
<input type="checkbox"/> Adalimumab _____	<input type="checkbox"/> Golimumab _____
<input type="checkbox"/> Certolizumab _____	<input type="checkbox"/> Rituximab _____
<input type="checkbox"/> Etanercept _____	<input type="checkbox"/> 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
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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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
CITY, PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED
POSTAL CODE			

Criteria for Coverage of EZETIMIBE	
<p><i>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</i></p> <p><i>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*</i></p> <p>Special authorization may be granted for 6 months. This product is eligible for auto-renewal.</p>	<p><i>*High cardiovascular risk is defined as possessing one of the following</i></p> <ol style="list-style-type: none"> 1) <i>pre-existing cardiovascular disease and/or cerebrovascular disease</i> 2) <i>diabetes</i> 3) <i>familial hypercholesterolemia</i> 4) <i>greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool</i> 5) <i>three or more of the following risk factors:</i> <ul style="list-style-type: none"> <li style="width: 50%;">• <i>family history of premature cardiovascular disease</i> <li style="width: 50%;">• <i>obesity</i> <li style="width: 50%;">• <i>smoking</i> <li style="width: 50%;">• <i>glucose intolerance</i> <li style="width: 50%;">• <i>hypertension</i> <li style="width: 50%;">• <i>renal disease.</i>

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
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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.

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		<input type="checkbox"/> Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			<input type="checkbox"/> Alberta Human Services
				<input type="checkbox"/> Other
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

NOTIFICATION	PATIENT CONSENT
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.	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	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER
			<input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C
			<input type="checkbox"/> ACP <input type="checkbox"/> Other
CITY, PROVINCE			PHONE _____ FAX _____
POSTAL CODE			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.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Evidence of active liver disease:	YES	NO	Not tested
At least one of the following			
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OR			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OR			
c) does the patient have elevated liver stiffness as demonstrated by transient elastography (fibrosis).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

INITIAL REQUEST:	EXTENSION REQUEST:
Is the patient intolerant to ribavirin? <input type="checkbox"/> YES <input type="checkbox"/> NO	Request for treatment extension at 14 weeks (excluding patients with advanced fibrosis and cirrhosis) Is the patient serum HCV RNA negative at 12 weeks? <input type="checkbox"/> YES → Patient may be eligible for an additional 34 weeks of coverage (total 48 wks) <input type="checkbox"/> NO → Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)? <input type="checkbox"/> YES → Patient may be eligible for an additional 34 weeks of coverage (total 48 wks) <input type="checkbox"/> NO
Is a baseline serum sample stored for future testing? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Initial length of approval	
<input type="checkbox"/> Advanced fibrosis or cirrhosis (regardless of genotype).....48 weeks	
<input type="checkbox"/> Genotype 114 weeks	
<input type="checkbox"/> Genotype 2 or 314 weeks	
<input type="checkbox"/> Genotype 4, 5 or 614 weeks	

PREVIOUS THERAPY: Consideration may be given to patients who have previously received therapy and who meet at least one of the following
<input type="checkbox"/> Advanced fibrosis or cirrhosis
<input type="checkbox"/> 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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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	
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other
POSTAL CODE	PHONE		FAX	
FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED				

Please provide the following information for ALL requests

Diagnosis	Indicate requested drug	For <u>tocilizumab</u> requests, indicate current weight (kg)	Dosage Dosing frequency
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Adalimumab <input type="checkbox"/> Tocilizumab <input type="checkbox"/> 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) _____ 2. Patient global assessment (0-10) _____ 3. No. of active joints* _____	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 _____	4. No. of joints with LROM _____ 5. CHAQ (0-3) _____ 6. ESR (mm/hr) _____ or CRP _____
<small>*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both</small>	<small>*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both</small>

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

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.

**ADALIMUMAB/CERTOLIZUMAB/ETANERCEPT/
GOLIMUMAB/INFLIXIMAB/IXEKIZUMAB/SECUKINUMAB
for Psoriatic Arthritis
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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
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
<input type="checkbox"/> Polyarticular Psoriatic Arthritis <input type="checkbox"/> Pauciarticular Psoriatic Arthritis → Joints affected <input type="checkbox"/> Knee joint(s) <input type="checkbox"/> Hip joint(s) <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Cimzia <input type="checkbox"/> Humira <input type="checkbox"/> Cosentyx <input type="checkbox"/> *Inflectra <input type="checkbox"/> Enbrel <input type="checkbox"/> *Remicade <input type="checkbox"/> Simponi <input type="checkbox"/> 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

*Pre-treatment scores	Current scores
DAS28 score ____ Date _____	DAS28 score ____ OR <input type="checkbox"/> ACR20 (renewals only) Date _____
HAQ score ____ 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
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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.

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		<input type="checkbox"/> Alberta Blue Cross	<input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			PHONE	FAX	
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.

<input type="checkbox"/> CIPROFLOXACIN Respiratory tract infection <input type="checkbox"/> End stage COPD with or without bronchiectasis, where there has been documentation of previous <i>Pseudomonas aeruginosa</i> colonization/infection <input type="checkbox"/> Pneumonic illness in cystic fibrosis Genitourinary tract infection <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Prostatitis <input type="checkbox"/> Prophylaxis of urinary tract surgical procedures <input type="checkbox"/> Gonococcal infection Skin and soft tissue / bone and joint infection <input type="checkbox"/> Malignant / invasive otitis externa <input type="checkbox"/> Bone / joint infection due to gram-negative organisms <input type="checkbox"/> Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole (e.g. diabetic foot infection, decubitus ulcers) Gastrointestinal tract infection <input type="checkbox"/> Bacterial gastroenteritis where antimicrobial therapy is indicated <input type="checkbox"/> Typhoid fever (enteric fever) <input type="checkbox"/> Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole (e.g. intra-abdominal infections) Other <input type="checkbox"/> Prophylaxis of adult contacts of cases of invasive meningococcal disease <input type="checkbox"/> Therapy / step-down therapy of hospital acquired gram-negative infections <input type="checkbox"/> Empiric therapy of febrile neutropenia in combination with other appropriate agents <input type="checkbox"/> 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) <p align="center">↓</p> <i>Please specify details</i> _____ <input type="checkbox"/> For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases	<input type="checkbox"/> LEVOFLOXACIN <input type="checkbox"/> MOXIFLOXACIN <input type="checkbox"/> 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 <input type="checkbox"/> 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) <input type="checkbox"/> Acute exacerbation of chronic bronchitis after failure of first <u>and</u> second line therapy as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy <input type="checkbox"/> 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 <input type="checkbox"/> For use in other current Health Canada approved indications when prescribed by a specialist in infectious diseases
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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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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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.

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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
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
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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.
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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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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 <input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NO. <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
STREET ADDRESS			PHONE: _____ FAX: _____
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of CELECOXIB
<p>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</p> <p>For patients who have a documented history of ulcers proven radiographically and/or endoscopically.</p> <p>Special authorization may be granted for six months.</p> <p>This product is eligible for auto-renewal.</p>
<input type="checkbox"/> NEW Please provide the following information for NEW requests (check ALL that apply):
1) Is this patient at high risk of upper GI complications? <input type="checkbox"/> Yes <input type="checkbox"/> No
2) Does this patient have a documented history of ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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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.

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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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	
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER	<input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE	
CITY, PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
POSTAL CODE				

Drug requested (check ONE box)

*Grastofil (filgrastim) → complete Section I or II
 Neulasta (pegfilgrastim) → complete Section I only
 *Neupogen (filgrastim) → complete Section I or II
 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
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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.

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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 myelosuppressive 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 myelosuppressive 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.

PATIENT INFORMATION				COVERAGE TYPE	
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
<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other					
PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME		FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
STREET ADDRESS		CITY, PROVINCE	POSTAL CODE	REGISTRATION NUMBER	
				<input type="checkbox"/> CPSPA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other	
				PHONE	
				FAX	
				FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
CRITERIA FOR COVERAGE OF FENTANYL					
<u>Fentanyl injection</u> 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.		<u>Fentanyl patch</u> 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		<input type="checkbox"/> FENTANYL INJECTION		<input type="checkbox"/> FENTANYL PATCH	
Nature of the patient's pain		<input type="checkbox"/> Persistent, severe chronic pain		<input type="checkbox"/> Other:	
For FENTANYL PATCH requests Patients must have tried at least <u>two discrete courses*</u> of therapy with <u>two</u> of the required agents: morphine, hydromorphone and oxycodone. * A <i>discrete course</i> 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) <input type="checkbox"/> morphine _____ <input type="checkbox"/> hydromorphone _____ <input type="checkbox"/> oxycodone _____ <input type="checkbox"/> other (specify) _____ Treatment course 2 MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug) <input type="checkbox"/> morphine _____ <input type="checkbox"/> hydromorphone _____ <input type="checkbox"/> oxycodone _____ <input type="checkbox"/> other (specify) _____			
For FENTANYL INJECTION requests		Previous MEDICATION used and RESPONSE to each drug (or CONTRAINDICATIONS to drug) <input type="checkbox"/> morphine _____ <input type="checkbox"/> hydromorphone _____			
If patient is unable to swallow, please provide information regarding <u>specific reasons</u> 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					

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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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

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	
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	
STREET ADDRESS			PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
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
<input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Cosentyx <input type="checkbox"/> Humira <input type="checkbox"/> *Remicade <input type="checkbox"/> Stelara <input type="checkbox"/> Enbrel <input type="checkbox"/> *Inflectra <input type="checkbox"/> *Renflexis <input type="checkbox"/> Taltz		
<p>*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.</p>			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
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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.

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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.

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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> 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	Indicate requested drug	Current weight (kg)	Dosage
<input type="checkbox"/> Ankylosing Spondylitis (meeting modified NY criteria) <input type="checkbox"/> Other (specify)	<input type="checkbox"/> *Brenzys <input type="checkbox"/> Cosentyx <input type="checkbox"/> *Erelzi <input type="checkbox"/> *Inflectra <input type="checkbox"/> *Renflexis <input type="checkbox"/> Cimzia <input type="checkbox"/> *Enbrel <input type="checkbox"/> Humira <input type="checkbox"/> *Remicade <input type="checkbox"/> Simponi		
<p>*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.</p>			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		RENEWAL requests: Please provide current scores	
BASDAI #1	Date (YYYY-MM-DD)	BASDAI	Date (YYYY-MM-DD)
BASDAI #2	Date (YYYY-MM-DD)	Spinal pain VAS (cm)	Date (YYYY-MM-DD)
Spinal Pain VAS #1 (cm)	Date (YYYY-MM-DD)	Please provide reason if a switch to a different biologic agent is requested	
Spinal Pain VAS #2 (cm)	Date (YYYY-MM-DD)	Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.	

* 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.

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



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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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				<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> 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 <input type="checkbox"/> Moderately to Severely Active Crohn's (MSAC) <input type="checkbox"/> Fistulizing Crohn's <input type="checkbox"/> Other (please specify)		Indicate requested drug <input type="checkbox"/> Entyvio <input type="checkbox"/> *Inflixetra <input type="checkbox"/> *Renflexis <input type="checkbox"/> Humira <input type="checkbox"/> *Remicade <small>*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.</small>		Current weight (kg)	Dosage Frequency Date of last dose
For INITIAL requests, please indicate if the drug is requested for a <input type="checkbox"/> NEW patient who has never been treated with the requested drug by any health care provider <input type="checkbox"/> 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. <small>Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy</small>		
Infliximab For Fistulizing Crohn's Disease			Adalimumab, Infliximab or Vedolizumab for MSAC		
INITIAL requests Dose, duration and response are required for all medications previously utilized.			INITIAL requests Dose, duration and response are required for all medications previously utilized.		
Azathioprine			Azathioprine		
6-mercaptopurine			6-mercaptopurine		
Antibiotic(s) (specify drug name)			Methotrexate		
Antibiotic(s) (specify drug name)			Mesalamine		
NEW patient Does the patient have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite previous therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Glucocorticoid(s) (specify drug name)		
EXISTING patient Please indicate response to treatment with Infliximab <input type="checkbox"/> Closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline. <input type="checkbox"/> Incomplete response (please specify) _____ <input type="checkbox"/> Loss of response to 5mg/kg dosing: increase to 10mg/kg required			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? <input type="checkbox"/> Yes <input type="checkbox"/> No 2) Confirm the patient had an incomplete response to Infliximab 5mg/kg dosing: <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
CITY, PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED
POSTAL CODE			

Please provide the following information for ALL requests:

Diagnosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other (specify) _____	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.
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* 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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.



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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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 <input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other	
STREET ADDRESS			PHONE	FAX
CITY, PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
POSTAL CODE				

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



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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
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? <input type="checkbox"/> Yes <input type="checkbox"/> No, specify reason _____	Previous aripiprazole therapy: does the patient possess clinical evidence of previous successful treatment with aripiprazole therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



Criteria for coverage

ARIPIRAZOLE 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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

Diagnosis <input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis <input type="checkbox"/> Other (please specify) _____	Current weight (kg) _____	Dosage Dosing frequency _____
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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)	ACR Pedi 30 RESPONSE score at 16 to 20 weeks after first dose of previous abatacept treatment (provide for RETREATMENT requests)
Date of assessment _____	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 _____	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 _____
<small>*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both</small>	<small>*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both</small>

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

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.

PATIENT INFORMATION				COVERAGE TYPE
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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	
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NO. <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other	
			PHONE	
CITY , PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
POSTAL CODE				

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

<p>A. Previous Medication Use</p> <p>a) Please indicate if an inhaled glucocorticosteroid was used <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please specify reason) _____</p> <p>b) Please indicate if a long-acting beta 2 agonist (e.g. salmeterol or formoterol) was tried <input type="checkbox"/> Yes → Response: <input type="checkbox"/> Persistent symptoms <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> No (If no please specify) _____</p>	<p>B. Use of Inhaler Device</p> <p>Please indicate if the patient has difficulty using an inhaler device: <input type="checkbox"/> Yes (Please elaborate on the nature of the difficulty) _____ <input type="checkbox"/> No</p>
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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
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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.

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

PATIENT INFORMATION				COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY , PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			PHONE	FAX	
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 sulfipyrazone. 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) Sulfipyrazone has been utilized
 Intolerance Lack of response Other (please specify) _____
 Sulfipyrazone 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
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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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			REGISTRATION NUMBER
CITY , PROVINCE			PHONE
POSTAL CODE			FAX
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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

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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.

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 <input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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	
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other
POSTAL CODE			PHONE	FAX
FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED				

Please provide the following information for ALL requests

Diagnosis <input type="checkbox"/> Severe persistent asthma <input type="checkbox"/> Other (please specify) _____	Current weight (kg)	Smoking status <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	Please indicate if this patient is <input type="checkbox"/> starting drug upon approval complete section I <input type="checkbox"/> new to coverage but currently maintained on drug ...complete section I and II <input type="checkbox"/> submitting renewal requestcomplete section II
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Section I: Please provide pre-treatment information for NEW requests for treatment-naïve and treatment-experienced patients

Total serum human immunoglobulin (IgE) (IU/ml)	Date	AQLQ – Juniper score	Date
<input type="checkbox"/> Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing	Date	ACQ-5 scores	Score #1
FEV1 (pre-bronchodilator per cent predicted)	Date		Score #2

*Number of exacerbations of asthma within the 12-month period prior to starting omalizumab 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 exact 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 while on omalizumab 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 exact 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
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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.

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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.

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 <input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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
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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?	<input type="checkbox"/> granulocyte <input type="checkbox"/> monocyte	<input type="checkbox"/>		
Does the patient have a Lactate/Dehydrogenase (LDH) level at least 1.5 times the upper limit of normal?	<input type="checkbox"/>	<input type="checkbox"/>		

Please mail this request to ■ Alberta Blue Cross, Clinical Drug Services 10009 108 Street, Edmonton, Alberta T5J 3C5	Or fax to ■ 780-401-1150 in Edmonton ■ 1-888-401-1150 toll free all other areas	Case number
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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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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.	<input type="checkbox"/>	<input type="checkbox"/>	
b) Transfusions: Evidence that the patient has been transfused with at least four units of red blood cells in the last 12 months.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	<input type="checkbox"/>	

CONTRAINDICATIONS TO COVERAGE

Does the patient have any of the following?	Yes	No
Small clone size - granulocyte and monocyte clone sizes below 10 percent.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
Presence of another medical condition that might reasonably be expected to compromise a response to therapy	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNIZATION

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.	Yes	No	Date (YY/MM/DD)	
	Meningococcal (A,C,Y and W135)	<input type="checkbox"/>	<input type="checkbox"/>	
	Pneumococcal 23-valent	<input type="checkbox"/>	<input type="checkbox"/>	
	Pneumococcal 13-valent	<input type="checkbox"/>	<input type="checkbox"/>	
	Hib	<input type="checkbox"/>	<input type="checkbox"/>	

TRANSFUSION HISTORY

Transfusion date (YYYY/MM/DD)	RBC units	Comments

Case Number



Patient's Alberta Personal
Health Number (only)

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



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



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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other			

SPECIALIST IN HEMATOLOGY INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS	CITY	PROVINCE
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.

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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.

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.

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		<input type="checkbox"/> Alberta Blue Cross	<input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER
			<input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C
CITY, PROVINCE			<input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis <input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis <input type="checkbox"/> Other (please specify) _____	Patient's current weight (kg)	Requested dose (mg/kg) Dosing frequency
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Please provide the following information for NEW requests

Please check all of the following that apply <input type="checkbox"/> Fever (>38°C) for at least two weeks <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Rash of systemic JIA <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Serositis <input type="checkbox"/> Splenomegaly
Previous medications utilized (specify agents): Dose, duration and response is required <input type="checkbox"/> NSAIDs <input type="checkbox"/> Systemic corticosteroids

Please provide the following information for RENEWAL requests

The patient is a responder as demonstrated by (check all that apply) <input type="checkbox"/> JIA ACR30 <input type="checkbox"/> Absence of fever <input type="checkbox"/> Reduction in inflammatory markers (e.g. CRP concentration of less than 15 mg/L or reduction in ESR) <input type="checkbox"/> 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



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.

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		<input type="checkbox"/> Alberta Blue Cross	<input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY , PROVINCE			PHONE	FAX	
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)
<input type="checkbox"/> CANAgli flozin (e.g. Invokana) <input type="checkbox"/> SAXAgliptin + metformin (e.g. Komboglyze) <input type="checkbox"/> LINAgliptin (e.g. Trajenta) <input type="checkbox"/> SITAgliptin (e.g. Januvia) <input type="checkbox"/> LINAgliptin + metformin (e.g. Jentaduet) <input type="checkbox"/> SITAgliptin + metformin (e.g. Janumet, Janumet XR) <input type="checkbox"/> SAXAgliptin (e.g. Onglyza)	First-line drug product(s): metformin Second-line drug product(s): sulfonylureas And where insulin is not an option	Sections I & II
<input type="checkbox"/> DAPAgli flozin (e.g. Forxiga) <input type="checkbox"/> DAPAgli flozin + 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)
<input type="checkbox"/> EMPAgli flozin (e.g. Jardiance) <input type="checkbox"/> EMPAgli flozin + 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 <input type="checkbox"/> Yes <input type="checkbox"/> No, specify reason _____
Section II.	Please indicate if a sulfonylurea was tried <input type="checkbox"/> Yes <input type="checkbox"/> No, specify reason _____ Please indicate if insulin was tried <input type="checkbox"/> Yes <input type="checkbox"/> No, indicate why insulin is not an option for this patient <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Manual dexterity concerns <input type="checkbox"/> Needle phobia <input type="checkbox"/> Visual impairment <input type="checkbox"/> Other, specify _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to <ul style="list-style-type: none"> ▪ 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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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.



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

Criteria for coverage

CANAgliptin (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.

DAPAgliptin (e.g. Forxiga) and DAPAgliptin + 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.

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.

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

PATIENT INFORMATION				COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			REGISTRATION NUMBER		
			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other		
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
<p>*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.</p>					
Drug requested (check ONE box) <input type="checkbox"/> Apixaban (e.g. Eliquis) → complete Section I, II, and/or III <input type="checkbox"/> Dabigatran (e.g. Pradaxa) → complete Section I only <input type="checkbox"/> Edoxaban (e.g. Lixiana) → complete Section I and/or II <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
b) Please indicate if warfarin was used: <input type="checkbox"/> Yes → If yes, please indicate if a two month trial of warfarin was used <input type="checkbox"/> Yes <input type="checkbox"/> No, please specify reason _____ <input type="checkbox"/> 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 thrombotic events			Section III APIXABAN 2.5mg (e.g. Eliquis) for prophylaxis of venous thromboembolism (VTE) following elective total hip or total knee replacement surgery		
<p>**Special authorization may be granted for up to six months**</p>					
a) Is the request for treatment of deep vein thrombosis (DVT)? <input type="checkbox"/> No <input type="checkbox"/> Yes → date of most recent event _____			a) Has the patient had elective total hip replacement surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b) Is the request for treatment of a pulmonary embolism (PE)? <input type="checkbox"/> No <input type="checkbox"/> Yes → date of most recent event _____			b) Has the patient had elective total knee replacement surgery? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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.

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

PATIENT INFORMATION				COVERAGE TYPE
PATIENT LAST NAME	FIRST NAME	INITIAL		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other	
			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 <input type="checkbox"/> Relapsing-remitting multiple sclerosis (RRMS) <input type="checkbox"/> Secondary-progressive multiple sclerosis (SPMS) with relapses <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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)
	<input type="checkbox"/> Clinical relapse <input type="checkbox"/> MRI relapse (T1 gadolinium-enhancing lesions)
	<input type="checkbox"/> Clinical relapse <input type="checkbox"/> 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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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> 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)
	<input type="checkbox"/> Clinical relapse <input type="checkbox"/> MRI relapse (T1 gadolinium-enhancing lesion(s))
	<input type="checkbox"/> Clinical relapse <input type="checkbox"/> 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)
	<input type="checkbox"/> Moderate to very severe clinical relapse <input type="checkbox"/> MRI relapse (T1 gadolinium-enhancing lesion(s))
	<input type="checkbox"/> Moderate to very severe clinical relapse <input type="checkbox"/> 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
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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.

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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.

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

PATIENT INFORMATION				COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			PHONE	FAX	
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) <u>one month</u> after starting treatment	Date	FEV ₁ (pre-bronchodilator % predicted)	Date
FEV ₁ (pre-bronchodilator % predicted) <u>three months</u> 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
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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.

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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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
			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
<input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Entyvio <input type="checkbox"/> *Inflectra <input type="checkbox"/> *Renflexis <input type="checkbox"/> Humira <input type="checkbox"/> *Remicade <input type="checkbox"/> Simponi		Frequency Date of last dose
<small>*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.</small>			

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	Current score
Partial Mayo score _____ Date _____	Partial Mayo score _____ Date _____
<small>*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).</small>	

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



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.

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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			REGISTRATION NUMBER		
			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other		
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		*Duration of therapy and coverage of ribavirin in combination with the selected drug regimen will be approved according to criteria specified in the <i>Alberta Drug Benefit List</i> .	
<input type="checkbox"/> Elbasvir/grazoprevir (e.g. Zepatier) +/- ribavirin (e.g. Ibavyr)		<input type="checkbox"/> Genotype 1 → Specify subtype _____ <input type="checkbox"/> Genotype 4			
<input type="checkbox"/> Glecaprevir/pibrentasvir (e.g. Maviret)		Genotype _____ (optional if treatment naïve)			
<input type="checkbox"/> Sofosbuvir (e.g. Sovaldi) + daclatasvir (e.g. Daklinza)		<input type="checkbox"/> Genotype 3			
<input type="checkbox"/> Sofosbuvir (e.g. Sovaldi) + ribavirin (e.g. Ibavyr)		<input type="checkbox"/> Genotype 2 <input type="checkbox"/> Genotype 3			
<input type="checkbox"/> Sofosbuvir/ledipasvir (e.g. Harvoni) +/- ribavirin (e.g. Ibavyr)		<input type="checkbox"/> Genotype 1			
<input type="checkbox"/> Sofosbuvir/velpatasvir (e.g. Epclusa) +/- ribavirin (e.g. Ibavyr)		Genotype _____ (optional)			
<input type="checkbox"/> Sofosbuvir/velpatasvir/voxilaprevir (e.g. Vosevi)		Genotype _____ (optional if prior NS5A inhibitor)			
2 a) Does the patient have a quantitative HCV RNA value within six months of this request?					
<input type="checkbox"/> Yes → Provide test date (YYYY-MM-DD) _____ <input type="checkbox"/> No <input type="checkbox"/> Not tested					
2 b) For sofosbuvir/ledipasvir requests, is the patient's most recent viral load greater than 6 M IU/mL? <input type="checkbox"/> Yes <input type="checkbox"/> No					
3) What is the patient's fibrosis stage (optional)? <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 <input type="checkbox"/> Not tested					
4) Does the patient have cirrhosis?					
<input type="checkbox"/> Yes, compensated cirrhosis with Child-Turcotte-Pugh A (i.e. score five to six) <input type="checkbox"/> Yes, decompensated cirrhosis with Child-Turcotte-Pugh B or C (i.e. score seven or above) <input type="checkbox"/> No					
5) Is treatment requested post liver transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
6) Has the patient previously been treated with an HCV antiviral drug regimen?					
<input type="checkbox"/> Yes → Specify drug regimen previously used _____ → Specify the patient's response <input type="checkbox"/> failure (i.e. null or partial response or virologic breakthrough/rebound) <input type="checkbox"/> intolerance <input type="checkbox"/> relapse <input type="checkbox"/> other; specify _____ <input type="checkbox"/> 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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
			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?
<input type="checkbox"/> lansoprazole 15 mg <input type="checkbox"/> omeprazole 10 mg	<input type="checkbox"/> Yes, rabeprazole sodium 10 mg was used. <input type="checkbox"/> No, rabeprazole sodium 10 mg was not used. Please specify reasons.
<input type="checkbox"/> lansoprazole 30 mg <input type="checkbox"/> omeprazole 20 mg <input type="checkbox"/> pantoprazole sodium 40 mg	<input type="checkbox"/> Yes, pantoprazole magnesium 40 mg was used. <input type="checkbox"/> 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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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	<i>MAC pricing has been applied based on the LCA price for rabeprazole sodium 1 X 10 mg enteric-coated tablet.</i>
OMEPRAZOLE 10 MG		
RABEPRAZOLE SODIUM 10 MG		
LANSOPRAZOLE 30 MG	\$0.1875	<i>MAC pricing has been applied based on the LCA price for pantoprazole magnesium 1 X 40 mg enteric-coated tablet.</i>
OMEPRAZOLE 20 MG		
PANTOPRAZOLE MAGNESIUM 40 MG		
PANTOPRAZOLE SODIUM 40 MG		
RABEPRAZOLE SODIUM 20 MG	<i>These products are not affected by MAC pricing. Least cost alternative pricing will continue to apply.</i>	

*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.

PATIENT INFORMATION				COVERAGE TYPE:
PATIENT LAST NAME	FIRST NAME	INITIAL		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
CITY, PROVINCE		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
POSTAL CODE			

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
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Initial Renewal (at six months): Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of $\geq 10\%$ 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 $\geq 10\%$ 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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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 $\geq 10\%$ 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 $\geq 10\%$ 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.

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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
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
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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 acclidinium bromide + formoterol fumarate dihydrate, budesonide + formoterol fumarate dihydrate, fluticasone furoate + vilanterol trifenate, indacaterol maleate + glycopyrronium bromide, salmeterol xinafoate + fluticasone propionate, tiotropium bromide + olodaterol hydrochloride or umeclidinium bromide + vilanterol trifenate 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.

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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED					

Please select requested drug (and strength, where applicable)	Complete the following section(s)
<input type="checkbox"/> Budesonide + formoterol fumarate dihydrate (e.g. Symbicort) <input type="checkbox"/> Fluticasone furoate + vilanterol trifrenatate (e.g. Breo Ellipta) → Applicable strength <input type="checkbox"/> 100 mcg/25 mcg <input type="checkbox"/> Fluticasone propionate + salmeterol xinafoate (e.g. Advair) → Applicable products <input type="checkbox"/> Advair 250 Diskus <input type="checkbox"/> Advair 500 Diskus	Section I and/or II
<input type="checkbox"/> Fluticasone furoate + vilanterol trifrenatate (e.g. Breo Ellipta) → Applicable strength <input type="checkbox"/> 200 mcg/25 mcg <input type="checkbox"/> Fluticasone propionate + salmeterol xinafoate (e.g. Advair) → Applicable products <input type="checkbox"/> Advair 100 Diskus <input type="checkbox"/> Advair 125 MDI <input type="checkbox"/> Advair 250 MDI	Section I only
<input type="checkbox"/> Acclidinium bromide + formoterol fumarate dihydrate (e.g. Duaklir Genuair) <input type="checkbox"/> Glycopyrronium bromide + indacaterol maleate (e.g. Ultibro Breezhaler) <input type="checkbox"/> Tiotropium bromide + olodaterol hydrochloride (e.g. Inspiolto Respimat) <input type="checkbox"/> Umeclidinium bromide + vilanterol trifrenatate (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. acclidinium, 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 <ul style="list-style-type: none"> ▪ 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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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.

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Criteria for Coverage

<p>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)</p>
<p>ASTHMA FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)</p> <p>"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."</p> <p>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])</p> <p>"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])."</p> <p>"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."</p> <p>"Special authorization may be granted for 24 months."</p>
<p>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)</p>
<p>ASTHMA FIRST-LINE DRUG PRODUCT(S): INHALED CORTICOSTEROID (ICS)</p> <p>"For the treatment of asthma in patients uncontrolled on inhaled steroid therapy."</p> <p>"Special authorization may be granted for 24 months."</p>
<p>ACLIDINIUM BROMIDE + FORMOTEROL FUMARATE DIHYDRATE (e.g. Duaklir Genuair) GLYCOPYRRONIUM BROMIDE + INDACATEROL MALEATE (e.g. Ultibro Breezhaler) TIOTROPIUM BROMIDE + OLODATEROL HYDROCHLORIDE (e.g. Inspiroto Respimat) UMECLIDIINIUM BROMIDE + VILANTEROL TRIFENATATE (e.g. Anoro Ellipta)</p>
<p>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])</p> <p>"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])."</p> <p>"For the long-term maintenance treatment of airflow obstruction in patients with severe (i.e., FEV1 < 50% predicted) chronic obstructive pulmonary disease (COPD)."</p> <p>"Special authorization may be granted for 24 months."</p>

Eplerenone/Ivabradine/Sacubitril+Valsartan Special Authorization Request Form

On the reverse is the official *Eplerenone/Ivabradine/Sacubitril + 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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other _____		
BIRTH DATE (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		
ADDRESS			REGISTRATION NUMBER		
			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other		
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
Drug requested <input type="checkbox"/> Eplerenone (e.g. Inspra) → complete section I only <input type="checkbox"/> Ivabradine (e.g. Lancora) → complete sections I, II and III <input type="checkbox"/> 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			b) Left ventricular ejection fraction (LVEF) (%) _____		
<input type="checkbox"/> Heart failure (HF) → chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (specify) _____			c) New York Heart Association (NYHA) class _____		
Section II. For Ivabradine or Sacubitril+Valsartan requests, please provide the following information					
d) Drugs utilized <i>prior to the requested drug</i> : 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.			<input type="checkbox"/> Angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor antagonist (ARB) _____ <input type="checkbox"/> Beta-blocker _____ <input type="checkbox"/> Aldosterone antagonist _____ <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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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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 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) \geq 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) \geq 600 pg/mL; or

- if the patient has been hospitalized for HF within the past 12 months and has plasma BNP \geq 100 pg/mL or NT-proBNP \geq 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.

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.

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

ADALIMUMAB for Hidradenitis Suppurativa SPECIAL AUTHORIZATION REQUEST FORM

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
			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
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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.

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 <input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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 REGISTRATION NUMBER	
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

Diagnosis <input type="checkbox"/> Moderate to severe Chronic Idiopathic Urticaria (CIU) <input type="checkbox"/> Other (specify) _____	Please indicate if this patient is <input type="checkbox"/> Starting drug upon approval complete section I <input type="checkbox"/> New to coverage but currently maintained on drug ... complete section I and II <input type="checkbox"/> Renewal request complete section II
--	--

Section I: Please provide pre-treatment 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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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 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 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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other	
			REGISTRATION NUMBER	
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

Diagnosis <input type="checkbox"/> Severe Eosinophilic Asthma <input type="checkbox"/> Other (please specify) _____	Please indicate if this patient is <input type="checkbox"/> Starting drug upon approval complete section I <input type="checkbox"/> New to coverage but currently maintained on drug ... complete section I and II <input type="checkbox"/> Renewal request complete section II
--	--

Section I: Please provide pre-treatment 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 prior to starting mepolizumab
 (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 while on mepolizumab
 (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 exact 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
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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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
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 <input type="checkbox"/> Praluent <input type="checkbox"/> Repatha	2) Dosage and frequency
3) Diagnosis	
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> 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 _____	
<i>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.</i>	
2) Previous therapy (check the applicable box)	
<input type="checkbox"/> Adherence to high dose statin (e.g. atorvastatin 80 mg or rosuvastatin 40 mg) <u>in combination</u> with ezetimibe for at least three months → Specify statin utilized _____ Dose _____	
OR	
<input type="checkbox"/> Adherence to ezetimibe for at least three months [please confirm if patient meets a) or b) below by checking the applicable box]	
→ a) <input type="checkbox"/> Statins are contraindicated (specify) _____	
→ b) <input type="checkbox"/> 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]	
<input type="checkbox"/> Statin #1 _____ Dose _____	<input type="checkbox"/> Statin #2 _____ Dose _____
ii) Dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality [creatinine kinase (CK) > five times the upper limit of normal (ULN)] resolution rather than discontinuation of statin altogether	<input type="checkbox"/> Statin #1 <input type="checkbox"/> 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	<input type="checkbox"/> Statin #1 <input type="checkbox"/> Statin #2
iv) Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out	<input type="checkbox"/> Statin #1 <input type="checkbox"/> Statin #2
v) Patient developed confirmed and documented rhabdomyolysis	<input type="checkbox"/> Statin #1 <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	2) Current LDL-C _____ (mmol/L) Date _____
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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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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST



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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
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 \geq 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 <ul style="list-style-type: none"> ▪ 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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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.

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.

Page 1 of 4

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 <input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other _____						

METABOLIC SPECIALIST INFORMATION

Last name	First name	Initial
Street address		Postal code
City		Province
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
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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

<input type="checkbox"/> Hypophosphatasia (HPP)	
→ Specify type	<input type="checkbox"/> Antenatal <input type="checkbox"/> Newborn <input type="checkbox"/> Infantile <input type="checkbox"/> Juvenile (Childhood) <input type="checkbox"/> Adult
→ Specify age at onset and nature of first symptom	_____
<input type="checkbox"/> 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))?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Serum alkaline phosphatase (ALP) level below the age-adjusted normal range?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Plasma pyridoxal-5-phosphate (PLP) above the upper limit of normal established and validated in testing laboratory?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Documented history of HPP-related skeletal abnormalities confirmed radiologically?	<input type="checkbox"/>	<input type="checkbox"/>	

FOR TREATMENT EXPERIENCED PATIENTS

1) Patient is currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No → specify stop date and reason	
2) Indicate initial therapy start date	3) Patient started therapy prior to 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please mail this request to	Or fax to	Case number
<input type="checkbox"/> Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta T5J 3C5	<input type="checkbox"/> 780-401-1150 in Edmonton <input type="checkbox"/> 1-888-401-1150 toll free all other areas	

Patient's Alberta Personal Health Number (only)

ADDITIONAL CLINICAL CRITERIA (continued)

System	Details (Check ALL that apply and attach relevant reports)
4) Pain	<input type="checkbox"/> Muscle pain <input type="checkbox"/> Bone pain <input type="checkbox"/> Joint pain Type of pain, location, pain at rest or with activity, daytime or at night <hr/> Interventions <input type="checkbox"/> Analgesics, specify drug(s) and dose _____ <input type="checkbox"/> Heating pad <input type="checkbox"/> Massage <input type="checkbox"/> Other, specify _____ Response to previous interventions <hr/> <input type="checkbox"/> Visual analog for pain report attached Comments
5) X-ray findings	<input type="checkbox"/> Skeletal survey, specify age at X-rays, X-ray findings, and most recent X-ray results <hr/> <input type="checkbox"/> X-ray report attached
6) Renal	<input type="checkbox"/> Nephrocalcinosis <input type="checkbox"/> Renal failure/reduced renal function <input type="checkbox"/> Lab report attached Comments
7) Respiratory	<input type="checkbox"/> Lung hypoplasia <input type="checkbox"/> Decreased thoracic volume <input type="checkbox"/> Respiratory failure <input type="checkbox"/> Supplemental O2 required <input type="checkbox"/> Assisted ventilation Comments
8) Biochemical	<input type="checkbox"/> Lab reports attached for calcium, phosphate, magnesium, alkaline phosphatase (ALP), PTH, 25 OH vitamin D, pyridoxal-5-phosphate (PLP), urine phosphoethanolamine (PEA)
9) Other	<input type="checkbox"/> Hearing Loss, specify _____ <input type="checkbox"/> Seizures → B6 responsive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Delayed cognitive development, specify _____ Comments

Additional information relating to request

Please mail this request to ▪ Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta T5J 3C5	Or fax to ▪ 780-401-1150 in Edmonton ▪ 1-888-401-1150 toll free all other areas	Case number
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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 ▪ Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta T5J 3C5	Or fax to ▪ 780-401-1150 in Edmonton ▪ 1-888-401-1150 toll free all other areas	Case number
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PATIENT INFORMATION

PATIENT LAST NAME		FIRST NAME		INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
POSTAL CODE					

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 _____

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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			REGISTRATION NUMBER		
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
<input type="checkbox"/> Giant cell arteritis (GCA) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Starting first treatment course upon approvalcomplete section I <input type="checkbox"/> Renewal request at 12 to 16 weeks of therapy.....complete section II <input type="checkbox"/> New to coverage but currently maintained on drug.....complete sections I and II <input type="checkbox"/> Re-treatment requestscomplete 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
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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.

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 <input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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 <input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NUMBER <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other	
STREET ADDRESS			PHONE	FAX
CITY, PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
POSTAL CODE				

Please provide the following information for ALL requests

Diagnosis <input type="checkbox"/> 5q Spinal Muscular Atrophy (SMA) Type 1 <input type="checkbox"/> Other (specify) _____	Current weight (kg) _____	Please indicate if this patient is <input type="checkbox"/> starting drug upon approval complete section I <input type="checkbox"/> new to coverage but currently maintained on drug complete section I and II <input type="checkbox"/> submitting renewal request complete section II
Dosage and frequency requested	Treatment start date	Date of last dose

Section I: Please provide pre-treatment information for all INITIAL requests

Confirmed diagnosis date _____ Date _____	Disease duration at treatment initiation _____
<input type="checkbox"/> Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote Note: copy of the test report must be provided	Age of onset of clinical signs and symptoms consistent with SMA _____
<input type="checkbox"/> Genetic documentation of two copies of the Survival Motor Neuron 2 (SMN2) gene Note: copy of the test report must be provided	Were symptoms present at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ventilation status Patient requires ventilation at treatment initiation? <input type="checkbox"/> Yes, specify how many hours per day _____ <input type="checkbox"/> No Patient requires permanent invasive ventilation* at treatment initiation? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.</small>	
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? <input type="checkbox"/> Yes, specify how many hours per day _____ <input type="checkbox"/> No Patient currently requires permanent invasive ventilation*? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.</small>	

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.

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

Criteria for coverage**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 $> \text{ULN}$ 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.

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.

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 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 <i>Alberta Drug Benefit List</i> .				
SIGNATURE OF PRESCRIBER (required) <input type="checkbox"/>			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.

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 <i>Alberta Drug Benefit List</i> for coverage under the program.				
SIGNATURE OF PRESCRIBER (required) <input checked="" type="checkbox"/>			DATE	
<small>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.</small>				

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-330-5211



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,

ALBERTA DRUG BENEFIT LIST

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,

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

ALBERTA DRUG BENEFIT LIST

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.

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

ALBERTA DRUG BENEFIT LIST

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:

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

ALBERTA DRUG BENEFIT LIST

- 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.

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

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;

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

ALBERTA DRUG BENEFIT LIST

- 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:

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

ALBERTA DRUG BENEFIT LIST

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

ALBERTA DRUG BENEFIT LIST

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

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

ALBERTA DRUG BENEFIT LIST

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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

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

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 abatacept will be provided for one intravenous dose of up to 1000 mg every 4 weeks, or one weekly 125 mg subcutaneous injection. Ongoing coverage

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 abatacept will be provided for one intravenous dose of up to 1000 mg every 4 weeks, or one weekly 125 mg subcutaneous injection. Ongoing coverage

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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).

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ABATACEPT

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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 acclidinium 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

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:

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

- 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

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 of 15 mg/week for a minimum of 3 months.

OR

- Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

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,

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

- 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 meets coverage 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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ADALIMUMAB

- 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.

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

ADALIMUMAB

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ALEMTUZUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 (creatinine 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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ALIROCUMAB

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

<input checked="" type="checkbox"/> 00002453754	PRALUENT	SAV	\$	279.3600
<input checked="" type="checkbox"/> 00002453819	PRALUENT	SAV	\$	279.3600

150 MG / ML INJECTION

<input checked="" type="checkbox"/> 00002453762	PRALUENT	SAV	\$	279.3600
<input checked="" type="checkbox"/> 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
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500 MG ORAL CAPSULE

00000020885	NOVO-AMPICILLIN	TEV	\$	0.8006
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

APIXABAN

Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

2.5 MG ORAL TABLET

00002377233 ELIQUIS

BMS

\$

1.6336

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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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
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400 MG / VIAL INJECTION

00002420872	ABILIFY MAINTENA	OTS	\$	456.1800
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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	

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 patient's 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.sbgf.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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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"

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 patient's 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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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300 MG ORAL TABLET

00002425491	INVOKANA	JAI	\$	2.8090
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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)

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

CERTOLIZUMAB PEGOL

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."

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

CERTOLIZUMAB PEGOL

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

CERTOLIZUMAB PEGOL

- 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

<input checked="" type="checkbox"/> 00002331675	CIMZIA	UCB	\$	664.5100
<input checked="" type="checkbox"/> 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
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"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	TAR	\$	0.7422
	KIT			
00002248472	BENZACLIN	VCL	\$	1.0141

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

CYSTEAMINE BITARTRATE

"For use in patients with an established diagnosis of infantile nephropathic cystinosis with documented cystinosis, 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

**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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

"For patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

According to the product monograph, Exjade (deferasirox) is contraindicated in high risk myelodysplastic syndrome (MDS) patients, any other MDS patient with a life expectancy less than one year and patients with other hematological and nonhematological malignancies who are not expected to benefit from chelation therapy due to the rapid progression of their disease.

Special authorization may be granted for 24 months."

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

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

500 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461560	APO-DEFERASIROX	APX	\$	10.4824
00002464470	SANDOZ DEFERASIROX	SDZ	\$	10.4824
00002463547	TARO-DEFERASIROX	TAR	\$	10.4824
00002407973	TEVA-DEFERASIROX	TEV	\$	10.4824
00002287447	EXJADE	NOV	\$	42.6532

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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100 MG / ML ORAL SOLUTION

00002436523	FERRIPROX	APP	\$	3.1878
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 HCl 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 patient's 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ECULIZUMAB

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/1.73m², 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ECULIZUMAB

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 $0.5 \times 10^9/L$, platelet count below $20 \times 10^9/L$, reticulocytes below $25 \times 10^9/L$, 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ECULIZUMAB

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 patient's 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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

ECULIZUMAB

Clinical Drug Services, Alberta Blue Cross.

300 MG / VIAL INJECTION

00002322285 SOLIRIS

APG

\$ 6742.0000

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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 \leq 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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

ELBASVIR/ GRAZOPRE VIR

"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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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2,000 UNIT / SYR INJECTION SYRINGE

00002231584	EPREX (0.5 ML SYRINGE)	JAI	\$	28.5000
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3,000 UNIT / SYR INJECTION SYRINGE

00002231585	EPREX (0.3 ML SYRINGE)	JAI	\$	42.7500
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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-naïve 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-naïve 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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).

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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-naïve 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-naïve 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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 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 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."

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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***Effective March 1, 2018, all new Special Authorization requests for the treatment of Rheumatoid Arthritis or Ankylosing Spondylitis for etanercept-naïve 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-naïve 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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 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 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."

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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-naïve 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-naïve 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:

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

- 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),

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

- 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 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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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,

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ETANERCEPT

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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 (creatin 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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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
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8 MG ORAL EXTENDED-RELEASE TABLET

00002380048	TOVIAZ	PFI	\$	1.5000
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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 myelosuppressive 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
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0.3 MG / SYR INJECTION SYRINGE

00002441489	GRASTOFIL	APX	\$	144.3135
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0.48 MG / SYR INJECTION SYRINGE

00002454548	GRASTOFIL	APX	\$	230.9017
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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 trifenate 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 trifenate 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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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-naïve 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

GOLIMUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

GOLIMUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

GOLIMUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

GOLIMUMAB

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

<input checked="" type="checkbox"/> 00002324776	SIMPONI	JAI	\$ 1516.0000
<input checked="" type="checkbox"/> 00002324784	SIMPONI	JAI	\$ 1516.0000

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

GOLIMUMAB

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

GOLIMUMAB

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

<input checked="" type="checkbox"/> 00002413175	SIMPONI	JAI	\$ 1516.0000
<input checked="" type="checkbox"/> 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
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10.8 MG / SYR (BASE) INJECTION SYRINGE

00002225905	ZOLADEX LA	TSA	\$ 1204.7322
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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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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.)

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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:

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

- 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 of 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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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:

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

- 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

- 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 of 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

'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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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').

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

100 MG / VIAL INJECTION

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***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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

- 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 of 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INFLIXIMAB

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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INTERFERON BETA-1B

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

INTERFERON BETA-1B

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
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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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

<input checked="" type="checkbox"/> 00002455110	TALTZ	LIL	\$ 1582.2369
<input checked="" type="checkbox"/> 00002455102	TALTZ AUTOINJECTOR	LIL	\$ 1582.2369

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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90 MG / SYR INJECTION SYRINGE

00002283409	SOMATULINE AUTOGEL (0.3 ML SYRINGE)	ISP	\$	1595.2501
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120 MG / SYR INJECTION SYRINGE

00002283417	SOMATULINE AUTOGEL (0.5 ML SYRINGE)	ISP	\$	1996.7757
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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5 MG / ML INJECTION

00000727695	LUPRON	ABV	\$	67.6464
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7.5 MG / VIAL INJECTION

00000836273	LUPRON DEPOT	ABV	\$	387.9700
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11.25 MG / VIAL INJECTION

00002239834	LUPRON DEPOT	ABV	\$	1065.4400
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22.5 MG / VIAL INJECTION

00002230248	LUPRON DEPOT	ABV	\$	1071.0000
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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
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100 MG / ML ORAL SOLUTION

00002144336	CARNITOR	SGM	\$	0.5711
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200 MG / ML INJECTION

00002144344	CARNITOR	SGM	\$	13.2000
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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"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
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

0000237877	MEROPENEM	SDZ	\$	9.2225
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1 G / VIAL INJECTION

0000237895	MEROPENEM	SDZ	\$	18.4450
0000243657	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
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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;

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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).

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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			
<input checked="" type="checkbox"/>	00002457717	MDK-NITISINONE	MEN \$ 12.9500
<input checked="" type="checkbox"/>	00002459698	ORFADIN	BVM \$ 12.9500
5 MG ORAL CAPSULE			
<input checked="" type="checkbox"/>	00002457725	MDK-NITISINONE	MEN \$ 25.0600
<input checked="" type="checkbox"/>	00002459701	ORFADIN	BVM \$ 25.0600
10 MG ORAL CAPSULE			
<input checked="" type="checkbox"/>	00002457733	MDK-NITISINONE	MEN \$ 47.4000
<input checked="" type="checkbox"/>	00002459728	ORFADIN	BVM \$ 47.4000
20 MG ORAL CAPSULE			
00002459736	ORFADIN	BVM	\$ 128.1000

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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10 MG ORAL TABLET

00002463148	OCALIVA	ICP	\$	98.6301
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

OCRELIZUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

OCRELIZUMAB

the Ocrelizumab for PPMS Special Authorization Request Form (ABC 60067).

30 MG / ML INJECTION

00002467224	OCREVUS	HLR	\$	815.0000
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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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

OMALIZUMAB

Treatment cessation should be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24-week treatment period.

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation should be considered should CIU symptoms reappear."

All requests (including renewal requests) for omalizumab for Chronic Idiopathic Urticaria must be completed using the Omalizumab for Chronic Idiopathic Urticaria Special Authorization Request Form (ABC 60056).

150 MG / VIAL INJECTION

00002260565 XOLAIR

NOV

\$ 628.8400

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

PEGFILGRASTIM

"In patients with non-myeloid malignancies, receiving myelosuppressive 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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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:

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
- 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, 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 daclatasvir + 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).

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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
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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
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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.)

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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30 MG ORAL TABLET

00002298384	TEVA-RISEDRONATE	TEV	\$	10.8388
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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37.5 MG / VIAL INJECTION

00002255723	RISPERDAL CONSTA	JAI	\$	254.3600
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50 MG / VIAL INJECTION

00002255758	RISPERDAL CONSTA	JAI	\$	339.1500
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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):

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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.

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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) \geq 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) \geq 600 pg/mL; or
 - if the patient has been hospitalized for HF within the past 12 months and has plasma BNP \geq 100 pg/mL or NT-proBNP \geq 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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

SARILUMAB

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

SECUKINUMAB

Plaque Psoriasis

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who:

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:
 - Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR
 - Cyclosporine (6 weeks treatment); AND
 - Phototherapy (unless restricted by geographic location)

Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered.

'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above.

'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs.

For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist").

Initial coverage may be approved for 12 weeks as follows:

- Four weekly doses of 300 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8 and 12.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter. Each 300 mg dose is provided as two subcutaneous injections of 150 mg.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of the initial coverage period.
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond seven doses, the patient must meet all of the following criteria:

- 1) The patient must be assessed by a Dermatology Specialist after the initial seven doses to determine response.
- 2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
 - Greater than or equal to 75% reduction in PASI score, OR
 - Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI.

Following this assessment, continued coverage may be considered for one 300 mg dose of secukinumab every month for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

SECUKINUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

SECUKINUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

SECUKINUMAB

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
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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
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400 MG / VIAL INJECTION

00002435136	SYLVANT	JAI	\$	2790.8000
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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50 MG ORAL TABLET

00002388847	JANUVIA	MFC	\$	3.0801
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100 MG ORAL TABLET

00002303922	JANUVIA	MFC	\$	3.0801
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ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

SOFOSBUVIR/ LEDIPASVIR

"For treatment-naïve 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-naïve, without cirrhosis, recent quantitative hepatitis C viral load less than 6 M IU/mL: 8 weeks or 12 weeks (3)

- Treatment-naïve, without cirrhosis, viral load greater than or equal to 6 M IU/mL: 12 weeks

- Treatment-naïve, with compensated cirrhosis (4): 12 weeks

- Treatment-experienced, without cirrhosis: 12 weeks

- Treatment-naïve or treatment-experienced with decompensated cirrhosis (5): 12 weeks in combination with ribavirin

- Treatment-naïve 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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		
<input checked="" type="checkbox"/> 00002325063	OMNITROPE	SDZ \$ 103.8667
<input checked="" type="checkbox"/> 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		
<input checked="" type="checkbox"/> 00002350130	SAIZEN (1.5 ML)	SRO \$ 353.2200
<input checked="" type="checkbox"/> 00002350149	SAIZEN (2.5 ML)	SRO \$ 353.2200

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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.

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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].

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

TOCILIZUMAB

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."

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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	

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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 trifenate 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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).

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 of 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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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200 MG / VIAL INJECTION

00002256487	VFEND	PFI	\$	160.0204
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**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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 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 <i>Alberta Drug Benefit List</i> .				
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

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA DRUG BENEFIT LIST
 CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

LEVOFLOXACIN

250 MG ORAL TABLET

00002315424	ACT LEV OFLOXACIN	APH	\$	1.2038
00002284707	APO-LEV OFLOXACIN	APX	\$	1.2038
00002298635	SANDOZ LEV OFLOXACIN	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).

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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).

ALBERTA DRUG BENEFIT LIST
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

LEVOFLOXACIN

750 MG ORAL TABLET

00002315440	ACT LEV OFLOXACIN	APH	\$	4.8478
00002325942	APO-LEV OFLOXACIN	APX	\$	4.8478
00002298651	SANDOZ LEV OFLOXACIN	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).

**ALBERTA DRUG BENEFIT LIST
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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 so¹.

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.

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

**ALBERTA DRUG BENEFIT LIST
RARE DISEASES DRUG COVERAGE PROGRAM**

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**

<input checked="" type="checkbox"/>	00000999955	BLOOD GLUCOSE TEST STRIPS	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000999941	BLOOD LETTING LANCET	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000999985	INSULIN PEN NEEDLES	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000999952	INSULIN SYRINGES	XXX	\$	0.0000
<input checked="" type="checkbox"/>	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

ALBERTA DRUG BENEFIT LIST

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
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08:00 ANTI-INFECTIVE AGENTS

08:12.02 ANTIBACTERIALS
(AMINOGLYCOSIDES)

GENTAMICIN SULFATE

40 MG / ML (BASE) INJECTION

<input checked="" type="checkbox"/> 00002242652	GENTAMICIN	SDZ	\$	8.9447
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TOBRAMYCIN

28 MG INHALATION CAPSULE

00002365154	TOBI PODHALER	NOV	\$	13.4510
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TOBRAMYCIN SULFATE

60 MG / ML (BASE) INHALATION SOLUTION

00002389622	TEVA-TOBRAMYCIN	TEV	\$	5.4763
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00002443368	TOBRAMYCIN	SDZ	\$	5.4763
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00002239630	TOBI	NOV	\$	10.7608
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40 MG / ML (BASE) INJECTION

<input checked="" type="checkbox"/> 00002420287	JAMP-TOBRAMYCIN	JPC	\$	2.7250
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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
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00002235134	TEVA-CEFADROXIL	TEV	\$	0.8421
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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
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00002108119	STERILE CEFAZOLIN SODIUM	TEV	\$	2.5000
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1 G / VIAL (BASE) INJECTION

00002297205	CEFAZOLIN	APX	\$	3.2308
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00002308959	CEFAZOLIN	SDZ	\$	3.2308
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00002108127	STERILE CEFAZOLIN SODIUM	TEV	\$	3.2308
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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
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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
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500 MG ORAL CAPSULE

00000342114	TEVA-CEPHALEXIN	TEV	\$	0.7615
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25 MG / ML ORAL SUSPENSION

00000342106	TEVA-CEPHALEXIN 125	TEV	\$	0.2323
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50 MG / ML ORAL SUSPENSION

00000342092	TEVA-CEPHALEXIN 250	TEV	\$	0.4468
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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
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CEFOTAXIME SODIUM

1 G / VIAL (BASE) INJECTION

00002434091	CEFOTAXIME SODIUM	STM	\$	8.7465
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2 G / VIAL (BASE) INJECTION

00002434105	CEFOTAXIME SODIUM	STM	\$	17.5198
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CEFTAZIDIME

1 G / VIAL INJECTION

<input checked="" type="checkbox"/> 00002212218	FORTAZ	GSK	\$	23.4770
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2 G / VIAL INJECTION

<input checked="" type="checkbox"/> 00002212226	FORTAZ	GSK	\$	46.1590
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6 G / VIAL INJECTION

<input checked="" type="checkbox"/> 00002212234	FORTAZ	GSK	\$	138.5417
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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
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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
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IMIPENEM/ CILASTATIN 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.)

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

<input checked="" type="checkbox"/> 00000717282	PRIMAXIN	MFC	\$ 26.6910
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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

<input checked="" type="checkbox"/> 00002378787	MEROPENEM	SDZ	\$ 9.2225
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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 PELLETT)			
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
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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.)

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
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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
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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.

(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.)

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			
<input checked="" type="checkbox"/> 00000872644	AMPICILLIN SODIUM	TEV	\$	3.1830
500 MG / VIAL (BASE)	INJECTION			
<input checked="" type="checkbox"/> 00000872652	AMPICILLIN SODIUM	TEV	\$	3.3384
1 G / VIAL (BASE)	INJECTION			
<input checked="" type="checkbox"/> 00001933345	AMPICILLIN SODIUM	TEV	\$	5.5886
2 G / VIAL (BASE)	INJECTION			
<input checked="" type="checkbox"/> 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
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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.

(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.)

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

<input checked="" type="checkbox"/> 00002244849	COLISTIMETHATE FOR INJECTION	STM	\$	33.7397
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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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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.)

2 MG / ML INJECTION

<input checked="" type="checkbox"/> 00000891835	DIFLUCAN	PFI	\$	0.4085
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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
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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
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200 MG / VIAL INJECTION

00002256487	VFEND	PFI	\$	160.0204
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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**

<input checked="" type="checkbox"/> 00000029149	FUNGIZONE IV	BMS	\$ 80.0438
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NYSTATIN**100,000 UNIT / ML ORAL SUSPENSION**

<input checked="" type="checkbox"/> 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
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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 FUMARATERESTRICTED 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
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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
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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
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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
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08:00 ANTI-INFECTIVE AGENTS

08:30.08 ANTIPROTOZOALS
(ANTIMALARIALS)

CHLOROQUINE PHOSPHATE

250 MG ORAL TABLET

00000021261	TEVA-CHLOROQUINE	TEV	\$	1.3495
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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
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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
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METRONIDAZOLE

250 MG ORAL TABLET

00000545066	METRONIDAZOLE	AAP	\$	0.0635
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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
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100 MG ORAL TABLET

00000312738	NITROFURANTOIN	AAP	\$	0.2376
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50 MG ORAL CAPSULE (MACROCRYSTALS)

00002231015	TEVA-NITROFURANTOIN	TEV	\$	0.3841
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100 MG ORAL CAPSULE (MACROCRYSTALS)

00002231016	TEVA-NITROFURANTOIN	TEV	\$	0.7761
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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
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200 MG ORAL TABLET

00002243117	TRIMETHOPRIM	AAP	\$	0.5623
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10:00

Antineoplastic Agents

10:00 ANTINEOPLASTIC AGENTS

10:00

5-FLUOROURACIL/ SALICYLIC ACID

0.5 % * 10 % TOPICAL SOLUTION

00002428946	ACTIKERALL	CIP	\$	1.5581
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METHOTREXATE

2.5 MG ORAL TABLET

00002182963	APO-METHOTREXATE	APX	\$	0.6325
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00002170698	PMS-METHOTREXATE	PMS	\$	0.6325
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10 MG ORAL TABLET

00002182750	METHOTREXATE	PFI	\$	2.6505
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METHOTREXATE SODIUM

25 MG / ML (BASE) INJECTION

00002099705	METHOTREXATE SOD.(UNPRESERVED)	TEV	\$	5.6250
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00002182955	METHOTREXATE SOD.(UNPRESERVED)	PFI	\$	5.6250
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25 MG / ML (BASE) INJECTION

00002398427	METHOTREXATE (PRESERVED)	SDZ	\$	4.4600
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00002182777	METHOTREXATE SOD. (PRESERVED)	PFI	\$	8.4472
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17.5 MG / SYR (BASE) INJECTION SYRINGE

00002454769	METOJECT SUBCUTANEOUS	MDX	\$	32.0000
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20 MG / SYR (BASE) INJECTION SYRINGE

00002454866	METOJECT SUBCUTANEOUS	MDX	\$	35.0000
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22.5 MG / SYR (BASE) INJECTION SYRINGE

00002454777	METOJECT SUBCUTANEOUS	MDX	\$	35.0000
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25 MG / SYR (BASE) INJECTION SYRINGE

00002454874	METOJECT SUBCUTANEOUS	MDX	\$	39.0000
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12:00

Autonomic Drugs

12:00 AUTONOMIC DRUGS

12:04 PARASYMPATHOMIMETIC (CHOLINERGIC) AGENTS

PILOCARPINE HCL

5 MG ORAL TABLET

00002216345	SALAGEN	PFI	\$	1.4641
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PYRIDOSTIGMINE BROMIDE

60 MG ORAL TABLET

00000869961	MESTINON	VCL	\$	0.4880
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180 MG ORAL SUSTAINED-RELEASE TABLET

00000869953	MESTINON-SR	VCL	\$	1.0861
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12:00 AUTONOMIC DRUGS12:08.08 ANTICHOLINERGIC AGENTS
(ANTIMUSCARINICS / ANTISPASMODICS)**ACLIDINIUM BROMIDE**

400 MCG / DOSE INHALATION METERED INHALATION POWDER

00002409720	TUDORZA GENUAIR	AZC	\$	0.8850
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ATROPINE SULFATE

0.4 MG / ML INJECTION

00000392782	ATROPINE SULFATE	SDZ	\$	2.2880
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0.6 MG / ML INJECTION

00000392693	ATROPINE SULFATE	SDZ	\$	2.4880
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GLYCOPYRROLATE

0.2 MG / ML INJECTION

<input checked="" type="checkbox"/> 00002039508	GLYCOPYRROLATE	SDZ	\$	3.9780
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HYOSCINE BUTYLBROMIDE

10 MG ORAL TABLET

00000363812	BUSCOPAN	SAV	\$	0.3368
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20 MG / ML INJECTION

00000363839	BUSCOPAN	SAV	\$	4.5860
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IPRATROPIUM BROMIDE

20 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002247686	ATROVENT HFA	BOE	\$	0.1013
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250 MCG / ML INHALATION SOLUTION

00002126222	APO-IPRAVENT	APX	\$	0.3155
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00002231136	PMS-IPRATROPIUM	PMS	\$	0.3155
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0.03 % NASAL SPRAY

00002239627	PMS-IPRATROPIUM	PMS	\$	0.8693
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IPRATROPIUM BROMIDE/ SALBUTAMOL SULFATE

0.2 MG / ML * 1 MG / ML (BASE) INHALATION SOLUTION

00002272695	TEVA-COMBO STERINEBS	TEV	\$	0.5318
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00002231675	COMBIVENT UDV	BOE	\$	0.6452
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TIOTROPIUM BROMIDE MONOHYDRATE

2.5 MCG / DOSE INHALATION SOLUTION

00002435381	SPIRIVA RESPIMAT	BOE	\$	0.9013
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18 MCG INHALATION CAPSULE

00002246793	SPIRIVA	BOE	\$	1.8027
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12:00 AUTONOMIC DRUGS

12:08.08 ANTICHOLINERGIC AGENTS
(ANTIMUSCARINICS / ANTISPASMODICS)

UMECLIDIUM 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
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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
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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
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4 MG ORAL TABLET

00000010391	SINTROM	PAL	\$	1.7663
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WARFARIN SODIUM

1 MG ORAL TABLET

00002242924	APO-WARFARIN	APX	\$	0.0780
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00002242680	TARO-WARFARIN	TAR	\$	0.0780
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00001918311	COUMADIN	BMS	\$	0.3618
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2 MG ORAL TABLET

00002242925	APO-WARFARIN	APX	\$	0.0825
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00002242681	TARO-WARFARIN	TAR	\$	0.0825
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00001918338	COUMADIN	BMS	\$	0.3828
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2.5 MG ORAL TABLET

00002242926	APO-WARFARIN	APX	\$	0.0660
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00002242682	TARO-WARFARIN	TAR	\$	0.0660
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00001918346	COUMADIN	BMS	\$	0.3065
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3 MG ORAL TABLET

00002245618	APO-WARFARIN	APX	\$	0.1023
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00002242683	TARO-WARFARIN	TAR	\$	0.1023
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00002240205	COUMADIN	BMS	\$	0.4744
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4 MG ORAL TABLET

00002242927	APO-WARFARIN	APX	\$	0.1023
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00002242684	TARO-WARFARIN	TAR	\$	0.1023
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00002007959	COUMADIN	BMS	\$	0.4744
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5 MG ORAL TABLET

00002242928	APO-WARFARIN	APX	\$	0.0662
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00002242685	TARO-WARFARIN	TAR	\$	0.0662
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00001918354	COUMADIN	BMS	\$	0.3070
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6 MG ORAL TABLET

00002242686	TARO-WARFARIN	TAR	\$	0.3603
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7.5 MG ORAL TABLET

00002242697	TARO-WARFARIN	TAR	\$	0.3586
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10 MG ORAL TABLET

00002242929	APO-WARFARIN	APX	\$	0.1187
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00002242687	TARO-WARFARIN	TAR	\$	0.1187
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00001918362	COUMADIN	BMS	\$	0.5509
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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
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25,000 IU / ML INJECTION

00002231171	FRAGMIN	PFI	\$	43.1494
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2,500 IU / SYR INJECTION SYRINGE

00002132621	FRAGMIN (0.2 ML SYRINGE)	PFI	\$	5.4656
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3,500 IU / SYR INJECTION SYRINGE

00002430789	FRAGMIN (0.28 ML SYRINGE)	PFI	\$	7.6514
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5,000 IU / SYR INJECTION SYRINGE

00002132648	FRAGMIN (0.2 ML SYRINGE)	PFI	\$	10.9309
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7,500 IU / SYR INJECTION SYRINGE

00002352648	FRAGMIN (0.3 ML SYRINGE)	PFI	\$	16.3960
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10,000 IU / SYR INJECTION SYRINGE

00002352656	FRAGMIN (0.4 ML SYRINGE)	PFI	\$	21.8619
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12,500 IU / SYR INJECTION SYRINGE

00002352664	FRAGMIN (0.5 ML SYRINGE)	PFI	\$	27.3281
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15,000 IU / SYR INJECTION SYRINGE

00002352672	FRAGMIN (0.6 ML SYRINGE)	PFI	\$	32.7941
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18,000 IU / SYR INJECTION SYRINGE

00002352680	FRAGMIN (0.72 ML SYRINGE)	PFI	\$	39.3518
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ENOXAPARIN SODIUM**100 MG / ML INJECTION**

00002236564	LOVENOX	SAV	\$	22.0567
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30 MG / SYR INJECTION SYRINGE

00002012472	LOVENOX (0.3 ML SYRINGE)	SAV	\$	6.6170
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40 MG / SYR INJECTION SYRINGE

00002236883	LOVENOX (0.4 ML SYRINGE)	SAV	\$	8.8220
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60 MG / SYR INJECTION SYRINGE

00002378426	LOVENOX (0.6 ML SYRINGE)	SAV	\$	13.2330
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80 MG / SYR INJECTION SYRINGE

00002378434	LOVENOX (0.8 ML SYRINGE)	SAV	\$	17.6450
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100 MG / SYR INJECTION SYRINGE

00002378442	LOVENOX (1 ML SYRINGE)	SAV	\$	22.0560
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120 MG / SYR INJECTION SYRINGE

00002242692	LOVENOX (0.8 ML SYRINGE)	SAV	\$	26.4670
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150 MG / SYR INJECTION SYRINGE

00002378469	LOVENOX HP (1 ML SYRINGE)	SAV	\$	33.0850
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HEPARIN SODIUM**1,000 UNIT / ML INJECTION**

00000453811	HEPARIN LEO	LEO	\$	0.5283
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100 UNIT / ML INJECTION LOCK FLUSH

00000727520	HEPARIN LEO	LEO	\$	0.4493
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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
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20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS

20:24 HEMORRHEOLOGIC AGENTS

PENTOXIFYLLINE

400 MG ORAL SUSTAINED-RELEASE TABLET

00002230090	PENTOXIFYLLINE SR	AAP	\$	0.8042
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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 ANTIARRYTHMICS)

DISOPYRAMIDE

100 MG ORAL CAPSULE

00002224801	RYTHMODAN	SAV	\$	0.2950
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24:00 CARDIOVASCULAR DRUGS

24:04.04.08 CARDIAC DRUGS
 ANTIARRHYTHMIC AGENTS
 (CLASS IB ANTIARRYTHMICS)

MEXILETINE HCL

100 MG ORAL CAPSULE

00002230359	NOVO-MEXILETINE	TEV	\$	1.4915
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200 MG ORAL CAPSULE

00002230360	NOVO-MEXILETINE	TEV	\$	1.9974
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24:00 CARDIOVASCULAR DRUGS

24:04.04.12 CARDIAC DRUGS
 ANTIARRHYTHMIC AGENTS
 (CLASS IC ANTIARRYTHMICS)

FLECAINIDE ACETATE

50 MG ORAL TABLET

00002275538	APO-FLECAINIDE	APX	\$	0.2778
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00002459957	AURO-FLECAINIDE	AUR	\$	0.2778
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100 MG ORAL TABLET

00002275546	APO-FLECAINIDE	APX	\$	0.5558
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00002459965	AURO-FLECAINIDE	AUR	\$	0.5558
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PROPAFENONE HCL

150 MG ORAL TABLET

00002243324	APO-PROPAFENONE	APX	\$	0.2965
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00002457172	MYLAN-PROPAFENONE	MYP	\$	0.2965
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00000603708	RYTHMOL	BGP	\$	1.2264
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300 MG ORAL TABLET

00002243325	APO-PROPAFENONE	APX	\$	0.5227
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00002457164	MYLAN-PROPAFENONE	MYP	\$	0.5227
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00000603716	RYTHMOL	BGP	\$	2.1617
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24:00 CARDIOVASCULAR DRUGS

24:04.04.20 **CARDIAC DRUGS**
 ANTIARRHYTHMIC AGENTS
 (CLASS III ANTIARRHYTHMICS)

AMIODARONE HCL**100 MG ORAL TABLET**

00002292173	PMS-AMIODARONE	PMS	\$	0.8593
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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
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0.125 MG ORAL TABLET

00002335719	TOLOXIN	PPH	\$	0.3018
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0.05 MG / ML ORAL ELIXIR

00002242320	TOLOXIN PEDIATRIC	PPH	\$	1.3111
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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
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3.75 G ORAL POWDER PACKET

00002432463	LODALIS	VCL	\$	6.9734
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COLESTIPOL HCL**1 G ORAL TABLET**

00002132680	COLESTID	PFI	\$	0.2844
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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
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200 MG ORAL CAPSULE

00002239864	APO-FENO-MICRO	APX	\$	0.2722
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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
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250 MG ORAL TABLET

00000360260	METHYLDOPA	AAP	\$	0.1579
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500 MG ORAL TABLET

00000426830	METHYLDOPA	AAP	\$	0.2705
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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 DRUGS24:08.20 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 DRUGS24:08.24.08 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
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30 MG ORAL TABLET

00000441694	ISDN	AAP	\$	0.0913
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5 MG ORAL SUBLINGUAL TABLET

00000670944	ISDN	AAP	\$	0.0662
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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 DRUGS24:12.08 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
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200 MG ORAL TABLET

00002106280	TRANDATE	PAL	\$	0.5226
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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
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80 MG ORAL TABLET

00000782467	NADOL	AAP	\$	0.3879
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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 DRUGS24:28.08 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
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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
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10 MG ORAL CAPSULE

00000755907	NIFEDIPINE	AAP	\$	0.5098
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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
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180 MG ORAL EXTENDED-RELEASE TABLET

00002256746	TIAZAC XC	VCL	\$	1.1839
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240 MG ORAL EXTENDED-RELEASE TABLET

00002256754	TIAZAC XC	VCL	\$	1.5736
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300 MG ORAL EXTENDED-RELEASE TABLET

00002256762	TIAZAC XC	VCL	\$	1.5705
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360 MG ORAL EXTENDED-RELEASE TABLET

00002256770	TIAZAC XC	VCL	\$	1.5712
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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
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10 MG ORAL TABLET

00002290340	BENAZEPRIL	AAP	\$	0.9870
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20 MG ORAL TABLET

00002273918	BENAZEPRIL	AAP	\$	1.1311
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CAPTOPRIL

12.5 MG ORAL TABLET

00001942964	TEVA-CAPTOPRIL	TEV	\$	0.1113
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25 MG ORAL TABLET

00001942972	TEVA-CAPTOPRIL	TEV	\$	0.1575
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50 MG ORAL TABLET

00001942980	TEVA-CAPTOPRIL	TEV	\$	0.2935
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100 MG ORAL TABLET

00001942999	TEVA-CAPTOPRIL	TEV	\$	0.5458
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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
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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
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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
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600 MG (BASE) ORAL TABLET

00002243942	TEVETEN	BGP	\$	1.1544
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EPROSARTAN MESYLATE/ HYDROCHLOROTHIAZIDE

600 MG * 12.5 MG ORAL TABLET

00002253631	TEVETEN PLUS	BGP	\$	1.1544
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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
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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 entity 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
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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 entity 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
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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 entity 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
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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 entity 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
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300 MG ORAL CAPSULE

00002232318	ETODOLAC	AAP	\$	0.7760
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FLOCTAFENINE

200 MG ORAL TABLET

00002244680	FLOCTAFENINE	AAP	\$	0.4348
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400 MG ORAL TABLET

00002244681	FLOCTAFENINE	AAP	\$	0.8459
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FLURBIPROFEN

50 MG ORAL TABLET

00001912046	APO-FLURBIPROFEN	APX	\$	0.2221
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100 MG ORAL TABLET

00001912038	APO-FLURBIPROFEN	APX	\$	0.3039
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IBUPROFEN

300 MG ORAL TABLET

00000441651	APO-IBUPROFEN	APX	\$	0.1377
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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
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100 MG RECTAL SUPPOSITORY

00002231800	SANDOZ INDOMETHACIN	SDZ	\$	0.9356
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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
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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
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100 MG ORAL ENTERIC-COATED TABLET

00000842664	KETOPROFEN-E	AAP		\$	0.7276
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50 MG ORAL CAPSULE

00000790427	KETOPROFEN	AAP		\$	0.3440
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KETOROLAC TROMETHAMINE**10 MG ORAL TABLET**

00002229080	APO-KETOROLAC	APX		\$	0.3546
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00002465124	MAR-KETOROLAC	MAR		\$	0.3546
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00002162660	TORADOL	AAP		\$	0.7241
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10 MG / ML INJECTION

00002162644	TORADOL	AMP		\$	1.2920
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30 MG / ML INJECTION

<input checked="" type="checkbox"/> 00002239944	KETOROLAC TROMETHAMINE	SDZ		\$	4.4100
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MEFENAMIC ACID**250 MG ORAL CAPSULE**

00002229452	MEFENAMIC	AAP		\$	0.3990
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NABUMETONE**500 MG ORAL TABLET**

00002238639	NABUMETONE	AAP		\$	0.6130
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NAPROXEN**125 MG ORAL TABLET**

00000522678	APO-NAPROXEN	APX		\$	0.0781
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250 MG ORAL TABLET

00000522651	APO-NAPROXEN	APX		\$	0.1068
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00002350750	NAPROXEN	SNS		\$	0.1068
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00000565350	TEVA-NAPROX	TEV		\$	0.1068
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375 MG ORAL TABLET

00000600806	APO-NAPROXEN	APX		\$	0.1458
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00002350769	NAPROXEN	SNS		\$	0.1458
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00000627097	TEVA-NAPROX	TEV		\$	0.1458
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500 MG ORAL TABLET

00000592277	APO-NAPROXEN	APX		\$	0.2110
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00002350777	NAPROXEN	SNS		\$	0.2110
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00000589861	TEVA-NAPROX	TEV		\$	0.2110
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750 MG ORAL SUSTAINED-RELEASE TABLET

00002162466	NAPROSYN SR	AMP	\$ 0.2916	\$	1.4086
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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
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00002243312	TEVA-NAPROX EC	TEV	\$ 0.1068	\$	0.1068
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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
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20 MG ORAL CAPSULE

00000695696	TEVA-PIROXICAM	TEV	\$	0.3897
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SULINDAC

150 MG ORAL TABLET

00000745588	TEVA-SULINDAC	TEV	\$	0.4216
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200 MG ORAL TABLET

00000745596	TEVA-SULINDAC	TEV	\$	0.5003
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TENOXICAM

20 MG ORAL TABLET

00002230661	TENOXICAM	AAP	\$	1.1783
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TIAPROFENIC ACID

200 MG ORAL TABLET

00002179679	TEVA-TIAPROFENIC ACID	TEV	\$	0.5455
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300 MG ORAL TABLET

00002179687	TEVA-TIAPROFENIC ACID	TEV	\$	0.8070
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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
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30 MG ORAL TABLET

00000593451	TEVA-CODEINE	TEV	\$	0.1522
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30 MG / ML INJECTION

00000544884	CODEINE PHOSPHATE	SDZ	\$	4.1828
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CODEINE PHOSPHATE/ ACETAMINOPHEN

30 MG * 300 MG ORAL TABLET

00000608882	TEVA-EMTEC-30	TEV	\$	0.1738
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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
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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**

0000999108 COMPOUND NARCOTIC MIXTURES - ORAL XXX \$ 0.0000
AND INJECTION

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 entity 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.

0000999208 COMPOUND NARCOTIC MIXTURES - ORAL XXX \$ 0.0000
AND INJECTION

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 entity 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
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2 MG / ML INJECTION

00002145901	HYDROMORPHONE	SDZ	\$	2.0591
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10 MG / ML INJECTION

00002145928	HYDROMORPHONE HP	SDZ	\$	4.3460
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20 MG / ML INJECTION

00002145936	HYDROMORPHONE HP 20	SDZ	\$	8.9289
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50 MG / ML INJECTION

00002146126	HYDROMORPHONE HP 50	SDZ	\$	21.1271
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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

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

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
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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
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PENTAZOCINE LACTATE

30 MG / ML INJECTION

00002241976	TALWIN	HSP	\$	12.6816
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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 AGENTS28:12.04 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 AGENTS28:12.08 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 AGENTS28:12.12 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 AGENTS28:12.20 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 AGENTS28:12.92 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
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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
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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
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25 MG ORAL CAPSULE

00002239908	TOPAMAX SPRINKLE	JAI	\$	1.3900
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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
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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

TRANLYCYPROMINE 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
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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
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25 MG ORAL TABLET

00000324019	ANAFRANIL	AAP	\$	0.4202
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50 MG ORAL TABLET

00000402591	ANAFRANIL	AAP	\$	0.7737
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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
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28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
 ANTIPSYCHOTICS
 (ATYPICAL ANTIPSYCHOTICS)

ARIPIRAZOLE**2 MG ORAL TABLET**

00002471086	APO-ARIPIRAZOLE	APX	\$	0.8092
00002460025	AURO-ARIPIRAZOLE	AUR	\$	0.8092
00002466635	PMS-ARIPIRAZOLE	PMS	\$	0.8092
00002473658	SANDOZ ARIPIRAZOLE	SDZ	\$	0.8092
00002464144	TEVA-ARIPIRAZOLE	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-ARIPIRAZOLE	APX	\$	0.9046
00002460033	AURO-ARIPIRAZOLE	AUR	\$	0.9046
00002466643	PMS-ARIPIRAZOLE	PMS	\$	0.9046
00002473666	SANDOZ ARIPIRAZOLE	SDZ	\$	0.9046
00002464152	TEVA-ARIPIRAZOLE	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)

ARIPIPIRAZOLE**10 MG ORAL TABLET**

00002471108	APO-ARIPIPIRAZOLE	APX	\$	1.0754
00002460041	AURO-ARIPIPIRAZOLE	AUR	\$	1.0754
00002466651	PMS-ARIPIPIRAZOLE	PMS	\$	1.0754
00002473674	SANDOZ ARIPIPIRAZOLE	SDZ	\$	1.0754
00002322390	ABILIFY	OTS	\$	4.1016

15 MG ORAL TABLET

00002471116	APO-ARIPIPIRAZOLE	APX	\$	1.2692
00002460068	AURO-ARIPIPIRAZOLE	AUR	\$	1.2692
00002466678	PMS-ARIPIPIRAZOLE	PMS	\$	1.2692
00002473682	SANDOZ ARIPIPIRAZOLE	SDZ	\$	1.2692
00002464179	TEVA-ARIPIPIRAZOLE	TEV	\$	1.2692
00002322404	ABILIFY	OTS	\$	4.1016

20 MG ORAL TABLET

00002471124	APO-ARIPIPIRAZOLE	APX	\$	1.0017
00002460076	AURO-ARIPIPIRAZOLE	AUR	\$	1.0017
00002466686	PMS-ARIPIPIRAZOLE	PMS	\$	1.0017
00002473690	SANDOZ ARIPIPIRAZOLE	SDZ	\$	1.0017
00002464187	TEVA-ARIPIPIRAZOLE	TEV	\$	1.0017
00002322412	ABILIFY	OTS	\$	4.1016

30 MG ORAL TABLET

00002471132	APO-ARIPIPIRAZOLE	APX	\$	1.0017
00002460084	AURO-ARIPIPIRAZOLE	AUR	\$	1.0017
00002466694	PMS-ARIPIPIRAZOLE	PMS	\$	1.0017
00002473704	SANDOZ ARIPIPIRAZOLE	SDZ	\$	1.0017
00002322455	ABILIFY	OTS	\$	4.1016

BREXPIPIRAZOLE**0.25 MG ORAL TABLET**

00002461749	REXULTI	OTS	\$	3.5000
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0.5 MG ORAL TABLET

00002461757	REXULTI	OTS	\$	3.5000
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1 MG ORAL TABLET

00002461765	REXULTI	OTS	\$	3.5000
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2 MG ORAL TABLET

00002461773	REXULTI	OTS	\$	3.5000
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3 MG ORAL TABLET

00002461781	REXULTI	OTS	\$	3.5000
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4 MG ORAL TABLET

00002461803	REXULTI	OTS	\$	3.5000
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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
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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
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LURASIDONE HCL**20 MG ORAL TABLET**

00002422050	LATUDA	SUN	\$	4.2500
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40 MG ORAL TABLET

00002387751	LATUDA	SUN	\$	4.2500
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60 MG ORAL TABLET

00002413361	LATUDA	SUN	\$	4.2500
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80 MG ORAL TABLET

00002387778	LATUDA	SUN	\$	4.2500
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120 MG ORAL TABLET

00002387786	LATUDA	SUN	\$	4.2500
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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
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6 MG ORAL EXTENDED-RELEASE TABLET

00002300281	INVEGA	JAI	\$	5.7833
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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
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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
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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
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1 MG ORAL DISINTEGRATING TABLET

00002413493	MYLAN-RISPERIDONE ODT	MYP	\$	0.5150
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2 MG ORAL DISINTEGRATING TABLET

00002413507	MYLAN-RISPERIDONE ODT	MYP	\$	1.0187
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3 MG ORAL DISINTEGRATING TABLET

00002413515	MYLAN-RISPERIDONE ODT	MYP	\$	1.5275
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4 MG ORAL DISINTEGRATING TABLET

00002413523	MYLAN-RISPERIDONE ODT	MYP	\$	2.0425
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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
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1 MG ORAL TABLET

00000363677	TEVA-HALOPERIDOL	TEV	\$	0.2046
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2 MG ORAL TABLET

00000363669	TEVA-HALOPERIDOL	TEV	\$	0.3058
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5 MG ORAL TABLET

00000363650	TEVA-HALOPERIDOL	TEV	\$	0.4877
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10 MG ORAL TABLET

00000713449	TEVA-HALOPERIDOL	TEV	\$	0.7095
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20 MG ORAL TABLET

00000768820	TEVA-HALOPERIDOL	TEV	\$	1.3047
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5 MG / ML INJECTION

00000808652	HALOPERIDOL	SDZ	\$	5.0715
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HALOPERIDOL DECANOATE

100 MG / ML (BASE) INJECTION

00002130300	HALOPERIDOL LA	SDZ	\$	18.6142
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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**

<input checked="" type="checkbox"/>	00002273950	APO-METHYLPHENIDATE	APX	\$	0.0947
<input checked="" type="checkbox"/>	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
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"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
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"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
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"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
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"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
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"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
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"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
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"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
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"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
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30 MG ORAL TABLET

00000178802	PHENOBARB	PPH	\$	0.1580
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60 MG ORAL TABLET

00000178810	PHENOBARB	PPH	\$	0.2142
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100 MG ORAL TABLET

00000178829	PHENOBARB	PPH	\$	0.3078
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5 MG / ML ORAL ELIXIR

00000645575	PHENOBARB	PPH	\$	0.1489
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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
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00000865397	APO-ALPRAZ	APX	\$	0.0609
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00002400111	JAMP-ALPRAZOLAM	JPC	\$	0.0609
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00001913484	TEVA-ALPRAZOL	TEV	\$	0.0609
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0.5 MG ORAL TABLET

00002349205	ALPRAZOLAM	SNS	\$	0.0728
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00000865400	APO-ALPRAZ	APX	\$	0.0728
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00002400138	JAMP-ALPRAZOLAM	JPC	\$	0.0728
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00001913492	TEVA-ALPRAZOL	TEV	\$	0.0728
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BROMAZEPAM

1.5 MG ORAL TABLET

00002177153	APO-BROMAZEPAM	APX	\$	0.1028
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3 MG ORAL TABLET

00002177161	APO-BROMAZEPAM	APX	\$	0.0776
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00002230584	TEVA-BROMAZEPAM	TEV	\$	0.0776
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6 MG ORAL TABLET

00002177188	APO-BROMAZEPAM	APX	\$	0.1134
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00002230585	TEVA-BROMAZEPAM	TEV	\$	0.1134
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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

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

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
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NITRAZEPAM

5 MG ORAL TABLET

00000511528	MOGADON	AAP	\$	0.1604
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10 MG ORAL TABLET

00000511536	MOGADON	AAP	\$	0.2400
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OXAZEPAM

10 MG ORAL TABLET

00000402680	APO-OXAZEPAM	APX	\$	0.0420
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15 MG ORAL TABLET

00000402745	APO-OXAZEPAM	APX	\$	0.0660
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30 MG ORAL TABLET

00000402737	APO-OXAZEPAM	APX	\$	0.0900
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TEMAZEPAM

15 MG ORAL CAPSULE

00000604453	RESTORIL	AAP	\$	0.2163
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30 MG ORAL CAPSULE

00000604461	RESTORIL	AAP	\$	0.2617
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TRIAZOLAM

0.25 MG ORAL TABLET

00000808571	TRIAZO	AAP	\$	0.2669
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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
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25 MG ORAL CAPSULE

00000738832	NOVO-HYDROXYZIN	TEV	\$	0.1425
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00000646024	HYDROXYZINE	AAP	\$	0.1459
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50 MG ORAL CAPSULE

00000738840	NOVO-HYDROXYZIN	TEV	\$	0.2068
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00000646016	HYDROXYZINE	AAP	\$	0.2118
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2 MG / ML ORAL SYRUP

00000024694	ATARAX	ERF	\$	0.0568
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ZOPICLONE**5 MG ORAL TABLET**

00002245077	APO-ZOPICLONE	APX	\$	0.0990
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00002406969	JAMP-ZOPICLONE	JPC	\$	0.0990
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00002386771	MAR-ZOPICLONE	MAR	\$	0.0990
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00002391716	MINT-ZOPICLONE	MPI	\$	0.0990
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00002243426	PMS-ZOPICLONE	PMS	\$	0.0990
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00002267918	RAN-ZOPICLONE	RAN	\$	0.0990
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00002246534	RATIO-ZOPICLONE	TEV	\$	0.0990
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00002257572	SANDOZ ZOPICLONE	SDZ	\$	0.0990
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00002386909	SEPTA-ZOPICLONE	SEP	\$	0.0990
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00002344122	ZOPICLONE	SNS	\$	0.0990
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00002385821	ZOPICLONE	SIV	\$	0.0990
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00002216167	IMOVANE	SAV	\$	1.0589
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7.5 MG ORAL TABLET

00002218313	APO-ZOPICLONE	APX	\$	0.1250
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00002406977	JAMP-ZOPICLONE	JPC	\$	0.1250
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00002386798	MAR-ZOPICLONE	MAR	\$	0.1250
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00002391724	MINT-ZOPICLONE	MPI	\$	0.1250
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00002240606	PMS-ZOPICLONE	PMS	\$	0.1250
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00002267926	RAN-ZOPICLONE	RAN	\$	0.1250
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00002242481	RATIO-ZOPICLONE	TEV	\$	0.1250
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00002008203	SANDOZ ZOPICLONE	SDZ	\$	0.1250
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00002386917	SEPTA-ZOPICLONE	SEP	\$	0.1250
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00002282445	ZOPICLONE	SNS	\$	0.1250
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00002385848	ZOPICLONE	SIV	\$	0.1250
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00001926799	IMOVANE	SAV	\$	1.3370
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28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:28 ANTIMANIC AGENTS

LITHIUM CARBONATE**150 MG ORAL CAPSULE**

00002242837	APO-LITHIUM CARBONATE	APX	\$	0.0667
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00002216132	PMS-LITHIUM CARBONATE	PMS	\$	0.0667
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00000461733	CARBOLITH	VCL	\$	0.1292
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150 MG ORAL CAPSULE

00002242837	APO-LITHIUM CARBONATE	APX	\$	0.0667
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00002013231	LITHANE	ERF	\$	0.1117
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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
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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
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20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY

00002230420	IMITREX	GSK	\$	16.0781
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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
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The DBL is not a prescribing or a diagnostic tool. Prescribers should refer to drug monographs and utilize professional judgment.

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
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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

<input checked="" type="checkbox"/>	00080004109	MAGNESIUM-ODAN	ODN	\$	0.0199
<input checked="" type="checkbox"/>	00000026697	ROUGIER MAGNESIUM	TEV	\$	0.0200

MAGNESIUM GLUCONATE

500 MG ORAL TABLET

<input checked="" type="checkbox"/>	00080009539	JAMP MAGNESIUM GLUCONATE	JPC	\$	0.1088
<input checked="" type="checkbox"/>	00000555126	MAGLUCATE	PPH	\$	0.1183

POTASSIUM BICARBONATE

975 MG (BASE) ORAL EFFERVESCENT TABLET

00080033602	JAMP-K EFFERVESCENT (25 MEQ)	JPC	\$	0.4760
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POTASSIUM CHLORIDE (K+)

8 MEQ ORAL SUSTAINED-RELEASE TABLET

<input checked="" type="checkbox"/>	00002246734	EURO-K	SDZ	\$ 0.0450	\$	0.0450
<input checked="" type="checkbox"/>	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
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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
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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

<input checked="" type="checkbox"/>	00002242261	EURO-K 20	SDZ	\$ 0.1995	\$	0.1995
<input checked="" type="checkbox"/>	00080013007	JAMP-K 20	JPC	\$ 0.1995	\$	0.1995
<input checked="" type="checkbox"/>	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
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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 BALANCE40:18.18 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 BALANCE40:28.16 DIURETICS
(POTASSIUM-SPARING DIURETICS)**AMILORIDE HCL**

5 MG ORAL TABLET

00002249510 MIDAMOR AAP \$ 0.2897

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE40:28.20 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
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HYDROCHLOROTHIAZIDE/ TRIAMTERENE

25 MG * 50 MG ORAL TABLET

00000441775	APO-TRIAZIDE	APX	\$	0.0608
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00000532657	TEVA-TRIAMTERENE/HCTZ	TEV	\$	0.0608
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40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.24 DIURETICS
(THIAZIDE-LIKE DIURETICS)

CHLORTHALIDONE

50 MG ORAL TABLET

00000360279	CHLORTHALIDONE	AAP	\$	0.1325
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INDAPAMIDE HEMIHYDRATE

1.25 MG (BASE) ORAL TABLET

00002245246	APO-INDAPAMIDE	APX	\$	0.0745
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00002373904	JAMP-INDAPAMIDE	JPC	\$	0.0745
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00002240067	MYLAN-INDAPAMIDE	MYP	\$	0.0745
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2.5 MG (BASE) ORAL TABLET

00002223678	APO-INDAPAMIDE	APX	\$	0.1182
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00002373912	JAMP-INDAPAMIDE	JPC	\$	0.1182
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00002153483	MYLAN-INDAPAMIDE	MYP	\$	0.1182
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00000564966	LOZIDE	SEV	\$	0.4990
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METOLAZONE

2.5 MG ORAL TABLET

00000888400	ZAROXOLYN	SAV	\$	0.2136
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40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:40 URICOSURIC AGENTS

SULFINPYRAZONE

200 MG ORAL TABLET

00000441767	SULFINPYRAZONE	AAP	\$	0.3121
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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 CROMOGLYCAT

100 MG ORAL CAPSULE

00000500895	NALCROM	SAV	\$	1.5755
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1% INHALATION SOLUTION

00002046113	PMS-SODIUM CROMOGLYCAT	PMS	\$	0.9836
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48:00 RESPIRATORY TRACT AGENTS

48:12.08 BRONCHODILATORS
(ANTICHOLINERGIC AGENTS)

GLYCOPYRRONIUM BROMIDE

50 MCG INHALATION CAPSULE

00002394936	SEEBRI BREEZHALER	NOV	\$	1.7700
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48:00 RESPIRATORY TRACT AGENTS

48:24 MUCOLYTIC AGENTS

ACETYLCYSTEINE

20% INHALATION SOLUTION

<input checked="" type="checkbox"/> 00002243098	ACETYLCYSTEINE	SDZ	\$	0.7000
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52:00

Eye, Ear, Nose and Throat
(EENT) Preparations

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS52:04.04 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
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OFLOXACIN

0.3 % OPHTHALMIC SOLUTION

00002143291	OCUFLOX	ALL	\$	2.6410
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TOBRAMYCIN

0.3 % OPHTHALMIC SOLUTION

00002241755	SANDOZ TOBRAMYCIN	SDZ	\$	1.3620
00000513962	TOBEX	NOV	\$	1.8580

0.3 % OPHTHALMIC OINTMENT

00000614254	TOBEX	NOV	\$	2.6343
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS52:04.20 ANTI-INFECTIVES
(ANTIVIRALS)**TRIFLURIDINE**

1 % OPHTHALMIC SOLUTION

00000687456	VIROPTIC	VCL	\$	3.4539
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS52:08.08 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
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100 MCG / DOSE NASAL METERED DOSE SPRAY

00002230648	MYLAN-BUDESONIDE AQ	MYP	\$	0.1006
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CIPROFLOXACIN HCL/ DEXAMETHASONE

0.3 % * 0.1 % OTIC SUSPENSION

00002252716	CIPRODEX	NOV	\$	3.7693
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DEXAMETHASONE

0.1 % OPHTHALMIC SUSPENSION

00000042560	MAXIDEX	NOV	\$	1.7180
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0.1 % OPHTHALMIC OINTMENT

00000042579	MAXIDEX	NOV	\$	2.6600
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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
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PREDNISOLONE ACETATE/ SULFACETAMIDE SODIUM

0.2 % * 10 % OPHTHALMIC SUSPENSION

00000807788	BLEPHAMIDE	ALL	\$	2.8405
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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
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00002454807	SANDOZ DICLOFENAC OPHTHA	SDZ	\$	1.7710
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00001940414	VOLTAREN OPHTHA	NOV	\$	2.6860
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KETOROLAC TROMETHAMINE

0.45 % OPHTHALMIC SOLUTION

00002369362	ACUVAIL	ALL	\$	0.6466
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0.5 % OPHTHALMIC SOLUTION

00002245821	KETOROLAC	AAP	\$	2.7585
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00001968300	ACULAR	ALL	\$	3.6490
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:16 LOCAL ANESTHETICS

LIDOCAINE HCL

2 % ORAL LIQUID

00001968823	LIDODAN VISCOUS	ODN	\$	0.0551
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00000001686	XYLOCAINE VISCOUS	APC	\$	0.1076
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PROPARACAINE HCL

0.5 % OPHTHALMIC SOLUTION

00000035076	ALCAINE	ALC	\$	0.8514
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS

52:24 MYDRIATICS

ATROPINE SULFATE

1 % OPHTHALMIC SOLUTION

<input checked="" type="checkbox"/> 00000035017	ISOPTO ATROPINE	ALC	\$	0.7320
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CYCLOPENTOLATE HCL

1 % OPHTHALMIC SOLUTION

00000252506	CYCLOGYL	ALC	\$	1.0060
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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	COMP-D-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT 0.12%)	XXX	\$	0.0000
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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 entity 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	COMP-D-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT .12%)	XXX	\$	0.0000
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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 entity 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
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PHENYLEPHRINE HCL

2.5 % OPHTHALMIC SOLUTION

00000465763	MYDFRIN	ALC	\$	1.2100
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS52:40.04 ANTIGLAUCOMA AGENTS
(ALPHA-ADRENERGIC AGONISTS)**BRIMONIDINE TARTRATE**

0.2 % OPHTHALMIC SOLUTION

00002260077	APO-BRIMONIDINE	APX	\$	1.1550
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00002305429	SANDOZ BRIMONIDINE	SDZ	\$	1.1550
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00002236876	ALPHAGAN	ALL	\$	3.6169
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS52:40.08 ANTIGLAUCOMA AGENTS
(BETA-ADRENERGIC AGENTS)**BETAXOLOL HCL**

0.25 % (BASE) OPHTHALMIC SUSPENSION

00001908448	BETOPTIC S	NOV	\$	2.4520
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LEVOBUNOLOL HCL

0.5 % OPHTHALMIC SOLUTION

00000637661	BETAGAN	ALL	\$	3.5505
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TIMOLOL MALEATE

0.25 % (BASE) OPHTHALMIC SOLUTION

00002166712	SANDOZ TIMOLOL MALEATE	SDZ	\$	0.9678
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0.5 % (BASE) OPHTHALMIC SOLUTION

00000755834	APO-TIMOP	APX	\$	1.2140
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00002166720	SANDOZ TIMOLOL MALEATE	SDZ	\$	1.2140
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00000451207	TIMOPTIC	PUR	\$	4.0360
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0.25 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION

00002171880	TIMOPTIC-XE	PUR	\$	4.3080
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0.5 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION

00002171899	TIMOPTIC-XE	PUR	\$	5.1520
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS52:40.12 ANTIGLAUCOMA AGENTS
(CARBONIC ANHYDRASE INHIBITORS)**ACETAZOLAMIDE**

250 MG ORAL TABLET

00000545015	ACETAZOLAMIDE	AAP	\$	0.1320
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52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS52:40.12 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) PREPARATIONS52:40.20 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) PREPARATIONS52:40.28 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
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BRINZOLAMIDE/ BRIMONIDINE TARTRATE

1 % * 0.2 % OPHTHALMIC SUSPENSION

00002435411	SIMBRINZA	NOV	\$	4.6810
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BRINZOLAMIDE/ TIMOLOL MALEATE

1 % * 0.5 % (BASE) OPHTHALMIC SUSPENSION

00002331624	AZARGA	NOV	\$	4.5440
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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
<input checked="" type="checkbox"/> 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 fluorescein 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
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APRACLONIDINE HCL**0.5 % OPHTHALMIC SOLUTION**

00002076306	IOPIDINE	NOV	\$ 4.9880
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OCRIPLASMIN**0.5 MG / VIAL INJECTION**

00002410818	JETREA	ONV	\$ 4068.5000
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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 fluorescein 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
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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
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20,880 UNIT * 113,400 UNIT * 112,500 UNIT ORAL TABLET

00002241933	VIOKACE	AXC	\$	0.3967
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8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE

00000263818	COTAZYM	MFC	\$	0.2025
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4,000 UNIT * 12,000 UNIT * 12,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000789445	PANCREASE MT 4	JAI	\$	0.5953
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8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000502790	COTAZYM ECS 8	MFC	\$	0.3655
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10,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000789437	PANCREASE MT 10	JAI	\$	1.4881
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10,000 UNIT * 33,200 UNIT * 37,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00002200104	CREON 10 MINIMICROSPHERES	BGP	\$	0.2723
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16,000 UNIT * 48,000 UNIT * 48,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000789429	PANCREASE MT 16	JAI	\$	2.3807
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20,000 UNIT * 55,000 UNIT * 55,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000821373	COTAZYM ECS 20	MFC	\$	0.9582
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25,000 UNIT * 74,000 UNIT * 62,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00001985205	CREON 25 MINIMICROSPHERES	BGP	\$	0.8507
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56:00 GASTROINTESTINAL DRUGS56:22.08 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 DRUGS56:22.20 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 ZOFTRAN ODT NOV \$ 14.0040

8 MG ORAL DISINTEGRATING TABLET/FILM

00002389991 ONDISSOLVE ODF TAK \$ 4.9930

00002444682 SANDOZ ONDANSETRON ODT SDZ \$ 4.9930

00002239373 ZOFTRAN 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
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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
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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
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300 MG ORAL TABLET

00000487872	CIMETIDINE	AAP	\$	0.3423
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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
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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
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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
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200 MCG ORAL TABLET

00002244023	MISOPROSTOL	AAP	\$	0.4589
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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
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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
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GOLD SODIUM THIOMALATE**10 MG / ML INJECTION**

00001927620	MYOCHRYSSINE	SAV	\$	13.1000
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50 MG / ML INJECTION

00001927604	MYOCHRYSSINE	SAV	\$	24.7800
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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
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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 entity 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
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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 entity 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

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

68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:04 ADRENALS****FLUDROCORTISONE ACETATE**

0.1 MG ORAL TABLET

00002086026	FLORINEF	PAL	\$	0.2725
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FLUTICASONE PROPIONATE

50 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002244291	FLOVENT HFA	GSK	\$	0.2078
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125 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002244292	FLOVENT HFA	GSK	\$	0.3583
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250 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002244293	FLOVENT HFA	GSK	\$	0.7167
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250 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237246	FLOVENT DISKUS	GSK	\$	0.7167
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500 MCG / DOSE INHALATION METERED INHALATION POWDER

00002237247	FLOVENT DISKUS	GSK	\$	1.1148
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HYDROCORTISONE

10 MG ORAL TABLET

00000030910	CORTEF	PFI	\$	0.2077
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20 MG ORAL TABLET

00000030929	CORTEF	PFI	\$	0.3747
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HYDROCORTISONE SODIUM SUCCINATE

100 MG / VIAL (BASE) INJECTION

00000030600	SOLU-CORTEF	PFI	\$	4.1472
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250 MG / VIAL (BASE) INJECTION

00000030619	SOLU-CORTEF	PFI	\$	7.1975
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500 MG / VIAL (BASE) INJECTION

00000030627	SOLU-CORTEF	PFI	\$	10.8794
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1 G / VIAL (BASE) INJECTION

00000030635	SOLU-CORTEF	PFI	\$	18.2312
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METHYLPREDNISOLONE

4 MG ORAL TABLET

00000030988	MEDROL	PFI	\$	0.4725
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16 MG ORAL TABLET

00000036129	MEDROL	PFI	\$	1.3615
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METHYLPREDNISOLONE ACETATE

20 MG / ML INJECTION

00001934325	DEPO-MEDROL	PFI	\$	2.7597
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40 MG / ML INJECTION

00000030759	DEPO-MEDROL	PFI	\$	6.1911
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80 MG / ML INJECTION

00000030767	DEPO-MEDROL	PFI	\$	11.9659
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40 MG / ML INJECTION

00001934333	DEPO-MEDROL (PRESERVED)	PFI	\$	5.9361
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80 MG / ML INJECTION

00001934341	DEPO-MEDROL (PRESERVED)	PFI	\$	9.1546
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METHYLPREDNISOLONE ACETATE/ LIDOCAINE HCL

40 MG / ML * 10 MG / ML INJECTION

00000260428	DEPO-MEDROL WITH LIDOCAINE	PFI	\$	6.8505
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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 PFI FREE)		\$	7.0167
125 MG / VIAL (BASE)	INJECTION			
00002231894	METHYLPREDNISOLONE SOD SUCCINATE	TEV	\$	10.4010
00002367955	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE PFI FREE)		\$	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 PFI FREE)		\$	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 PFI FREE)		\$	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
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52 MG INTRAUTERINE INSERT

00002243005	MIRENA SYSTEM	BAI	\$ 348.4500
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LEVONORGESTREL/ ETHINYL ESTRADIOL**100 MCG * 20 MCG ORAL TABLET**

00002387875	ALYSENA 21	APX	\$ 0.3629
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00002298538	AVIANE 21	TEV	\$ 0.3629
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00002236974	ALESSE (21 DAY)	PFI	\$ 0.7470
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150 MCG * 30 MCG ORAL TABLET

00002387085	OVIMA 21	APX	\$ 0.3467
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00002295946	PORTIA 21	TEV	\$ 0.3467
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100 MCG * 20 MCG ORAL TABLET

00002387883	ALYSENA 28	APX	\$ 0.2721
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00002298546	AVIANE 28	TEV	\$ 0.2721
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00002236975	ALESSE (28 DAY)	PFI	\$ 0.5604
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150 MCG * 30 MCG ORAL TABLET

00002387093	OVIMA 28	APX	\$ 0.2600
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00002295954	PORTIA 28	TEV	\$ 0.2600
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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
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50 MCG * 30 MCG * 75 MCG * 40 MCG * 125 MCG * 30 MCG ORAL TABLET

00000707503	TRIQUILAR (28 DAY)	BAI	\$ 0.5625
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NORETHINDRONE**0.35 MG ORAL TABLET**

00002441306	JENCYCLA (28 DAY)	LPC	\$ 0.3925
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00002410303	MOVISSE (28 DAY)	MYP	\$ 0.3925
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00000037605	MICRONOR (28 DAY)	JAI	\$ 0.9536
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NORETHINDRONE ACETATE/ ETHINYL ESTRADIOL**1 MG * 20 MCG ORAL TABLET**

00000315966	MINESTRIN 1/20 (21 DAY)	ASC	\$ 0.6460
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1.5 MG * 0.03 MG ORAL TABLET

00000297143	LOESTRIN 1.5/30 (21 DAY)	ASC	\$ 0.6460
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1 MG * 20 MCG ORAL TABLET

00000343838	MINESTRIN 1/20 (28 DAY)	ASC	\$ 0.4845
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1.5 MG * 0.03 MG ORAL TABLET

00000353027	LOESTRIN 1.5/30 (28 DAY)	ASC	\$ 0.4845
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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
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0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

00002187116	SYNPHASIC (28 DAY)	PFI	\$ 0.4460
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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

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

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
<input checked="" type="checkbox"/> 00002243724	OESCLIM 50 (10 MG/PTH)	SLP	\$	2.9145
00002244000	ESTRADOT 50 (0.78 MG/PTH)	NOV	\$	3.0662
<input checked="" type="checkbox"/> 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
<input checked="" type="checkbox"/> 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
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2 MG VAGINAL SLOW-RELEASE RING

00002168898	ESTRING	PAL	\$	72.2002
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NORETHINDRONE ACETATE/ ESTRADIOL-17B**140 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH**

00002241835	ESTALIS (2.7*.62 MG/PTH)	NOV	\$	3.4012
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250 MCG/DAY * 50 MCG/DAY TRANSDERMAL PATCH

00002241837	ESTALIS (4.8*.51 MG/PTH)	NOV	\$	3.4012
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68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:20.02 ANTIDIABETIC AGENTS
(ALPHA-GLUCOSIDASE INHIBITORS)****ACARBOSE****50 MG ORAL TABLET**

00002190885	GLUCOBAY	BAI	\$	0.2695
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100 MG ORAL TABLET

00002190893	GLUCOBAY	BAI	\$	0.3733
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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**

<input checked="" type="checkbox"/>	00002245397	NOVORAPID	NNA	\$	3.0190
<input checked="" type="checkbox"/>	00002244353	NOVORAPID CARTRIDGE	NNA	\$	4.0820
<input checked="" type="checkbox"/>	00002377209	NOVORAPID FLEXTOUCH	NNA	\$	4.2500

INSULIN DEGLUDEC**100 UNIT / ML INJECTION**

00002467879	TRESIBA FLEXTOUCH PEN	NNA	\$	7.4333
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200 UNIT / ML INJECTION

00002467887	TRESIBA FLEXTOUCH PEN	NNA	\$	14.8666
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INSULIN DETEMIR**100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/>	00002271842	LEVEMIR CARTRIDGE	NNA	\$	7.2006
<input checked="" type="checkbox"/>	00002412829	LEVEMIR FLEXTOUCH	NNA	\$	7.4333

68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:20.08 ANTIDIABETIC AGENTS
(INSULINS)****INSULIN GLARGINE****100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/>	00002444844	BASAGLAR CARTRIDGE	LIL	\$	4.6425
<input checked="" type="checkbox"/>	00002444852	BASAGLAR KWIKPEN	LIL	\$	4.6425
<input checked="" type="checkbox"/>	00002461528	BASAGLAR KWIKPEN (80 UNIT)	LIL	\$	4.6425
<input checked="" type="checkbox"/>	00002245689	LANTUS	SAV	\$	6.1690
<input checked="" type="checkbox"/>	00002251930	LANTUS CARTRIDGE	SAV	\$	6.1900
<input checked="" type="checkbox"/>	00002294338	LANTUS PEN	SAV	\$	6.1900

INSULIN GLULISINE (RDNA ORIGIN)**100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/>	00002279460	APIDRA	SAV	\$	2.6580
<input checked="" type="checkbox"/>	00002279479	APIDRA CARTRIDGE	SAV	\$	3.5100
<input checked="" type="checkbox"/>	00002294346	APIDRA PEN	SAV	\$	3.5433

INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)**100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/>	00000587737	HUMULIN N	LIL	\$	2.3800
<input checked="" type="checkbox"/>	00002024225	NOVOLIN GE NPH	NNA	\$	2.4360
<input checked="" type="checkbox"/>	00001959239	HUMULIN N CARTRIDGE	LIL	\$	3.1146
<input checked="" type="checkbox"/>	00002403447	HUMULIN N KWIKPEN	LIL	\$	3.1146
<input checked="" type="checkbox"/>	00002024268	NOVOLIN GE NPH CARTRIDGE	NNA	\$	3.1926

INSULIN HUMAN BIOSYNTHETIC (REGULAR)**100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/>	00000586714	HUMULIN R	LIL	\$	2.3800
<input checked="" type="checkbox"/>	00002024233	NOVOLIN GE TORONTO	NNA	\$	2.3820
<input checked="" type="checkbox"/>	00001959220	HUMULIN R CARTRIDGE	LIL	\$	3.1146
<input checked="" type="checkbox"/>	00002024284	NOVOLIN GE TORONTO CARTRIDGE	NNA	\$	3.1180

INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)**30 UNIT / ML * 70 UNIT / ML INJECTION**

<input checked="" type="checkbox"/>	00000795879	HUMULIN 30/70	LIL	\$	2.3800
<input checked="" type="checkbox"/>	00002024217	NOVOLIN GE 30/70	NNA	\$	2.4480
<input checked="" type="checkbox"/>	00002025248	NOVOLIN GE 30/70 CARTRIDGE	NNA	\$	3.0853
<input checked="" type="checkbox"/>	00001959212	HUMULIN 30/70 CARTRIDGE	LIL	\$	3.1146

40 UNIT / ML * 60 UNIT / ML INJECTION

	00002024314	NOVOLIN GE 40/60 CARTRIDGE	NNA	\$	3.1073
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50 UNIT / ML * 50 UNIT / ML INJECTION

	00002024322	NOVOLIN GE 50/50 CARTRIDGE	NNA	\$	3.1073
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INSULIN LISPRO**100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/>	00002229704	HUMALOG	LIL	\$	2.9155
<input checked="" type="checkbox"/>	00002403412	HUMALOG KWIKPEN	LIL	\$	3.8394
<input checked="" type="checkbox"/>	00002229705	HUMALOG CARTRIDGE	LIL	\$	3.8912

200 UNIT / ML INJECTION

	00002439611	HUMALOG KWIKPEN	LIL	\$	7.1467
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68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:20.08 ANTIDIABETIC AGENTS
(INSULINS)****INSULIN LISPRO/ INSULIN LISPRO PROTAMINE****25 % * 75 % INJECTION**

<input checked="" type="checkbox"/>	00002403420	HUMALOG MIX 25 KWIKPEN	LIL	\$	3.8846
<input checked="" type="checkbox"/>	00002240294	HUMALOG MIX 25 CARTRIDGE	LIL	\$	3.9353

50 % * 50 % INJECTION

<input checked="" type="checkbox"/>	00002403439	HUMALOG MIX 50 KWIKPEN	LIL	\$	3.8200
<input checked="" type="checkbox"/>	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

<input checked="" type="checkbox"/>	00002333619	GLUCAGEN	NPA	\$	84.4086
<input checked="" type="checkbox"/>	00002333627	GLUCAGEN HYPOKIT	NPA	\$	84.4086
<input checked="" type="checkbox"/>	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
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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
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80:00 SERUMS, TOXOIDS, AND VACCINES

80:12 VACCINES

HEPATITIS B VACCINE (RECOMBINANT)**20 MCG / ML INJECTION**

00001919431	ENGERIX-B	GSK	\$	23.0600
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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 entity 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 entity 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 entity 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 entity 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 AGENTS84:04.04 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 AGENTS84:04.08.04 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 AGENTS84:04.08.08 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
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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
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84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:06 ANTI-INFLAMMATORY AGENTS

AMCINONIDE

0.1% TOPICAL CREAM

00002246714	TARO-AMCINONIDE	TAR	\$	0.2253
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BECLOMETHASONE DIPROPIONATE

250 MCG / G TOPICAL CREAM

00002089602	PROPADERM	VCL	\$	0.4596
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BETAMETHASONE DIPROPIONATE

0.05% (BASE) TOPICAL CREAM

00000804991	TEVA-TOPISONE	TEV	\$	0.2046
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00000323071	DIPROSONE	MFC	\$	0.2091
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0.05% (BASE) TOPICAL GLYCOL CREAM

00000688622	DIPROLENE GLYCOL	MFC	\$	0.5186
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00000849650	TEVA-TOPILENE	TEV	\$	0.5186
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0.05% (BASE) TOPICAL OINTMENT

00000805009	TEVA-TOPISONE	TEV	\$	0.2186
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00000344923	DIPROSONE	MFC	\$	0.2197
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0.05% (BASE) TOPICAL GLYCOL OINTMENT

00000629367	DIPROLENE GLYCOL	MFC	\$	0.5186
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00000849669	TEVA-TOPILENE	TEV	\$	0.5186
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0.05% (BASE) TOPICAL LOTION

00000417246	DIPROSONE	MFC	\$	0.2022
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00000809187	TEVA-TOPISONE	TEV	\$	0.2079
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0.05% (BASE) TOPICAL GLYCOL LOTION

00001927914	TEVA-TOPILENE	TEV	\$	0.2832
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BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID

0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT

00000578436	DIPROSALIC	MFC	\$	0.9084
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0.5 MG / ML (BASE) * 20 MG / ML TOPICAL LOTION

00000578428	DIPROSALIC	MFC	\$	0.4512
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00002245688	RATIO-TOPISALIC	TEV	\$	0.4582
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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
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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 entity 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 determine eligibility of a compound, pharmacies can contact Alberta Blue Cross for verification.

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- 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
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- the compounded prescription must not include a chemical entity 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.

DESONIDE**0.05 % TOPICAL CREAM**

00002229315	PDP-DESONIDE	PPH	\$	0.3757
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0.05 % TOPICAL OINTMENT

00002229323	PDP-DESONIDE	PPH	\$	0.3742
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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
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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
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0.1 % TOPICAL OINTMENT

00002194031	ARISTOCORT R	VCL	\$	0.1404
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0.1 % DENTAL PASTE

00001964054	ORACORT	TAR	\$	1.4707
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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
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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 XXX \$ 0.0000
/CORTICOSTEROID

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 entity 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.

00000999211 COMBINATION ANTI- XXX \$ 0.0000
INFECTIVE/CORTICOSTEROID

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 entity 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

84:06.00 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

<input checked="" type="checkbox"/> 00002143879	LIDODAN	ODN	\$	0.3625
<input checked="" type="checkbox"/> 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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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 entity 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

00000999204	COMPOUND- SALICYLIC ACID (TOPICAL)	XXX	\$	0.0000
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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
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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.

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
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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
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CALCIPOTRIOL**50 MCG / G TOPICAL OINTMENT**

00001976133	DOVONEX	LEO	\$	0.7837
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**CALCIPOTRIOL MONOHYDRATE/ BETAMETHASONE
DIPROPIONATE****50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL OINTMENT**

00002244126	DOVOBET	LEO	\$	1.5477
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50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL GEL

00002319012	DOVOBET	LEO	\$	1.5210
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50 MCG / G (BASE) * 0.5 MG / G (BASE) TOPICAL FOAM

00002457393	ENSTILAR	LEO	\$	1.5746
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COLLAGENASE**250 UNIT / G TOPICAL OINTMENT**

00002063670	SANTYL	SNE	\$	3.0330
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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
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0.1 % TOPICAL GEL

00002230785	TAZORAC	ALL	\$	1.3886
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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
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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
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PROPIVERINE HYDROCHLORIDE**5 MG ORAL TABLET**

00002460289	MICTORYL PEDIATRIC	DUI	\$	0.3700
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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
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OXTRIPHYLLINE/ GUAIFENESIN**20 MG / ML * 10 MG / ML ORAL ELIXIR**

00000476374	CHOLEDYL EXPECTORANT	ERF	\$	0.0807
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THEOPHYLLINE**100 MG ORAL SUSTAINED-RELEASE TABLET**

00000692689	APO-THEO LA	APX	\$	0.1624
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200 MG ORAL SUSTAINED-RELEASE TABLET

00000692697	APO-THEO LA	APX	\$	0.1805
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300 MG ORAL SUSTAINED-RELEASE TABLET

00000692700	APO-THEO LA	APX	\$	0.2186
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400 MG ORAL SUSTAINED-RELEASE TABLET

00002014165	UNIPHYL	PUR	\$	0.5030
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600 MG ORAL SUSTAINED-RELEASE TABLET

00002014181	UNIPHYL	PUR	\$	0.6090
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5.3 MG / ML ORAL LIQUID

00001966219	THEOLAIR	VCL	\$	0.0278
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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

<input checked="" type="checkbox"/> 00002285673	EURO FOLIC	SDZ	\$	0.0198
<input checked="" type="checkbox"/> 00002366061	JAMP-FOLIC ACID	JPC	\$	0.0198
<input checked="" type="checkbox"/> 00000426849	FOLIC ACID	AAP	\$	0.0404

5 MG / ML INJECTION

<input checked="" type="checkbox"/> 00000816086	FOLIC ACID	SDZ	\$	3.9500
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THIAMINE HCL

100 MG / ML INJECTION

00002193221	THIAMJECT	OMG	\$	1.1880
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88:00 VITAMINS**88:16 VITAMIN D****ALFACALCIDOL**

0.25 MCG ORAL CAPSULE

00000474517	ONE-ALPHA	LEO	\$	0.4735
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1 MCG ORAL CAPSULE

00000474525	ONE-ALPHA	LEO	\$	1.4172
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2 MCG / ML ORAL DROPS

00002240329	ONE-ALPHA	LEO	\$	5.4146
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2 MCG / ML INJECTION

00002242502	ONE-ALPHA	LEO	\$	17.3640
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CALCITRIOL

0.25 MCG ORAL CAPSULE

00002431637	CALCITRIOL-ODAN	ODN	\$	0.6960
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00000481823	ROCALTROL	HLR	\$	0.7071
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0.5 MCG ORAL CAPSULE

00002431645	CALCITRIOL-ODAN	ODN	\$	1.1069
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00000481815	ROCALTROL	HLR	\$	1.1246
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1 MCG / ML INJECTION

00002399334	CALCITRIOL	STM	\$	9.4337
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88:00 VITAMINS**88:24 VITAMIN K ACTIVITY****PHYTONADIONE**

2 MG / ML INJECTION

00000781878	VITAMIN K1 PEDIATRIC	SDZ	\$	10.5900
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10 MG / ML INJECTION

00000804312	VITAMIN K1	SDZ	\$	6.0000
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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
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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
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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
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92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

CLONIDINE HCL

0.025 MG ORAL TABLET

00002304163	TEVA-CLONIDINE	TEV	\$	0.2713
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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
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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 entity 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
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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 entity 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

0000099999	MISCELLANEOUS COMPOUND	XXX	\$	0.0000
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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 entity 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
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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 entity 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
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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 entity 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
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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 entity 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
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ETIDRONATE DISODIUM/ CALCIUM CARBONATE**400 MG * 500 MG ORAL TABLET**

00002263866	ACT ETIDROCAL	APH	\$	0.3332
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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
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500 IU / VIAL INJECTION

00002456117	DYSPORT THERAPEUTIC	ISP	\$ 642.6000
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BOTULINUMTOXINA(150KD), FREE FROM COMPLEXING PROTEIN**50 UNIT / VIAL INJECTION**

00002371081	XEOMIN	MPC	\$ 165.0000
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100 UNIT / VIAL INJECTION

00002324032	XEOMIN	MPC	\$ 330.0000
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ONABOTULINUMTOXINA**INJECTION**

00001981501	BOTOX (50/100/200 UNITS/VIAL)	ALL	\$ 3.5700
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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.

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

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

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Indices

Alphabetical List of
Pharmaceutical Products

Numerical List by
Drug Identification Number

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

NUMERIC	
5-FLUOROURACIL	191
5-FLUOROURACIL/ SALICYLIC ACID	25

A

AA-CLOZAPINE	106
AA-CLOZAPINE	107
ABATACEPT	SEC 3.5
ABATACEPT	SEC 3.8
ABILIFY	105
ABILIFY	106
ABILIFY MAINTENA	SEC 3.31
ABOBOTULINUMTOXINA	203
ACAMPROSATE CALCIUM.....	SEC 3.8
ACARBOSE	172
ACCEL-CITALOPRAM.....	96
ACCEL-CITALOPRAM.....	97
ACCEL-PIOGLITAZONE.....	SEC 3.197
ACCUPRIL	63
ACCURETIC 10/12.5	63
ACCURETIC 20/12.5	63
ACCURETIC 20/25	63
AC CUTANE	192
ACEBUTOLOL HCL	52
ACENOCOUMAROL.....	33
ACETAZOLAMIDE	143
ACETYLCYSTEINE	138
ACH-ESCITALOPRAM	98
ACH-EZETIMIBE.....	SEC 3.105
ACH-TELMISARTAN HCTZ.....	71
ACITRETIN	192
ACLASTA.....	SEC 3.265
ACLIDINIUM BROMIDE	27
ACLIDINIUM BROMIDE/ FORMOTEROL FUMARATE DIHYDRATE	SEC 3.9
ACT ALENDRONATE	SEC 3.21
ACT AMLODIPINE	56
ACT ATENOLOL.....	52
ACT BUPRENORPHINE/NALOXONE	87
ACT BUPROPION XL	104
ACT CELECOXIB.....	SEC 3.42
ACT CIPROFLOXACIN.....	SEC 3A.2
ACT CIPROFLOXACIN.....	SEC 3A.3
ACT CITALOPRAM.....	96
ACT CITALOPRAM.....	97
ACT CLARITHROMYCIN XL	10

ACT DEXTROAMPHETAMINE SR.....	116
ACT DILTIAZEM CD	58
ACT DILTIAZEM T	58
ACT DILTIAZEM T	59
ACT DORZOTIMOLOL	145
ACT DUTASTERIDE.....	202
ACT ENALAPRIL	60
ACT ENALAPRIL	61
ACT ETIDROCAL	200
ACT FLUCONAZOLE	17
ACT FLUVOXAMINE	99
ACT LATANOPROST/TIMOLOL.....	145
ACT LEVETIRACETAM	91
ACT LEVOFLOXACIN	SEC 3A.4
ACT LEVOFLOXACIN	SEC 3A.5
ACT LEVOFLOXACIN	SEC 3A.6
ACT METFORMIN	173
ACT NABILONE.....	154
ACT OLANZAPINE ODT.....	108
ACT OLMESARTAN	49
ACT OLMESARTAN HCT	49
ACT PAROXETINE	100
ACT PRAMIPEXOLE	127
ACT QUETIAPINE	109
ACT QUETIAPINE	110
ACT RALOXIFENE	SEC 3.201
ACT RANITIDINE.....	155
ACT REPAGLINIDE.....	175
ACT RIZATRIPTAN	123
ACT RIZATRIPTAN	SEC 3.212
ACT ROPINIROLE	127
ACT ROPINIROLE	128
ACT ROSUVASTATIN	44
ACT SUMATRIPTAN	124
ACT SUMATRIPTAN	SEC 3.235
ACT TERBINAFINE	17
ACT VENLAFAXINE XR	95
ACT VENLAFAXINE XR	96
ACTEMRA (0.9 ML SYRINGE)	SEC 3.254
ACTEMRA (10 ML)	SEC 3.248
ACTEMRA (20 ML)	SEC 3.251
ACTEMRA (4 ML)	SEC 3.244
ACTIKERALL	25
ACTONEL	201
ACULAR	141
ACUVAIL.....	141
ACYCLOVIR	21
ADALAT XL.....	57
ADALIMUMAB	SEC 3.19
ADEFOVIR DIPIVOXIL	21

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
ADRENALIN.....	143	ALYSENA 28.....	170
ADRENALIN.....	29	AMANTADINE HCL	125
ADVAIR 100 DISKUS.....	SEC 3.216	AMCINONIDE	184
ADVAIR 125.....	SEC 3.215	AMERGE	122
ADVAIR 250.....	SEC 3.215	AMERGE	SEC 3.172
ADVAIR 250 DISKUS.....	SEC 3.217	AMILORIDE HCL	134
ADVAIR 500 DISKUS.....	SEC 3.218	AMINOPHYLLINE	194
AEROCHAMBER PLUS FLOW-VU W/ ADULT SMALL MASK.....	205	AMIODARONE.....	40
AEROCHAMBER PLUS FLOW-VU W/ LARGE MASK.....	205	AMIODARONE HCL	40
AEROCHAMBER PLUS FLOW-VU W/ MEDIUM MASK.....	205	AMITRIPTYLINE HCL.....	102
AEROCHAMBER PLUS FLOW-VU W/ MOUTHPIECE.....	205	AMLODIPINE	56
AEROCHAMBER PLUS FLOW-VU W/ SMALL MASK.....	205	AMLODIPINE BESYLATE	56
AEROCHAMBER PLUS FLOW-VU YOUTH W/ MOUTHPIECE	205	AMOXICILLIN	11
AEROSOL HOLDING CHAMBER.....	205	AMOXICILLIN	12
AEROSOL HOLDING CHAMBER/MASK.....	205	AMOXICILLIN SUGAR-REDUCED.....	12
AFLIBERCEPT.....	147	AMOXICILLIN TRIHYDRATE.....	11
AGGRENOX	36	AMOXICILLIN TRIHYDRATE.....	12
AIROMIR CFC-FREE.....	28	AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM.....	12
ALCAINE.....	141	AMPHOTERICIN B	19
ALDARA.....	SEC 3.125	AMPICILLIN	12
ALEMTUZUMAB	SEC 3.21	AMPICILLIN	SEC 3.24
ALENDRONATE	197	AMPICILLIN SODIUM.....	12
ALENDRONATE SODIUM.....	197	ANAFRANIL	102
ALENDRONATE SODIUM.....	SEC 3.21	ANAKINRA.....	SEC 3.26
ALENDRONATE SODIUM/ VITAMIN D3.....	197	ANAPROX	80
ALERTEC.....	SEC 3.170	ANAPROX DS.....	80
ALERTONIC.....	196	ANDROCUR	SEC 3.47
ALESSE (21 DAY).....	170	ANDROCUR DEPOT	SEC 3.47
ALESSE (28 DAY).....	170	ANDRODERM (2.5 MG/DAY)	SEC 3.239
ALFACALCIDOL	195	ANDRODERM (5 MG/DAY)	SEC 3.239
ALFUZOSIN	SEC 3.22	ANODAN-HC	188
ALFUZOSIN HCL.....	SEC 3.22	ANORO ELLIPTA.....	SEC 3.257
ALIROCUMAB	SEC 3.24	ANUGESIC-HC.....	188
ALLERGY SERUM.....	179	ANUSOL-HC	188
ALLOPURINOL	197	APIDRA.....	174
ALMOTRIPTAN.....	122	APIDRA CARTRIDGE.....	174
ALMOTRIPTAN.....	SEC 3.24	APIDRA PEN	174
ALMOTRIPTAN MALATE	122	APIXABAN	SEC 3.29
ALMOTRIPTAN MALATE	SEC 3.24	APIXABAN	SEC 3.31
ALPHAGAN.....	143	APO-ACEBUTOLOL	52
ALPRAZOLAM	118	APO-ACYCLOVIR.....	21
ALPROSTADIL	50	APO-ADEFOVIR	21
ALTACE (CAPSULE)	64	APO-ALENDRONATE	197
ALTACE HCT.....	65	APO-ALENDRONATE	SEC 3.21
ALVESCO	166	APO-ALENDRONATE/VITAMIN D3	197
ALYSENA 21.....	170	APO-ALFUZOSIN	SEC 3.22
		APO-ALLOPURINOL	197
		APO-ALMOTRIPTAN.....	122
		APO-ALMOTRIPTAN.....	SEC 3.24
		APO-ALPRAZ	118
		APO-AMILZIDE.....	135

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
APO-AMIODARONE	40	APO-DOMPERIDONE	158
APO-AMITRIPTYLINE	102	APO-DONEPEZIL	SEC 3.66
APO-AMLODIPINE	56	APO-DORZO-TIMOP	145
APO-AMOXI	11	APO-DOXAZOSIN	51
APO-AMOXI	12	APO-DOXY	14
APO-AMOXI CLAV	12	APO-DOXYLAMINE/B6	154
APO-ARIPIPIRAZOLE	105	APO-DULOXETINE	95
APO-ARIPIPIRAZOLE	106	APO-DUTASTERIDE	202
APO-ATENIDONE	53	APO-ENALAPRIL	60
APO-ATENOL	52	APO-ENALAPRIL	61
APO-ATORVASTATIN	42	APO-ENTECAVIR	21
APO-AZATHIOPRINE	197	APO-ESCITALOPRAM	98
APO-AZITHROMYCIN Z	10	APO-EZETIMIBE	SEC 3.105
APO-BACLOFEN	30	APO-FELODIPINE	57
APO-BECLOMETHASONE	139	APO-FENO-MICRO	41
APO-BISOPROLOL	53	APO-FENO-SUPER	41
APO-BRIMONIDINE	143	APO-FENO-SUPER (TABLET)	41
APO-BROMAZEPAM	118	APO-FENTANYL 100	SEC 3.107
APO-BUSPIRONE	120	APO-FINASTERIDE	202
APO-CABERGOLINE	SEC 3.40	APO-FLECAINIDE	39
APO-CANDESARTAN	66	APO-FLUCONAZOLE	17
APO-CARVEDILOL	53	APO-FLUOXETINE	99
APO-CARVEDILOL	54	APO-FLURBIPROFEN	78
APO-CEFADROXIL	5	APO-FLUTAMIDE	SEC 3.111
APO-CEFADROXIL	SEC 3.41	APO-FLUVOXAMINE	99
APO-CEFPROZIL	6	APO-FOSINOPRIL	61
APO-CEFUROXIME	7	APO-FUROSEMIDE	48
APO-CELECOXIB	SEC 3.42	APO-GABAPENTIN	90
APO-CEPHALEX	6	APO-GEMFIBROZIL	41
APO-CILAZAPRIL	60	APO-GLICLAZIDE	175
APO-CILAZAPRIL/HCTZ	60	APO-GLICLAZIDE MR	175
APO-CIPROFLOX	SEC 3A.3	APO-GLICLAZIDE MR	176
APO-CITALOPRAM	96	APO-GLYBURIDE	176
APO-CITALOPRAM	97	APO-GRANISETRON	152
APO-CLARITHROMYCIN XL	10	APO-HYDRALAZINE	47
APO-CLINDAMYCIN	15	APO-HYDRALAZINE	48
APO-CLOBAZAM	88	APO-HYDRO	134
APO-CLONAZEPAM	88	APO-HYDROMORPHONE	83
APO-CLOPIDOGREL	36	APO-HYDROMORPHONE CR	83
APO-CYCLOBENZAPRINE	30	APO-HYDROXYQUINE	22
APO-DEFERASIROX	SEC 3.58	APO-IBUPROFEN	78
APO-DEFERASIROX	SEC 3.59	APO-IMIQUIMOD	SEC 3.125
APO-DEFERASIROX	SEC 3.60	APO-INDAPAMIDE	135
APO-DEXAMETHASONE	166	APO-IPRAVENT	27
APO-DIAZEPAM	119	APO-ISMN	49
APO-DICLO	77	APO-KETOCONAZOLE	18
APO-DICLO SR	77	APO-KETOROLAC	79
APO-DICLOFENAC OPHTHALMIC	141	APO-LAMIVUDINE HBV	20
APO-DILTIAZ	57	APO-LAMOTRIGINE	90
APO-DILTIAZ CD	58	APO-LAMOTRIGINE	91
APO-DIPYRIDAMOLE (FC)	50	APO-LANSOPRAZOLE	156
APO-DIVALPROEX	89		

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ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
APO-LANSOPRAZOLE-AMOXICILLIN- CLARITHROMYCIN	156	APO-PAROXETINE	100
APO-LATANOPROST	144	APO-PERINDOPRIL	62
APO-LEFLUNOMIDE	202	APO-PHENYTOIN SODIUM	88
APO-LEVETIRACETAM	91	APO-PINAVERIUM	160
APO-LEVOCARB	126	APO-PRAMIPEXOLE	127
APO-LEVOCARB CR	126	APO-PRAVASTATIN	43
APO-LEVOFLOXACIN	SEC 3A.4	APO-PRAVASTATIN	44
APO-LEVOFLOXACIN	SEC 3A.5	APO-PRAZO	51
APO-LEVOFLOXACIN	SEC 3A.6	APO-PREDNISONE	168
APO-LINEZOLID	16	APO-PREGABALIN	92
APO-LINEZOLID	SEC 3.166	APO-PROPAFENONE	39
APO-LISINOPRIL	61	APO-QUETIAPINE	109
APO-LISINOPRIL	62	APO-QUETIAPINE	110
APO-LITHIUM CARBONATE	121	APO-QUETIAPINE XR	110
APO-LITHIUM CARBONATE	122	APO-QUETIAPINE XR	111
APO-LORAZEPAM	119	APO-QUINAPRIL	63
APO-LOSARTAN	69	APO-QUINAPRIL/HCTZ	63
APO-LOVASTATIN	43	APO-QUININE	23
APO-MEDROXY	177	APO-RABEPRAZOLE	158
APO-METFORMIN	173	APO-RALOXIFENE	SEC 3.201
APO-METHOTREXATE	25	APO-RAMIPRIL (CAPSULE)	64
APO-METHYLPHENIDATE	117	APO-RANITIDINE	155
APO-METHYLPHENIDATE SR	117	APO-RILUZOLE	SEC 3.202
APO-METOPROLOL	54	APO-RISEDRONATE	201
APO-METOPROLOL (TYPE L)	54	APO-RISPERIDONE	111
APO-METOPROLOL SR	54	APO-RISPERIDONE	112
APO-MIDODRINE	28	APO-RIVASTIGMINE	SEC 3.211
APO-MINOCYCLINE	14	APO-RIZATRIPTAN	123
APO-MIRTAZAPINE	105	APO-RIZATRIPTAN	SEC 3.212
APO-MODAFINIL	SEC 3.170	APO-ROSUVASTATIN	44
APO-MOMETASONE	140	APO-ROSUVASTATIN	45
APO-MONTELUKAST	137	APO-SALVENT CFC FREE	28
APO-MONTELUKAST	SEC 3.171	APO-SELEGILINE	128
APO-MOXIFLOXACIN	SEC 3A.7	APO-SERTRALINE	101
APO-NALTREXONE	87	APO-SIMVASTATIN	46
APO-NAPRO-NA	80	APO-SIMVASTATIN	47
APO-NAPRO-NA DS	80	APO-SOLIFENACIN	193
APO-NAPROXEN	79	APO-SOTALOL	55
APO-NAPROXEN EC	80	APO-SUMATRIPTAN	124
APO-OLANZAPINE	107	APO-SUMATRIPTAN	SEC 3.235
APO-OLANZAPINE	108	APO-TAMSULOSIN CR	51
APO-OLANZAPINE ODT	108	APO-TENOFOVIR	20
APO-OLMESARTAN	49	APO-TERAZOSIN	51
APO-OLMESARTAN/HCTZ	49	APO-TERBINAFINE	17
APO-OMEPRAZOLE (DELAYED-RELEASE CAPSULE)	157	APO-TETRABENAZINE	SEC 3.239
APO-ONDANSETRON	153	APO-THEO LA	194
APO-OXAZEPAM	120	APO-TIMOP	143
APO-OXYBUTYNIN	193	APO-TOPIRAMATE	93
APO-OXYCODONE	87	APO-TRAVOPROST Z	144
APO-PANTOPRAZOLE	158	APO-TRAVOPROST-TIMOP	145
		APO-TRAZODONE	102
		APO-TRIAZIDE	135

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
APO-TRYPTOPHAN.....	104	ATIVAN.....	120
APO-VALACYCLOVIR (CAPLET).....	22	ATORVASTATIN CALCIUM.....	42
APO-VALGANCICLOVIR.....	22	ATORVASTATIN-10.....	42
APO-VALPROIC.....	93	ATORVASTATIN-20.....	42
APO-VALSARTAN.....	71	ATORVASTATIN-40.....	42
APO-VALSARTAN.....	72	ATORVASTATIN-80.....	42
APO-VARENICLINE.....	31	ATOVAQUONE.....	23
APO-VARENICLINE.....	SEC 3.259	ATROPINE SULFATE.....	141
APO-VARENICLINE (STARTER PACK).....	31	ATROPINE SULFATE.....	27
APO-VARENICLINE (STARTER PACK).....	SEC 3.259	ATROVENT HFA.....	27
APO-VENLAFAXINE XR.....	95	AUBAGIO.....	SEC 3.239
APO-VENLAFAXINE XR.....	96	AURANOFIN.....	161
APO-VERAP.....	59	AURO-ALENDRONATE.....	197
APO-VERAP SR.....	59	AURO-ALENDRONATE.....	SEC 3.21
APO-WARFARIN.....	33	AURO-ALFUZOSIN.....	SEC 3.22
APO-ZOPICLONE.....	121	AURO-AMLODIPINE.....	56
APRACLONIDINE HCL.....	147	AURO-AMOXICILLIN.....	11
APREPITANT.....	154	AURO-ARIPIRAZOLE.....	105
APREPITANT/ APREPITANT.....	154	AURO-ARIPIRAZOLE.....	106
APRI 21.....	169	AURO-ATORVASTATIN.....	42
APRI 28.....	169	AURO-BETAHISTINE.....	197
APTIOM.....	SEC 3.78	AURO-CANDESARTAN.....	66
ARANESP (0.3 ML SYRINGE).....	SEC 3.53	AURO-CANDESARTAN HCT.....	66
ARANESP (0.4 ML SYRINGE).....	SEC 3.53	AURO-CANDESARTAN HCT.....	67
ARANESP (0.5 ML SYRINGE).....	SEC 3.53	AURO-CARVEDILOL.....	53
ARANESP (0.6 ML SYRINGE).....	SEC 3.53	AURO-CARVEDILOL.....	54
ARANESP (0.65 ML SYRINGE).....	SEC 3.53	AURO-CEFIXIME.....	7
ARANESP (1.0 ML SYR).....	SEC 3.53	AURO-CEFUROXIME.....	7
ARAVA.....	202	AURO-CELECOXIB.....	SEC 3.42
ARICEPT.....	SEC 3.66	AURO-CEPHALEXIN.....	6
ARIPIRAZOLE.....	105	AURO-CIPROFLOXACIN.....	SEC 3A.2
ARIPIRAZOLE.....	106	AURO-CIPROFLOXACIN.....	SEC 3A.3
ARIPIRAZOLE.....	SEC 3.31	AURO-CITALOPRAM.....	96
ARISTOCORT C.....	188	AURO-CITALOPRAM.....	97
ARISTOCORT R.....	188	AURO-CLINDAMYCIN.....	15
ARIXTRA (0.5 ML SYRINGE).....	35	AURO-CLOPIDOGREL.....	36
ARIXTRA (0.6 ML SYRINGE).....	35	AURO-CYCLOBENZAPRINE.....	30
ARNUITY ELLIPTA.....	140	AURO-DONEPEZIL.....	SEC 3.66
ARTHROTEC-50.....	78	AURO-DULOXETINE.....	95
ARTHROTEC-75.....	78	AURO-DUTASTERIDE.....	202
ASACOL.....	159	AURO-ENTECAVIR.....	21
ASACOL 800.....	159	AURO-ESCITALOPRAM.....	98
ASENAPINE MALEATE.....	SEC 3.32	AURO-EZETIMIBE.....	SEC 3.105
ASFOTASE ALFA.....	SEC 3.37	AURO-FINASTERIDE.....	202
ASMANEX TWISTHALER.....	168	AURO-FLECAINIDE.....	39
ATACAND.....	66	AURO-FLUOXETINE.....	99
ATACAND PLUS.....	66	AURO-GABAPENTIN.....	90
ATACAND PLUS.....	67	AURO-GALANTAMINE ER.....	SEC 3.113
ATARAX.....	121	AURO-GALANTAMINE ER.....	SEC 3.114
ATENOLOL.....	52	AURO-IRBESARTAN.....	67
ATENOLOL/ CHLORTHALIDONE.....	53	AURO-IRBESARTAN HCT.....	68
ATIVAN.....	119	AURO-LACOSAMIDE.....	SEC 3.161

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
AURO-LAMOTRIGINE	90	AVAPRO	67
AURO-LAMOTRIGINE	91	AVELOX.....	SEC 3A.7
AURO-LEVETIRACETAM.....	91	AVENTYL.....	103
AURO-LISINOPRIL	61	AVIANE 21.....	170
AURO-LISINOPRIL	62	AVIANE 28.....	170
AURO-LOSARTAN	69	AVODART.....	202
AURO-LOSARTAN HCT.....	70	AVONEX PS/PEN (30 MCG/0.5 ML)	SEC 3.152
AURO-METFORMIN.....	173	AXID.....	154
AURO-MIRTAZAPINE.....	105	AZARGA	145
AURO-MODAFINIL	SEC 3.170	AZATHIOPRINE.....	197
AURO-MONTELUKAST.....	137	AZELAIC ACID.....	192
AURO-MONTELUKAST.....	SEC 3.171	AZITHROMYCIN.....	10
AURO-MOXIFLOXACIN.....	SEC 3A.7	AZITHROMYCIN.....	SEC 3.37
AURO-OLANZAPINE ODT	108	AZOPT	144
AURO-OLMESARTAN	49	AZTREONAM.....	SEC 3.37
AURO-PANTOPRAZOLE.....	158		
AURO-PAROXETINE.....	100		
AURO-PERINDOPRIL	62		
AURO-PRAMIPEXOLE	127		
AURO-PRAVASTATIN.....	43		
AURO-PRAVASTATIN.....	44		
AURO-PREGABALIN.....	92		
AURO-QUETIAPINE	109		
AURO-QUETIAPINE	110		
AURO-RAMIPRIL (CAPSULE).....	64		
AURO-REPAGLINIDE.....	175		
AURO-RISEDRONATE.....	201		
AURO-RIZATRIPTAN	123		
AURO-RIZATRIPTAN	SEC 3.212		
AURO-ROSUVASTATIN.....	44		
AURO-ROSUVASTATIN.....	45		
AURO-SERTRALINE	101		
AURO-SIMVASTATIN.....	46		
AURO-SIMVASTATIN.....	47		
AURO-SOLIFENACIN.....	193		
AURO-TELMISARTAN.....	70		
AURO-TELMISARTAN HCTZ	71		
AURO-TENOFOVIR.....	20		
AURO-TERBINAFINE	17		
AURO-TOPIRAMATE	93		
AURO-TRANDOLAPRIL	65		
AURO-VALACYCLOVIR	22		
AURO-VALGANCICLOVIR	22		
AURO-VALSARTAN	71		
AURO-VALSARTAN	72		
AURO-VALSARTAN HCT	72		
AURO-VENLAFAXINE XR	95		
AURO-VENLAFAXINE XR	96		
AURO-ZIPRASIDONE	113		
AVALIDE 150/12.5	68		
AVALIDE 300/12.5	68		
AVANDIA	SEC 3.213		

B

BACKUP PLAN ONESTEP	170
BACLOFEN.....	30
BACLOFEN INJECTION.....	30
BACLOFEN INTRATHECAL.....	30
BANZEL	SEC 3.214
BARACLUDE	21
BASAGLAR CARTRIDGE.....	174
BASAGLAR KWIKPEN	174
BASAGLAR KWIKPEN (80 UNIT).....	174
BECLOMETHASONE DIPROPIONATE	139
BECLOMETHASONE DIPROPIONATE	166
BECLOMETHASONE DIPROPIONATE	184
BENZAEPRILOL.....	59
BENZAEPRILOL HCL.....	59
BENZAFLIN.....	SEC 3.46
BENZTROPINE MESYLATE.....	125
BENZTROPINE OMEGA	125
BENZYDAMINE HCL	142
BETADERM MILD.....	185
BETADERM REGULAR.....	185
BETAGAN	143
BETAHISTINE.....	197
BETAHISTINE DIHYDROCHLORIDE.....	197
BETAMETHASONE DIPROPIONATE	184
BETAMETHASONE DIPROPIONATE/ CLOTRIMAZOLE	188
BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID	184
BETAMETHASONE SODIUM PHOSPHATE.....	185
BETAMETHASONE SODIUM PHOSPHATE/ BETAMETHASONE ACETATE.....	166
BETAMETHASONE VALERATE	185
BETASERON (0.3 MG).....	SEC 3.155

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
BETAXOLOL HCL.....	143	BUPROPION HCL	104
BETNESOL (5MG/100ML).....	185	BUPROPION SR.....	104
BETOPTIC S.....	143	BUSCOPAN.....	27
BEZAFIBRATE.....	41	BUSERELIN ACETATE	SEC 3.39
BEZALIP	41	BUSPIRONE HCL.....	120
BIAXIN	10	BUTALBITAL/ CAFFEINE/ ASA.....	77
BIAXIN	11	BUTALBITAL/ CODEINE PHOSPHATE/ ASA/ CAFFEINE	81
BIAXIN BID	10		
BIAXIN XL.....	10	C	
BIMATOPROST.....	144		
BIO-CELECOXIB	SEC 3.42	CABERGOLINE	SEC 3.40
BIO-DONEPEZIL.....	SEC 3.66	CALCIMAR	176
BIO-FLUOXETINE	99	CALCIPOTRIOL.....	192
BIO-LOSARTAN.....	69	CALCIPOTRIOL MONOHYDRATE/ BETAMETHASONE DIPROPIONATE	192
BIO-QUETIAPINE	109	CALCITRIOL.....	195
BIO-QUETIAPINE	110	CALCITRIOL-ODAN	195
BIPHENTIN	117	CALCIUM POLYSTYRENE SULPHONATE	134
BIPHENTIN	118	CAMPRAL.....	SEC 3.8
BISOPROLOL	53	CANAGLIFLOZIN.....	SEC 3.40
BISOPROLOL FUMARATE	53	CANCIDAS	19
BLEPHAMIDE	141	CANCIDAS	SEC 3.41
BLOOD GLUCOSE TEST STRIPS	1	CANDESARTAN.....	66
BLOOD LETTING LANCET	1	CANDESARTAN CILEXETIL	66
BOTOX (50/100/200 UNITS/VIAL).....	203	CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE.....	66
BOTULINUMTOXINA (150KD), FREE FROM COMPLEXING PROTEIN	203	CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE.....	67
BRENZYS	SEC 3.88	CANDESARTAN HCT.....	66
BRENZYS	SEC 3.90	CANDESARTAN/HCTZ	66
BREO ELLIPTA.....	SEC 3.112	CAPTOPRIL.....	59
BREO ELLIPTA.....	SEC 3.113	CARBAMAZEPINE	89
BREXPIPIRAZOLE	106	CARBOLITH.....	121
BRICANYL TURBUHALER	29	CARBOLITH.....	122
BRILINTA	36	CARNITOR	SEC 3.162
BRILINTA	SEC 3.240	CARVEDILOL	53
BRIMONIDINE TARTRATE	143	CARVEDILOL	54
BRIMONIDINE TARTRATE/ TIMOLOL MALEATE	145	CASPOFUNGIN.....	19
BRINZOLAMIDE	144	CASPOFUNGIN.....	SEC 3.41
BRINZOLAMIDE/ BRIMONIDINE TARTRATE.....	145	CAYSTON.....	SEC 3.37
BRINZOLAMIDE/ TIMOLOL MALEATE	145	CCP-CITALOPRAM	96
BRIVARACETAM.....	SEC 3.38	CCP-CITALOPRAM	97
BRIVLERA	SEC 3.38	CCP-ONDANSETRON	153
BROMAZEPAM.....	118	CEFADROXIL	5
BROMOCRIPTINE	127	CEFADROXIL	SEC 3.41
BROMOCRIPTINE MESYLATE	127	CEFAZOLIN.....	5
BUDESONIDE	139	CEFAZOLIN.....	6
BUDESONIDE	166	CEFAZOLIN SODIUM.....	5
BUDESONIDE	185	CEFAZOLIN SODIUM.....	6
BUDESONIDE	SEC 3.38	CEFIXIME	7
BUDESONIDE/ FORMOTEROL FUMARATE DIHYDRATE	SEC 3.39		
BUPRENORPHINE HCL/ NALOXONE HYDROCHLORIDE DIHYDRATE	87		

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
CEFOTAXIME SODIUM.....	7	CIPROFLOXACIN HCL.....	139
CEFOXITIN	9	CIPROFLOXACIN HCL.....	SEC 3A.2
CEFOXITIN	SEC 3.41	CIPROFLOXACIN HCL.....	SEC 3A.3
CEFOXITIN SODIUM.....	9	CIPROFLOXACIN HCL/ DEXAMETHASONE	139
CEFOXITIN SODIUM.....	SEC 3.41	CITALOPRAM.....	96
CEFPROZIL	6	CITALOPRAM.....	97
CEFTAZIDIME	7	CITALOPRAM HYDROBROMIDE	96
CEFTIN	7	CITALOPRAM HYDROBROMIDE	97
CEFTRIAOXONE FOR INJECTION USP	7	CLARITHROMYCIN.....	10
CEFTRIAOXONE SODIUM	7	CLARITHROMYCIN.....	11
CEFTRIAOXONE SODIUM	8	CLARUS	192
CEFTRIAOXONE SODIUM FOR INJECTION	7	CLASTEON.....	197
CEFTRIAOXONE SODIUM FOR INJECTION BP	7	CLAVULIN-125F	12
CEFUROXIME AXETIL	7	CLAVULIN-200	12
CELEBREX	SEC 3.42	CLAVULIN-250F	12
CELECOXIB.....	SEC 3.42	CLAVULIN-400	12
CELESTONE SOLUSPAN	166	CLAVULIN-500F	12
CELEXA	96	CLAVULIN-875	12
CELEXA	97	CLIMARA 25 (2 MG/PTH)	171
CEPHALEXIN	6	CLIMARA 50 (3.9 MG/PTH).....	172
CERTOLIZUMAB PEGOL.....	SEC 3.46	CLIMARA 75 (5.7 MG/PTH).....	172
CESAMET	154	CLINDAMYCIN	16
CHAMPIX.....	31	CLINDAMYCIN (60 & 120 ML).....	16
CHAMPIX.....	SEC 3.259	CLINDAMYCIN HCL	15
CHAMPIX (STARTER PACK)	31	CLINDAMYCIN PALMITATE HCL	16
CHAMPIX (STARTER PACK)	SEC 3.259	CLINDAMYCIN PHOSPHATE	16
CHLORAMPHENICOL SODIUM SUCCINATE	9	CLINDAMYCIN PHOSPHATE/ BENZOYL PEROXIDE	SEC 3.46
CHLORAX.....	119	SEC 3.46
CHLORDIAZEPOXIDE.....	119	CLINDOXYL.....	SEC 3.46
CHLORDIAZEPOXIDE HCL	119	CLINDOXYL ADV	SEC 3.46
CHLORDIAZEPOXIDE HCL/ CLIDINIUM BROMIDE..	119	CLOBAZAM	88
CHLOROMYCETIN.....	9	CLOBETASOL 17-PROPIONATE.....	185
CHLOROQUINE PHOSPHATE	22	CLODRONATE DISODIUM	197
CHLORPROMAZINE HCL	114	CLOMIPRAMINE HCL	102
CHLORTHALIDONE	135	CLONAZEPAM	88
CHOLEDYL EXPECTORANT	194	CLONIDINE HCL	198
CHOLESTYRAMINE RESIN	40	CLONIDINE HCL	47
CHOLESTYRAMINE-ODAN	40	CLOPIDOGREL	36
CICLESONIDE	166	CLOPIDOGREL BISULFATE.....	36
CICLOPIROX OLAMINE	184	CLOPIXOL	115
CILAZAPRIL.....	60	CLOPIXOL ACUPHASE	115
CILAZAPRIL/ HYDROCHLOROTHIAZIDE	60	CLOPIXOL DEPOT.....	115
CILOXAN	139	CLORAZEPATE.....	119
CIMETIDINE	154	CLORAZEPATE DIPOTASSIUM.....	119
CIMZIA	SEC 3.46	CLOXACILLIN.....	13
CIMZIA AUTO-INJECTOR	SEC 3.46	CLOXACILLIN SODIUM	13
CIPRALEX	98	CLOZAPINE.....	106
CIPRO.....	SEC 3A.1	CLOZAPINE.....	107
CIPRODEX	139	CLOZARIL	106
CIPROFLOXACIN	SEC 3A.1	CLOZARIL	107
CIPROFLOXACIN	SEC 3A.2	CO CLOPIDOGREL.....	36
CIPROFLOXACIN	SEC 3A.3	CO LATANOPROST	144

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
CO LOVASTATIN.....	43	COPAXONE.....	SEC 3.116
CO ONDANSETRON.....	153	CORTEF.....	167
CODEINE PHOSPHATE.....	81	CORTENEMA (100MG/60ML).....	187
CODEINE PHOSPHATE/ ACETAMINOPHEN.....	81	CORTIFOAM.....	187
CODEINE PHOSPHATE/ ACETAMINOPHEN/ CAFFEINE.....	81	CORTISONE ACETATE.....	166
COLCHICINE.....	198	CORTODERM MILD.....	187
COLESEVELAM HCL.....	40	CORTODERM REGULAR.....	187
COLESTID.....	40	COSENTYX.....	SEC 3.225
COLESTIPOL HCL.....	40	COSOPT.....	145
COLISTIMETHATE FOR INJECTION.....	16	COSOPT PRESERVATIVE-FREE.....	145
COLISTIMETHATE SODIUM.....	16	COTAZYM.....	151
COLLAGENASE.....	192	COTAZYM ECS 20.....	151
COMBIGAN.....	145	COTAZYM ECS 8.....	151
COMBINATION ANTI-INFECTIVE /CORTICOSTEROID.....	189	COUMADIN.....	33
COMBINATION ANTI-INFECTIVE/ CORTICOSTEROID.....	189	COVERSYL.....	62
COMBIVENT UDV.....	27	COVERSYL PLUS.....	63
COMPD- NSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)-TOPICAL.....	75	COVERSYL PLUS HD.....	63
COMPD-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT .12%).....	142	COZAAR.....	69
COMPD-CHLORHEX. MOUTH RINSE (ANY CONCENTRATION, NOT 0.12%).....	142	CREON 10 MINIMICROSPHERES.....	151
COMPD-NSAID/ ANALG/MUSCLE RELAX (NOT DICLOFENAC)-TOPICAL.....	75	CREON 25 MINIMICROSPHERES.....	151
COMPOUND - RETINOIC ACID (TRETINOIN) (TOPICAL).....	181	CRESTOR.....	44
COMPOUND HORMONES (ESTROGEN PROGEST TESTOSTERONE).....	165	CRESTOR.....	45
COMPOUND NARCOTIC MIXTURES - ORAL AND INJECTION.....	82	CTP 30.....	97
COMPOUND PRESCRIPTION.....	142	CUBICIN RF.....	SEC 3.52
COMPOUND PRESCRIPTION.....	165	CUPRIMINE.....	163
COMPOUND PRESCRIPTION.....	181	CYANOCOBALAMIN.....	195
COMPOUND PRESCRIPTION.....	182	CYCLEN (21 DAY).....	171
COMPOUND PRESCRIPTION.....	186	CYCLEN (28 DAY).....	171
COMPOUND PRESCRIPTION.....	189	CYCLOBENZAPRINE.....	30
COMPOUND PRESCRIPTION.....	191	CYCLOBENZAPRINE HCL.....	30
COMPOUND PRESCRIPTION.....	198	CYCLOGYL.....	141
COMPOUND PRESCRIPTION.....	199	CYCLOMEN.....	169
COMPOUND PRESCRIPTION.....	200	CYCLOPENTOLATE HCL.....	141
COMPOUND PRESCRIPTION.....	75	CYCLOSPORINE.....	SEC 3.47
COMPOUND PRESCRIPTION.....	76	CYMBALTA.....	95
COMPOUND PRESCRIPTION.....	82	CYPROTERONE.....	SEC 3.47
COMPOUND- SALICYLIC ACID (TOPICAL).....	191	CYPROTERONE ACETATE.....	SEC 3.47
COMPOUND-ANTI-INFECTIVE (TOPICAL).....	182	CYSTEAMINE BITARTRATE.....	SEC 3.48
COMPOUND-CORTICOSTEROIDS - TOPICAL.....	186	CYTOMEL.....	178
COMPOUND-DICLOFENAC (TOPICAL).....	76	CYTOVENE.....	21
COMTAN.....	125		
CONJUGATED ESTROGENS.....	171		

D

DABIGATRAN ETEXILATE.....	SEC 3.49
DACLATASVIR DIHYDROCHLORIDE.....	SEC 3.50
DAKLINZA.....	SEC 3.50
DALACIN C PALMITATE.....	16
DALACIN C PHOSPHATE.....	16
DALTEPARIN SODIUM.....	34
DANAZOL.....	169
DANTRIUM.....	30

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
DANTROLENE SODIUM	30	DEXAMETHASONE/ NEOMYCIN SULFATE/ POLYMYXIN B SULFATE	140
DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE	SEC 3.51	DEXAMETHASONE/ TOBRAMYCIN	140
DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE/ METFORMIN HCL	SEC 3.52	DEXEDRINE	116
DAPSONE	19	DEXIRON	33
DAPTOMYCIN	SEC 3.52	DEXTROAMPHETAMINE	116
DARBEPOETIN	SEC 3.53	DEXTROAMPHETAMINE SULFATE	116
DARIFENACIN HYDROBROMIDE	SEC 3.54	DIABETA	176
DDAVP	176	DIABETES SUPPLIES	1
DDAVP	177	DIACOMIT	SEC 3.234
DEFERASIROX	SEC 3.55	DIAMICRON	175
DEFERASIROX	SEC 3.56	DIAMICRON MR	175
DEFERASIROX	SEC 3.57	DIAMICRON MR	176
DEFERASIROX	SEC 3.58	DIAZEPAM	119
DEFERASIROX	SEC 3.59	DICETEL	160
DEFERASIROX	SEC 3.60	DICLECTIN	154
DEFERIPRONE	SEC 3.61	DICLOFENAC SODIUM	141
DEFEROXAMINE MESYLATE	163	DICLOFENAC SODIUM	77
DELATESTRYL	169	DICLOFENAC SODIUM/ MISOPROSTOL	78
DEMEROL	84	DIENOGEST	SEC 3.63
DEMULEN 30 (21 DAY)	169	DIFICID	SEC 3.108
DEMULEN 30 (28 DAY)	169	DIFLUCAN	17
DENOSUMAB	SEC 3.62	DIFLUCAN	SEC 3.111
DEPAKENE	93	DIGOXIN	40
DEPO-MEDROL	167	DIHYDROERGOTAMINE (DHE)	29
DEPO-MEDROL (PRESERVED)	167	DIHYDROERGOTAMINE MESYLATE	29
DEPO-MEDROL WITH LIDOCAINE	167	DILANTIN	88
DEPO-PROVERA	177	DILANTIN INFATABS	88
DEPO-TESTOSTERONE CYPIONATE	169	DILANTIN-125	88
DERMAFLEX HC	187	DILANTIN-30	88
DERMAFLEX HC	188	DILAUDID	83
DERMOVATE	185	DILTIAZEM CD	58
DESFERAL	163	DILTIAZEM HCL	57
DESICCATED THYROID	177	DILTIAZEM HCL	58
DESIPRAMINE	103	DILTIAZEM HCL	59
DESIPRAMINE HCL	103	DIMENHYDRINATE	152
DESMOPRESSIN	176	DIMENHYDRINATE I.M.	152
DESMOPRESSIN ACETATE	176	DIMENHYDRINATE I.V.	152
DESMOPRESSIN ACETATE	177	DIMETHYL FUMARATE	SEC 3.65
DESOGESTREL/ ETHINYL ESTRADIOL	169	DIMETHYL SULFOXIDE	200
DESOGESTREL/ ETHINYL ESTRADIOL/ DESOGESTREL/ ETHINYL ESTRADIOL	169	DIOVAN	71
DESONIDE	186	DIOVAN	72
DESOXIMETASONE	187	DIOVAN-HCT	72
DETROL LA	194	DIPENTUM	159
DEXAMETHASONE	139	DIPHENHYDRAMINE	3
DEXAMETHASONE	166	DIPHENHYDRAMINE HCL	3
DEXAMETHASONE SODIUM PHOSPHATE	166	DIPHENOXYLATE HCL/ ATROPINE SULFATE	151
DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN	140	DIPROLENE GLYCOL	184
		DIPROSALIC	184
		DIPROSONE	184
		DIPYRIDAMOLE	50
		DIPYRIDAMOLE/ ASA	36

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
DISOPYRAMIDE.....	39	ENALAPRIL	61
DIVALPROEX SODIUM (VALPROIC ACID EQUIV.)....	89	ENALAPRIL MALEATE.....	60
DIVIGEL (0.25 MG PACK)	171	ENALAPRIL MALEATE.....	61
DIVIGEL (0.5 MG PACK)	171	ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE ...	61
DIVIGEL (1 MG PACK)	171	ENALAPRIL MALEATE/HCTZ	61
DOMPERIDONE	158	ENBREL.....	SEC 3.79
DOMPERIDONE MALEATE	158	ENBREL.....	SEC 3.98
DONEPEZIL.....	SEC 3.66	ENGERIX-B	179
DONEPEZIL HCL.....	SEC 3.66	ENOXAPARIN SODIUM	34
DONEPEZIL HYDROCHLORIDE.....	SEC 3.66	ENSTILAR	192
DORZOLAMIDE HCL.....	144	ENTACAPONE	125
DORZOLAMIDE HCL/ TIMOLOL MALEATE	145	ENTECAVIR.....	21
DOSTINEX.....	SEC 3.40	ENTOCORT	SEC 3.38
DOVOBET.....	192	ENTOCORT (115 ML).....	185
DOVONEX	192	ENTRESTO.....	SEC 3.214
DOXAZOSIN MESYLATE	51	ENTYVIO	SEC 3.262
DOXEPIN	103	EPCLUSA	SEC 3.231
DOXEPIN HCL.....	103	EPINEPHRINE.....	29
DOXYCYCLINE	14	EPINEPHRINE HCL.....	143
DOXYCYCLINE HYCLATE	14	EPINEPHRINE HCL.....	29
DOXYLAMINE SUCCINATE/ PYRIDOXINE HCL.....	154	EPIPEN.....	29
DROSPIRENONE/ ETHINYL ESTRADIOL.....	169	EPIPEN JR	29
DUAKLIR GENUAIR	SEC 3.9	EPIVAL	89
DULOXETINE	95	EPLERENONE.....	SEC 3.76
DULOXETINE DR	95	EPOETIN ALFA	SEC 3.76
DULOXETINE HYDROCHLORIDE	95	EPOETIN ALFA	SEC 3.77
DUOTRAV PQ	145	EPREX.....	SEC 3.77
DUTASTERIDE.....	202	EPREX (0.3 ML SYRINGE)	SEC 3.76
DYSPORT THERAPEUTIC.....	203	EPREX (0.4 ML SYRINGE)	SEC 3.77
<hr/> E <hr/>			
ECULIZUMAB	SEC 3.71	EPREX (0.5 ML SYRINGE)	SEC 3.76
EDECRIN	48	EPREX (0.5 ML SYRINGE)	SEC 3.77
EDOXABAN TOSYLATE MONOHYDRATE	SEC 3.72	EPREX (0.6 ML SYRINGE)	SEC 3.77
EFFEXOR XR	95	EPREX (0.6 ML SYRINGE)	SEC 3.77
EFFEXOR XR	96	EPREX (0.8 ML SYRINGE)	SEC 3.77
EFUDEX.....	191	EPREX (1 ML SYRINGE)	SEC 3.77
ELAVIL.....	102	EPROSARTAN MESYLATE	67
ELBASVIR/ GRAZOPREVIR.....	SEC 3.73	EPROSARTAN MESYLATE/ HYDROCHLOROTHIAZIDE	67
ELIQUIS.....	SEC 3.29	ERELZI	SEC 3.84
ELIQUIS.....	SEC 3.31	ERELZI	SEC 3.92
ELMIRON.....	201	ERELZI	SEC 3.95
ELOCOM.....	188	ERTAPENEM.....	8
ELTROXIN	178	ERTAPENEM.....	SEC 3.78
EMEND	154	ERYC	9
EMEND TRI-PACK.....	154	ERYTHRO-BASE.....	9
EMPAGLIFLOZIN.....	SEC 3.74	ERYTHRO-S.....	9
EMPAGLIFLOZIN/ METFORMIN HCL.....	SEC 3.75	ERYTHROMYCIN	139
ENABLEX.....	SEC 3.54	ERYTHROMYCIN	9
ENALAPRIL	60	ERYTHROMYCIN STEARATE	9
		ESBRIET.....	SEC 3.199
		ESCITALOPRAM.....	98
		ESLICARBAZEPINE ACETATE.....	SEC 3.78
		ESTALIS (2*.62 MG/PTH).....	172

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
ESTALIS (4.8*.51 MG/PTH).....	172	FESOTERODINE FUMARATE	SEC 3.107
ESTRACE	171	FIBRISTAL	201
ESTRADIOL-17B	171	FIDAXOMICIN.....	SEC 3.108
ESTRADIOL-17B	172	FILGRASTIM.....	SEC 3.108
ESTRADOT 100 (1.56 MG/PTH)	172	FINACEA	192
ESTRADOT 25 (0.39 MG/PTH)	171	FINASTERIDE	202
ESTRADOT 37.5 (0.585 MG/PTH).....	171	FINGOLIMOD HYDROCHLORIDE	SEC 3.110
ESTRADOT 50 (0.78 MG/PTH)	172	FINGOLIMOD HYDROCHLORIDE	SEC 3.111
ESTRADOT 75 (1.17 MG/PTH)	172	FIORINAL	77
ESTRING	172	FIORINAL-C 1/2.....	81
ESTROGEL.....	171	FIORINAL-C 1/4.....	81
ETANERCEPT	SEC 3.103	FIRAZYR.....	SEC 3.124
ETANERCEPT	SEC 3.79	FLAGYL	183
ETANERCEPT	SEC 3.84	FLAGYL	23
ETANERCEPT	SEC 3.87	FLAGYSTATIN.....	183
ETANERCEPT	SEC 3.88	FLAMAZINE	184
ETANERCEPT	SEC 3.90	FLAREX	140
ETANERCEPT	SEC 3.92	FLECAINIDE ACETATE	39
ETANERCEPT	SEC 3.95	FLOCTAFENINE	78
ETANERCEPT	SEC 3.98	FLOMAX CR	51
ETHACRYNIC ACID	48	FLORINEF	167
ETHOPROPAZINE HCL	125	FLOVENT DISKUS	167
ETHOSUXIMIDE	89	FLOVENT HFA	167
ETHYNODIOL DIACETATE/ ETHINYL ESTRADIOL..	169	FLUANXOL	115
ETIDRONATE DISODIUM/ CALCIUM CARBONATE .	200	FLUANXOL DEPOT.....	115
ETODOLAC	78	FLUCONAZOLE.....	17
EURO FOLIC	195	FLUCONAZOLE.....	SEC 3.111
EURO-K	133	FLUDROCORTISONE ACETATE.....	167
EURO-K 20	133	FLUMETHASONE PIVALATE/ CLIOQUINOL.....	141
EVISTA	SEC 3.201	FLUNARIZINE.....	201
EVOLOCUMAB.....	SEC 3.105	FLUNARIZINE HCL	201
EXELON.....	SEC 3.211	FLUOCINONIDE	187
EXJADE	SEC 3.58	FLUOR-A-DAY	129
EXJADE	SEC 3.59	FLUOROMETHOLONE	140
EXJADE	SEC 3.60	FLUOROMETHOLONE ACETATE	140
EXTAVIA (0.3 MG).....	SEC 3.155	FLUOXETINE.....	99
EYLEA.....	147	FLUOXETINE BP.....	99
EZETIMIBE	SEC 3.105	FLUOXETINE HCL	99
EZETROL.....	SEC 3.105	FLUPENTIXOL DECANOATE	115
		FLUPENTIXOL DIHYDROCHLORIDE.....	115
		FLUPHENAZINE.....	114
		FLUPHENAZINE DECANOATE.....	114
		FLUPHENAZINE HCL.....	114
		FLURAZEPAM.....	119
		FLURAZEPAM HCL	119
		FLURBIPROFEN	78
		FLUTAMIDE.....	SEC 3.111
		FLUTICASONE FUROATE	140
		FLUTICASONE FUROATE/ VILANTEROL	
		TRIFENATATE.....	SEC 3.112
		FLUTICASONE FUROATE/ VILANTEROL	
		TRIFENATATE.....	SEC 3.113

F

FAMOTIDINE	154
FEBUXOSTAT	SEC 3.106
FELODIPINE.....	57
FENOFIBRATE	41
FENTANYL	SEC 3.106
FENTANYL	SEC 3.107
FENTANYL CITRATE	SEC 3.107
FERRIPROX	SEC 3.61

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
FLUTICASONE PROPIONATE.....	167	GD-TRANEXAMIC ACID	37
FLUVASTATIN SODIUM.....	43	GEMFIBROZIL.....	41
FLUVOXAMINE MALEATE	99	GEN-CLOZAPINE	106
FOLIC ACID	195	GEN-CLOZAPINE	107
FONDAPARINUX SODIUM	35	GENOTROPIN GOQUICK	SEC 3.233
FONDAPARINUX SODIUM (0.5 ML SYRINGE)	35	GENOTROPIN MINIQUICK	SEC 3.232
FONDAPARINUX SODIUM (0.6 ML SYRINGE)	35	GENOTROPIN MINIQUICK	SEC 3.233
FORADIL.....	28	GENTAMICIN.....	5
FORMOTEROL FUMARATE	28	GENTAMICIN SULFATE	5
FORMOTEROL FUMARATE DIHYDRATE.....	28	GILENYA	SEC 3.110
FORTAZ.....	7	GLATECT	SEC 3.115
FORXIGA	SEC 3.51	GLATIRAMER ACETATE	SEC 3.115
FOSAMAX.....	197	GLATIRAMER ACETATE	SEC 3.116
FOSAVANCE	197	GLATIRAMER ACETATE	SEC 3.117
FOSFOMYCIN TROMETHAMINE	23	GLICLAZIDE	175
FOSINOPRIL	61	GLICLAZIDE	176
FOSINOPRIL SODIUM	61	GLUCAGEN.....	176
FRAGMIN.....	34	GLUCAGEN HYPOKIT	176
FRAGMIN (0.2 ML SYRINGE)	34	GLUCAGON.....	176
FRAGMIN (0.28 ML SYRINGE)	34	GLUCAGON, RDNA ORIGIN.....	176
FRAGMIN (0.3 ML SYRINGE)	34	GLUCOBAY	172
FRAGMIN (0.4 ML SYRINGE)	34	GLUCONORM	175
FRAGMIN (0.5 ML SYRINGE)	34	GLUCOPHAGE.....	173
FRAGMIN (0.6 ML SYRINGE)	34	GLYBURIDE	176
FRAGMIN (0.72 ML SYRINGE)	34	GLYCEROL PHENYL BUTYRATE	SEC 3.117
FRAXIPARINE (0.3-1 ML SYR)	35	GLYCOPYRROLATE	27
FRAXIPARINE FORTE (0.6-1 ML SYR)	35	GLYCOPYRROLATE	138
FREYA 21	169	GOLD SODIUM THIOMALATE.....	161
FREYA 28	169	GOLIMUMAB	SEC 3.122
FUCIDIN.....	183	GOLIMUMAB	SEC 3.124
FUNGIZONE IV.....	19	GOSERELIN ACETATE.....	SEC 3.124
FUROSEMIDE	48	GRANISETRON HCL.....	152
FUROSEMIDE INJECTION SDZ	48	GRASTOFIL.....	SEC 3.108
FUSIDIC ACID	183		
FYCOMPA	SEC 3.195		
<hr/>			
G			
<hr/>			
GABAPENTIN	90	HALOBETASOL PROPIONATE	187
GALANTAMINE ER.....	SEC 3.113	HALOPERIDOL.....	113
GALANTAMINE ER.....	SEC 3.114	HALOPERIDOL DECANOATE	113
GALANTAMINE HYDROBROMIDE	SEC 3.113	HALOPERIDOL LA	113
GALANTAMINE HYDROBROMIDE	SEC 3.114	HARVONI.....	SEC 3.230
GANCICLOVIR SODIUM	21	HEMANGIOL.....	SEC 3.200
GD-AMLODIPINE.....	56	HEPARIN LEO	34
GD-AZITHROMYCIN	10	HEPARIN SODIUM.....	34
GD-CELECOXIB	SEC 3.42	HEPATITIS B VACCINE (RECOMBINANT)	179
GD-DICLOFENAC/MISOPROSTOL 50	78	HEPSERA	21
GD-DICLOFENAC/MISOPROSTOL 75	78	HEPTOVIR.....	20
GD-LATANOPROST	144	HP-PAC (KIT).....	156
GD-LATANOPROST/TIMOLOL	145	HUMALOG	174
		HUMALOG CARTRIDGE	174
		HUMALOG KWIKPEN	174

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE).....	174	JAMP OLANZAPINE FC.....	108
INSULIN LISPRO.....	174	JAMP POTASSIUM CHLORIDE.....	133
INSULIN LISPRO/ INSULIN LISPRO PROTAMINE....	175	JAMP-ALENDRONATE.....	197
INSULIN PEN NEEDLES.....	1	JAMP-ALPRAZOLAM.....	118
INSULIN SYRINGES.....	1	JAMP-AMLODIPINE.....	56
INTERFERON BETA-1A.....	SEC 3.152	JAMP-ATENOLOL.....	52
INTERFERON BETA-1B.....	SEC 3.155	JAMP-ATORVASTATIN.....	42
INVANZ.....	8	JAMP-AZITHROMYCIN.....	10
INVANZ.....	SEC 3.78	JAMP-BEZAFIBRATE.....	41
INVEGA.....	108	JAMP-CANDESARTAN.....	66
INVEGA.....	109	JAMP-CARVEDILOL.....	53
INVEGA SUSTENNA (0.5 ML SYR).....	SEC 3.185	JAMP-CARVEDILOL.....	54
INVEGA SUSTENNA (0.75 ML SYR).....	SEC 3.185	JAMP-CELECOXIB.....	SEC 3.42
INVEGA SUSTENNA (1 ML SYR).....	SEC 3.186	JAMP-CIPROFLOXACIN.....	SEC 3A.2
INVEGA SUSTENNA (1.5 ML SYR).....	SEC 3.186	JAMP-CIPROFLOXACIN.....	SEC 3A.3
INVEGA TRINZA (0.875 ML SYR).....	SEC 3.187	JAMP-CLOPIDOGREL.....	36
INVEGA TRINZA (1.315 ML SYR).....	SEC 3.187	JAMP-COLCHICINE.....	198
INVEGA TRINZA (1.75 ML SYR).....	SEC 3.188	JAMP-CYANOCOBALAMIN.....	195
INVEGA TRINZA (2.625 ML SYR).....	SEC 3.188	JAMP-CYCLOBENZAPRINE.....	30
INVOKANA.....	SEC 3.40	JAMP-DOMPERIDONE.....	158
IOPIDINE.....	147	JAMP-DONEPEZIL.....	SEC 3.66
IPRATROPIUM BROMIDE.....	27	JAMP-DULOXETINE.....	95
IPRATROPIUM BROMIDE.....	SEC 3.155	JAMP-ENTECAVIR.....	21
IPRATROPIUM BROMIDE/ SALBUTAMOL SULFATE.	27	JAMP-ESCITALOPRAM.....	98
IRBESARTAN.....	67	JAMP-EZETIMIBE.....	SEC 3.105
IRBESARTAN HCT.....	68	JAMP-FINASTERIDE.....	202
IRBESARTAN/ HYDROCHLOROTHIAZIDE.....	68	JAMP-FLUOXETINE.....	99
IRBESARTAN/HCTZ.....	68	JAMP-FOLIC ACID.....	195
IRON DEXTRAN COMPLEX.....	33	JAMP-FOSFOMYCIN.....	23
ISDN.....	49	JAMP-FOSINOPRIL.....	61
ISOPTIN SR.....	59	JAMP-GABAPENTIN.....	90
ISOPTO ATROPINE.....	141	JAMP-HYDRALAZINE.....	47
ISOPTO CARPINE.....	144	JAMP-HYDRALAZINE.....	48
ISOSORBIDE DINITRATE.....	49	JAMP-HYDROCORTISONE.....	187
ISOSORBIDE-5-MONONITRATE.....	49	JAMP-INDAPAMIDE.....	135
ISOTRETINOIN.....	192	JAMP-IRBESARTAN.....	67
ITRACONAZOLE.....	18	JAMP-IRBESARTAN-HYDROCHLOROTHIAZIDE.....	68
ITRACONAZOLE.....	SEC 3.156	JAMP-K 20.....	133
IVABRADINE HYDROCHLORIDE.....	SEC 3.156	JAMP-K 8.....	133
IVACAFTOR.....	SEC 3.157	JAMP-K EFFERVESCENT (25 MEQ).....	133
IXEKIZUMAB.....	SEC 3.160	JAMP-LACTULOSE.....	133
IZBA.....	144	JAMP-LEVETIRACETAM.....	91
<hr/> J <hr/>			
JADENU.....	SEC 3.55	JAMP-LISINOPRIL.....	61
JADENU.....	SEC 3.56	JAMP-LISINOPRIL.....	62
JADENU.....	SEC 3.57	JAMP-LOSARTAN.....	69
JAMP MAGNESIUM GLUCONATE.....	133	JAMP-LOSARTAN HCTZ.....	70
JAMP OLANZAPINE FC.....	107	JAMP-METFORMIN.....	173
		JAMP-METOPROLOL-L.....	54
		JAMP-MONTELUKAST.....	137
		JAMP-MONTELUKAST.....	SEC 3.171
		JAMP-MOXIFLOXACIN.....	SEC 3A.7
		JAMP-NYSTATIN.....	19

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
JAMP-OLANZAPINE ODT	108	JARDIANCE	SEC 3.74
JAMP-OLMESARTAN	49	JENCYCLA (28 DAY).....	170
JAMP-OMEPRAZOLE DR (DELAYED-RELEASE TABLET)	157	JENTADUETO	SEC 3.165
JAMP-ONDANSETRON.....	153	JETREA	147
JAMP-ONDANSETRON (PRESERVATIVE FREE)	153	<hr/> K <hr/>	
JAMP-ONDANSETRON (WITH PRESERVATIVE).....	153	K-LYTE	134
JAMP-PANTOPRAZOLE	158	KADIAN.....	85
JAMP-PAROXETINE	100	KALYDECO	SEC 3.157
JAMP-POTASSIUM CHLORIDE ER.....	133	KAYEXALATE.....	134
JAMP-PRAVASTATIN.....	43	KENALOG-10.....	168
JAMP-PRAVASTATIN.....	44	KENALOG-40.....	168
JAMP-PREGABALIN.....	92	KEPPRA	91
JAMP-QUETIAPINE.....	109	KETOCONAZOLE.....	18
JAMP-QUETIAPINE.....	110	KETOCONAZOLE.....	183
JAMP-QUININE	23	KETODERM.....	183
JAMP-RAMIPRIL (CAPSULE)	64	KETOPROFEN	79
JAMP-RANITIDINE	155	KETOPROFEN SR	79
JAMP-RISEDRONATE.....	201	KETOPROFEN-E.....	79
JAMP-RISPERIDONE.....	111	KETOROLAC	141
JAMP-RISPERIDONE.....	112	KETOROLAC TROMETHAMINE.....	141
JAMP-RISPERIDONE.....	113	KETOROLAC TROMETHAMINE.....	79
JAMP-RIZATRIPTAN	123	KETOTIFEN FUMARATE	3
JAMP-RIZATRIPTAN	SEC 3.212	KEVZARA	SEC 3.220
JAMP-RIZATRIPTAN IR	123	KINERET	SEC 3.26
JAMP-RIZATRIPTAN IR	SEC 3.212	KOMBOGLYZE	SEC 3.221
JAMP-RIZATRIPTAN ODT	123	KYLEENA	170
JAMP-RIZATRIPTAN ODT	SEC 3.212	<hr/> L <hr/>	
JAMP-ROPINIROLE	127	L-TRYPTOPHAN	104
JAMP-ROPINIROLE	128	LABETALOL HCL	54
JAMP-ROSUVASTATIN.....	44	LACOSAMIDE.....	SEC 3.161
JAMP-ROSUVASTATIN.....	45	LACTULOSE.....	133
JAMP-SERTRALINE	101	LAMICTAL	90
JAMP-SIMVASTATIN.....	46	LAMICTAL	91
JAMP-SIMVASTATIN.....	47	LAMISIL	17
JAMP-SODIUM PHOSPHATE	134	LAMISIL	183
JAMP-SOLIFENACIN.....	193	LAMIVUDINE	20
JAMP-SOTALOL.....	55	LAMOTRIGINE	90
JAMP-TENOFOVIR.....	20	LAMOTRIGINE	91
JAMP-TOBRAMYCIN.....	5	LANCORA.....	SEC 3.156
JAMP-URSODIOL.....	151	LANREOTIDE ACETATE.....	SEC 3.161
JAMP-VALACYCLOVIR	22	LANSOPRAZOLE	156
JAMP-VANCOMYCIN	15	LANSOPRAZOLE/ AMOXICILLIN TRIHYDRATE/ CLARITHROMYCIN	156
JAMP-ZOLMITRIPTAN	124	LANTUS.....	174
JAMP-ZOLMITRIPTAN	SEC 3.265	LANTUS CARTRIDGE	174
JAMP-ZOLMITRIPTAN ODT.....	124	LANTUS PEN.....	174
JAMP-ZOLMITRIPTAN ODT.....	SEC 3.265	LASIX.....	48
JAMP-ZOPICLONE.....	121		
JAMPZINC-HC	188		
JANUMET	SEC 3.227		
JANUMET XR	SEC 3.227		
JANUVIA	SEC 3.226		

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
LASIX SPECIAL.....	48	LISINOPRIL/ HYDROCHLOROTHIAZIDE.....	62
LATANOPROST.....	144	LISINOPRIL/HCTZ (TYPE Z).....	62
LATANOPROST/ TIMOLOL MALEATE.....	145	LISINOPRIL/HCTZ (TYPE Z).....	62
LATUDA.....	107	LITHANE.....	121
LEDERLE LEUCOVORIN CALCIUM.....	201	LITHANE.....	122
LEFLUNOMIDE.....	202	LITHIUM CARBONATE.....	121
LEMTRADA.....	SEC 3.21	LITHIUM CARBONATE.....	122
LESCOL XL.....	43	LIXIANA.....	SEC 3.72
LEUCOVORIN CALCIUM.....	201	LOCACORTEN VIOFORM.....	141
LEUPROLIDE ACETATE.....	SEC 3.162	LODALIS.....	40
LEVEMIR CARTRIDGE.....	173	LOESTRIN 1.5/30 (21 DAY).....	170
LEVEMIR FLEXTOUCH.....	173	LOESTRIN 1.5/30 (28 DAY).....	170
LEVETIRACETAM.....	91	LOMOTIL.....	151
LEVOBUNOLOL HCL.....	143	LONITEN.....	48
LEVOCARNITINE.....	SEC 3.162	LOPRESOR SR.....	54
LEVODOPA/ BENSERAZIDE HCL.....	126	LOPROX.....	184
LEVODOPA/ CARBIDOPA.....	126	LORAZEPAM.....	119
LEVODOPA/ CARBIDOPA/ ENTACAPONE.....	126	LORAZEPAM.....	120
LEVOFLOXACIN.....	SEC 3.163	LOSARTAN.....	69
LEVOFLOXACIN.....	SEC 3A.4	LOSARTAN POTASSIUM.....	69
LEVOFLOXACIN.....	SEC 3A.5	LOSARTAN POTASSIUM/ HYDROCHLOROTHIAZIDE.....	70
LEVOFLOXACIN.....	SEC 3A.6	LOSARTAN/HCT.....	70
LEVONORGESTREL.....	170	LOSARTAN/HCTZ.....	70
LEVONORGESTREL/ ETHINYL ESTRADIOL.....	170	LOSEC (SUSTAINED-RELEASE CAPSULE).....	157
LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL.....	170	LOSEC (SUSTAINED-RELEASE TABLET).....	157
LEVOTHYROXINE SODIUM.....	178	LOTRIDERM.....	188
LIBRAX.....	119	LOVASTATIN.....	43
LIDEMOL.....	187	LOVENOX.....	34
LIDEX.....	187	LOVENOX (0.3 ML SYRINGE).....	34
LIDOCAINE.....	190	LOVENOX (0.4 ML SYRINGE).....	34
LIDOCAINE HCL.....	141	LOVENOX (0.6 ML SYRINGE).....	34
LIDOCAINE HCL.....	190	LOVENOX (0.8 ML SYRINGE).....	34
LIDODAN.....	190	LOVENOX (1 ML SYRINGE).....	34
LIDODAN VISCOUS.....	141	LOVENOX HP (1 ML SYRINGE).....	34
LINAGLIPTIN.....	SEC 3.164	LOXAPINE SUCCINATE.....	116
LINAGLIPTIN/ METFORMIN HCL.....	SEC 3.165	LOZIDE.....	135
LINESSA 21.....	169	LUCENTIS.....	149
LINESSA 28.....	169	LUMIGAN RC 0.01%.....	144
LINEZOLID.....	16	LUPIN-ESTRADIOL.....	171
LINEZOLID.....	SEC 3.166	LUPRON.....	SEC 3.162
LIORESAL.....	30	LUPRON DEPOT.....	SEC 3.162
LIORESAL D.S.....	30	LURASIDONE HCL.....	107
LIORESAL INTRATHECAL.....	30	LUVOX.....	99
LIOthyronine Sodium.....	178	LYDERM.....	187
LIPASE/ AMYLASE/ PROTEASE.....	151		
LIPIDIL SUPRA (TABLET).....	41		
LIPITOR.....	42		
LISDEXAMFETAMINE DIMESYLATE.....	116		
LISINOPRIL.....	61		
LISINOPRIL.....	62		

M

M-EDIAT.....	85
M-ESLON.....	85
MACROBID.....	23

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
MAGLUCATE	133	MAR-VALACYCLOVIR	22
MAGNESIUM GLUCOHEPTONATE	133	MAR-ZOLMITRIPTAN	124
MAGNESIUM GLUCONATE	133	MAR-ZOLMITRIPTAN	SEC 3.265
MAGNESIUM-ODAN	133	MAR-ZOPICLONE	121
MAR-ALLOPURINOL	197	MARVELON (21 DAY)	169
MAR-AMLODIPINE	56	MARVELON (28 DAY)	169
MAR-ATENOLOL	52	MAVIK	65
MAR-ATORVASTATIN	42	MAVIRET	SEC 3.197
MAR-AZITHROMYCIN	10	MAXALT	123
MAR-CELECOXIB	SEC 3.42	MAXALT	SEC 3.212
MAR-CIPROFLOXACIN	SEC 3A.2	MAXALT RPD	123
MAR-CIPROFLOXACIN	SEC 3A.3	MAXALT RPD	SEC 3.212
MAR-CITALOPRAM	96	MAXIDEX	139
MAR-CITALOPRAM	97	MAXITROL	140
MAR-CLOPIDOGREL	36	MDK-NITISINONE	SEC 3.176
MAR-DAPSONE	19	MEBENDAZOLE	5
MAR-DILTIAZEM T	58	MED-CYPROTERONE	SEC 3.47
MAR-DILTIAZEM T	59	MED-DORZOLAMIDE-TIMOLOL	145
MAR-DOMPERIDONE	158	MED-DUTASTERIDE	202
MAR-DONEPEZIL	SEC 3.66	MED-LATANOPROST	144
MAR-DULOXETINE	95	MED-MOXIFLOXACIN	SEC 3A.7
MAR-ESCITALOPRAM	98	MED-RIVASTIGMINE	SEC 3.211
MAR-EZETIMIBE	SEC 3.105	MED-ROSUVASTATIN	44
MAR-GABAPENTIN	90	MED-ROSUVASTATIN	45
MAR-KETOROLAC	79	MED-SOLIFENACIN	193
MAR-METHIMAZOLE	178	MEDROL	167
MAR-MIDODRINE	28	MEDROXYPROGESTERONE ACETATE	177
MAR-MODAFINIL	SEC 3.170	MEFENAMIC	79
MAR-MONTELUKAST	137	MEFENAMIC ACID	79
MAR-MONTELUKAST	SEC 3.171	MEGESTROL	SEC 3.167
MAR-MOXIFLOXACIN	SEC 3A.7	MEGESTROL ACETATE	SEC 3.167
MAR-OLANZAPINE ODT	108	MEPERIDINE HCL	84
MAR-ONDANSETRON	153	MEPERIDINE HYDROCHLORIDE	84
MAR-PANTOPRAZOLE	158	MEPOLIZUMAB	SEC 3.168
MAR-PAROXETINE	100	MEPRON	23
MAR-PRAVASTATIN	43	MEROPENEM	8
MAR-PRAVASTATIN	44	MEROPENEM	SEC 3.169
MAR-QUETIAPINE	109	MEROPENEM FOR INJECTION USP	8
MAR-QUETIAPINE	110	MEROPENEM FOR INJECTION USP	SEC 3.169
MAR-RAMIPRIL (CAPSULE)	64	MESALAZINE	159
MAR-RANITIDINE	155	MESTINON	27
MAR-RISPERIDONE	111	MESTINON-SR	27
MAR-RISPERIDONE	112	METADOL	84
MAR-RIZATRIPTAN	123	METADOL CONCENTRATE	84
MAR-RIZATRIPTAN	SEC 3.212	METADOL-D	84
MAR-RIZATRIPTAN ODT	123	METFORMIN	173
MAR-RIZATRIPTAN ODT	SEC 3.212	METFORMIN FC	173
MAR-ROSUVASTATIN	44	METFORMIN HCL	173
MAR-ROSUVASTATIN	45	METHADONE HCL	84
MAR-SERTRALINE	101	METHADOSE	84
MAR-SIMVASTATIN	46	METHADOSE SUGAR FREE	84
MAR-SIMVASTATIN	47	METHAZOLAMIDE	144

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
METHOPRAZINE.....	114	MINOXIDIL.....	48
METHOTREXATE.....	25	MINT-ACITRETIN.....	192
METHOTREXATE (PRESERVED).....	25	MINT-ALENDRONATE.....	197
METHOTREXATE SOD. (PRESERVED).....	25	MINT-AMLODIPINE.....	56
METHOTREXATE SOD.(UNPRESERVED).....	25	MINT-ATENOL.....	52
METHOTREXATE SODIUM.....	25	MINT-CANDESARTAN.....	66
METHOTRIMEPRAZINE HCL.....	114	MINT-CELECOXIB.....	SEC 3.42
METHOTRIMEPRAZINE MALEATE.....	114	MINT-CIPROFLOX.....	SEC 3A.2
METHYLDOPA.....	47	MINT-CIPROFLOX.....	SEC 3A.3
METHYLPHENIDATE HCL.....	117	MINT-CITALOPRAM.....	96
METHYLPHENIDATE HCL.....	118	MINT-CITALOPRAM.....	97
METHYLPREDNISOLONE.....	167	MINT-CLONIDINE.....	47
METHYLPREDNISOLONE ACETATE.....	167	MINT-CLOPIDOGREL.....	36
METHYLPREDNISOLONE ACETATE/ LIDOCAINE HCL.....	167	MINT-DORZOLAMIDE/TIMOLOL.....	145
METHYLPREDNISOLONE ACETATE/ NEOMYCIN.....		MINT-DULOXETINE.....	95
SULFATE/ ALUMINUM CHLORHYDROXIDE.....		MINT-DUTASTERIDE.....	202
COMPLEX/ SULFUR.....	SEC 3.169	MINT-EPLERENONE.....	SEC 3.76
METHYLPREDNISOLONE SOD SUCCIN.....	168	MINT-ESCITALOPRAM.....	98
METHYLPREDNISOLONE SOD SUCCINATE.....	168	MINT-EZETIMIBE.....	SEC 3.105
METHYLPREDNISOLONE SODIUM SUCCINATE....	168	MINT-FINASTERIDE.....	202
METOCLOPRAMIDE HCL.....	159	MINT-FLUOXETINE.....	99
METOCLOPRAMIDE HYDROCHLORIDE.....	159	MINT-FUROSEMIDE.....	48
METOJECT SUBCUTANEOUS.....	25	MINT-GLICLAZIDE MR.....	175
METOLAZONE.....	135	MINT-GLICLAZIDE MR.....	176
METONIA.....	159	MINT-HYDRALAZINE.....	47
METOPROLOL.....	54	MINT-HYDRALAZINE.....	48
METOPROLOL TARTRATE.....	54	MINT-HYDROXYCHLOROQUINE.....	22
METOPROLOL-L.....	54	MINT-INDOMETHACIN.....	78
METROGEL.....	183	MINT-IRBESARTAN.....	67
METRONIDAZOLE.....	183	MINT-IRBESARTAN/HCTZ.....	68
METRONIDAZOLE.....	23	MINT-ITRACONAZOLE.....	18
METRONIDAZOLE/ NYSTATIN.....	183	MINT-LEVOCARB.....	126
MEXILETINE HCL.....	39	MINT-LOSARTAN.....	69
MEZAVANT.....	159	MINT-LOSARTAN/HCTZ.....	70
MEZERA.....	159	MINT-LOSARTAN/HCTZ DS.....	70
MICARDIS.....	70	MINT-METFORMIN.....	173
MICARDIS PLUS.....	71	MINT-MONTELUKAST.....	137
MICRO-K EXTENCAPS.....	133	MINT-MONTELUKAST.....	SEC 3.171
MICRONOR (28 DAY).....	170	MINT-OLANZAPINE ODT.....	108
MICTORYL PEDIATRIC.....	193	MINT-ONDANSETRON.....	153
MIDAMOR.....	134	MINT-PANTOPRAZOLE.....	158
MIDAZOLAM.....	120	MINT-PAROXETINE.....	100
MIDAZOLAM HCL.....	120	MINT-PRAVASTATIN.....	43
MIDODRINE HCL.....	28	MINT-PRAVASTATIN.....	44
MIGRANAL.....	29	MINT-PREGABALIN.....	92
MINESTRIN 1/20 (21 DAY).....	170	MINT-QUETIAPINE.....	109
MINESTRIN 1/20 (28 DAY).....	170	MINT-QUETIAPINE.....	110
MINITRAN 0.2.....	50	MINT-RAMIPRIL (CAPSULE).....	64
MINITRAN 0.4.....	50	MINT-RISPERIDON.....	111
MINITRAN 0.6.....	50	MINT-RISPERIDON.....	112
MINOCYCLINE HCL.....	14	MINT-ROSUVASTATIN.....	44
		MINT-ROSUVASTATIN.....	45

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
MINT-SERTRALINE.....	101	MYLAN-AMLODIPINE	56
MINT-SIMVASTATIN	46	MYLAN-AMOXICILLIN	11
MINT-SIMVASTATIN	47	MYLAN-ATORVASTATIN	42
MINT-SOLIFENACIN	193	MYLAN-BACLOFEN	30
MINT-TOPIRAMATE	93	MYLAN-BECLO AQ	139
MINT-ZOLMITRIPTAN	124	MYLAN-BUDESONIDE AQ.....	139
MINT-ZOLMITRIPTAN	SEC 3.265	MYLAN-BUPROPION XL.....	104
MINT-ZOPICLONE.....	121	MYLAN-CILAZAPRIL	60
MIRABEGRON.....	SEC 3.170	MYLAN-CLOBETASOL.....	185
MIRAPEX	127	MYLAN-DIVALPROEX.....	89
MIRENA SYSTEM.....	170	MYLAN-ENALAPRIL.....	60
MIRTAZAPINE	105	MYLAN-ENALAPRIL.....	61
MIRVALA 21	169	MYLAN-ESCITALOPRAM	98
MIRVALA 28	169	MYLAN-FENTANYL MATRIX	SEC 3.106
MISCELLANEOUS COMPOUND.....	199	MYLAN-FLUCONAZOLE	17
MISCELLANEOUS INJECTABLE COMPOUND.....	198	MYLAN-GALANTAMINE ER	SEC 3.113
MISCELLANEOUS ORAL COMPOUND.....	200	MYLAN-GALANTAMINE ER	SEC 3.114
MISCELLANEOUS TOPICAL COMPOUND	181	MYLAN-GLICLAZIDE MR	175
MISOPROSTOL	155	MYLAN-INDAPAMIDE	135
MOCLOBEMIDE	94	MYLAN-LAMOTRIGINE	90
MODAFINIL.....	SEC 3.170	MYLAN-LAMOTRIGINE	91
MODECATE CONCENTRATE.....	114	MYLAN-LANSOPRAZOLE.....	156
MOGADON	120	MYLAN-MINOCYCLINE.....	14
MOMETASONE FUROATE	140	MYLAN-MIRTAZAPINE	105
MOMETASONE FUROATE	168	MYLAN-NIFEDIPINE EXTENDED RELEASE.....	57
MOMETASONE FUROATE	188	MYLAN-NITRO	50
MONTELUKAST	137	MYLAN-NITRO PATCH	50
MONTELUKAST	SEC 3.171	MYLAN-ONDANSETRON.....	153
MONTELUKAST SODIUM.....	137	MYLAN-PANTOPRAZOLE T	157
MONTELUKAST SODIUM.....	138	MYLAN-PROPAFENONE	39
MONTELUKAST SODIUM.....	SEC 3.171	MYLAN-RILUZOLE	SEC 3.202
MONUROL.....	23	MYLAN-RISPERIDONE ODT	112
MORPHINE HP 50.....	86	MYLAN-RIZATRIPTAN ODT.....	123
MORPHINE LP EPIDURAL.....	86	MYLAN-RIZATRIPTAN ODT.....	SEC 3.212
MORPHINE SR.....	84	MYLAN-SIMVASTATIN.....	46
MORPHINE SR.....	85	MYLAN-SIMVASTATIN.....	47
MORPHINE SULFATE	84	MYLAN-SUMATRIPTAN.....	124
MORPHINE SULFATE	85	MYLAN-SUMATRIPTAN.....	SEC 3.235
MORPHINE SULFATE	86	MYLAN-TENOFOVIR DISOPROXIL.....	20
MOVISSE (28 DAY).....	170	MYLAN-TOLTERODINE ER	194
MOXIFLOXACIN HCL.....	SEC 3A.7	MYLAN-TOPIRAMATE	93
MOZOBIL	SEC 3.200	MYLAN-VALACYCLOVIR (CAPLET).....	22
MS CONTIN	84	MYLAN-VERAPAMIL	59
MS CONTIN	85	MYLAN-VERAPAMIL SR	59
MS.IR	84	MYOCHRYSSINE	161
MUPIROCIN.....	183	MYRBETRIQ.....	SEC 3.170
MYCOBUTIN.....	19		
MYCOBUTIN.....	SEC 3.202		
MYDFRIN.....	143		
MYLAN-ACYCLOVIR	21		
MYLAN-ALMOTRIPTAN	122		
MYLAN-ALMOTRIPTAN	SEC 3.24		

N

NABILONE	154
NABUMETONE.....	79

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
NADOL.....	54	NITRO-DUR 0.4.....	50
NADOL.....	55	NITRO-DUR 0.6.....	50
NADOLOL.....	54	NITRO-DUR 0.8.....	50
NADOLOL.....	55	NITROFURANTOIN.....	23
NADROPARIN CALCIUM.....	35	NITROGLYCERIN.....	50
NAFARELIN ACETATE.....	201	NITROL.....	50
NALCROM.....	138	NITROLINGUAL PUMPSPRAY.....	50
NALTREXONE HCL.....	87	NITROSTAT.....	50
NALTREXONE HYDROCHLORIDE.....	87	NIZATIDINE.....	154
NAPROSYN E.....	80	NORETHINDRONE.....	170
NAPROSYN SR.....	79	NORETHINDRONE ACETATE/ ESTRADIOL-17B.....	172
NAPROXEN.....	79	NORETHINDRONE ACETATE/ ETHINYL ESTRADIOL.....	170
NAPROXEN.....	80	NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL.....	170
NAPROXEN EC.....	79	NORGESTIMATE/ ETHINYL ESTRADIOL.....	171
NAPROXEN EC.....	80	NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL.....	171
NAPROXEN SODIUM.....	80	NORITATE.....	183
NAPROXEN SODIUM DS.....	80	NORPROLAC.....	SEC 3.200
NARATRIPTAN HCL.....	122	NORTRIPTYLINE HCL.....	103
NARATRIPTAN HCL.....	SEC 3.172	NORVASC.....	56
NARDIL.....	94	NOVAMOXIN.....	11
NASONEX.....	140	NOVAMOXIN.....	12
NAT-CITALOPRAM.....	96	NOVAMOXIN SUGAR-REDUCED.....	12
NAT-CITALOPRAM.....	97	NOVO-5 ASA.....	159
NAT-DONEPEZIL.....	SEC 3.66	NOVO-AMPICILLIN.....	12
NAT-ESCITALOPRAM.....	98	NOVO-AMPICILLIN.....	SEC 3.24
NAT-GRANISETRON.....	152	NOVO-AZITHROMYCIN.....	10
NAT-LEVETIRACETAM.....	91	NOVO-BUSPIRONE.....	120
NAT-OMEPRAZOLE DR (DELAYED-RELEASE TABLET).....	157	NOVO-CILAZAPRIL/HCTZ.....	60
NAT-ONDANSETRON.....	153	NOVO-CLOXIN.....	13
NAT-QUETIAPINE.....	109	NOVO-DIVALPROEX.....	89
NAT-QUETIAPINE.....	110	NOVO-FLUCONAZOLE.....	17
NAT-RIZATRIPTAN ODT.....	123	NOVO-HYDROXYZIN.....	121
NAT-RIZATRIPTAN ODT.....	SEC 3.212	NOVO-MEXILETINE.....	39
NAT-TENOFOVIR.....	20	NOVO-MINOCYCLINE.....	14
NAT-ZOLMITRIPTAN.....	124	NOVO-PROFEN.....	78
NAT-ZOLMITRIPTAN.....	SEC 3.265	NOVO-SELEGILINE.....	128
NATALIZUMAB.....	SEC 3.175	NOVOLIN GE 30/70.....	174
NEO-MEDROL ACNE.....	SEC 3.169	NOVOLIN GE 30/70 CARTRIDGE.....	174
NEOCATE WITH DHA & ARA.....	SEC 3.127	NOVOLIN GE 40/60 CARTRIDGE.....	174
NEORAL.....	SEC 3.47	NOVOLIN GE 50/50 CARTRIDGE.....	174
NEULASTA (0.6 ML SYRINGE).....	SEC 3.189	NOVOLIN GE NPH.....	174
NEULEPTIL.....	114	NOVOLIN GE NPH CARTRIDGE.....	174
NEUPOGEN.....	SEC 3.108	NOVOLIN GE TORONTO.....	174
NEUPRO.....	SEC 3.213	NOVOLIN GE TORONTO CARTRIDGE.....	174
NEURONTIN.....	90	NOVORAPID.....	173
NIFEDIPINE.....	57	NOVORAPID CARTRIDGE.....	173
NINTEDANIB ESILATE.....	SEC 3.175	NOVORAPID FLEXTOUCH.....	173
NITISINONE.....	SEC 3.176	NOZINAN.....	114
NITOMAN.....	SEC 3.239		
NITRAZEPAM.....	120		
NITRO-DUR 0.2.....	50		

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
NUCALA.....	SEC 3.168	ONDANSETRON INJECTION USP.....	153
NUSINERSEN SODIUM.....	SEC 3.177	ONDISSOLVE ODF.....	152
NYSTATIN.....	19	ONE-ALPHA.....	195
<hr/>			
O			
<hr/>			
OBETICHOIC ACID.....	SEC 3.178	ONGLYZA.....	SEC 3.220
OCALIVA.....	SEC 3.178	OPIUM/ BELLADONNA.....	86
OCRELIZUMAB.....	SEC 3.181	OPTICAMBER ADVANTAGE II (CHAMBER ONLY).....	205
OCREVUS.....	SEC 3.181	OPTICAMBER ADVANTAGE II (WITH LARGE MASK).....	205
OCRIPLASMIN.....	147	OPTICAMBER ADVANTAGE II (WITH MEDIUM MASK).....	205
OCTOSTIM.....	177	OPTICAMBER ADVANTAGE II (WITH SMALL MASK).....	205
OCTREOTIDE ACETATE.....	SEC 3.181	OPTICAMBER DIAMOND (CHAMBER ONLY).....	205
OCTREOTIDE ACETATE OMEGA.....	SEC 3.181	OPTICAMBER DIAMOND (WITH LARGE MASK).....	205
OCUFLOX.....	139	OPTICAMBER DIAMOND (WITH MEDIUM MASK).....	205
ODAN K-20.....	133	OPTICAMBER DIAMOND (WITH SMALL MASK).....	205
ODAN-BENZYDAMINE.....	142	ORACORT.....	188
ODAN-FLUOXETINE.....	99	ORAP.....	116
OESCLIM 25 (5 MG/PTH).....	171	ORCIPRENALINE.....	28
OESCLIM 50 (10 MG/PTH).....	172	ORCIPRENALINE SULFATE.....	28
OFEV.....	SEC 3.175	ORENCIA.....	SEC 3.5
OFLOXACIN.....	139	ORENCIA.....	SEC 3.8
OLANZAPINE.....	107	ORFADIN.....	SEC 3.176
OLANZAPINE.....	108	OVIMA 21.....	170
OLANZAPINE ODT.....	108	OVIMA 28.....	170
OLESTYR LIGHT.....	40	OXAZEPAM.....	120
OLESTYR REGULAR.....	40	OXEZE TURBUHALER.....	28
OLMESARTAN MEDOXOMIL.....	49	OXTRIPHYLLINE/ GUAIFENESIN.....	194
OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE.....	49	OXY-IR.....	86
OLMETEC.....	49	OXYBUTYNIN.....	193
OLMETEC PLUS.....	49	OXYBUTYNIN CHLORIDE.....	193
OLSALAZINE SODIUM.....	159	OXYCODONE HCL.....	86
OMALIZUMAB.....	SEC 3.184	OXYCODONE HCL/ ACETAMINOPHEN.....	87
OMEPRAZOLE.....	157	OXYCODONE HCL/ ASA.....	87
OMEPRAZOLE (DELAYED-RELEASE CAPSULE).....	157	OXYCODONE/ACET.....	87
OMEPRAZOLE (DELAYED-RELEASE TABLET).....	157	OXYNEO.....	86
OMEPRAZOLE-20 (DELAYED-RELEASE CAPSULE).....	157	<hr/> P <hr/>	
OMNITROPE.....	SEC 3.233	PALIPERIDONE.....	108
ONABOTULINUMTOXINA.....	203	PALIPERIDONE.....	109
ONBREZ BREEZHALER.....	28	PALIPERIDONE PALMITATE.....	SEC 3.185
ONDANSETRON.....	152	PALIPERIDONE PALMITATE.....	SEC 3.186
ONDANSETRON.....	153	PALIPERIDONE PALMITATE.....	SEC 3.187
ONDANSETRON (PRESERVATIVE FREE).....	153	PALIPERIDONE PALMITATE.....	SEC 3.188
ONDANSETRON (PRESERVED).....	153	PAMIDRONATE DISODIUM.....	201
ONDANSETRON (UNPRESERVED).....	153	PANCREASE MT 10.....	151
ONDANSETRON (WITH PRESERVATIVE).....	153	PANCREASE MT 16.....	151
ONDANSETRON HCL DIHYDRATE.....	153	PANCREASE MT 4.....	151
ONDANSETRON HYDROCHLORIDE DIHYDRATE (PRESERVED).....	153	PANECTYL.....	3

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
PANTOLOC	158	PHENOBARBITAL	118
PANTOPRAZOLE	158	PHENYLEPHRINE HCL.....	143
PANTOPRAZOLE MAGNESIUM.....	157	PHENYTOIN	88
PANTOPRAZOLE SODIUM.....	158	PHENYTOIN SODIUM.....	88
PANTOPRAZOLE T.....	157	PHYTONADIONE	195
PANTOPRAZOLE-40.....	158	PIBRENTASVIR/ GLECAPREVIR	SEC 3.197
PARIET	158	PILOCARPINE HCL.....	144
PARNATE	94	PILOCARPINE HCL.....	27
PAROXETINE	100	PIMOZIDE.....	116
PAROXETINE HCL.....	100	PINAVERIUM BROMIDE	160
PARSITAN	125	PIOGLITAZONE HCL	SEC 3.197
PAXIL	100	PIPERACILLIN AND TAZOBACTAM.....	13
PDP-AMANTADINE HYDROCHLORIDE.....	125	PIPERACILLIN AND TAZOBACTAM.....	SEC 3.198
PDP-BENZTROPINE	125	PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM.....	13
PDP-DESONIDE.....	186	PIPERACILLIN SODIUM/ TAZOBACTAM	
PDP-ERYTHROMYCIN.....	139	SODIUM.....	SEC 3.198
PEDIAPRED	168	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM.....	13
PEGASYS (0.5 ML SYRINGE).....	20	PIPERACILLIN SODIUM/TAZOBACTAM	
PEGASYS (0.5 ML SYRINGE).....	SEC 3.191	SODIUM.....	SEC 3.198
PEGFILGRASTIM	SEC 3.189	PIPERACILLIN/TAZOBACTAM	13
PEGINTERFERON ALFA-2A.....	20	PIPERACILLIN/TAZOBACTAM	SEC 3.198
PEGINTERFERON ALFA-2A.....	SEC 3.191	PIPRADROL HCL/ THIAMINE HCL/ RIBOFLAVIN/	
PEGINTERFERON BETA-1A	SEC 3.193	PYRIDOXINE HCL/ NIACINAMIDE (NICOTINAMIDE)/	
PEGINTERFERON BETA-1A/ PEGINTERFERON		CHOLINE/ INOSITOL	196
BETA-1A	SEC 3.195	PIRFENIDONE.....	SEC 3.199
PEN-VK.....	11	PIROXICAM.....	80
PENICILLAMINE.....	163	PIZOTIFEN MALATE	125
PENICILLIN G SODIUM.....	11	PLAN B	170
PENICILLIN V POTASSIUM	11	PLAQUENIL SULFATE.....	22
PENTASA	159	PLAVIX	36
PENTASA (1G/100ML)	159	PLEGRIDY.....	SEC 3.193
PENTASA (4G/100 ML)	159	PLEGRIDY.....	SEC 3.195
PENTAZOCINE HCL.....	87	PLENDIL	57
PENTAZOCINE LACTATE.....	87	PLERIXAFOR	SEC 3.200
PENTOSAN POLYSULFATE SODIUM.....	201	PMS-ACETAMINOPHEN WITH CODEINE	81
PENTOXIFYLLINE	37	PMS-ALENDRONATE-FC	197
PENTOXIFYLLINE SR	37	PMS-AMIODARONE.....	40
PERAMPANEL.....	SEC 3.195	PMS-AMLODIPINE	56
PERICIAZINE.....	114	PMS-AMOXICILLIN	11
PERINDOPRIL ERBUMINE	62	PMS-ARIPIRAZOLE	105
PERINDOPRIL ERBUMINE/ INDAPAMIDE		PMS-ARIPIRAZOLE	106
HEMIHYDRATE	63	PMS-ATENOLOL	52
PERPHENAZINE	114	PMS-ATORVASTATIN.....	42
PHARMA-AMLODIPINE.....	56	PMS-AZITHROMYCIN	10
PHARMA-ESCITALOPRAM.....	98	PMS-AZITHROMYCIN	SEC 3.37
PHARMA-LACOSAMIDE	SEC 3.161	PMS-BACLOFEN.....	30
PHARMA-RAMIPRIL (CAPSULE).....	64	PMS-BENZYDAMINE	142
PHARMA-SIMVASTATIN.....	46	PMS-BETAHISTINE.....	197
PHARMA-SIMVASTATIN.....	47	PMS-BUPRENORPHINE/NALOXONE	87
PHEBURANE	SEC 3.228	PMS-BUSPIRONE	120
PHENELZINE SULFATE.....	94	PMS-CANDESARTAN	66
PHENOBARB.....	118	PMS-CANDESARTAN HCTZ.....	66

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
PMS-CARBAMAZEPINE-CR	89	PMS-METFORMIN	173
PMS-CARVEDILOL.....	53	PMS-METHOTREXATE.....	25
PMS-CARVEDILOL.....	54	PMS-METHYLPHENIDATE	117
PMS-CELECOXIB.....	SEC 3.42	PMS-METOPROLOL-L	54
PMS-CIPROFLOXACIN	SEC 3A.2	PMS-MIRTAZAPINE	105
PMS-CIPROFLOXACIN	SEC 3A.3	PMS-MONTELUKAST	137
PMS-CITALOPRAM.....	96	PMS-MONTELUKAST	SEC 3.171
PMS-CITALOPRAM.....	97	PMS-MONTELUKAST FC	137
PMS-CLARITHROMYCIN	10	PMS-MONTELUKAST FC	SEC 3.171
PMS-CLONAZEPAM.....	88	PMS-NABILONE	154
PMS-CLONAZEPAM-R.....	88	PMS-NITROFURANTOIN	23
PMS-CLOPIDOGREL	36	PMS-NYSTATIN	19
PMS-COLCHICINE	198	PMS-OLANZAPINE	107
PMS-CYCLOBENZAPRINE	30	PMS-OLANZAPINE	108
PMS-DEXAMETHASONE	166	PMS-OLANZAPINE ODT	108
PMS-DEXAMETHASONE SODIUM PHOSP	166	PMS-OLMESARTAN	49
PMS-DICLOFENAC	77	PMS-OMEPRAZOLE (SUSTAINED-RELEASE CAP)	157
PMS-DICLOFENAC-SR	77	PMS-OMEPRAZOLE DR (DELAYED-RELEASE TAB)	157
PMS-DOMPERIDONE	158	PMS-ONDANSETRON	153
PMS-DONEPEZIL	SEC 3.66	PMS-OXYBUTYNIN.....	193
PMS-DOXYLAMINE-PYRIDOXINE.....	154	PMS-OXYCODONE.....	86
PMS-DULOXETINE	95	PMS-PANTOPRAZOLE	158
PMS-DUTASTERIDE	202	PMS-PAROXETINE	100
PMS-ENTECAVIR.....	21	PMS-PERINDOPRIL.....	62
PMS-ESCITALOPRAM	98	PMS-PRAMIPEXOLE	127
PMS-EZETIMIBE	SEC 3.105	PMS-PRAVASTATIN	43
PMS-FENTANYL MTX	SEC 3.106	PMS-PRAVASTATIN	44
PMS-FENTANYL MTX	SEC 3.107	PMS-PREDNISOLONE.....	168
PMS-FINASTERIDE.....	202	PMS-PREGABALIN	92
PMS-FLUCONAZOLE.....	17	PMS-QUETIAPINE	109
PMS-FLUOXETINE	99	PMS-QUETIAPINE	110
PMS-GABAPENTIN	90	PMS-RABEPRAZOLE EC.....	158
PMS-GALANTAMINE ER.....	SEC 3.113	PMS-RAMIPRIL (CAPSULE)	64
PMS-GALANTAMINE ER.....	SEC 3.114	PMS-RAMIPRIL-HCTZ	65
PMS-HYDROCHLOROTHIAZIDE.....	134	PMS-RANITIDINE	155
PMS-HYDROMORPHONE	83	PMS-RISEDRONATE	201
PMS-IPRATROPIUM	27	PMS-RISPERIDONE	111
PMS-IPRATROPIUM	SEC 3.155	PMS-RISPERIDONE	112
PMS-IPRATROPIUM (1ML).....	SEC 3.155	PMS-RISPERIDONE	113
PMS-IPRATROPIUM (2ML).....	SEC 3.155	PMS-RIZATRIPTAN RDT	123
PMS-IRBESARTAN	67	PMS-RIZATRIPTAN RDT	SEC 3.212
PMS-IRBESARTAN-HCTZ.....	68	PMS-ROSUVASTATIN	44
PMS-ISMN	49	PMS-ROSUVASTATIN	45
PMS-LACTULOSE	133	PMS-SALBUTAMOL	29
PMS-LACTULOSE-PHARMA	133	PMS-SALBUTAMOL POLYNEB	29
PMS-LAMOTRIGINE.....	90	PMS-SERTRALINE.....	101
PMS-LAMOTRIGINE.....	91	PMS-SODIUM CROMOGLYCATE	138
PMS-LITHIUM CARBONATE.....	121	PMS-SOLIFENACIN	193
PMS-LITHIUM CARBONATE.....	122	PMS-SOTALOL.....	55
PMS-LORAZEPAM	119	PMS-SULFASALAZINE	14
PMS-LOSARTAN	69	PMS-SUMATRIPTAN	124
PMS-LOSARTAN-HCTZ	70		

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
PMS-SUMATRIPTAN.....	SEC 3.235	PROCHLORAZINE	152
PMS-TENOFOVIR	20	PROCHLORPERAZINE	152
PMS-TERAZOSIN.....	51	PROCTODAN-HC.....	188
PMS-TERBINAFINE.....	17	PROCTOFOAM-HC.....	187
PMS-TESTOSTERONE	SEC 3.239	PROCTOL.....	190
PMS-TETRABENAZINE.....	SEC 3.239	PROCTOSEDYL.....	190
PMS-TOPIRAMATE	93	PROCYSBI	SEC 3.48
PMS-TRANDOLAPRIL.....	65	PROGESTERONE.....	177
PMS-TRAZODONE	102	PROLIA.....	SEC 3.62
PMS-URSODIOL C.....	151	PROLOPA 100-25.....	126
PMS-VALACYCLOVIR (CAPLET)	22	PROLOPA 200-50.....	126
PMS-VALPROIC ACID.....	93	PROLOPA 50-12.5.....	126
PMS-VALPROIC ACID E.C.....	93	PROMETRIUM.....	177
PMS-VENLAFAXINE XR.....	95	PROPADERM.....	184
PMS-VENLAFAXINE XR.....	96	PROPAFENONE HCL	39
PMS-ZOLMITRIPTAN	124	PROPARACAINE HCL	141
PMS-ZOLMITRIPTAN	SEC 3.265	PROPIVERINE HYDROCHLORIDE	193
PMS-ZOPICLONE.....	121	PROPRANOLOL HCL.....	55
PORTIA 21	170	PROPRANOLOL HCL.....	SEC 3.200
PORTIA 28.....	170	PROPYL-THYRACIL.....	178
POTASSIUM BICARBONATE	133	PROPYLTHIOURACIL.....	178
POTASSIUM CHLORIDE (K+).....	133	PROSCAR	202
POTASSIUM CHLORIDE (K+)(CL-).....	133	PROSTIN VR	50
POTASSIUM CITRATE (K+).....	134	PROTOPIC	SEC 3.236
PRADAXA	SEC 3.49	PROZAC	99
PRALUENT	SEC 3.24	PULMICORT NEBUAMP	166
PRAMIPEXOLE	127	PULMICORT TURBUHALER.....	166
PRAMIPEXOLE DIHYDROCHLORIDE.....	127	PURAMINO A+	SEC 3.127
PRAVACHOL	43	PYRIDOSTIGMINE BROMIDE	27
PRAVACHOL	44		
PRAVASTATIN	43		
PRAVASTATIN	44		
PRAVASTATIN SODIUM.....	43		
PRAVASTATIN SODIUM.....	44		
PRAZOSIN HCL.....	51		
PRED FORTE	140		
PRED MILD.....	140		
PREDNISOLONE ACETATE	140		
PREDNISOLONE ACETATE/ SULFACETAMIDE			
SODIUM.....	141		
PREDNISOLONE SODIUM PHOSPHATE	168		
PREDNISON	168		
PREGABALIN	92		
PREMARIN	171		
PREVACID.....	156		
PREVEX HC	187		
PRIMAQUINE PHOSPHATE	22		
PRIMAXIN.....	8		
PRIMAXIN.....	SEC 3.125		
PRIMIDONE.....	88		
PRINIVIL	61		
PRINIVIL	62		

Q	
QUETIAPINE	109
QUETIAPINE	110
QUETIAPINE FUMARATE.....	109
QUETIAPINE FUMARATE.....	110
QUETIAPINE FUMARATE.....	111
QUETIAPINE XR	110
QUETIAPINE XR	111
QUINAGOLIDE	SEC 3.200
QUINAPRIL.....	63
QUINAPRIL/ HYDROCHLOROTHIAZIDE	63
QUININE SULFATE	23
QUINSAIR.....	SEC 3.163
QVAR CFC-FREE.....	166

R	
RABEPRAZOLE.....	158
RABEPRAZOLE EC.....	158

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
RABEPRAZOLE SODIUM	158	RAN-SIMVASTATIN	46
RALOXIFENE HCL	SEC 3.201	RAN-SIMVASTATIN	47
RAMIPRIL	64	RAN-SOLIFENACIN	193
RAMIPRIL (CAPSULE)	64	RAN-VALSARTAN	71
RAMIPRIL/ HYDROCHLOROTHIAZIDE	65	RAN-VENLAFAXINE XR	95
RAN-AMLODIPINE	56	RAN-VENLAFAXINE XR	96
RAN-ATENOLOL	52	RAN-ZOPICLONE	121
RAN-ATORVASTATIN	42	RANIBIZUMAB	149
RAN-CANDESARTAN	66	RANITIDINE	155
RAN-CEFPROZIL	6	RANITIDINE HCL	155
RAN-CELECOXIB	SEC 3.42	RATIO-LACTULOSE	133
RAN-CIPROFLOX	SEC 3A.2	RATIO-METFORMIN HYDROCHLORIDE	173
RAN-CIPROFLOX	SEC 3A.3	RATIO-TOPISALIC	184
RAN-CITALO	96	RATIO-ZOPICLONE	121
RAN-CLARITHROMYCIN	10	RAVICTI	SEC 3.117
RAN-CLOPIDOGREL	36	REBIF (0.5 ML SYRINGE)	SEC 3.152
RAN-DOMPERIDONE	158	REBIF (1.5 ML CARTRIDGE)	SEC 3.152
RAN-DONEPEZIL	SEC 3.66	REDDY-ATORVASTATIN	42
RAN-DULOXETINE	95	REMERON	105
RAN-ENALAPRIL	60	REMICADE	SEC 3.135
RAN-ENALAPRIL	61	RENFLEXIS	SEC 3.128
RAN-ESCITALOPRAM	98	REPAGLINIDE	175
RAN-EZETIMIBE	SEC 3.105	REPATHA	SEC 3.105
RAN-FENTANYL MATRIX	SEC 3.106	REPATHA AUTOINJECTOR	SEC 3.105
RAN-FENTANYL MATRIX	SEC 3.107	RESONIUM CALCIUM	134
RAN-GABAPENTIN	90	RESTORIL	120
RAN-GLICLAZIDE MR	175	REVESTIVE	SEC 3.237
RAN-GLICLAZIDE MR	176	REXULTI	106
RAN-IRBESARTAN	67	RHINOCORT TURBUHALER	139
RAN-LANSOPRAZOLE	156	RHO-NITRO PUMPSPRAY	50
RAN-LISINOPRIL	61	RIBAVIRIN	SEC 3.201
RAN-LISINOPRIL	62	RIDAURA	161
RAN-METFORMIN	173	RIFABUTIN	19
RAN-MONTELUKAST	137	RIFABUTIN	SEC 3.202
RAN-MONTELUKAST	SEC 3.171	RIFAXIMIN	SEC 3.202
RAN-OLANZAPINE ODT	108	RILUTEK	SEC 3.202
RAN-PANTOPRAZOLE	158	RILUZOLE	SEC 3.202
RAN-PRAVASTATIN	43	RIMSO-50	200
RAN-PRAVASTATIN	44	RISEDRONATE	201
RAN-PREGABALIN	92	RISEDRONATE SODIUM	201
RAN-QUETIAPINE	109	RISEDRONATE SODIUM	SEC 3.203
RAN-QUETIAPINE	110	RISEDRONATE-35	201
RAN-RABEPRAZOLE	158	RISPERDAL	111
RAN-RAMIPRIL (CAPSULE)	64	RISPERDAL	112
RAN-RAMIPRIL HCTZ	65	RISPERDAL	113
RAN-RANITIDINE	155	RISPERDAL CONSTA	SEC 3.204
RAN-RISPERIDONE	111	RISPERIDONE	111
RAN-RISPERIDONE	112	RISPERIDONE	112
RAN-ROPINIROLE	127	RISPERIDONE	SEC 3.204
RAN-ROPINIROLE	128	RISPERIDONE TARTRATE	113
RAN-ROSUVASTATIN	44	RITALIN	117
RAN-ROSUVASTATIN	45	RITALIN SR	117

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
RITUXAN	SEC 3.206	SALMETEROL XINAFOATE/ FLUTICASONE	
RITUXIMAB	SEC 3.206	PROPIONATE.....	SEC 3.218
RIVAROXABAN	36	SALOFALK	159
RIVAROXABAN	SEC 3.208	SALOFALK (2G/60G).....	159
RIVAROXABAN	SEC 3.210	SALOFALK (4G/60G).....	159
RIVASTIGMINE HYDROGEN TARTRATE	SEC 3.211	SANDOMIGRAN	125
RIVOTRIL	88	SANDOMIGRAN DS	125
RIZATRIPTAN BENZOATE	123	SANDOSTATIN.....	SEC 3.181
RIZATRIPTAN BENZOATE	SEC 3.212	SANDOSTATIN LAR.....	SEC 3.181
RIZATRIPTAN ODT	123	SANDOZ ALENDRONATE	197
RIZATRIPTAN ODT	SEC 3.212	SANDOZ ALENDRONATE	SEC 3.21
ROCALTROL	195	SANDOZ ALENDRONATE/CHOLECALCIFEROL.....	197
ROPINIROLE	127	SANDOZ ALFUZOSIN	SEC 3.22
ROPINIROLE HCL	127	SANDOZ ALMOTRIPTAN.....	122
ROPINIROLE HCL	128	SANDOZ ALMOTRIPTAN.....	SEC 3.24
ROSIGLITAZONE	SEC 3.213	SANDOZ AMIODARONE.....	40
ROSIGLITAZONE MALEATE	SEC 3.213	SANDOZ AMLODIPINE	56
ROSUVASTATIN	44	SANDOZ ANUZINC HC	188
ROSUVASTATIN	45	SANDOZ ANUZINC HC PLUS.....	188
ROSUVASTATIN CALCIUM	44	SANDOZ ARIPIRAZOLE	105
ROSUVASTATIN CALCIUM	45	SANDOZ ARIPIRAZOLE	106
ROSUVASTATIN-10	44	SANDOZ ATORVASTATIN.....	42
ROSUVASTATIN-20	45	SANDOZ AZITHROMYCIN	10
ROSUVASTATIN-40	45	SANDOZ BISOPROLOL	53
ROSUVASTATIN-5	44	SANDOZ BRIMONIDINE	143
ROTIGOTINE	SEC 3.213	SANDOZ BUPROPION SR.....	104
ROUGIER MAGNESIUM	133	SANDOZ CANDESARTAN	66
ROVAMYCINE-250	15	SANDOZ CANDESARTAN PLUS.....	66
ROVAMYCINE-500	15	SANDOZ CANDESARTAN PLUS.....	67
RUFINAMIDE	SEC 3.214	SANDOZ CARBAMAZEPINE CR	89
RYTHMODAN	39	SANDOZ CEFPROZIL	6
RYTHMOL.....	39	SANDOZ CIPROFLOXACIN	139
		SANDOZ CIPROFLOXACIN	SEC 3A.2
		SANDOZ CIPROFLOXACIN	SEC 3A.3
		SANDOZ CITALOPRAM	96
		SANDOZ CITALOPRAM	97
		SANDOZ CLARITHROMYCIN	10
		SANDOZ CLOPIDOGREL	36
		SANDOZ CYCLOSPORINE.....	SEC 3.47
		SANDOZ DEFERASIROX	SEC 3.58
		SANDOZ DEFERASIROX	SEC 3.59
		SANDOZ DEFERASIROX	SEC 3.60
		SANDOZ DICLOFENAC	77
		SANDOZ DICLOFENAC OPHTHA	141
		SANDOZ DICLOFENAC SR	77
		SANDOZ DILTIAZEM CD	58
		SANDOZ DILTIAZEM T	58
		SANDOZ DILTIAZEM T	59
		SANDOZ DONEPEZIL	SEC 3.66
		SANDOZ DORZOLAMIDE	144
		SANDOZ DORZOLAMIDE/ TIMOLOL	145
		SANDOZ DULOXETINE	95

S

SABRIL	94
SACUBITRIL/ VALSARTAN.....	SEC 3.214
SAIZEN	SEC 3.233
SAIZEN (1.5 ML).....	SEC 3.233
SAIZEN (2.5 ML).....	SEC 3.233
SALAGEN	27
SALBUTAMOL	28
SALBUTAMOL HFA.....	28
SALBUTAMOL SULFATE	29
SALMETEROL XINAFOATE.....	29
SALMETEROL XINAFOATE/ FLUTICASONE	
PROPIONATE.....	SEC 3.215
SALMETEROL XINAFOATE/ FLUTICASONE	
PROPIONATE.....	SEC 3.216
SALMETEROL XINAFOATE/ FLUTICASONE	
PROPIONATE.....	SEC 3.217

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
SANDOZ DUTASTERIDE	202	SANDOZ OLANZAPINE	107
SANDOZ ENALAPRIL	60	SANDOZ OLANZAPINE	108
SANDOZ ENALAPRIL	61	SANDOZ OLANZAPINE ODT	108
SANDOZ ENTACAPONE	125	SANDOZ OLMESARTAN	49
SANDOZ ESCITALOPRAM	98	SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAP)	157
SANDOZ ESTRADIOL DERM 100 (8 MG/PTH)	172	SANDOZ OMEPRAZOLE (SUSTAINED-RELEASE CAPSULE)	157
SANDOZ ESTRADIOL DERM 50 (4 MG/PTH)	172	SANDOZ ONDANSETRON	153
SANDOZ ESTRADIOL DERM 75 (6 MG/PTH)	172	SANDOZ ONDANSETRON ODT	152
SANDOZ EZETIMIBE	SEC 3.105	SANDOZ OPIUM & BELLADONNA	86
SANDOZ FELODIPINE	57	SANDOZ PANTOPRAZOLE	158
SANDOZ FENOFIBRATE S	41	SANDOZ PAROXETINE	100
SANDOZ FENOFIBRATE S (TABLET)	41	SANDOZ PERINDOPRIL ERBUMINE	62
SANDOZ FENTANYL PATCH	SEC 3.106	SANDOZ PERINDOPRIL/INDAPAMIDE	63
SANDOZ FENTANYL PATCH	SEC 3.107	SANDOZ PERINDOPRIL/INDAPAMIDE HD	63
SANDOZ FINASTERIDE	202	SANDOZ PRAMIPEXOLE	127
SANDOZ FLUOROMETHOLONE	140	SANDOZ PRAVASTATIN	43
SANDOZ FLUOXETINE	99	SANDOZ PRAVASTATIN TABLETS	44
SANDOZ GLICLAZIDE MR	175	SANDOZ PREDNISOLONE ACETATE	140
SANDOZ GLICLAZIDE MR	176	SANDOZ PREGABALIN	92
SANDOZ INDOMETHACIN	78	SANDOZ PROCHLORPERAZINE	152
SANDOZ IRBESARTAN	67	SANDOZ PROCTOMYXIN HC	190
SANDOZ IRBESARTAN HCT	68	SANDOZ QUETIAPINE	109
SANDOZ LACOSAMIDE	SEC 3.161	SANDOZ QUETIAPINE	110
SANDOZ LANSOPRAZOLE	156	SANDOZ QUETIAPINE XRT	110
SANDOZ LATANOPROST	144	SANDOZ QUETIAPINE XRT	111
SANDOZ LATANOPROST/TIMOLOL	145	SANDOZ RABEPRAZOLE	158
SANDOZ LEFLUNOMIDE	202	SANDOZ RANITIDINE	155
SANDOZ LEVETIRACETAM	91	SANDOZ REPAGLINIDE	175
SANDOZ LEVOFLOXACIN	SEC 3A.4	SANDOZ RISEDRONATE	201
SANDOZ LEVOFLOXACIN	SEC 3A.5	SANDOZ RISPERIDONE	111
SANDOZ LEVOFLOXACIN	SEC 3A.6	SANDOZ RISPERIDONE	112
SANDOZ LINEZOLID	16	SANDOZ RIVASTIGMINE	SEC 3.211
SANDOZ LINEZOLID	SEC 3.166	SANDOZ RIZATRIPTAN ODT	123
SANDOZ LISINOPRIL	61	SANDOZ RIZATRIPTAN ODT	SEC 3.212
SANDOZ LISINOPRIL HCT	62	SANDOZ ROSUVASTATIN	44
SANDOZ LOSARTAN	69	SANDOZ ROSUVASTATIN	45
SANDOZ LOSARTAN HCT	70	SANDOZ SERTRALINE	101
SANDOZ LOSARTAN HCT DS	70	SANDOZ SOLIFENACIN	193
SANDOZ METFORMIN FC	173	SANDOZ SUMATRIPTAN	124
SANDOZ METHYLPHENIDATE	117	SANDOZ SUMATRIPTAN	SEC 3.235
SANDOZ METOPROLOL (TYPE L)	54	SANDOZ TAMSULOSIN	51
SANDOZ METOPROLOL SR	54	SANDOZ TAMSULOSIN CR	51
SANDOZ MIRTAZAPINE	105	SANDOZ TELMISARTAN	70
SANDOZ MOMETASONE	140	SANDOZ TELMISARTAN HCT	71
SANDOZ MONTELUKAST	137	SANDOZ TIMOLOL MALEATE	143
SANDOZ MONTELUKAST	138	SANDOZ TOBRAMYCIN	139
SANDOZ MONTELUKAST	SEC 3.171	SANDOZ TOLTERODINE LA	194
SANDOZ MORPHINE SR	84	SANDOZ TOPIRAMATE	93
SANDOZ MORPHINE SR	85	SANDOZ TRANDOLAPRIL	65
SANDOZ MOXIFLOXACIN	SEC 3A.7	SANDOZ TRAVOPROST	144
SANDOZ NARATRIPTAN	122		
SANDOZ NARATRIPTAN	SEC 3.172		

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
SANDOZ VALACYCLOVIR	22	SINEMET 250/25	126
SANDOZ VALSARTAN	71	SINEMET CR 100/25	126
SANDOZ VALSARTAN	72	SINEMET CR 200/50	126
SANDOZ VALSARTAN HCT	72	SINGULAIR	137
SANDOZ VENLAFAXINE XR	95	SINGULAIR	138
SANDOZ VENLAFAXINE XR	96	SINGULAIR	SEC 3.171
SANDOZ VORICONAZOLE	18	SINTROM	33
SANDOZ VORICONAZOLE	SEC 3.263	SITAGLIPTIN PHOSPHATE MONOHYDRATE SEC 3.226	
SANDOZ ZOLMITRIPTAN	124	SITAGLIPTIN PHOSPHATE MONOHYDRATE/ METFORMIN HCL	SEC 3.227
SANDOZ ZOLMITRIPTAN	SEC 3.265	SODIUM ACID PHOSPHATE/ SODIUM BICARBONATE/ POTASSIUM BICARBONATE	134
SANDOZ ZOPICLONE	121	SODIUM CROMOGLYCATE	138
SANDOZ-OXYCODONE ACET	87	SODIUM FLUORIDE	129
SANTYL	192	SODIUM FUSIDATE	183
SAPHRIS	SEC 3.32	SODIUM PHENYLBUTYRATE	SEC 3.228
SARILUMAB	SEC 3.220	SODIUM POLYSTYRENE SULFONATE	134
SAXAGLIPTIN HCL	SEC 3.220	SOFOSBUVIR	SEC 3.229
SAXAGLIPTIN HCL/ METFORMIN HCL	SEC 3.221	SOFOSBUVIR/ LEDIPASVIR	SEC 3.230
SDZ CELECOXIB	SEC 3.42	SOFOSBUVIR/ VELPATASVIR	SEC 3.231
SECUKINUMAB	SEC 3.225	SOFOSBUVIR/ VELPATASVIR/ VOXILAPREVIR	SEC 3.232
SEEBRI BREEZHALER	138	SOFRACORT	140
SELEGILINE HCL	128	SOLIFENACIN	193
SEPTA DONEPEZIL	SEC 3.66	SOLIFENACIN SUCCINATE	193
SEPTA-AMLODIPINE	56	SOLIRIS	SEC 3.71
SEPTA-ATENOLOL	52	SOLU-CORTEF	167
SEPTA-CIPROFLOXACIN	SEC 3A.2	SOLU-MEDROL	168
SEPTA-CIPROFLOXACIN	SEC 3A.3	SOLU-MEDROL ACT-O-VIAL (PRESERVATIVE FREE)	168
SEPTA-CITALOPRAM	96	SOLYSTAT	134
SEPTA-CITALOPRAM	97	SOMATROPIN	SEC 3.232
SEPTA-LOSARTAN	69	SOMATROPIN	SEC 3.233
SEPTA-LOSARTAN HCTZ	70	SOMATROPIN R-DNA ORIGIN	SEC 3.233
SEPTA-METFORMIN	173	SOMATULINE AUTOGEL (0.3 ML SYRINGE) SEC 3.161	
SEPTA-ONDANSETRON	153	SOMATULINE AUTOGEL (0.5 ML SYRINGE) SEC 3.161	
SEPTA-ZOLMITRIPTAN-ODT	124	SORIATANE	192
SEPTA-ZOLMITRIPTAN-ODT	SEC 3.265	SOTALOL HCL	55
SEPTA-ZOPICLONE	121	SOVALDI	SEC 3.229
SEPTRA	14	SPINRAZA	SEC 3.177
SERC	197	SPIRAMYCIN	15
SEREVENT DISKUS	29	SPIRIVA	27
SEROQUEL	109	SPIRIVA RESPIMAT	27
SEROQUEL	110	SPIRONOLACTONE	73
SEROQUEL XR	110	SPORANOX	18
SEROQUEL XR	111	SPORANOX	SEC 3.156
SERTRALINE	101	STALEVO	126
SERTRALINE HCL	101	STATEX	84
SILTUXIMAB	SEC 3.225	STATEX	85
SILVER SULFADIAZINE	184	STATEX	86
SIMBRINZA	145	STELARA (0.5 ML VIAL OR SYRINGE)	SEC 3.259
SIMPONI	SEC 3.122	STELARA (1.0 ML SYRINGE)	SEC 3.259
SIMPONI	SEC 3.124		
SIMVASTATIN	46		
SIMVASTATIN	47		
SINEMET 100/25	126		

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
STERILE CEFAZOLIN SODIUM.....	5	TARO-BENZOYL PEROXIDE/CLINDAMYCIN KIT	SEC 3.46
STERILE CEFAZOLIN SODIUM.....	6	TARO-CARBAMAZEPINE	89
STERILE VANCOMYCIN HCL	15	TARO-CLARITHROMYCIN.....	10
STIEVA-A.....	SEC 3.256	TARO-CLARITHROMYCIN.....	11
STIRIPENTOL.....	SEC 3.234	TARO-CLINDAMYCIN/BENZOYL PEROXIDE ..	SEC 3.46
STRENSIQ.....	SEC 3.37	TARO-CLOBETASOL	185
SUBOXONE.....	87	TARO-DEFERASIROX	SEC 3.58
SUCRALFATE	155	TARO-DEFERASIROX	SEC 3.59
SULCRATE	155	TARO-DEFERASIROX	SEC 3.60
SULCRATE SUSPENSION PLUS	155	TARO-DIPYRIDAMOLE/ASA.....	36
SULFAMETHOXAZOLE/ TRIMETHOPRIM.....	14	TARO-MOMETASONE	188
SULFASALAZINE	14	TARO-MUPIROCIN	183
SULFATRIM.....	14	TARO-PHENYTOIN	88
SULFATRIM DS.....	14	TARO-SUMATRIPTAN (0.5 ML).....	124
SULFINPYRAZONE.....	135	TARO-SUMATRIPTAN (0.5 ML).....	SEC 3.235
SULINDAC	80	TARO-TESTOSTERONE.....	SEC 3.239
SUMATRIPTAN	124	TARO-WARFARIN.....	33
SUMATRIPTAN	SEC 3.235	TARO-ZOLEDRONIC ACID.....	SEC 3.265
SUMATRIPTAN DF.....	124	TARO-ZOLEDRONIC ACID CONCENTRATE .	SEC 3.265
SUMATRIPTAN DF.....	SEC 3.235	TAZAROTENE	192
SUMATRIPTAN HEMISULFATE	123	TAZORAC	192
SUMATRIPTAN HEMISULFATE	SEC 3.234	TECFIDERA.....	SEC 3.65
SUMATRIPTAN SUCCINATE.....	124	TECTA	157
SUMATRIPTAN SUCCINATE.....	SEC 3.235	TEDUGLUTIDE.....	SEC 3.237
SUPEUDOL	86	TEGRETOL.....	89
SUPRAX	7	TEGRETOL CR.....	89
SUPREFACT	SEC 3.39	TELMISARTAN.....	70
SUPREFACT DEPOT	SEC 3.39	TELMISARTAN HCTZ	71
SUPREFACT INTRANASAL.....	SEC 3.39	TELMISARTAN/ AMLODIPINE BESYLATE	71
SYLVANT.....	SEC 3.225	TELMISARTAN/ HYDROCHLOROTHIAZIDE	71
SYMBICORT 100 TURBUHALER.....	SEC 3.39	TELMISARTAN/HCTZ	71
SYMBICORT 200 TURBUHALER.....	SEC 3.39	TEMAZEPAM.....	120
SYNAREL	201	TENOFOVIR DISOPROXIL FUMARATE.....	20
SYNJARDY	SEC 3.75	TENORETIC 50/25	53
SYNPHASIC (21 DAY).....	170	TENORETIC 100/25	53
SYNPHASIC (28 DAY).....	170	TENORMIN	52
SYNTHETIC CALCITONIN SALMON (SALCATONIN).....	176	TENOXICAM.....	80
SYNTHROID.....	178	TERAZOSIN.....	51
<hr/> T <hr/>			
TACROLIMUS.....	SEC 3.236	TERAZOSIN HCL	51
TALTZ	SEC 3.160	TERBINAFINE	17
TALTZ AUTOINJECTOR	SEC 3.160	TERBINAFINE HCL	17
TALWIN.....	87	TERBINAFINE HCL	183
TAMSULOSIN CR.....	51	TERBUTALINE SULFATE	29
TAMSULOSIN HCL.....	51	TERIFLUNOMIDE	SEC 3.239
TAPAZOLE	178	TESTOSTERONE	SEC 3.239
TARO-ACITRETIN	192	TESTOSTERONE CYPIONATE	169
TARO-AMCINONIDE	184	TESTOSTERONE ENANTHATE	169
		TESTOSTERONE UNDECANOATE	SEC 3.239
		TETRABENAZINE	SEC 3.239
		TETRACYCLINE.....	14
		TETRACYCLINE HCL.....	14

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
TEVA-ACEBUTOLOL.....	52	TEVA-DOMPERIDONE	158
TEVA-ACYCLOVIR	21	TEVA-DONEPEZIL	SEC 3.66
TEVA-ALENDRONATE.....	197	TEVA-DOXAZOSIN	51
TEVA-ALENDRONATE/CHOLECALCIFEROL	197	TEVA-DOXYCYCLINE	14
TEVA-ALPRAZOL	118	TEVA-DUTASTERIDE	202
TEVA-AMIODARONE	40	TEVA-ECTOSONE MILD	185
TEVA-AMLODIPINE.....	56	TEVA-ECTOSONE REGULAR	185
TEVA-ARIPIPRAZOLE.....	105	TEVA-ECTOSONE SCALP.....	185
TEVA-ARIPIPRAZOLE.....	106	TEVA-EMTEC-30.....	81
TEVA-ATENOLOL.....	52	TEVA-ENTACAPONE	125
TEVA-ATENOLTHALIDONE.....	53	TEVA-ESCITALOPRAM	98
TEVA-ATORVASTATIN	42	TEVA-EZETIMIBE.....	SEC 3.105
TEVA-AZATHIOPRINE	197	TEVA-FAMOTIDINE	154
TEVA-BETAHISTINE	197	TEVA-FENTANYL.....	SEC 3.106
TEVA-BISOPROLOL.....	53	TEVA-FENTANYL.....	SEC 3.107
TEVA-BROMAZEPAM	118	TEVA-FINASTERIDE	202
TEVA-BUDESONIDE	166	TEVA-FLUOXETINE	99
TEVA-CANDESARTAN.....	66	TEVA-FLUVASTATIN	43
TEVA-CANDESARTAN/HCTZ	66	TEVA-FOSINOPRIL	61
TEVA-CAPTOPRIL	59	TEVA-FUROSEMIDE.....	48
TEVA-CARBAMAZ.....	89	TEVA-GABAPENTIN	90
TEVA-CARVEDILOL.....	53	TEVA-GEMFIBROZIL	41
TEVA-CARVEDILOL.....	54	TEVA-GLICLAZIDE.....	175
TEVA-CEFADROXIL.....	5	TEVA-GLYBURIDE	176
TEVA-CEFADROXIL.....	SEC 3.41	TEVA-HALOPERIDOL	113
TEVA-CEPHALEXIN.....	6	TEVA-HYDRAZIDE	134
TEVA-CEPHALEXIN 125.....	6	TEVA-INDOMETHACIN.....	78
TEVA-CEPHALEXIN 250.....	6	TEVA-IPRATROPIUM STERINEBS	SEC 3.155
TEVA-CHLOROQUINE	22	TEVA-IRBESARTAN.....	67
TEVA-CHLORPROMAZINE.....	114	TEVA-IRBESARTAN HCTZ	68
TEVA-CITALOPRAM	96	TEVA-KETOCONAZOLE	18
TEVA-CITALOPRAM	97	TEVA-LACOSAMIDE	SEC 3.161
TEVA-CLARITHROMYCIN	10	TEVA-LACTULOSE	133
TEVA-CLINDAMYCIN	15	TEVA-LAMOTRIGINE	90
TEVA-CLOBAZAM.....	88	TEVA-LAMOTRIGINE	91
TEVA-CLOBETASOL.....	185	TEVA-LANSOPRAZOLE.....	156
TEVA-CLONIDINE	198	TEVA-LEFLUNOMIDE	202
TEVA-CLONIDINE	47	TEVA-LENOLTEC NO. 4	81
TEVA-CLOPIDOGREL.....	36	TEVA-LENOLTEC NO.2	81
TEVA-CODEINE	81	TEVA-LENOLTEC NO.3	81
TEVA-COMBO STERINEBS.....	27	TEVA-LEVOCARBIDOPA	126
TEVA-CYCLOBENZAPRINE	30	TEVA-LISINOPRIL (TYPE P).....	61
TEVA-DEFERASIROX	SEC 3.58	TEVA-LISINOPRIL (TYPE P).....	62
TEVA-DEFERASIROX	SEC 3.59	TEVA-LISINOPRIL (TYPE Z).....	61
TEVA-DEFERASIROX	SEC 3.60	TEVA-LISINOPRIL (TYPE Z).....	62
TEVA-DICLOFENAC EC.....	77	TEVA-LISINOPRIL/HCTZ (TYPE P)	62
TEVA-DICLOFENAC SR.....	77	TEVA-LISINOPRIL/HCTZ (TYPE Z)	62
TEVA-DILTIAZEM	57	TEVA-LORAZEPAM	119
TEVA-DILTIAZEM CD.....	58	TEVA-LOSARTAN	69
TEVA-DILTIAZEM CD.....	58	TEVA-LOSARTAN/HCTZ.....	70
TEVA-DILTIAZEM HCL ER.....	58	TEVA-MEDROXYPROGESTERONE	177
TEVA-DILTIAZEM HCL ER.....	59	TEVA-METOPROL	54

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
TEVA-METOPROLOL (FC)	54	TEVA-RIZATRIPTAN ODT	SEC 3.212
TEVA-MIRTAZAPINE	105	TEVA-ROSUVASTATIN	44
TEVA-MODAFINIL	SEC 3.170	TEVA-ROSUVASTATIN	45
TEVA-MOMETASONE	140	TEVA-SALBUTAMOL STERINEBS P.F.	29
TEVA-MOMETASONE	188	TEVA-SERTRALINE	101
TEVA-MONTELUKAST	137	TEVA-SIMVASTATIN	46
TEVA-MONTELUKAST	SEC 3.171	TEVA-SIMVASTATIN	47
TEVA-MORPHINE SR	84	TEVA-SOLIFENACIN	193
TEVA-MORPHINE SR	85	TEVA-SPIRONOLACTONE	73
TEVA-MOXIFLOXACIN	SEC 3A.7	TEVA-SPIRONOLACTONE/HCTZ	73
TEVA-NABILONE	154	TEVA-SUCRALFATE	155
TEVA-NAPROXEN	79	TEVA-SULINDAC	80
TEVA-NAPROXEN EC	79	TEVA-SUMATRIPTAN	124
TEVA-NAPROXEN EC	80	TEVA-SUMATRIPTAN	SEC 3.235
TEVA-NAPROXEN SODIUM	80	TEVA-SUMATRIPTAN DF	124
TEVA-NAPROXEN SODIUM DS	80	TEVA-SUMATRIPTAN DF	SEC 3.235
TEVA-NARATRIPTAN	122	TEVA-TAMSULOSIN CR	51
TEVA-NARATRIPTAN	SEC 3.172	TEVA-TECNAL	77
TEVA-NITROFURANTOIN	23	TEVA-TECNAL-C 1/2	81
TEVA-NYSTATIN	19	TEVA-TECNAL-C 1/4	81
TEVA-OLANZAPINE	107	TEVA-TELMISARTAN	70
TEVA-OLANZAPINE	108	TEVA-TELMISARTAN HCTZ	71
TEVA-OMEPRAZOLE (DELAYED-RELEASE TABLET)	157	TEVA-TENOFOVIR	20
TEVA-OXYBUTYNYN	193	TEVA-TERAZOSIN	51
TEVA-OXYCOCET	87	TEVA-TERBINAFINE	17
TEVA-OXYCODAN	87	TEVA-TIAPROFENIC ACID	80
TEVA-PANTOPRAZOLE	158	TEVA-TOBRAMYCIN	5
TEVA-PANTOPRAZOLE MAGNESIUM	157	TEVA-TOLTERODINE LA	194
TEVA-PAROXETINE	100	TEVA-TOPILENE	184
TEVA-PERINDOPRIL	62	TEVA-TOPIRAMATE	93
TEVA-PERINDOPRIL/INDAPAMIDE	63	TEVA-TOPISONE	184
TEVA-PIROXICAM	80	TEVA-TRANDOLAPRIL	65
TEVA-PRAVASTATIN	43	TEVA-TRAVOPROST Z	144
TEVA-PRAVASTATIN	44	TEVA-TRAZODONE	102
TEVA-PRazosin	51	TEVA-TRIAMTERENE/HCTZ	135
TEVA-PREDNISOLONE	140	TEVA-TRIMEL	14
TEVA-PREGABALIN	92	TEVA-TRYPTOPHAN	104
TEVA-PROCTOSONE	190	TEVA-VALACYCLOVIR	22
TEVA-PROGESTERONE (PEANUT OIL)	177	TEVA-VALGANCICLOVIR	22
TEVA-PROPRANOLOL	55	TEVA-VALSARTAN	71
TEVA-QUETIAPINE	109	TEVA-VALSARTAN	72
TEVA-QUETIAPINE XR	110	TEVA-VALSARTAN/HCTZ	72
TEVA-QUETIAPINE XR	111	TEVA-VENLAFAXINE XR	95
TEVA-QUININE	23	TEVA-VENLAFAXINE XR	96
TEVA-RABEPRAZOLE	158	TEVA-VORICONAZOLE	18
TEVA-RAMIPRIL (CAPSULE)	64	TEVA-VORICONAZOLE	SEC 3.263
TEVA-RISEDRONATE	201	TEVA-ZOLMITRIPTAN	124
TEVA-RISEDRONATE	SEC 3.203	TEVA-ZOLMITRIPTAN	SEC 3.265
TEVA-RISPERIDONE	111	TEVETEN	67
TEVA-RISPERIDONE	112	TEVETEN PLUS	67
TEVA-RIZATRIPTAN ODT	123	THEOLAIR	194
		THEOPHYLLINE	194

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
THIAMAZOLE	178	TRAVATAN Z	144
THIAMIJECT	195	TRAVOPROST	144
THIAMINE HCL	195	TRAVOPROST/ TIMOLOL MALEATE	145
THYROGEN	131	TRAZODONE	102
THYROID	177	TRAZODONE HCL	102
THYTROPIN ALFA	131	TRESIBA FLEXTOUCH PEN	173
TIAMOL	187	TRETINOIN	SEC 3.256
TIAPROFENIC ACID	80	TRI-CYCLEN (21 DAY)	171
TIAZAC	58	TRI-CYCLEN (28 DAY)	171
TIAZAC	59	TRI-CYCLEN LO 21	171
TIAZAC XC	57	TRI-CYCLEN LO 28	171
TICAGRELOR	36	TRIADERM REGULAR	188
TICAGRELOR	SEC 3.240	TRIAMCINOLONE ACETONIDE	168
TICLOPIDINE	37	TRIAMCINOLONE ACETONIDE	188
TICLOPIDINE HCL	37	TRIAMCINOLONE ACETONIDE USP	168
TIMOLOL MALEATE	143	TRIAZO	120
TIMOPTIC	143	TRIAZOLAM	120
TIMOPTIC-XE	143	TRIFLUOPERAZINE	115
TINZAPARIN SODIUM	35	TRIFLUOPERAZINE HCL	115
TIOTROPIUM BROMIDE MONOHYDRATE	27	TRIFLURIDINE	139
TIOTROPIUM BROMIDE MONOHYDRATE/ OLODATEROL HYDROCHLORIDE	SEC 3.240	TRIHEXYPHENIDYL	125
TOBI	5	TRIHEXYPHENIDYL HCL	125
TOBI PODHALER	5	TRIMEBUTINE	160
TOBRADEX	140	TRIMEBUTINE MALEATE	160
TOBRAMYCIN	139	TRIMEPRAZINE TARTRATE	3
TOBRAMYCIN	5	TRIMETHOPRIM	23
TOBRAMYCIN SULFATE	5	TRIMIPRAMINE	103
TOBREX	139	TRIMIPRAMINE MALEATE	103
TOCILIZUMAB	SEC 3.244	TRINIPATCH 0.2	50
TOCILIZUMAB	SEC 3.248	TRINIPATCH 0.4	50
TOCILIZUMAB	SEC 3.251	TRINIPATCH 0.6	50
TOCILIZUMAB	SEC 3.254	TRIQUILAR (21 DAY)	170
TOFACITINIB CITRATE	SEC 3.256	TRIQUILAR (28 DAY)	170
TOLOXIN	40	TROSEC	SEC 3.256
TOLOXIN PEDIATRIC	40	TROSPIUM CHLORIDE	SEC 3.256
TOLTERODINE L-TARTRATE	194	TRUSOPT	144
TOPAMAX	93	TRUSOPT (PRESERVATIVE-FREE)	144
TOPAMAX SPRINKLE	93	TRYPTAN	104
TOPICORT	187	TUDORZA GENUAIR	27
TOPICORT MILD	187	TWYNSTA	71
TOPIRAMATE	93	TYLENOL NO. 2	81
TORADOL	79	TYLENOL NO. 3	81
TOVIAZ	SEC 3.107	TYLENOL NO. 4	81
TRAJENTA	SEC 3.164	TYSABRI	SEC 3.175
TRANDATE	54		
TRANDOLAPRIL	65		
TRANEXAMIC ACID	37		
TRANSDERM-NITRO 0.2	50		
TRANSDERM-NITRO 0.4	50		
TRANSDERM-NITRO 0.6	50		
TRANLYCYPROMINE SULFATE	94		

U

ULIPRISTAL ACETATE	201
ULORIC	SEC 3.106
ULTIBRO BREEZHALER	SEC 3.126
ULTRAVATE	187

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
UMECLIDINIUM BROMIDE	28	VIROPTIC	139
UMECLIDINIUM BROMIDE/ VILANTEROL TRIFENATATE	SEC 3.257	VISANNE	SEC 3.63
UNIPHYL	194	VISTITAN 0.03%	144
URINE TEST STRIPS	1	VITAMIN A ACID	SEC 3.256
URSO	151	VITAMIN B12	195
URSO DS	151	VITAMIN K1	195
URSODIOL	151	VITAMIN K1 PEDIATRIC	195
URSODIOL TABLETS USP	151	VOLTAREN	77
USTEKINUMAB	SEC 3.259	VOLTAREN OPHTHA	141
<hr/> V <hr/>		VOLTAREN SR	77
VAGIFEM	172	VORICONAZOLE	18
VALACYCLOVIR	22	VORICONAZOLE	SEC 3.263
VALCYTE	22	VORTEX	205
VALGANCICLOVIR HCL	22	VORTEX CHILD/PEDIATRIC MASK DEVICE	205
VALPROIC ACID	93	VORTEX TODDLER/INFANT MASK DEVICE	205
VALSARTAN	71	VOSEVI	SEC 3.232
VALSARTAN	72	VYVANSE	116
VALSARTAN HCT	72	<hr/> W <hr/>	
VALSARTAN/ HYDROCHLOROTHIAZIDE	72	WARFARIN SODIUM	33
VALTRES (CAPLET)	22	WELLBUTRIN SR	104
VANCOGIN	15	WELLBUTRIN XL	104
VANCOMYCIN HCL	15	WINPRED	168
VARENICLINE TARTRATE	31	<hr/> X <hr/>	
VARENICLINE TARTRATE	SEC 3.259	XALACOM	145
VARENICLINE TARTRATE/ VARENICLINE TARTRATE	31	XALATAN	144
VARENICLINE TARTRATE/ VARENICLINE TARTRATE	SEC 3.259	XARELTO	36
VASERETIC	61	XARELTO	SEC 3.208
VASOTEC	60	XARELTO	SEC 3.210
VASOTEC	61	XATRAL	SEC 3.22
VEDOLIZUMAB	SEC 3.262	XELJANZ	SEC 3.256
VENLAFAXINE HCL	95	XEOMIN	203
VENLAFAXINE HCL	96	XIGDUO	SEC 3.52
VENLAFAXINE XR	95	XOLAIR	SEC 3.184
VENLAFAXINE XR	96	XYLAC	116
VENTOLIN	29	XYLOCAINE	190
VENTOLIN HFA	28	XYLOCAINE JELLY	190
VENTOLIN NEBULES P.F.	29	XYLOCAINE VISCOUS	141
VERAPAMIL HCL	59	<hr/> Y <hr/>	
VERMOX	5	YASMIN 21	169
VESICARE	193	YASMIN 28	169
VFEND	18	<hr/> Z <hr/>	
VFEND	SEC 3.263	ZADITEN	3
VIGABATRIN	94		
VIMPAT	SEC 3.161		
VIKACE	151		
VIREAD	20		

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

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

Product Name	Page	Product Name	Page
ZANTAC.....	155		
ZARONTIN.....	89		
ZAROXOLYN.....	135		
ZAXINE.....	SEC 3.202		
ZELDOX.....	113		
ZEPATIER.....	SEC 3.73		
ZESTORETIC.....	62		
ZESTRIL.....	61		
ZESTRIL.....	62		
ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE.....	113		
ZITHROMAX.....	10		
ZOCOR.....	46		
ZOFRAN.....	153		
ZOFRAN ODT.....	152		
ZOLADEX.....	SEC 3.124		
ZOLADEX LA.....	SEC 3.124		
ZOLEDRONIC ACID.....	SEC 3.265		
ZOLEDRONIC ACID - Z.....	SEC 3.265		
ZOLEDRONIC ACID CONCENTRATE.....	SEC 3.265		
ZOLMITRIPTAN.....	124		
ZOLMITRIPTAN.....	SEC 3.265		
ZOLOFT.....	101		
ZOMETA CONCENTRATE.....	SEC 3.265		
ZOMIG.....	124		
ZOMIG.....	SEC 3.265		
ZOMIG RAPIMELT.....	124		
ZOMIG RAPIMELT.....	SEC 3.265		
ZOPICLONE.....	121		
ZOVIRAX.....	21		
ZUCLOPENTHIXOL ACETATE.....	115		
ZUCLOPENTHIXOL DECANOATE.....	115		
ZUCLOPENTHIXOL DIHYDROCHLORIDE.....	115		
ZYLOPRIM.....	197		
ZYPREXA.....	107		
ZYPREXA.....	108		
ZYPREXA ZYDIS.....	108		
ZYVOXAM.....	16		
ZYVOXAM.....	SEC 3.166		

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

**ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER**

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
0000000868.....	144	00000030910.....	167	00000315966.....	170	00000386464.....	126
0000000884.....	144	00000030929.....	167	00000319511.....	23	00000386472.....	126
0000001686.....	141	00000030988.....	167	00000323071.....	184	00000392472.....	86
0000001694.....	190	00000035017.....	141	00000323098.....	184	00000392480.....	86
0000001961.....	190	00000035076.....	141	00000324019.....	102	00000392537.....	152
0000004596.....	197	00000036129.....	167	00000326836.....	115	00000392561.....	86
0000005606.....	117	00000036137.....	168	00000326844.....	134	00000392588.....	86
0000005614.....	117	00000036323.....	151	00000326852.....	103	00000392693.....	27
00000010200.....	178	00000037605.....	170	00000328219.....	126	00000392731.....	152
00000010219.....	178	00000037613.....	50	00000329320.....	125	00000392782.....	27
00000010383.....	33	00000037621.....	50	00000330566.....	102	00000396761.....	88
00000010391.....	33	00000042560.....	139	00000330582.....	191	00000396788.....	48
00000010405.....	89	00000042579.....	139	00000335053.....	102	00000399310.....	88
00000015229.....	103	00000042676.....	140	00000335061.....	102	00000399728.....	119
00000015237.....	103	00000074454.....	141	00000335088.....	102	00000402516.....	177
00000015741.....	178	00000115630.....	119	00000335096.....	114	00000402591.....	102
00000016055.....	163	00000125083.....	83	00000335118.....	114	00000402680.....	120
00000020877.....	12	00000125121.....	83	00000335126.....	114	00000402737.....	120
00000020877.SEC 3.24		00000155357.....	29	00000335134.....	114	00000402745.....	120
00000020885.....	12	00000155365.....	143	00000337420.....	78	00000402796.....	197
00000020885.SEC 3.24		00000176192.....	81	00000337439.....	78	00000402818.....	197
00000021008.....	23	00000176206.....	81	00000337730.....	48	00000405329.....	119
00000021016.....	23	00000178799.....	118	00000337749.....	48	00000405337.....	119
00000021261.....	22	00000178802.....	118	00000337757.....	13	00000405345.....	114
00000021474.....	134	00000178810.....	118	00000337765.....	13	00000405361.....	114
00000021482.....	134	00000178829.....	118	00000337773.....	13	00000406716.....	11
00000022772.....	88	00000195057SEC 3.169		00000342084.....	6	00000406724.....	11
00000022780.....	88	00000225851.....	16	00000342092.....	6	00000406775.....	122
00000022799.....	89	00000226327.....	77	00000342106.....	6	00000410632.....	114
00000023442.....	88	00000232807.....	114	00000342114.....	6	00000417246.....	184
00000023450.....	88	00000232823.....	114	00000343838.....	170	00000426830.....	47
00000023485.....	89	00000232831.....	114	00000344923.....	184	00000426849.....	195
00000023698.....	88	00000236683.....	122	00000345539.....	115	00000432814.....	140
00000023949.....	177	00000252506.....	141	00000353027.....	170	00000441619.....	47
00000023957.....	177	00000260428.....	167	00000358177.....	140	00000441627.....	47
00000023965.....	177	00000260436.....	16	00000360201.....	103	00000441635.....	48
00000024694.....	121	00000263818.....	151	00000360252.....	47	00000441651.....	78
00000026697.....	133	00000271373.....	168	00000360260.....	47	00000441686.....	49
00000027243.....	29	00000280437.....	166	00000360279.....	135	00000441694.....	49
00000028096.....	166	00000297143.....	170	00000362158.....	119	00000441767.....	135
00000029149.....	19	00000299405.....	140	00000362166.....	48	00000441775.....	135
00000029246.....	169	00000301175.....	140	00000363014.....	187	00000443832.....	93
00000030600.....	167	00000312363.....	9	00000363650.....	113	00000443948.....	86
00000030619.....	167	00000312738.....	23	00000363669.....	113	00000445266.....	14
00000030627.....	167	00000312746.....	115	00000363677.....	113	00000445274.....	14
00000030635.....	167	00000312754.....	115	00000363685.....	113	00000445282.....	14
00000030678.....	168	00000312770.....	168	00000363812.....	27	00000451207.....	143
00000030759.....	167	00000312797.....	103	00000363839.....	27	00000452130.....	12
00000030767.....	167	00000312800.....	134	00000382825.....	88	00000453811.....	34
00000030783.....	169	00000313823.....	116	00000382841.....	88	00000455881.....	30

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00000461733.....	121	00000545058.....	125	00000596965.....	86	00000646016.....	121
00000465763.....	143	00000545066.....	23	00000598461.....	14	00000646024.....	121
00000469327.....	169	00000545074.....	125	00000598488.....	14	00000646059.....	121
00000471526.....	169	00000545678.....	9	00000598933.....	187	00000648035.....	54
00000474517.....	195	00000548375.....	154	00000600806.....	79	00000648043.....	54
00000474525.....	195	00000550086.....	14	00000603708.....	39	00000649074.....	23
00000476242.....	188	00000550957.....	168	00000603716.....	39	00000653209.....	185
00000476285.....	188	00000555126.....	133	00000604453.....	120	00000653217.....	185
00000476374.....	194	00000556734.....	5	00000604461.....	120	00000653241.....	81
00000476552.....	94	00000559253.....	50	00000608157.....	87	00000653276.....	81
00000479799.....	197	00000564966.....	135	00000608165.....	87	00000654531.....	104
00000481815.....	195	00000565350.....	79	00000608181.....	81	00000655740.....	119
00000481823.....	195	00000572349.....	198	00000608203.....	81	00000655759.....	119
00000487872.....	154	00000575569.....	129	00000608211.....	77	00000655767.....	119
00000493392.....	200	00000577308.....	3	00000608238.....	77	00000657182.....	73
00000496480.....	55	00000578428.....	184	00000608882.....	81	00000657204SEC 3.256	
00000496499.....	55	00000578436.....	184	00000609129.....	154	00000657298.....	61
00000496502.....	55	00000578576SEC 3.256		00000611174.....	188	00000658855.....	54
00000497193.....	194	00000578657.....	29	00000613215.....	73	00000664227.....	166
00000500895.....	138	00000579335.....	187	00000613223.....	73	00000670901.....	60
00000502790.....	151	00000580929.....	14	00000613231.....	73	00000670928.....	61
00000505773.....	188	00000582344.....	192	00000614254.....	139	00000670944.....	49
00000505781.....	188	00000582352.....	192	00000617288.....	86	00000675962.....	84
00000506052.....	78	00000583413.....	6	00000618454.....	119	00000681989.....	188
00000509558.....	29	00000583421.....	6	00000618632.....	54	00000681997.....	187
00000511528.....	120	00000584215.....	154	00000618640.....	54	00000682020.....	9
00000511536.....	120	00000584223.....	50	00000621463.....	81	00000687456.....	139
00000511552.....	125	00000584991.....	117	00000621935.....	85	00000688568.....	9
00000513962.....	139	00000585009.....	117	00000627097.....	79	00000688622.....	184
00000513997.....	126	00000585092.....	177	00000628115.....	11	00000692689.....	194
00000514012.....	77	00000585114.....	78	00000628123.....	11	00000692697.....	194
00000514497.....	48	00000586668.....	183	00000628131.....	12	00000692700.....	194
00000514500.....	48	00000586676.....	183	00000628158.....	12	00000695696.....	80
00000518182SEC 3.256		00000586714.....	174	00000629340.....	78	00000695718.....	80
00000521515.....	195	00000587737.....	174	00000629359.....	78	00000700401.....	140
00000521698.....	119	00000589861.....	79	00000629367.....	184	00000703486.....	133
00000521701.....	119	00000590827.....	77	00000632201.....	86	00000704423 SEC 3.47	
00000522597.....	126	00000591467.....	85	00000632228.....	86	00000704431 SEC 3.47	
00000522651.....	79	00000591475.....	85	00000632724.....	77	00000705438.....	83
00000522678.....	79	00000592277.....	79	00000632775.....	117	00000705799.....	85
00000522724.....	119	00000593435.....	81	00000636576.....	30	00000706531.....	125
00000522988.....	119	00000593451.....	81	00000636622.....	99	00000707503.....	170
00000522996.....	119	00000594636.....	84	00000637661.....	143	00000707570.....	48
00000527033.....	48	00000594644.....	84	00000637742.....	119	00000707600.....	170
00000532657.....	135	00000594652.....	84	00000637750.....	119	00000708879.....	60
00000534560.....	54	00000595942.....	115	00000639389.....	86	00000711101.....	119
00000535427.....	185	00000596418.....	89	00000642215.....	11	00000713449.....	113
00000535435.....	185	00000596426.....	89	00000644552.....	134	00000716618.....	185
00000544884.....	81	00000596434.....	89	00000644579.....	103	00000716626.....	185
00000545015.....	143	00000596612.....	3	00000645575.....	118	00000716642.....	185

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00000716650.....	185	00000773689.....	52	00000839205SEC 3.181		00000885436.....	83
00000716685.....	187	00000773697.....	52	00000839396.....	61	00000885444.....	83
00000716693.....	187	00000778338.....	154	00000839418.....	62	00000886157.....	21
00000716820.....	187	00000778389.....	80	00000842648.....	54	00000886432.....	152
00000716839.....	187	00000778907.....	140	00000842656.....	54	00000886440.....	152
00000716863.....	187	00000778915.....	140	00000842664.....	79	00000888400.....	135
00000716960.....	188	00000781878.....	195	00000846503.....	157	00000890960.....	40
00000717282.....	8	00000782459.....	77	00000849650.....	184	00000891835.....	17
00000717282SEC 3.125		00000782467.....	54	00000849669.....	184	00000893757.....	43
00000718149.....	104	00000782475.....	55	00000851736.....	188	00000894737.....	106
00000725110.....	57	00000782483.....	59	00000851744.....	188	00000894745.....	107
00000725250.....	14	00000782491.....	59	00000851752.....	166	00000895644.....	50
00000725765.....	84	00000782505.....	54	00000851760.....	166	00000895652.....	50
00000726540.....	14	00000782718.....	89	00000851779.....	57	00000895660.....	50
00000727520.....	34	00000783900.....	166	00000851787.....	57	00000990015.....	205
00000727695SEC 3.162		00000784354.....	80	00000852074.....	166	00000990016.....	205
00000728195.....	119	00000784400.....	135	00000852384.....	50	00000990080.....	205
00000728209.....	119	00000786543.....	83	00000854409.....	133	00000990091.....	205
00000733059.....	155	00000786616.....	29	00000860689.....	119	00000990092.....	205
00000733067.....	155	00000788716.....	15	00000860697.....	119	00000990093.....	205
00000738832.....	121	00000789429.....	151	00000860700.....	119	00000990094.....	205
00000738840.....	121	00000789437.....	151	00000862924.....	57	00000990095.....	205
00000740675.....	55	00000789445.....	151	00000862932.....	57	00000990096.....	205
00000740713.....	14	00000789720.....	152	00000865397.....	118	00000990097.....	205
00000740799.....	103	00000789739.....	86	00000865400.....	118	00000990098.....	205
00000740802.....	103	00000790427.....	79	00000868965.....	7	00000990100.....	205
00000740810.....	103	00000790435.....	79	00000868981.....	7	00000990101.....	205
00000740829.....	103	00000792667.....	19	00000869953.....	27	00000990102.....	205
00000742554.....	59	00000795879.....	174	00000869961.....	27	00000990103.....	205
00000745588.....	80	00000800430.....	15	00000870420.....	23	00000990109.....	205
00000745596.....	80	00000804312.....	195	00000870935.....	126	00000999102.....	76
00000749354.....	54	00000804533.....	187	00000871095.....	188	00000999103.....	182
00000750050.....	185	00000804991.....	184	00000872644.....	12	00000999104.....	191
00000751170.....	54	00000805009.....	184	00000872652.....	12	00000999105.....	75
00000754129.....	102	00000807788.....	141	00000873454.....	9	00000999107.....	186
00000755338.....	134	00000808539.....	77	00000873993.....	177	00000999108.....	82
00000755575.....	114	00000808547.....	77	00000874256.....	14	00000999109.....	142
00000755583.....	89	00000808571.....	120	00000874582.....	166	00000999110.....	189
00000755834.....	143	00000808652.....	113	00000878928.....	56	00000999111.....	165
00000755907.....	57	00000809187.....	184	00000878936.....	56	00000999112.....	181
00000756784.....	140	00000816027.....	81	00000882801.....	51	00000999113.....	200
00000765953.....	48	00000816086.....	195	00000882828.....	51	00000999114.....	198
00000765996.....	175	00000821373.....	151	00000882836.....	51	00000999119.....	181
00000768715.....	6	00000824143.....	176	00000883751.....	11	00000999202.....	76
00000768723.....	6	00000824305.....	176	00000884332.....	46	00000999203.....	182
00000768820.....	113	00000836273SEC 3.162		00000884340.....	46	00000999204.....	191
00000769541.....	134	00000836362.....	176	00000884359.....	46	00000999205.....	75
00000771376.....	57	00000839175.....	77	00000884502SEC 3.162		00000999207.....	186
00000771384.....	57	00000839183.....	77	00000885401.....	83	00000999208.....	82
00000773611.....	89	00000839191SEC 3.181		00000885428.....	83	00000999209.....	142

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
0000999211	189	00001918346	33	00001940481	100	00002013231	121
0000999212	165	00001918354	33	00001942964	59	00002014165	194
0000999213	181	00001918362	33	00001942972	59	00002014181	194
0000999214	200	00001919342	99	00001942980	59	00002014203	84
0000999215	198	00001919369	99	00001942999	59	00002014211	84
0000999216	199	00001919431	179	00001945270	139	00002014238	84
0000999219	181	00001919458	178	00001947664	63	00002014254	84
0000999396	205	00001919466	178	00001947672	63	00002014297	84
0000999397	205	00001919598	94	00001947680	63	00002014300	85
0000999398	205	00001924516	116	00001947699	63	00002014319	85
0000999399	205	00001924559	116	00001950592	160	00002014327	85
0000999543SEC 3.127		00001924567	116	00001959212	174	00002015439	84
0000999568SEC 3.127		00001926292	3	00001959220	174	00002017709	22
0000999941	1	00001926306	3	00001959239	174	00002017741	134
0000999952	1	00001926454	50	00001962701	187	00002017776	22
0000999955	1	00001926462SEC 3.256		00001962779	101	00002018144	169
0000999957	1	00001926470SEC 3.256		00001962817	101	00002018152	169
0000999981	179	00001926489SEC 3.256		00001964054	188	00002018160	169
0000999985	1	00001926691	176	00001964070	166	00002018985	99
0000999999	199	00001926756	114	00001964968	166	00002019884	60
00001901869	86	00001926772	114	00001964976	166	00002019892	60
00001907123	59	00001926780	114	00001966219	194	00002019906	61
00001908448	143	00001926799	121	00001968017SEC 3.108		00002019930	85
00001910272	185	00001926829	183	00001968300	141	00002019949	85
00001910280	185	00001926861	183	00001968440	171	00002019957	85
00001910299	185	00001926934	29	00001968823	141	00002019965	85
00001911473	60	00001927604	161	00001976133	192	00002020025	60
00001911481	60	00001927620	161	00001977547	166	00002021048	86
00001911902	50	00001927698	114	00001977563	168	00002022133	154
00001911910	50	00001927744	125	00001977652	177	00002022141	154
00001911929	50	00001927817	15	00001978918	166	00002022826	125
00001912038	78	00001927825	15	00001978926	166	00002024152	17
00001912046	78	00001927914	184	00001979574	41	00002024152SEC 3.111	
00001912070	158	00001930672	11	00001979582	41	00002024187	185
00001912755	139	00001930680	11	00001981242	163	00002024217	174
00001913484	118	00001933345	12	00001981501	203	00002024225	174
00001913492	118	00001933353	12	00001984853	10	00002024233	174
00001913654	176	00001934163	12	00001985205	151	00002024268	174
00001913662	176	00001934198	51	00001987003	195	00002024284	174
00001913670	176	00001934201	51	00001990403	125	00002024314	174
00001913689	176	00001934228	51	00001992872	171	00002024322	174
00001916203	140	00001934317	59	00001997580	159	00002025248	174
00001916386	83	00001934325	167	00001997602	30	00002025280	111
00001916823	161	00001934333	167	00001999761	168	00002025299	112
00001916858	12	00001934341	167	00001999869	168	00002025302	112
00001916874	12	00001937227	102	00002007959	33	00002025310	112
00001916882	12	00001937235	102	00002008203	121	00002026600	80
00001917056	78	00001940309	80	00002010909	202	00002026767	185
00001918311	33	00001940414	141	00002011271	50	00002026961	134
00001918338	33	00001940473	100	00002012472	34	00002028700	171

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002028786.....	126	00002063786.....	19	00002125366.....	83	00002150689	SEC 3.47
00002029421.....	171	00002063786SEC 3.202		00002125382.....	83	00002150697	SEC 3.47
00002029448.....	201	00002063808.....	159	00002125390.....	83	00002153483.....	135
00002029456.....	104	00002065819.....	94	00002126222.....	27	00002153521.....	159
00002031094.....	183	00002068036.....	94	00002126559.....	49	00002153556.....	159
00002031116.....	17	00002068087.....	128	00002126710.....	10	00002153564.....	159
00002035324.....	139	00002070847.....	192	00002128187.....	9	00002155907.....	57
00002036355.....	11	00002070863.....	192	00002128187.SEC 3.41		00002155990.....	57
00002039508.....	27	00002070987.....	103	00002128195.....	9	00002156008.....	115
00002039532.....	52	00002076306.....	147	00002128195.SEC 3.41		00002156016.....	115
00002039540.....	52	00002080052.....	30	00002128446.....	188	00002156032.....	115
00002041413.....	119	00002083523.....	41	00002130300.....	113	00002156040.....	115
00002041421.....	119	00002083795.....	190	00002131048.....	30	00002156091.....	183
00002041448.....	119	00002084090.....	14	00002131056.....	30	00002158574.....	14
00002041456.....	120	00002084104.....	14	00002131064.....	30	00002158582.....	77
00002041464.....	120	00002084260.....	90	00002132621.....	34	00002161923.....	187
00002041472.....	120	00002084279.....	90	00002132648.....	34	00002161966.....	187
00002041510.....	19	00002084287.....	90	00002132664.....	34	00002161974.....	187
00002042304.....	133	00002085992.....	134	00002132680.....	40	00002162415.....	80
00002042479.....	169	00002086026.....	167	00002132702.....	101	00002162423.....	80
00002042487.....	169	00002087316.....	201	00002137984.....	87	00002162466.....	79
00002043440.....	171	00002087324.....	127	00002138018.....	84	00002162644.....	79
00002045702.....	155	00002088398.....	30	00002139332.....	30	00002162660.....	79
00002045729.....	62	00002088401.....	30	00002139391.....	30	00002162695.....	21
00002045737.....	62	00002089602.....	184	00002142074.....	41	00002162717.....	80
00002046113.....	138	00002091194.....	77	00002142082.....	90	00002162725.....	80
00002046121.....	47	00002099233.....	173	00002142104.....	90	00002162806.....	50
00002046148.....	47	00002099683.....	159	00002142112.....	91	00002162814.....	77
00002046156.....	50	00002099705.....	25	00002143291.....	139	00002162849.....	173
00002047454.....	18	00002100622.....	155	00002143879.....	190	00002163152.....	187
00002048701.....	88	00002103052.....	196	00002144263.....	102	00002163527.....	50
00002048728.....	88	00002103567.....	155	00002144271.....	102	00002163535.....	50
00002048736.....	88	00002103613.....	158	00002144298.....	102	00002163543.....	193
00002049325SEC 3.124		00002103729.....	62	00002144328SEC 3.162		00002163918.....	81
00002049333.....	61	00002106272.....	54	00002144336SEC 3.162		00002163926.....	81
00002049376.....	61	00002106280.....	54	00002144344SEC 3.162		00002163934.....	81
00002049384.....	62	00002108119.....	5	00002145901.....	83	00002165503.....	156
00002049392SEC 3.181		00002108127.....	5	00002145928.....	83	00002165511.....	156
00002049961.....	53	00002108135.....	6	00002145936.....	83	00002166704.....	177
00002049988.....	53	00002108143.....	14	00002146126.....	83	00002166712.....	143
00002049996.....	103	00002108151.....	14	00002146908.....	10	00002166720.....	143
00002050013.....	103	00002112736.....	187	00002147602.....	52	00002167786.....	173
00002050048.....	103	00002112760.....	159	00002147610.....	52	00002167794.....	55
00002052431.....	185	00002112787.....	159	00002147629.....	52	00002167840.....	35
00002057778.....	57	00002112795.....	159	00002147637.....	102	00002168898.....	172
00002060884.....	185	00002112809.....	159	00002147645.....	102	00002169649SEC 3.155	
00002063662.....	23	00002123274.....	62	00002148587.....	171	00002170493.....	201
00002063670.....	192	00002123282.....	62	00002148595.....	171	00002170698.....	25
00002063735.....	30	00002125323.....	83	00002150662.SEC 3.47		00002171228.....	178
00002063743.....	30	00002125331.....	83	00002150670.SEC 3.47		00002171791.....	52

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002171805.....	52	00002194058.....	188	00002213567.....	153	00002224550.....	176
00002171880.....	143	00002194066.....	188	00002213575.....	153	00002224569.....	176
00002171899.....	143	00002194201.....	19	00002213745.....	153	00002224623.....	140
00002171929.....	159	00002194333.....	89	00002215136SEC 3.233		00002224720.....	48
00002172062.....	178	00002195917SEC 3.167		00002216132.....	121	00002224755.....	48
00002172070.....	178	00002195925SEC 3.167		00002216140.....	122	00002224801.....	39
00002172089.....	178	00002195933.....	126	00002216159.....	122	00002225158 SEC 3.39	
00002172097.....	178	00002195941.....	126	00002216167.....	121	00002225166 SEC 3.39	
00002172100.....	178	00002195968.....	126	00002216205.....	144	00002225190.....	171
00002172119.....	178	00002199270SEC 3.239		00002216213.....	185	00002225905SEC 3.124	
00002172127.....	178	00002200104.....	151	00002216221SEC 3.155		00002226383.....	190
00002172135.....	178	00002204517.....	52	00002216248.....	103	00002226391.....	190
00002172143.....	178	00002204525.....	52	00002216256.....	103	00002228947.....	29
00002172151.....	178	00002204533.....	52	00002216264.....	103	00002228955 SEC 3.39	
00002172577.....	79	00002205963.....	33	00002216272.....	103	00002229080.....	79
00002172712.....	139	00002207621.....	21	00002216345.....	27	00002229099.....	166
00002173360.....	29	00002207648.....	21	00002216353.....	99	00002229250.....	107
00002177145.....	30	00002207656.....	21	00002216361.....	99	00002229269.....	107
00002177153.....	118	00002207818.....	88	00002216582.....	99	00002229277.....	107
00002177161.....	118	00002208229.....	29	00002216590.....	99	00002229285.....	108
00002177188.....	118	00002208237.....	29	00002217422.....	23	00002229293 SEC 3.38	
00002177579.....	99	00002208245.....	29	00002217481.....	61	00002229315.....	186
00002177587.....	99	00002210320.....	40	00002217503.....	61	00002229323.....	186
00002177749.....	85	00002210347.....	59	00002217511.....	62	00002229452.....	79
00002177757.....	85	00002210428.....	55	00002218313.....	121	00002229453.....	158
00002177889.....	88	00002211076.....	120	00002219492.....	22	00002229515.....	35
00002177897.....	88	00002212021.....	10	00002220172.....	43	00002229523 SEC 3A.3	
00002179660.....	88	00002212048.....	30	00002220180.....	43	00002229526.....	58
00002179679.....	80	00002212153.....	124	00002220261.....	11	00002229628.....	93
00002179687.....	80	00002212153SEC 3.235		00002220288.....	11	00002229639.....	153
00002181479.....	60	00002212161.....	124	00002220296.....	11	00002229704.....	174
00002182750.....	25	00002212161SEC 3.235		00002221284.....	177	00002229705.....	174
00002182777.....	25	00002212188.....	124	00002221292.....	177	00002229755.....	35
00002182815.....	69	00002212188SEC 3.235		00002221306.....	177	00002229785.....	173
00002182874.....	69	00002212218.....	7	00002221802.....	184	00002229837.....	78
00002182882.....	69	00002212226.....	7	00002221829.....	64	00002230019.....	151
00002182955.....	25	00002212234.....	7	00002221837.....	64	00002230047.....	70
00002182963.....	25	00002212277.....	7	00002221845.....	64	00002230090.....	37
00002184435.....	85	00002212285.....	7	00002221853.....	64	00002230244.....	11
00002184443.....	85	00002212366.....	155	00002221896.....	187	00002230248SEC 3.162	
00002184451.....	85	00002213192.....	178	00002221918.....	187	00002230359.....	39
00002185431.....	159	00002213206.....	178	00002222051.....	44	00002230360.....	39
00002187108.....	170	00002213214.....	178	00002223252.....	190	00002230394.....	193
00002187116.....	170	00002213222.....	178	00002223376.....	193	00002230402.....	115
00002188783.....	201	00002213265.....	185	00002223562.....	173	00002230403.....	115
00002190885.....	172	00002213273.....	185	00002223678.....	135	00002230405.....	115
00002190893.....	172	00002213281.....	185	00002223716.....	10	00002230406.....	115
00002190915.....	157	00002213419.....	29	00002223724.....	10	00002230418.....	123
00002193221.....	195	00002213427.....	29	00002223767SEC 3.200		00002230418SEC 3.234	
00002194031.....	188	00002213486.....	29	00002223775SEC 3.200		00002230420.....	123

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002230420SEC 3.234		00002231154	58	00002235134 .SEC 3.41		00002237860	177
00002230431	159	00002231155	59	00002236399	188	00002237921	59
00002230433	159	00002231171	34	00002236466	158	00002237922	59
00002230454	127	00002231244SEC 3.155		00002236564	34	00002237923	67
00002230535	16	00002231245SEC 3.155		00002236783	28	00002237924	67
00002230540	16	00002231328	99	00002236807	93	00002237925	67
00002230584	118	00002231329	99	00002236819	197	00002237971SEC 3.233	
00002230585	118	00002231330	99	00002236876	143	00002238048	93
00002230619	168	00002231347	18	00002236883	34	00002238103	175
00002230641	128	00002231347SEC 3.156		00002236913	35	00002238172	11
00002230648	139	00002231441	50	00002236950	113	00002238216	137
00002230661	80	00002231457	65	00002236951	109	00002238216SEC 3.171	
00002230684	160	00002231459	65	00002236952	109	00002238217	137
00002230711	42	00002231460	65	00002236953	110	00002238217SEC 3.171	
00002230713	42	00002231478	35	00002236974	170	00002238280	101
00002230714	42	00002231492	120	00002236975	170	00002238281	101
00002230732	50	00002231493	144	00002236978	17	00002238282	101
00002230733	50	00002231504	77	00002236979	17	00002238316	52
00002230734	50	00002231505	77	00002236996	187	00002238318	52
00002230735	14	00002231506	77	00002236997	187	00002238326	55
00002230736	14	00002231508	77	00002237140	6	00002238327	55
00002230737	157	00002231509	172	00002237145	127	00002238334	88
00002230768	93	00002231543	89	00002237224	28	00002238341	158
00002230784	192	00002231544	89	00002237225	28	00002238370	93
00002230785	192	00002231583 .SEC 3.76		00002237235	18	00002238403	114
00002230803	54	00002231584 .SEC 3.76		00002237246	167	00002238404	114
00002230804	54	00002231585 .SEC 3.76		00002237247	167	00002238405	114
00002230805	51	00002231586 .SEC 3.77		00002237250	104	00002238406	114
00002230806	51	00002231587 .SEC 3.77		00002237279	95	00002238465	140
00002230807	51	00002231675	27	00002237280	95	00002238525	156
00002230808	51	00002231799	78	00002237282	96	00002238560SEC 3.111	
00002230838	116	00002231800	78	00002237319SEC 3.152		00002238639	79
00002230839	116	00002231893	168	00002237320SEC 3.152		00002238660	124
00002230893	93	00002231894	168	00002237339	102	00002238660SEC 3.265	
00002230894	93	00002231895	168	00002237367	63	00002238682	36
00002230896	93	00002232043 .SEC 3.66		00002237368	63	00002238703	183
00002230898	28	00002232044 .SEC 3.66		00002237369	63	00002238704	171
00002230942	120	00002232148	94	00002237370	17	00002238796	139
00002230997	58	00002232150	94	00002237371	17	00002238829	12
00002230998	58	00002232317	78	00002237514 SEC 3A.1		00002238830	12
00002230999	58	00002232318	78	00002237600	52	00002238831	12
00002231015	23	00002232570	28	00002237601	52	00002238850	108
00002231016	23	00002233852	178	00002237618	57	00002238873	144
00002231061	18	00002234466	188	00002237671 .SEC 3.47		00002238903	125
00002231129	29	00002234502	51	00002237701	37	00002238984	151
00002231135SEC 3.155		00002234503	51	00002237820	122	00002238998	50
00002231136	27	00002234504	51	00002237820SEC 3.172		00002239028SEC 3.201	
00002231150	58	00002234505	51	00002237821	122	00002239091	66
00002231151	58	00002234749	117	00002237821SEC 3.172		00002239092	66
00002231152	58	00002235134	5	00002237825	104	00002239193	20

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002239267	65	00002240346	17	00002241888	202	00002242797	188
00002239323	SEC 3.181	00002240432	67	00002241889	202	00002242821	SEC 3.47
00002239324	SEC 3.181	00002240434	SEC 3.107	00002241900	72	00002242837	121
00002239325	SEC 3.181	00002240456	94	00002241901	72	00002242838	122
00002239326	104	00002240481	101	00002241927	SEC 3.206	00002242868	116
00002239327	104	00002240484	101	00002241933	151	00002242903	SEC 3.79
00002239367	124	00002240485	101	00002241976	87	00002242907	197
00002239367	SEC 3.235	00002240518	123	00002242029	166	00002242924	33
00002239372	152	00002240518	SEC 3.212	00002242030	166	00002242925	33
00002239373	152	00002240519	123	00002242115	SEC 3.211	00002242926	33
00002239505	SEC 3.125	00002240519	SEC 3.212	00002242116	SEC 3.211	00002242927	33
00002239537	142	00002240521	123	00002242117	SEC 3.211	00002242928	33
00002239607	96	00002240521	SEC 3.212	00002242118	SEC 3.211	00002242929	33
00002239608	97	00002240549	193	00002242119	36	00002242931	173
00002239627	27	00002240550	193	00002242146	159	00002242965	SEC 3A.7
00002239630	5	00002240551	111	00002242163	85	00002242974	173
00002239653	SEC 3.239	00002240552	111	00002242261	133	00002242984	187
00002239665	SEC 3.170	00002240588	51	00002242320	40	00002242985	187
00002239698	89	00002240589	51	00002242453	155	00002242987	175
00002239699	89	00002240590	51	00002242454	155	00002243005	170
00002239700	89	00002240606	121	00002242463	21	00002243045	124
00002239701	89	00002240722	SEC 3.77	00002242464	21	00002243045	SEC 3.265
00002239702	89	00002240769	70	00002242465	176	00002243077	SEC 3.233
00002239703	89	00002240770	70	00002242471	SEC 3.40	00002243078	SEC 3.233
00002239834	SEC 3.162	00002240774	5	00002242472	40	00002243086	108
00002239835	40	00002240774	SEC 3.41	00002242481	121	00002243087	108
00002239864	41	00002240835	SEC 3.216	00002242502	195	00002243097	42
00002239893	17	00002240836	SEC 3.217	00002242527	190	00002243098	138
00002239907	93	00002240837	SEC 3.218	00002242528	190	00002243116	23
00002239908	93	00002240851	188	00002242538	58	00002243117	23
00002239924	175	00002240908	100	00002242539	58	00002243158	SEC 3.46
00002239925	175	00002240909	100	00002242540	58	00002243180	41
00002239926	175	00002241007	70	00002242541	58	00002243229	155
00002239941	SEC 3.42	00002241112	SEC 3.213	00002242589	173	00002243230	155
00002239942	SEC 3.42	00002241113	SEC 3.213	00002242652	5	00002243239	SEC 3.77
00002239944	79	00002241114	SEC 3.213	00002242680	33	00002243297	176
00002240067	135	00002241229	168	00002242681	33	00002243312	79
00002240113	145	00002241377	84	00002242682	33	00002243313	80
00002240114	35	00002241497	28	00002242683	33	00002243314	80
00002240115	91	00002241600	163	00002242684	33	00002243324	39
00002240131	86	00002241602	41	00002242685	33	00002243325	39
00002240132	86	00002241704	41	00002242686	33	00002243338	58
00002240205	33	00002241709	15	00002242687	33	00002243339	58
00002240286	120	00002241710	15	00002242692	34	00002243340	58
00002240294	175	00002241755	139	00002242697	33	00002243341	58
00002240297	175	00002241807	15	00002242728	51	00002243350	12
00002240329	195	00002241818	68	00002242729	51	00002243351	12
00002240333	104	00002241819	68	00002242730	51	00002243400	SEC 3.77
00002240334	104	00002241835	172	00002242763	SEC 3.202	00002243401	SEC 3.77
00002240335	23	00002241837	172	00002242784	21	00002243403	SEC 3.77

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002243426.....	121	00002244344.....	71	00002245385 .SEC 3.39		00002246569.....	63
00002243446.....	90	00002244353.....	173	00002245386 .SEC 3.39		00002246581.....	52
00002243447.....	90	00002244393.....	7	00002245397.....	173	00002246582.....	46
00002243448.....	90	00002244394.....	7	00002245432.....	116	00002246583.....	46
00002243506.....	43	00002244494.....	126	00002245433.....	116	00002246584.....	46
00002243507.....	43	00002244495.....	126	00002245522.....	185	00002246585.....	47
00002243508.....	44	00002244496.....	126	00002245523.....	185	00002246619.....	145
00002243518.....	51	00002244513.....	90	00002245524.....	185	00002246624.....	62
00002243519.....	51	00002244514.....	90	00002245531.....	35	00002246691.....	22
00002243520.....	51	00002244515.....	90	00002245532.....	168	00002246700.....	80
00002243521.....	51	00002244550.....	201	00002245565 .SEC 3.22		00002246701.....	80
00002243562.....	83	00002244551.....	201	00002245618.....	33	00002246714.....	184
00002243588.....	50	00002244552.....	201	00002245619 .SEC 3.116		00002246734.....	133
00002243595.....	168	00002244612.....	194	00002245623.....	12	00002246737.....	46
00002243596.....	168	00002244613.....	194	00002245643.....	17	00002246793.....	27
00002243602.....	137	00002244638.....	88	00002245644.....	17	00002246820.....	173
00002243684.....	16	00002244641.....	11	00002245662.....	183	00002246821.....	173
00002243684 .SEC 3.166		00002244680.....	78	00002245663.....	160	00002246859.....	41
00002243722.....	171	00002244681.....	78	00002245664.....	160	00002246860.....	41
00002243724.....	172	00002244726.....	177	00002245669.....	28	00002246893.....	59
00002243763.....	125	00002244727.....	177	00002245676.....	171	00002246895.....	59
00002243796.....	158	00002244756.....	10	00002245688.....	184	00002246896.....	201
00002243797.....	158	00002244781.....	71	00002245689.....	174	00002246897.....	90
00002243836.....	40	00002244782.....	71	00002245777.....	22	00002246898.....	90
00002243878.....	197	00002244790.....	84	00002245821.....	141	00002246899.....	91
00002243910.....	105	00002244791.....	84	00002245828.....	197	00002246955.....	72
00002243942.....	67	00002244792.....	85	00002245882.....	144	00002246967.....	172
00002243999.....	171	00002244838.....	101	00002245894.....	151	00002246968.....	172
00002244000.....	172	00002244839.....	101	00002245898 .SEC 3.47		00002246969.....	172
00002244001.....	172	00002244840.....	101	00002245913 .SEC 3.26		00002247008.....	43
00002244002.....	172	00002244849.....	16	00002245914.....	53	00002247009.....	43
00002244016 .SEC 3.135		00002245058.....	157	00002245915.....	53	00002247010.....	44
00002244021.....	66	00002245077.....	121	00002245916.....	53	00002247011.....	46
00002244022.....	155	00002245126 .SEC 3.215		00002245917.....	54	00002247012.....	46
00002244023.....	155	00002245127 .SEC 3.215		00002245918.....	58	00002247013.....	46
00002244107.....	110	00002245159.....	101	00002245919.....	58	00002247014.....	46
00002244126.....	192	00002245160.....	101	00002245920.....	58	00002247015.....	47
00002244148 .SEC 3.236		00002245161.....	101	00002245921.....	58	00002247022.....	163
00002244149 .SEC 3.236		00002245208.....	90	00002245922.....	59	00002247027.....	91
00002244265.....	19	00002245209.....	90	00002245972 .SEC 3.239		00002247028.....	91
00002244265 .SEC 3.41		00002245210.....	91	00002246010.....	54	00002247029.....	91
00002244266.....	19	00002245211.....	126	00002246016.....	131	00002247073 .SEC 3.47	
00002244266 .SEC 3.41		00002245232.....	15	00002246056.....	96	00002247074 .SEC 3.47	
00002244290.....	84	00002245233.....	15	00002246057.....	97	00002247128.....	20
00002244291.....	167	00002245240 .SEC 3.211		00002246082.....	201	00002247162.....	44
00002244292.....	167	00002245246.....	135	00002246194.....	40	00002247163.....	45
00002244293.....	167	00002245247.....	175	00002246314.....	90	00002247164.....	45
00002244304.....	90	00002245292.....	17	00002246315.....	90	00002247182.....	52
00002244305.....	90	00002245293.....	17	00002246316.....	90	00002247243.....	106
00002244306.....	90	00002245329.....	197	00002246534.....	121	00002247244.....	107

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002247322.....	190	00002248130.....	188	00002249510.....	134	00002256444.....	124
00002247339 SEC 3A.2		00002248170.....	96	00002249790SEC 3.189		00002256444SEC 3.235	
00002247340 SEC 3A.3		00002248171.....	97	00002250055.....	166	00002256460.....	18
00002247341 SEC 3A.3		00002248233.....	90	00002250144.....	46	00002256460SEC 3.263	
00002247374.....	84	00002248234.....	91	00002250152.....	46	00002256479.....	18
00002247437.....	8	00002248296SEC 3.265		00002250160.....	46	00002256479SEC 3.263	
00002247437.SEC 3.78		00002248347.....	145	00002250179.....	46	00002256487.....	18
00002247439.....	53	00002248437 SEC 3A.2		00002250187.....	47	00002256487SEC 3.263	
00002247440.....	53	00002248438 SEC 3A.3		00002250497.....	56	00002256495.....	202
00002247499.....	171	00002248439 SEC 3A.3		00002250500.....	56	00002256509.....	202
00002247500.....	172	00002248472.SEC 3.46		00002250527.....	43	00002256711.....	155
00002247521SEC 3.105		00002248499.....	63	00002250608.....	105	00002256738.....	57
00002247573.....	10	00002248500.....	63	00002250896.....	88	00002256746.....	57
00002247574.....	10	00002248501.....	63	00002251515.....	64	00002256754.....	57
00002247655.....	43	00002248502.....	63	00002251531.....	64	00002256762.....	57
00002247656.....	43	00002248538.....	104	00002251574.....	64	00002256770.....	57
00002247657.....	44	00002248539.....	104	00002251582.....	64	00002257238.....	169
00002247686.....	27	00002248540.....	104	00002251930.....	174	00002257572.....	121
00002247691.....	188	00002248557.....	100	00002252007.....	111	00002257726.....	173
00002247694.....	84	00002248558.....	100	00002252015.....	111	00002257734.....	173
00002247698.....	84	00002248570.....	155	00002252023.....	111	00002257904.....	124
00002247699.....	84	00002248571.....	155	00002252031.....	112	00002257904SEC 3.235	
00002247700.....	84	00002248572.....	43	00002252058.....	112	00002257955.....	192
00002247701.....	84	00002248573.....	43	00002252066.....	112	00002257963.....	192
00002247751.....	100	00002248639SEC 3.181		00002252309.....	53	00002258056.....	35
00002247752.....	100	00002248640SEC 3.181		00002252317.....	53	00002258102 SEC 3.21	
00002247802.....	61	00002248641SEC 3.181		00002252325.....	53	00002258188.....	153
00002247803.....	61	00002248642SEC 3.181		00002252333.....	54	00002258196.....	153
00002247813.....	202	00002248728.SEC 3.21		00002252716.....	139	00002258528.....	48
00002247823.....	21	00002248730.....	197	00002252767.....	36	00002258560.....	171
00002247882.....	190	00002248752.....	53	00002253631.....	67	00002258587.....	171
00002247917.....	64	00002248753.....	53	00002254514.....	23	00002258595 SEC 3.19	
00002247918.....	64	00002248754.....	53	00002254522.....	23	00002258692.....	145
00002247919.....	64	00002248755.....	54	00002254727.....	17	00002259354.....	105
00002247933.....	53	00002248756 SEC 3A.2		00002254786.....	144	00002260077.....	143
00002247934.....	53	00002248757 SEC 3A.3		00002255529.....	99	00002260565SEC 3.184	
00002247935.....	53	00002248758 SEC 3A.3		00002255537.....	99	00002261081.....	166
00002247936.....	54	00002248762.....	105	00002255545.....	52	00002261251.....	202
00002247945.....	64	00002248763.....	53	00002255553.....	52	00002261278.....	202
00002247946.....	64	00002248764.....	53	00002255707SEC 3.204		00002261634.....	10
00002247947.....	64	00002248804.....	10	00002255723SEC 3.204		00002261642.....	10
00002247997.....	138	00002248805.....	10	00002255758SEC 3.204		00002261642 SEC 3.37	
00002248010.....	96	00002248855.....	54	00002256096.....	105	00002261715.....	197
00002248011.....	97	00002248860.....	93	00002256118.....	105	00002261723.....	169
00002248034.....	106	00002248861.....	93	00002256126.....	105	00002261731.....	169
00002248035.....	107	00002248862.....	93	00002256134.....	53	00002261839.....	89
00002248050.....	96	00002248993.....	124	00002256177.....	53	00002261847.....	89
00002248051.....	97	00002248993SEC 3.265		00002256193.....	154	00002261901.....	77
00002248077.....	20	00002249324.....	117	00002256436.....	124	00002261928.....	77
00002248077SEC 3.191		00002249332.....	117	00002256436SEC 3.235		00002261936.....	77

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002261944.....	77	00002268914SEC 3.235		00002275546.....	39	00002281260.....	17
00002261960.....	77	00002268922.....	124	00002275562.....	96	00002281279.....	17
00002262754.....	100	00002268922SEC 3.235		00002275570.....	97	00002281791.....	107
00002262983.....	86	00002269031.....	173	00002276712.....	107	00002281805.....	107
00002262991.....	93	00002269058.....	173	00002276720.....	107	00002281813.....	107
00002263009.....	93	00002269090.....	144	00002276739.....	107	00002281821.....	108
00002263017.....	93	00002269198SEC 3.265		00002276747.....	108	00002281848.....	108
00002263025.....	124	00002269201SEC 3.152		00002276755.....	108	00002282097.. SEC 3.8	
00002263025SEC 3.235		00002270102.....	51	00002277131.....	117	00002282119.....	111
00002263033.....	124	00002270609.....	96	00002277158.....	117	00002282127.....	111
00002263033SEC 3.235		00002270811.....	192	00002277166.....	117	00002282135.....	111
00002263238.....	98	00002271605.....	58	00002277174.....	117	00002282143.....	112
00002263254.....	98	00002271613.....	58	00002277182.....	117	00002282151.....	112
00002263351.....	93	00002271621.....	58	00002277190.....	117	00002282178.....	112
00002263378.....	93	00002271648.....	58	00002277204.....	117	00002282224.....	21
00002263386.....	93	00002271656.....	59	00002277212.....	118	00002282445.....	121
00002263866.....	200	00002271842.....	173	00002277263.....	193	00002282690.....	111
00002264188.....	111	00002272113.....	56	00002277271.....	193	00002282852.....	100
00002264196.....	111	00002272121.....	56	00002277298.....	177	00002282860.....	100
00002264218.....	112	00002272695.....	27	00002278251.....	145	00002282941SEC 3.106	
00002264226.....	112	00002272830.....	49	00002278545.....	95	00002282968SEC 3.106	
00002264234.....	112	00002272873.....	126	00002278553.....	95	00002282976SEC 3.107	
00002265494.....	90	00002272903.....	169	00002278561.....	96	00002282984SEC 3.107	
00002265508.....	90	00002273217 .SEC 3.54		00002278677.....	28	00002283131.....	65
00002265516.....	91	00002273225 .SEC 3.54		00002278685.....	28	00002283158.....	65
00002265540.....	44	00002273373.....	56	00002279215SEC 3.201		00002283166.....	65
00002265826.....	10	00002273381.....	56	00002279266.....	113	00002283174.....	65
00002266008.....	61	00002273497.....	151	00002279363.....	166	00002283182.....	65
00002266016.....	61	00002273500.....	151	00002279428.....	153	00002283395SEC 3.161	
00002266385.....	188	00002273918.....	59	00002279436.....	153	00002283409SEC 3.161	
00002266539.....	10	00002273942.....	105	00002279460.....	174	00002283417SEC 3.161	
00002266547.....	10	00002273950.....	117	00002279479.....	174	00002283778.....	60
00002266660.....	52	00002274086.....	134	00002279614.....	93	00002283786.....	60
00002266687.....	117	00002274183.....	91	00002279630.....	93	00002283794.....	60
00002267217.....	159	00002274191.....	91	00002279649.....	93	00002283964.....	202
00002267233.....	157	00002274205.....	91	00002279800.....	111	00002283972.....	202
00002267470.....	53	00002274310.....	153	00002279819.....	112	00002284006.....	197
00002267489.....	53	00002274329.....	153	00002279827.....	112	00002284030.....	176
00002267640.....	177	00002274418.....	153	00002279835.....	112	00002284049.....	176
00002267845.....	10	00002274574.....	10	00002279983.....	183	00002284251.....	109
00002267918.....	121	00002274728 .SEC 3.98		00002279991.....	18	00002284383.....	56
00002267926.....	121	00002275023.....	95	00002279991SEC 3.263		00002284391.....	56
00002267985.....	52	00002275031.....	95	00002280132.....	56	00002284421.....	43
00002267993.....	52	00002275058.....	96	00002280140.....	56	00002284448.....	43
00002268078.....	158	00002275066SEC 3.256		00002280191.....	197	00002284456.....	44
00002268388.....	124	00002275074.....	104	00002280264.....	57	00002284707 SEC 3A.4	
00002268388SEC 3.235		00002275082.....	104	00002280272.....	57	00002284715 SEC 3A.5	
00002268396.....	124	00002275090.....	104	00002280515.....	156	00002284723.....	46
00002268396SEC 3.235		00002275104.....	104	00002280523.....	156	00002284731.....	46
00002268914.....	124	00002275538.....	39	00002280833.....	155	00002284758.....	46

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002284766.....	46	00002288192.....	153	00002294230.....	61	00002298082.....	158
00002284774.....	47	00002288680.SEC	3.77	00002294249.....	61	00002298309.....	31
00002284987.....	60	00002289199.....	61	00002294257.....	62	00002298309SEC	3.259
00002285088.....	61	00002289261.....	62	00002294273.....	17	00002298376SEC	3.203
00002285096.....	62	00002289288.....	62	00002294338.....	174	00002298384SEC	3.203
00002285118.....	61	00002289296.....	62	00002294346.....	174	00002298392.....	201
00002285126.....	61	00002289504.....	72	00002295016.....	98	00002298457.....	22
00002285134.....	62	00002290111.....	127	00002295024.....	98	00002298538.....	170
00002285169.....	54	00002290146.....	127	00002295148.....	56	00002298546.....	170
00002285177.....	54	00002290154.....	127	00002295261.....	42	00002298597.....	113
00002285398SEC	3.170	00002290332.....	59	00002295288.....	42	00002298600.....	113
00002285487.....	158	00002290340.....	59	00002295296.....	42	00002298619.....	113
00002285606.....	166	00002291134.....	60	00002295318.....	42	00002298627.....	113
00002285614.....	166	00002291142.....	60	00002295369.....	64	00002298635 SEC	3A.4
00002285622.....	96	00002291150.....	60	00002295407.....	157	00002298643 SEC	3A.5
00002285673.....	195	00002291177.....	31	00002295415.....	157	00002298651 SEC	3A.6
00002285924.....	91	00002291177SEC	3.259	00002295695.....	87	00002298791.....	154
00002285932.....	91	00002291185.....	31	00002295709.....	87	00002298813.....	154
00002285940.....	91	00002291185SEC	3.259	00002295822.....	22	00002299224.....	43
00002285959.....	21	00002291711.....	9	00002295881.....	133	00002299232.....	43
00002285967.....	21	00002291711.SEC	3.41	00002295946.....	170	00002299615.....	145
00002285975.....	21	00002291738.....	9	00002295954.....	170	00002299623.....	13
00002286068.....	99	00002291738.SEC	3.41	00002296152.....	97	00002299623SEC	3.198
00002286076.....	99	00002291878.....	60	00002296349.....	153	00002299631.....	13
00002286386SEC	3.175	00002291886.....	60	00002296357.....	153	00002299631SEC	3.198
00002286521.....	124	00002291894.....	60	00002296438.....	157	00002299658.....	13
00002286521SEC	3.235	00002291908.....	61	00002296446.....	157	00002299658SEC	3.198
00002286548.....	124	00002291967.....	153	00002296527.....	144	00002299712.....	197
00002286548SEC	3.235	00002291975.SEC	3.42	00002296551.....	109	00002299933.....	60
00002286629.....	105	00002291983.SEC	3.42	00002296578.....	109	00002299941.....	60
00002286823.....	124	00002292173.....	40	00002296594.....	110	00002299968.....	60
00002286823SEC	3.235	00002292270.....	7	00002296608.....	110	00002299976.....	61
00002286831.....	124	00002292289.....	7	00002296632.....	158	00002300036.....	60
00002286831SEC	3.235	00002292378.....	127	00002296640.....	158	00002300044.....	60
00002287021.....	30	00002292394.....	127	00002296810.....	149	00002300052.....	60
00002287048.....	30	00002292408.....	127	00002297205.....	5	00002300060.....	61
00002287064.....	30	00002292866.....	7	00002297213.....	6	00002300184.....	110
00002287072.....	175	00002292874.....	7	00002297302.....	127	00002300192.....	110
00002287420.SEC	3.58	00002292882.....	7	00002297329.....	127	00002300206.....	111
00002287439.SEC	3.59	00002292920.....	158	00002297337.....	127	00002300214.....	111
00002287447.SEC	3.60	00002292998.....	6	00002297477.....	56	00002300273.....	108
00002287633.....	7	00002293161.....	36	00002297485.....	56	00002300281.....	108
00002287927.....	64	00002293218.....	96	00002297493.....	56	00002300303.....	109
00002287935.....	64	00002293226.....	97	00002297558.....	159	00002301083.....	158
00002287943.....	64	00002293269..SEC	3.8	00002297795.....	175	00002301288.....	49
00002288044.....	41	00002293528.....	6	00002297809.....	183	00002301482.....	95
00002288052.....	41	00002293536.....	6	00002297841.....	70	00002301490.....	95
00002288087.SEC	3.21	00002293811.....	156	00002297868.....	153	00002301768.....	62
00002288109.....	197	00002293838.....	156	00002297876.....	153	00002301776.....	62
00002288184.....	153	00002293854.....	170	00002298074.....	158	00002301784.....	62

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002302136.....	62	00002306085.....	22	00002313340.....	69	00002316412.....	67
00002302179.....	6	00002307871.....	158	00002313359.....	69	00002316846.....	127
00002302187.....	6	00002307898.....	87	00002313375.....	70	00002316854.....	127
00002302209.....	201	00002308363.....	64	00002313383.....	70	00002316862.....	127
00002302365.....	62	00002308444.....	13	00002313685.....	153	00002316870.....	128
00002302373.....	62	00002308444SEC 3.198		00002313693.....	153	00002316986.....	36
00002302381.....	62	00002308452.....	13	00002313707.....	42	00002317060.....	67
00002302616.....	77	00002308452SEC 3.198		00002313715.....	42	00002317079.....	67
00002302624.....	77	00002308460.....	13	00002313723.....	42	00002317087.....	67
00002302764.....	84	00002308460SEC 3.198		00002313731.....	60	00002317192.....	169
00002302772.....	84	00002308894.....	152	00002313758.....	42	00002317206.....	169
00002302780.....	85	00002308908.....	72	00002313901.....	109	00002317451.....	43
00002302799.....	85	00002308916.....	72	00002313928.....	109	00002317478.....	43
00002302802.....	85	00002308932.....	5	00002313936.....	110	00002317486.....	44
00002302918.....	53	00002308959.....	5	00002313944.....	110	00002317893.....	109
00002302926.....	53	00002308967.....	6	00002313960.....	124	00002317907.....	109
00002303027.....	36	00002309122.....	127	00002313960SEC 3.265		00002317923.....	110
00002303116.....	107	00002309149.....	127	00002313995.....	109	00002317931.....	110
00002303159.....	107	00002309157.....	127	00002314002.....	109	00002318008.....	144
00002303167.....	107	00002309467.....	98	00002314010.....	110	00002318180.....	98
00002303175.....	108	00002309475.....	98	00002314029.....	110	00002318202.....	98
00002303183.....	108	00002309750.....	69	00002314037.....	127	00002318253SEC 3.152	
00002303191.....	108	00002309769.....	69	00002314053.....	127	00002318261SEC 3.152	
00002303205.....	108	00002309777.....	69	00002314061.....	127	00002318660.....	49
00002303396.....	54	00002310112.....	202	00002314088.....	128	00002318679.....	49
00002303418.....	54	00002310260.....	157	00002314177.....	158	00002318709.....	71
00002303442SEC 3.197		00002310317.....	95	00002314185.....	158	00002319012.....	192
00002303450SEC 3.197		00002310325.....	95	00002314290.....	122	00002319063.....	90
00002303469SEC 3.197		00002310333.....	96	00002314290SEC 3.172		00002319217.....	51
00002303655.....	111	00002310341.....	107	00002314304.....	122	00002319616.....	49
00002303663.....	111	00002310368.....	107	00002314304SEC 3.172		00002319624.....	49
00002303728 SEC 3A.2		00002310376.....	107	00002314665SEC 3.107		00002319632.....	49
00002303736 SEC 3A.3		00002310384.....	108	00002314940.....	197	00002319977.....	86
00002303744 SEC 3A.3		00002310392.....	108	00002315262.....	127	00002319985.....	86
00002303922SEC 3.226		00002310503.....	64	00002315289.....	127	00002319993.....	86
00002303949.....	98	00002310511.....	64	00002315297.....	127	00002320134.....	17
00002303965.....	98	00002310538.....	64	00002315424 SEC 3A.4		00002320177.....	70
00002304163.....	198	00002310546.....	64	00002315432 SEC 3A.5		00002320185.....	70
00002304317.....	95	00002310805.....	158	00002315440 SEC 3A.6		00002320312.....	117
00002304333.....	96	00002310813.....	158	00002315645.....	93	00002320398.....	85
00002304678.SEC 3.22		00002310899.....	42	00002315653.....	93	00002320428.....	85
00002305003.....	106	00002310902.....	42	00002315661.....	93	00002320436.....	85
00002305011.....	107	00002310910.....	42	00002315866.SEC 3.22		00002320444.....	85
00002305046.....	158	00002310929.....	42	00002316080.....	109	00002320673SEC 3.259	
00002305259.....	153	00002311658.....	66	00002316099.....	109	00002320681SEC 3.259	
00002305267.....	153	00002311925SEC 3.106		00002316110.....	110	00002320851.....	157
00002305429.....	143	00002312085.....	93	00002316129.....	110	00002321149.....	57
00002305933.....	126	00002312336.....	96	00002316307.....	144	00002321203.....	90
00002305941.....	126	00002312441.SEC 3.49		00002316390.....	67	00002321211.....	90
00002305968.....	126	00002313332.....	69	00002316404.....	67	00002321238.....	90

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002321475.....	175	00002325942 SEC 3A.6		00002330474.....	56	00002338726.....	44
00002321483.....	175	00002326965.....	66	00002330512.....	68	00002338734.....	44
00002321491.....	175	00002326973.....	66	00002330520.....	68	00002338742.....	45
00002321513.....	110	00002327112SEC 3.106		00002330539.....	68	00002338750.....	45
00002321653.....	63	00002327120SEC 3.106		00002330881.....	10	00002339439SEC 3.113	
00002321858.....	56	00002327147SEC 3.106		00002330954.....	43	00002339447SEC 3.113	
00002321866.....	56	00002327155SEC 3.107		00002330962.....	43	00002339455SEC 3.114	
00002322285.SEC 3.71		00002327163SEC 3.107		00002330970.....	44	00002339765.....	44
00002322323.....	122	00002327295.....	201	00002331004.....	61	00002340208.....	51
00002322323SEC 3.172		00002327562.....	108	00002331012.....	61	00002340607 SEC 3.66	
00002322331.SEC 3.66		00002327570.....	108	00002331101.....	64	00002340615 SEC 3.66	
00002322358.SEC 3.66		00002327775.....	108	00002331128.....	64	00002341379SEC 3.106	
00002322374.....	105	00002327783.....	108	00002331136.....	64	00002341387SEC 3.106	
00002322382.....	105	00002327856.....	134	00002331144.....	64	00002341395SEC 3.106	
00002322390.....	106	00002327902.....	66	00002331284.....	56	00002341409SEC 3.107	
00002322404.....	106	00002328305.....	111	00002331292.....	56	00002341417SEC 3.107	
00002322412.....	106	00002328313.....	111	00002331551.....	133	00002341689.....	78
00002322455.....	106	00002328321.....	111	00002331624.....	145	00002341697.....	78
00002322498SEC 3.239		00002328348.....	112	00002331675.SEC 3.46		00002342154.....	65
00002322579.....	202	00002328364.....	112	00002331683.....	95	00002342170.....	65
00002322951.....	116	00002328372.....	112	00002331691.....	95	00002342855.....	15
00002322978.....	116	00002328461.....	67	00002331705.....	96	00002342863.....	15
00002323052.SEC 3.76		00002328488.....	67	00002332388.....	10	00002343010.....	90
00002323060.SEC 3.76		00002328496.....	67	00002332396.....	10	00002343029.....	90
00002324032.....	203	00002328518.....	68	00002332922.....	66	00002343037.....	91
00002324229.....	124	00002328526.....	68	00002332957.....	67	00002343541 SEC 3.62	
00002324229SEC 3.265		00002328534.....	68	00002333554SEC 3.220		00002343665.....	108
00002324563SEC 3.211		00002328593.....	137	00002333619.....	176	00002343673.....	108
00002324571SEC 3.211		00002328593SEC 3.171		00002333627.....	176	00002344122.....	121
00002324598SEC 3.211		00002328666.SEC 3.66		00002333856SEC 3.227		00002344351.....	145
00002324601SEC 3.211		00002328682.SEC 3.66		00002333864SEC 3.227		00002344823.....	7
00002324628.....	87	00002329131.....	46	00002333872SEC 3.227		00002344831.....	7
00002324776SEC 3.122		00002329158.....	46	00002335700.....	40	00002345579.....	158
00002324784SEC 3.122		00002329166.....	46	00002335719.....	40	00002345803.....	93
00002324946.....	42	00002329174.....	46	00002336480.....	155	00002345838.....	93
00002324954.....	42	00002329182.....	47	00002336502.....	155	00002345846.....	93
00002324962.....	42	00002329840.SEC 3.37		00002336715SEC 3.211		00002347091.....	22
00002324970.....	42	00002330105SEC 3.106		00002336723SEC 3.211		00002347156.....	116
00002324997.....	144	00002330113SEC 3.106		00002336731SEC 3.211		00002347164.....	116
00002325063SEC 3.233		00002330148SEC 3.107		00002336758SEC 3.211		00002347172.....	116
00002325071SEC 3.233		00002330156SEC 3.107		00002337428.....	68	00002348004.....	36
00002325462.....	172	00002330210.....	197	00002337436.....	68	00002348500.....	202
00002325594.....	7	00002330288.....	71	00002337444.....	68	00002348691.....	157
00002325616.....	7	00002330385.....	137	00002337819SEC 3.155		00002348772.....	102
00002325624.....	7	00002330393.....	137	00002337827.....	126	00002348780.....	102
00002325632.....	8	00002330393SEC 3.171		00002337835.....	126	00002348799.....	102
00002325721.....	65	00002330415.....	109	00002337975.....	44	00002348853.....	30
00002325748.....	65	00002330423.....	109	00002337983.....	44	00002349167.....	57
00002325756.....	65	00002330458.....	110	00002337991.....	45	00002349191.....	118
00002325764.....	65	00002330466.....	110	00002338009.....	45	00002349205.....	118

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002350092	SEC 3.244	00002352354	127	00002354187	54	00002356856	93
00002350106	SEC 3.248	00002352362	128	00002354195	54	00002356864	93
00002350114	SEC 3.251	00002352397	77	00002354217	SEC 3.185	00002356872	93
00002350122	SEC 3.233	00002352583	SEC 3.202	00002354225	SEC 3.185	00002356880	111
00002350130	SEC 3.233	00002352648	34	00002354233	SEC 3.186	00002356899	111
00002350149	SEC 3.233	00002352656	34	00002354241	SEC 3.186	00002356902	111
00002350238	193	00002352664	34	00002354608	44	00002356910	112
00002350394	54	00002352672	34	00002354616	44	00002356929	112
00002350408	54	00002352680	34	00002354624	45	00002356937	112
00002350440	158	00002352710	11	00002354632	45	00002356996	72
00002350459	176	00002352729	11	00002354705	22	00002357003	72
00002350467	176	00002352753	12	00002354713	95	00002357011	72
00002350475	51	00002352788	12	00002354721	95	00002357038	72
00002350483	51	00002352923	61	00002354748	96	00002357046	72
00002350491	51	00002352931	61	00002354977	137	00002357054	158
00002350505	51	00002352966	197	00002354985	137	00002357127	30
00002350750	79	00002352974	108	00002354985	SEC 3.171	00002357143	101
00002350769	79	00002352982	108	00002355043	202	00002357151	101
00002350777	79	00002353016	155	00002355248	96	00002357178	101
00002350785	79	00002353024	155	00002355256	96	00002357186	56
00002350793	80	00002353040	127	00002355264	97	00002357208	56
00002350807	80	00002353059	127	00002355272	96	00002357224	202
00002350815	84	00002353121	17	00002355280	97	00002357380	SEC 3.106
00002350890	84	00002353164	109	00002355442	SEC 3.42	00002357453	175
00002350912	85	00002353172	109	00002355450	SEC 3.42	00002357461	175
00002351013	80	00002353199	110	00002355507	137	00002357488	175
00002351021	80	00002353202	110	00002355515	137	00002357534	22
00002351080	119	00002353229	43	00002355515	SEC 3.171	00002357615	SEC 3.161
00002351099	119	00002353237	43	00002355523	137	00002357623	SEC 3.161
00002351102	154	00002353245	90	00002355523	SEC 3.171	00002357631	SEC 3.161
00002351110	154	00002353253	90	00002356422	176	00002357658	SEC 3.161
00002351234	14	00002353261	90	00002356511	158	00002357682	156
00002351242	14	00002353318	SEC 3A.2	00002356538	158	00002357690	156
00002351420	48	00002353326	SEC 3A.3	00002356546	43	00002357712	56
00002351439	48	00002353342	91	00002356554	43	00002357720	56
00002351447	48	00002353350	91	00002356562	44	00002357755	65
00002351560	22	00002353369	91	00002356651	71	00002357763	65
00002351579	22	00002353377	173	00002356678	71	00002357771	65
00002351668	202	00002353385	173	00002356686	72	00002357798	65
00002351676	202	00002353504	69	00002356694	72	00002357968	69
00002351870	123	00002353512	69	00002356708	72	00002357976	69
00002351870	SEC 3.212	00002353520	101	00002356716	72	00002358158	35
00002351889	123	00002353539	101	00002356724	72	00002358166	35
00002351889	SEC 3.212	00002353547	101	00002356732	72	00002358174	35
00002352230	60	00002353660	96	00002356759	71	00002358182	35
00002352249	60	00002353679	97	00002356767	71	00002358263	70
00002352257	60	00002353687	201	00002356775	72	00002358611	138
00002352265	61	00002353830	156	00002356813	54	00002358808	SEC 3.49
00002352338	127	00002353849	156	00002356821	54	00002358840	SEC 3.201
00002352346	127	00002354101	SEC 3.105	00002356848	54	00002359316	36

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002359502.....	83	00002362678.....	56	00002368021.....	52	00002371758.....	153
00002359510.....	83	00002362945.....	62	00002368048.....	52	00002371766.....	111
00002359529.....	111	00002362953.....	62	00002368242.....	51	00002371774.....	111
00002359537.....	111	00002362961.....	62	00002368544.....	36	00002371782.....	111
00002359545.....	111	00002362988.....	124	00002368544SEC 3.240		00002371790.....	112
00002359553.....	112	00002362988SEC 3.265		00002368552.....	201	00002371804.....	112
00002359561.....	112	00002363100.....	71	00002368617.....	55	00002371812.....	112
00002359588.....	112	00002363119.....	71	00002368625.....	55	00002371871.....	96
00002359596.....	92	00002364077.....	98	00002368641.....	52	00002371898.....	96
00002359618.....	92	00002364085.....	98	00002368668.....	52	00002371901.....	97
00002359626.....	92	00002364115.....	83	00002368870.....	100	00002371979.....	52
00002359634.....	92	00002364123.....	83	00002368889.....	100	00002371987.....	52
00002359642.....	92	00002364131.....	83	00002368897.....	53	00002371995.....	52
00002359790.....	111	00002364158.....	83	00002368900.....	53	00002372347.....	67
00002359804.....	111	00002364336.....	40	00002368919.....	53	00002372371.....	67
00002359812.....	111	00002364913.....	53	00002368927.....	54	00002372398.....	67
00002359820.....	112	00002364921.....	53	00002369206.....	158	00002372525.....	86
00002359839.....	112	00002364948.....	53	00002369362.....	141	00002372533.....	86
00002359847.....	112	00002364956.....	54	00002369613SEC 3.214		00002372541.....	86
00002360594.....	134	00002365154.....	5	00002369621SEC 3.214		00002372568.....	86
00002360608.....	134	00002365359.....	66	00002369648SEC 3.214		00002372576.....	86
00002360616.....	108	00002365367.....	66	00002370166.....	13	00002372584.....	86
00002360624.....	108	00002365383.....	202	00002370166SEC 3.198		00002372797.....	86
00002361159.....	92	00002365480SEC 3.110		00002370174.....	13	00002372819.....	107
00002361175.....	92	00002366061.....	195	00002370174SEC 3.198		00002372827.....	107
00002361183.....	92	00002366312.....	66	00002370255.....	201	00002372835.....	107
00002361205.....	92	00002366320.....	66	00002370441.....	58	00002372843.....	108
00002361248.....	92	00002366339.....	66	00002370492.....	58	00002372851.....	108
00002361361.....	87	00002366959.....	71	00002370506.....	58	00002372886.....	68
00002361426.....	10	00002366967.....	71	00002370514.....	58	00002372894.....	68
00002361469.....	90	00002366975.....	72	00002370522.....	59	00002372908.....	68
00002361485.....	90	00002367009.....	72	00002370611.....	58	00002372932.....	46
00002361493.....	90	00002367017.....	72	00002370638.....	58	00002372940.....	46
00002361531.....	61	00002367025.....	72	00002370646.....	58	00002372959.....	46
00002361558.....	61	00002367033.....	72	00002370654.....	58	00002372967.....	46
00002361566.....	62	00002367041.....	72	00002370689.....	105	00002372975.....	47
00002361698.....	124	00002367157.....	188	00002370808.....	158	00002373041.....	144
00002361698SEC 3.235		00002367335.....	144	00002370921SEC 3.164		00002373068.....	145
00002361892.....	109	00002367394.....	89	00002371022.....	71	00002373823.....	198
00002362260.SEC 3.66		00002367408.....	13	00002371030.....	71	00002373904.....	135
00002362279.SEC 3.66		00002367416.....	13	00002371049.....	71	00002373912.....	135
00002362406.....	51	00002367424.....	13	00002371057.....	71	00002373947.....	137
00002362449.....	70	00002367556.....	52	00002371081.....	203	00002373947SEC 3.171	
00002362619.....	13	00002367564.....	52	00002371529.....	71	00002373955.....	40
00002362619SEC 3.198		00002367572.....	52	00002371537.....	71	00002373963.....	52
00002362627.....	13	00002367947.....	168	00002371545.....	72	00002374447.....	99
00002362627SEC 3.198		00002367955.....	168	00002371707.....	56	00002374455.....	99
00002362635.....	13	00002367963.....	168	00002371715.....	56	00002374609.....	137
00002362635SEC 3.198		00002367971.....	168	00002371723.....	56	00002374609SEC 3.171	
00002362651.....	56	00002368013.....	52	00002371731.....	153	00002374803 SEC 3.32	

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002374811	SEC 3.32	00002379198	SEC 3.212	00002381362	90	00002385481	98
00002374846	64	00002379201	123	00002381370	91	00002385503	98
00002374854	64	00002379201	SEC 3.212	00002381486	SEC 3.21	00002385570	124
00002374862	64	00002379236	137	00002381494	197	00002385570	SEC 3.235
00002374900	SEC 3.63	00002379236	SEC 3.171	00002381508	SEC 3.66	00002385589	124
00002375036	46	00002379252	71	00002381516	SEC 3.66	00002385589	SEC 3.235
00002375044	46	00002379279	66	00002381702	123	00002385627	99
00002375052	46	00002379287	66	00002381702	SEC 3.212	00002385635	99
00002375060	46	00002379295	66	00002381907	SEC 3A.2	00002385643	156
00002375079	47	00002379317	137	00002381923	SEC 3A.3	00002385651	156
00002375249	91	00002379325	137	00002382075	104	00002385767	156
00002375257	91	00002379325	SEC 3.171	00002382083	104	00002385783	56
00002375265	91	00002379333	137	00002382458	137	00002385791	56
00002375559	125	00002379333	SEC 3.171	00002382466	137	00002385805	56
00002375591	46	00002379627	SEC 3A.2	00002382466	SEC 3.171	00002385813	36
00002375605	46	00002379635	SEC 3A.3	00002382474	137	00002385821	121
00002375613	46	00002379643	SEC 3A.3	00002382474	SEC 3.171	00002385848	121
00002375621	46	00002379678	123	00002382539	48	00002385864	107
00002375648	47	00002379678	SEC 3.212	00002382644	44	00002385872	107
00002375702	SEC 3A.7	00002379686	SEC 3A.2	00002382652	44	00002385880	107
00002375842	SEC 3.220	00002379694	SEC 3A.3	00002382660	45	00002385899	108
00002375958	70	00002379708	SEC 3A.3	00002382679	45	00002385902	108
00002375966	70	00002379767	173	00002382822	SEC 3.46	00002385929	95
00002376091	153	00002379775	173	00002383055	53	00002385937	95
00002376105	153	00002379813	36	00002383063	53	00002385945	96
00002376938	28	00002380005	125	00002383241	99	00002385953	155
00002377144	70	00002380021	SEC 3.107	00002383284	100	00002385961	155
00002377152	70	00002380048	SEC 3.107	00002383292	100	00002386070	101
00002377209	173	00002380072	95	00002383381	SEC 3A.7	00002386089	101
00002377225	SEC 3.200	00002380080	95	00002384531	71	00002386097	101
00002377233	SEC 3.29	00002380099	96	00002384558	71	00002386119	SEC 3A.2
00002377608	137	00002380196	173	00002384566	72	00002386127	SEC 3A.3
00002377616	137	00002380218	173	00002384736	72	00002386232	61
00002377616	SEC 3.171	00002380358	SEC 3A.2	00002384744	72	00002386240	61
00002378426	34	00002380366	SEC 3A.3	00002384752	72	00002386259	62
00002378434	34	00002380374	SEC 3A.3	00002384884	154	00002386291	46
00002378442	34	00002380455	123	00002384892	154	00002386305	46
00002378469	34	00002380455	SEC 3.212	00002385031	197	00002386313	46
00002378523	44	00002380463	123	00002385279	17	00002386321	46
00002378531	44	00002380463	SEC 3.212	00002385287	67	00002386348	47
00002378558	45	00002380560	99	00002385295	67	00002386402	99
00002378566	45	00002380579	99	00002385309	67	00002386518	66
00002378604	SEC 3.208	00002380692	66	00002385317	68	00002386526	66
00002378612	SEC 3.210	00002380706	66	00002385325	68	00002386534	66
00002378787	8	00002380714	66	00002385333	68	00002386771	121
00002378787	SEC 3.169	00002380838	69	00002385341	173	00002386798	121
00002378795	8	00002380900	154	00002385368	173	00002386909	121
00002378795	SEC 3.169	00002380919	154	00002385449	158	00002386917	121
00002379058	69	00002381230	22	00002385457	158	00002387085	170
00002379198	123	00002381354	90	00002385465	40	00002387093	170

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002387131.....	139	00002389622.....	5	00002391570.....	104	00002394235.....	92
00002387174SEC 3.108		00002389657.....	70	00002391589.....	53	00002394243.....	92
00002387239.....	188	00002389665.....	70	00002391597.....	53	00002394251.....	92
00002387387.....	64	00002389673.....	70	00002391716.....	121	00002394278.....	92
00002387395.....	64	00002389703.....	43	00002391724.....	121	00002394294.....	92
00002387409.....	64	00002389738.....	43	00002391740.SEC 3.53		00002394472.....	61
00002387417.....	64	00002389746.....	44	00002391759.SEC 3.53		00002394480.....	61
00002387751.....	107	00002389878.....	202	00002391767.SEC 3.53		00002394499.....	62
00002387778.....	107	00002389983.....	152	00002391775.SEC 3.53		00002394596.....	84
00002387786.....	107	00002389991.....	152	00002391783.SEC 3.53		00002394618.....	84
00002387794.....	109	00002390019.....	153	00002391791.SEC 3.53		00002394685.....	145
00002387808.....	109	00002390051.....	153	00002391805.SEC 3.53		00002394804.....	66
00002387824.....	110	00002390205.....	109	00002391821.SEC 3.53		00002394812.....	66
00002387832.....	110	00002390213.....	109	00002392224.....	70	00002394871.....	197
00002387875.....	170	00002390248.....	110	00002392232.....	70	00002394936.....	138
00002387883.....	170	00002390256.....	110	00002392240.....	70	00002395355.....	71
00002387948.....	96	00002390299SEC 3.202		00002392313.SEC 3.53		00002395363.....	71
00002387956.....	96	00002390302.....	71	00002392321.SEC 3.53		00002395444.....	110
00002387964.....	97	00002390310.....	71	00002392348.SEC 3.53		00002395452.....	110
00002388073.....	11	00002390345.....	70	00002392356.SEC 3.53		00002395460.....	110
00002388081.....	11	00002390353.....	70	00002392364.SEC 3.53		00002395479.....	111
00002388235.....	100	00002390442.....	10	00002392801.....	92	00002395487.....	111
00002388243.....	100	00002390450.....	11	00002392828.....	92	00002395541.....	66
00002388545.SEC 3.21		00002390760.SEC 3.47		00002392836.....	92	00002395568.....	66
00002388553.....	197	00002390817.....	92	00002392844.....	92	00002395738.....	93
00002388707.....	66	00002390825.....	92	00002392860.....	92	00002395746.....	93
00002388715.....	66	00002390833.....	92	00002392933.....	42	00002395754.....	93
00002388766.....	173	00002390841.....	92	00002392941.....	42	00002396327.....	197
00002388774.....	173	00002390868.....	92	00002392968.....	42	00002396335.....	197
00002388790.....	69	00002390906.....	101	00002392976.....	42	00002396343.....	197
00002388804.....	69	00002390914.....	101	00002392992.....	68	00002396491.....	169
00002388812.....	69	00002390922.....	101	00002393018.....	68	00002396610.....	169
00002388839SEC 3.226		00002391058.....	42	00002393026.....	68	00002396661.....	123
00002388847SEC 3.226		00002391066.....	42	00002393220.....	202	00002396661SEC 3.212	
00002388928.....	66	00002391074.....	42	00002393239.....	20	00002396688.....	123
00002388936.....	66	00002391082.....	42	00002393360.....	123	00002396688SEC 3.212	
00002388944.....	70	00002391198.....	66	00002393360SEC 3.212		00002396696SEC 3.106	
00002388952.....	70	00002391201.....	66	00002393379.....	123	00002396726SEC 3.106	
00002388960.....	70	00002391228.....	66	00002393379SEC 3.212		00002396866.....	18
00002388979.....	70	00002391252.....	44	00002393441.....	99	00002396866SEC 3.263	
00002388987.....	70	00002391260.....	44	00002393468.....	123	00002396874.....	18
00002389088.....	108	00002391279.....	45	00002393468SEC 3.212		00002396874SEC 3.263	
00002389096.....	108	00002391287.....	45	00002393476.....	123	00002396955.....	21
00002389169SEC 3.221		00002391295.....	66	00002393476SEC 3.212		00002397072.....	56
00002389177SEC 3.221		00002391422.....	137	00002393557.....	71	00002397080.....	56
00002389185SEC 3.221		00002391422SEC 3.171		00002393565.....	71	00002397099.....	109
00002389460.....	93	00002391473.....	90	00002393581.....	154	00002397102.....	109
00002389487.....	93	00002391481.....	90	00002393603.....	154	00002397110.....	110
00002389517.....	137	00002391503.....	90	00002393751SEC 3.199		00002397129.....	110
00002389517SEC 3.171		00002391562.....	104	00002393824.....	22	00002397358.....	98

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002397374.....	98	00002399849.....	110	00002402408.....	101	00002404419	SEC 3.66
00002397412SEC 3.157		00002399857.....	110	00002402424SEC 3.239		00002404427	SEC 3.66
00002397714.SEC 3.31		00002399865.....	137	00002402475...SEC 3.5		00002404508	SEC 3.65
00002397781.....	44	00002399873.....	137	00002402610.....	156	00002404516SEC 3.195	
00002397803.....	44	00002399873SEC 3.171		00002402629.....	156	00002404524SEC 3.195	
00002397811.....	45	00002399997.....	137	00002402645.SEC 3.66		00002404532SEC 3.195	
00002397838.....	45	00002399997SEC 3.171		00002402653.SEC 3.66		00002404540SEC 3.195	
00002397900.....	193	00002400111.....	118	00002402769.....	197	00002404559SEC 3.195	
00002397919.....	193	00002400138.....	118	00002402777.....	197	00002404567SEC 3.195	
00002398370SEC 3.113		00002400553.....	36	00002402785.....	197	00002404923	SEC 3A.7
00002398389SEC 3.113		00002400561.SEC 3.66		00002402874SEC 3.170		00002405040.....	22
00002398397SEC 3.114		00002400588.SEC 3.66		00002402882SEC 3.170		00002405148.....	46
00002398427.....	25	00002400650.....	60	00002403005.....	91	00002405156.....	46
00002398435.....	122	00002400669.....	60	00002403021.....	91	00002405164.....	46
00002398435.SEC 3.24		00002400677.....	60	00002403048.....	91	00002405172.....	46
00002398443.....	122	00002400685.....	61	00002403137.....	102	00002405180.....	47
00002398443.SEC 3.24		00002401029.....	6	00002403145.....	102	00002405334.....	122
00002398834.....	69	00002401231.....	37	00002403153.....	102	00002405334	SEC 3.24
00002398842.....	69	00002401274.....	137	00002403161.....	102	00002405539.....	92
00002398850.....	69	00002401274SEC 3.171		00002403196.....	10	00002405547.....	92
00002398958SEC 3.234		00002401312.....	13	00002403250SEC 3.165		00002405555.....	92
00002398966SEC 3.234		00002401312SEC 3.198		00002403269SEC 3.165		00002405563.....	92
00002398974SEC 3.234		00002401320.....	13	00002403277SEC 3.165		00002405598.....	92
00002399032.....	193	00002401320SEC 3.198		00002403323.....	69	00002405628.....	44
00002399040.....	193	00002401339.....	13	00002403331.....	69	00002405636.....	44
00002399105.....	66	00002401339SEC 3.198		00002403358.....	69	00002405644.....	45
00002399164.....	44	00002401495.....	11	00002403366SEC 3.213		00002405652.....	45
00002399172.....	44	00002401509.....	11	00002403374SEC 3.213		00002405733.....	69
00002399180.....	45	00002401541.....	12	00002403382SEC 3.213		00002405741.....	69
00002399199.....	45	00002401606SEC 3.265		00002403412.....	174	00002405768.....	69
00002399245.....	18	00002401614SEC 3.211		00002403420.....	175	00002405792.....	122
00002399245SEC 3.263		00002401622SEC 3.211		00002403439.....	175	00002405792	SEC 3.24
00002399253.....	18	00002401630SEC 3.211		00002403447.....	174	00002405806.....	122
00002399253SEC 3.263		00002401649SEC 3.211		00002403587.....	140	00002405806	SEC 3.24
00002399334.....	195	00002401703SEC 3.233		00002403641.....	197	00002405814.....	202
00002399377.....	42	00002401711SEC 3.233		00002403692.....	92	00002405830.....	15
00002399385.....	42	00002401762SEC 3.232		00002403706.....	92	00002406098.....	67
00002399393.....	42	00002401770SEC 3.232		00002403714.....	92	00002406101.....	67
00002399407.....	42	00002401789SEC 3.232		00002403722.....	92	00002406128.....	67
00002399415.....	101	00002401797SEC 3.233		00002403730.....	92	00002406187.....	154
00002399423.....	101	00002401800SEC 3.233		00002403870.....	158	00002406306.....	201
00002399431.....	101	00002401819SEC 3.233		00002403889.....	20	00002406624.....	108
00002399458.....	124	00002401827SEC 3.233		00002403900SEC 3.213		00002406632.....	108
00002399458SEC 3.265		00002401835SEC 3.233		00002403927SEC 3.213		00002406810.....	67
00002399466.....	159	00002401894.....	99	00002403935SEC 3.213		00002406829.....	67
00002399776.....	91	00002402092.SEC 3.66		00002403943SEC 3.213		00002406837.....	67
00002399784.....	91	00002402106.SEC 3.66		00002404184.....	194	00002406853.....	35
00002399792.....	91	00002402181.....	198	00002404192.....	194	00002406896.....	35
00002399822.....	109	00002402378.....	101	00002404206.....	202	00002406969.....	121
00002399830.....	109	00002402394.....	101	00002404389.....	145	00002406977.....	121

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002407124.....	176	00002409011.....	96	00002413345.....	10	00002417359.....	110
00002407256.....	42	00002409038.....	97	00002413361.....	107	00002417367.....	110
00002407264.....	42	00002409097.....	37	00002413485.....	112	00002417375.....	110
00002407272.....	42	00002409720.....	27	00002413493.....	112	00002417383.....	111
00002407280.....	42	00002410249.....	169	00002413507.....	112	00002417391.....	111
00002407418.....	98	00002410257.....	169	00002413515.....	112	00002417448.....	158
00002407434.....	98	00002410303.....	170	00002413523.....	112	00002417723.....	193
00002407442.....	50	00002410338SEC 3.239		00002413620.....	30	00002417731.....	193
00002407450.....	50	00002410389.....	156	00002413639.....	30	00002417839.....	153
00002407469.....	50	00002410702SEC 3.202		00002413647.....	30	00002417847.....	153
00002407477.....	50	00002410745.....	120	00002413795.....	195	00002417936.....	42
00002407485.....	70	00002410753.....	120	00002413825.....	22	00002417944.....	42
00002407493.....	70	00002410761.....	120	00002414090.....	108	00002417952.....	42
00002407515.....	89	00002410818.....	147	00002414104.....	108	00002417960.....	42
00002407590SEC 3.239		00002411350.....	42	00002414228.....	71	00002418193.....	67
00002407639SEC 3.265		00002411369.....	42	00002414236.....	71	00002418207.....	67
00002407671.....	110	00002411377.....	42	00002414244.....	72	00002418215.....	67
00002407698.....	110	00002411385.....	42	00002414678.....	171	00002418223.....	68
00002407701.....	110	00002411407.....	201	00002414686.....	171	00002418231.....	68
00002407728.....	111	00002411628.....	44	00002414694.....	171	00002418258.....	68
00002407736.....	111	00002411636.....	44	00002415100SEC 3.265		00002418282SEC 3.126	
00002407744.....	15	00002411644.....	45	00002415186SEC 3.265		00002418320 SEC 3.21	
00002407752.....	15	00002411652.....	45	00002415208.....	158	00002418355SEC 3.229	
00002407825SEC 3.125		00002411695.....	105	00002415305.....	145	00002418401SEC 3.257	
00002407957.SEC 3.58		00002411709.....	105	00002415429.....	65	00002418495.....	53
00002407965.SEC 3.59		00002411857.....	157	00002415437.....	65	00002418509.....	53
00002407973.SEC 3.60		00002411954.....	100	00002415445.....	65	00002418517.....	53
00002408112.....	72	00002411962.....	100	00002415453.....	65	00002418525.....	54
00002408120.....	72	00002412063.....	144	00002415542.....	10	00002418932 SEC 3.42	
00002408139.....	72	00002412195.....	194	00002415550.....	36	00002418940 SEC 3.42	
00002408147.....	72	00002412209.....	194	00002415739.....	144	00002419114.....	71
00002408155.....	72	00002412268.....	133	00002415992.....	147	00002419122.....	71
00002408163.....	201	00002412373.SEC 3.42		00002416298.....	202	00002419475SEC 3.143	
00002408244.....	70	00002412381.SEC 3.42		00002416328SEC 3.239		00002419521.....	124
00002408252.....	70	00002412497.SEC 3.42		00002416387.....	36	00002419521SEC 3.265	
00002408287.....	202	00002412500.SEC 3.42		00002416409SEC 3.105		00002419548SEC 3.105	
00002408570.....	157	00002412691.....	202	00002416549.....	157	00002419556.....	56
00002408627.....	137	00002412829.....	173	00002416565.....	158	00002419564.....	56
00002408635.....	137	00002412853.SEC 3.66		00002416778SEC 3.105		00002419572.....	56
00002408635SEC 3.171		00002412861.SEC 3.66		00002416786SEC 3.227		00002419858.....	28
00002408643.....	137	00002413051.....	44	00002416794SEC 3.227		00002419882.....	31
00002408643SEC 3.171		00002413078.....	44	00002416808SEC 3.227		00002419882SEC 3.259	
00002408767.....	63	00002413086.....	45	00002416948.SEC 3.66		00002419890.....	31
00002408775.....	63	00002413108.....	45	00002416956.SEC 3.66		00002419890SEC 3.259	
00002408783.....	63	00002413140.....	194	00002417243.....	107	00002420058 SEC 3.42	
00002408872SEC 3.112		00002413159.....	194	00002417251.....	107	00002420066 SEC 3.42	
00002408910.....	36	00002413167.....	144	00002417278.....	107	00002420147.....	195
00002408988.....	10	00002413175SEC 3.124		00002417286.....	108	00002420155 SEC 3.42	
00002408996.....	11	00002413183SEC 3.124		00002417294.....	108	00002420163 SEC 3.42	
00002409003.....	96	00002413248.....	154	00002417340.....	66	00002420198.....	157

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002420260	SEC 3.170	00002423588	SEC 3A.3	00002426897	SEC 3.78	00002430118	98
00002420287	5	00002423596	28	00002426900	151	00002430126	98
00002420333	21	00002423642	70	00002426919	151	00002430487	SEC 3.170
00002420414	153	00002423650	70	00002426935	144	00002430517	96
00002420422	153	00002423669	70	00002427117	51	00002430541	96
00002420457	64	00002423804	92	00002427648	70	00002430568	97
00002420465	64	00002423812	92	00002427656	70	00002430576	21
00002420473	64	00002423898	SEC 3.256	00002427664	70	00002430789	34
00002420481	64	00002424061	127	00002427826	SEC 3.105	00002431300	SEC 3.105
00002420597	SEC 3.66	00002424096	127	00002428180	158	00002431629	96
00002420600	SEC 3.66	00002424118	127	00002428202	90	00002431637	195
00002420732	66	00002424185	92	00002428210	90	00002431645	195
00002420740	67	00002424207	92	00002428229	91	00002431785	100
00002420864	SEC 3.31	00002424258	175	00002428237	124	00002431793	100
00002420872	SEC 3.31	00002424266	175	00002428237	SEC 3.265	00002431807	93
00002421038	66	00002424274	175	00002428474	124	00002431815	93
00002421046	66	00002424339	193	00002428474	SEC 3.265	00002431823	93
00002421054	67	00002424347	193	00002428482	SEC 3.66	00002432048	43
00002421186	SEC 3.239	00002424444	202	00002428490	SEC 3.66	00002432056	43
00002421305	64	00002424533	SEC 3.42	00002428539	70	00002432064	44
00002421313	64	00002424541	SEC 3.42	00002428547	70	00002432226	SEC 3.230
00002421321	64	00002424584	30	00002428873	202	00002432242	SEC 3A.7
00002421380	100	00002424770	SEC 3.254	00002428911	193	00002432463	40
00002421399	100	00002424835	171	00002428938	193	00002432560	SEC 3.170
00002421402	153	00002424843	171	00002428946	25	00002432773	7
00002421410	153	00002424851	87	00002429012	202	00002433001	156
00002421534	124	00002424878	87	00002429039	98	00002433028	156
00002421534	SEC 3.265	00002424924	171	00002429047	98	00002433443	19
00002421623	124	00002424967	69	00002429063	144	00002433532	170
00002421623	SEC 3.265	00002424975	69	00002429160	197	00002433869	92
00002422050	107	00002424983	69	00002429217	56	00002433877	92
00002422255	36	00002424991	22	00002429225	56	00002433885	92
00002422425	SEC 3.265	00002425157	SEC 3.113	00002429233	123	00002433907	92
00002422433	SEC 3.265	00002425165	SEC 3.113	00002429233	SEC 3.212	00002434091	7
00002422662	SEC 3.105	00002425173	SEC 3.114	00002429241	123	00002434105	7
00002422689	16	00002425483	SEC 3.40	00002429241	SEC 3.212	00002434652	98
00002422689	SEC 3.166	00002425491	SEC 3.40	00002429446	95	00002434660	98
00002422980	67	00002425610	SEC 3.105	00002429454	95	00002435128	SEC 3.225
00002422999	67	00002425696	SEC 3.124	00002429462	35	00002435136	SEC 3.225
00002423006	67	00002425890	SEC 3.201	00002429470	35	00002435179	22
00002423235	SEC 3.105	00002425904	SEC 3.201	00002429489	35	00002435381	27
00002423243	SEC 3.105	00002426382	SEC 3.42	00002429659	SEC 3.105	00002435411	145
00002423286	175	00002426390	SEC 3.42	00002429667	51	00002435462	SEC 3.51
00002423294	176	00002426552	16	00002429675	SEC 3.42	00002435470	SEC 3.51
00002423375	193	00002426552	SEC 3.166	00002429683	SEC 3.42	00002435675	31
00002423383	193	00002426846	SEC 3.66	00002429691	96	00002435675	SEC 3.259
00002423480	98	00002426854	SEC 3.66	00002429705	96	00002435845	66
00002423502	98	00002426862	SEC 3.78	00002429713	97	00002435977	92
00002423553	SEC 3A.2	00002426870	SEC 3.78	00002429780	98	00002435985	92
00002423561	SEC 3A.3	00002426889	SEC 3.78	00002429799	98	00002435993	92

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002436000.....	92	00002439565 .SEC 3.66		00002442957	60	00002445794	66
00002436256.....	145	00002439611	174	00002442965	60	00002445964	69
00002436299 .SEC 3.42		00002439654	104	00002442973	60	00002445972	69
00002436302 .SEC 3.42		00002439662	104	00002442981	61	00002445980	69
00002436507	8	00002439913	177	00002443015 SEC 3.113		00002445999	58
00002436507 SEC 3.169		00002439948	95	00002443023 SEC 3.113		00002446006	58
00002436523 .SEC 3.61		00002439956	95	00002443031 SEC 3.114		00002446014	58
00002436558 .SEC 3.61		00002440180 .SEC 3.46		00002443058	202	00002446022	58
00002436604	123	00002440202	91	00002443066 SEC 3.175		00002446057 SEC 3.105	
00002436604 SEC 3.212		00002440210	91	00002443074 SEC 3.175		00002446081	95
00002436612	123	00002440229	91	00002443090	145	00002446103	95
00002436612 SEC 3.212		00002440296	98	00002443112	49	00002446111	123
00002436647	95	00002440318	98	00002443120	49	00002446111 SEC 3.212	
00002436655	95	00002440423	95	00002443139	49	00002446138	123
00002436663 SEC 3.228		00002440431	95	00002443171	193	00002446138 SEC 3.212	
00002436841 SEC 3.262		00002440628	157	00002443198	193	00002446375	193
00002436906	15	00002441020	141	00002443201 .SEC 3.22		00002446383	193
00002436914	15	00002441144	123	00002443236	116	00002446561	140
00002436965	108	00002441144 SEC 3.212		00002443368	5	00002446588	140
00002436973	108	00002441306	170	00002443414	49	00002446928 SEC 3.214	
00002437082	95	00002441454	22	00002443422	49	00002446936 SEC 3.214	
00002437090	95	00002441489 SEC 3.108		00002443708	155	00002446944 SEC 3.214	
00002437120	6	00002441586	22	00002443716	155	00002447053 SEC 3A.7	
00002437686	145	00002441853	157	00002443864	49	00002447061 SEC 3A.7	
00002437945	158	00002441888 SEC 3.240		00002443872	49	00002447193	109
00002437988	193	00002442000	22	00002443929 SEC 3A.7		00002447207	109
00002437996	193	00002442051	88	00002443937 .SEC 3.74		00002447223	110
00002438003	109	00002442124	54	00002443945 .SEC 3.74		00002447258	110
00002438011	109	00002442132	54	00002444186 SEC 3.113		00002447541	202
00002438046	110	00002442191	49	00002444275	87	00002447576 SEC 3.22	
00002438054	110	00002442205	49	00002444399 SEC 3.193		00002447878	68
00002438070 SEC 3.225		00002442302 SEC 3.163		00002444402 SEC 3.195		00002447886	68
00002438259	95	00002442353	137	00002444615 .SEC 3.37		00002447894	68
00002438267	95	00002442361	137	00002444623 .SEC 3.37		00002448319	116
00002438275	173	00002442361 SEC 3.171		00002444631 .SEC 3.37		00002448327	116
00002438283	173	00002442434	10	00002444658 .SEC 3.37		00002448335	193
00002438658	175	00002442469	10	00002444674	152	00002448343	193
00002438690	168	00002442531	91	00002444682	152	00002448432	99
00002438984	95	00002442558	91	00002444739 SEC 3.265		00002448726	108
00002438992	95	00002442566	91	00002444747 .SEC 3.50		00002448734	108
00002439158	109	00002442574	44	00002444755 .SEC 3.50		00002448777	21
00002439166	109	00002442582	44	00002444844	174	00002449048	171
00002439174	109	00002442590	45	00002444852	174	00002449056	171
00002439182	110	00002442604	45	00002445077	202	00002449064	171
00002439190	110	00002442639 .SEC 3.42		00002445190	23	00002449145	197
00002439212 SEC 3.201		00002442647 .SEC 3.42		00002445204	23	00002449153	197
00002439328	176	00002442906	123	00002445670 .SEC 3.42		00002449439	65
00002439530 ... SEC 3.9		00002442906 SEC 3.212		00002445689 .SEC 3.42		00002449447	65
00002439549	157	00002442914	123	00002445719	96	00002449455	65
00002439557 .SEC 3.66		00002442914 SEC 3.212		00002445727 SEC 3.237		00002449463	65

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ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002449471	65	00002453916	87	00002457717	SEC 3.176	00002460068	106
00002449544	113	00002453940	20	00002457725	SEC 3.176	00002460076	106
00002449552	113	00002454017	42	00002457733	SEC 3.176	00002460084	106
00002449560	113	00002454025	42	00002457814	SEC 3A.7	00002460173	20
00002449579	113	00002454033	42	00002457857	SEC 3.200	00002460203	203
00002449781	SEC 3.168	00002454041	42	00002457865	47	00002460289	193
00002449811	140	00002454319	113	00002457873	47	00002460521	SEC 3.220
00002449935	SEC 3.52	00002454475	197	00002457881	48	00002460548	SEC 3.220
00002449943	SEC 3.52	00002454548	SEC 3.108	00002457954	126	00002460661	SEC 3.115
00002450488	59	00002454645	22	00002457962	126	00002460912	88
00002450496	59	00002454653	91	00002457970	126	00002460947	19
00002451131	SEC 3.73	00002454661	91	00002457997	144	00002460947	SEC 3.41
00002451883	87	00002454688	91	00002458241	193	00002460955	19
00002451913	95	00002454769	25	00002458268	193	00002460955	SEC 3.41
00002451921	95	00002454777	25	00002458616	SEC 3.176	00002461307	49
00002451980	20	00002454807	141	00002458624	SEC 3.176	00002461315	49
00002452219	SEC 3.55	00002454866	25	00002458632	SEC 3.176	00002461323	175
00002452227	SEC 3.56	00002454874	25	00002458640	SEC 3.72	00002461331	176
00002452235	SEC 3.57	00002455102	SEC 3.160	00002458659	SEC 3.72	00002461528	174
00002452308	10	00002455110	SEC 3.160	00002458667	SEC 3.72	00002461536	78
00002452324	10	00002455323	SEC 3.88	00002458721	104	00002461544	SEC 3.58
00002452359	152	00002455331	SEC 3.90	00002458802	153	00002461552	SEC 3.59
00002452367	57	00002455609	40	00002458810	153	00002461560	SEC 3.60
00002452375	57	00002455676	23	00002458926	89	00002461641	49
00002452383	57	00002455897	SEC 3.40	00002458934	89	00002461668	49
00002452634	20	00002455943	SEC 3.187	00002458977	43	00002461749	106
00002452839	95	00002455986	SEC 3.187	00002458985	43	00002461757	106
00002452847	95	00002455994	SEC 3.188	00002458993	44	00002461765	106
00002452855	96	00002456001	SEC 3.188	00002459019	89	00002461773	106
00002452936	SEC 3.38	00002456117	203	00002459361	99	00002461781	106
00002452944	SEC 3.38	00002456370	SEC 3.231	00002459388	61	00002461803	106
00002452952	SEC 3.38	00002456389	71	00002459396	61	00002461811	78
00002452960	SEC 3.38	00002456397	71	00002459523	170	00002461986	91
00002452979	SEC 3.38	00002456575	SEC 3.75	00002459698	SEC 3.176	00002461994	91
00002453304	SEC 3.117	00002456583	SEC 3.75	00002459701	SEC 3.176	00002462001	91
00002453312	41	00002456591	SEC 3.75	00002459728	SEC 3.176	00002462192	47
00002453452	49	00002456605	SEC 3.75	00002459736	SEC 3.176	00002462206	47
00002453460	49	00002456613	SEC 3.75	00002459779	SEC 3.105	00002462559	18
00002453568	70	00002456621	SEC 3.75	00002459817	62	00002462788	123
00002453576	70	00002457059	30	00002459825	62	00002462788	SEC 3.212
00002453606	49	00002457067	30	00002459833	62	00002462796	123
00002453614	49	00002457075	30	00002459914	96	00002462796	SEC 3.212
00002453622	49	00002457164	39	00002459922	97	00002462850	SEC 3.92
00002453630	95	00002457172	39	00002459957	39	00002462869	SEC 3.95
00002453649	95	00002457229	110	00002459965	39	00002462877	SEC 3.84
00002453754	SEC 3.24	00002457237	110	00002459973	SEC 3.156	00002463105	142
00002453762	SEC 3.24	00002457245	110	00002459981	SEC 3.156	00002463121	SEC 3.178
00002453819	SEC 3.24	00002457253	111	00002460025	105	00002463148	SEC 3.178
00002453835	SEC 3.24	00002457261	111	00002460033	105	00002463520	SEC 3.58
00002453908	87	00002457393	192	00002460041	106	00002463539	SEC 3.59

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

ALBERTA DRUG BENEFIT LIST
INDEX 2 - NUMERICAL LIST BY DRUG IDENTIFICATION NUMBER

DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS

DIN	Page	DIN	Page	DIN	Page	DIN	Page
00002463547	SEC 3.60	00002466759	48	00002470683	62	00002476916	66
00002463571	175	00002466767	48	00002470691	62	00002476924	66
00002463717	155	00002466775	48	00002470780	156	00002478196	SEC 3.161
00002463725	155	00002466821	122	00002471051	36	00002478218	SEC 3.161
00002464020	63	00002466821	SEC 3.24	00002471086	105	00002478226	SEC 3.161
00002464039	63	00002467224	SEC 3.181	00002471094	105	00002478234	SEC 3.161
00002464144	105	00002467232	21	00002471108	106	00002478889	85
00002464152	105	00002467542	SEC 3.232	00002471116	106	00002478897	85
00002464179	106	00002467550	SEC 3.197	00002471124	106	00002479087	20
00002464187	106	00002467879	173	00002471132	106	00002479486	99
00002464454	SEC 3.58	00002467887	173	00002471442	SEC 3.76	00002479494	99
00002464462	SEC 3.59	00002468700	43	00002471450	SEC 3.76	00002480107	178
00002464470	SEC 3.60	00002468719	43	00002471868	65	00002481227	19
00002464489	SEC 3.199	00002468727	44	00002471876	65	00080004109	133
00002464500	SEC 3.199	00002468778	47	00002471884	65	00080004415	133
00002464519	SEC 3.46	00002468786	47	00002471892	65	00080009539	133
00002464578	153	00002468794	48	00002472392	151	00080013005	133
00002464705	SEC 3.48	00002468840	192	00002472406	151	00080013007	133
00002464713	SEC 3.48	00002468859	192	00002472511	20	00080024835	133
00002464985	62	00002469022	56	00002472902	SEC 3.161	00080033602	133
00002464993	62	00002469030	56	00002472910	SEC 3.161	00080047562	134
00002465000	62	00002469049	56	00002472929	SEC 3.161	00080057191	187
00002465086	123	00002469057	64	00002472937	SEC 3.161	00080062704	133
00002465086	SEC 3.212	00002469065	64	00002473658	105	00080062704	139
00002465094	123	00002469073	64	00002473666	105		
00002465094	SEC 3.212	00002469081	64	00002473674	106		
00002465124	79	00002469243	98	00002473682	106		
00002465353	58	00002469251	98	00002473690	106		
00002465361	58	00002469286	SEC 3.105	00002473704	106		
00002465388	58	00002469308	202	00002473801	23		
00002465396	58	00002469391	133	00002473984	28		
00002465418	59	00002469626	101	00002473992	28		
00002465493	SEC 3.52	00002469634	101	00002474018	159		
00002465574	SEC 3.46	00002469642	101	00002474670	SEC 3.161		
00002465663	SEC 3.177	00002469677	160	00002474689	SEC 3.161		
00002465949	166	00002469685	160	00002474697	SEC 3.161		
00002465957	166	00002469979	46	00002474700	SEC 3.161		
00002466074	192	00002469987	46	00002475332	SEC 3.161		
00002466082	192	00002469995	46	00002475340	SEC 3.161		
00002466120	10	00002470004	46	00002475359	SEC 3.161		
00002466147	157	00002470012	47	00002475367	SEC 3.161		
00002466449	197	00002470225	62	00002475863	140		
00002466465	52	00002470233	62	00002476614	83		
00002466473	52	00002470241	62	00002476622	83		
00002466635	105	00002470373	SEC 3.128	00002476630	83		
00002466643	105	00002470438	63	00002476649	83		
00002466651	106	00002470446	63	00002476657	83		
00002466678	106	00002470578	6	00002476665	83		
00002466686	106	00002470586	6	00002476673	83		
00002466694	106	00002470675	62	00002476681	83		

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