

Alberta Human Services Drug Benefit Supplement

Effective April 1, 2022

Alberta  Human Services

Inquiries should be directed to:

Pharmacy Services

Alberta Blue Cross
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Website: <https://www.alberta.ca/alberta-supports.aspx>

Administered by Alberta Blue Cross
on behalf of *Alberta Human Services*.

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

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PART 1
SECTION 1
Policies
and
Guidelines

INTRODUCTION

Eligibility

The *Alberta Human Services Drug Benefit Supplement (HSDBS)* defines the drugs and drug products that are covered for Alberta Human Services clients in addition to the drugs and drug products defined in the *Alberta Drug Benefit List* (with certain exclusions).

The *Supplement* was developed to take into consideration the essential needs of clients covered under Alberta Human Services programs.

Additional Notes Regarding Application of the *Supplement*

1. The *Supplement* 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 *Supplement*.
3. Drugs are classified according to the Pharmacologic–Therapeutic classifications (PTC) developed by the American Society of Hospital Pharmacists for the purpose of the American Hospital Formulary Service.

Permission to use this system has been granted by the American Society of Hospital 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 Blue Cross to facilitate product location in the *Supplement*.

4. Where appropriate, the *Compendium of Pharmaceuticals and Specialties*, published by the Canadian Pharmaceutical 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 Identification Number (DIN) notification form
 - Notice of Compliance (NOC)
 - Product Monograph
6. DINs listed reflect current manufacturer information available as of April 1, 2022.

Interchangeable Drug Products



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

RESTRICTED BENEFITS

Restricted Benefits

Selected drug products in the PTCs listed below are eligible benefits with restrictions in the *Supplement*. For these products a comment is displayed in the *HSDBS* after the ingredient name or specific strength for each restricted drug product. The comment initially states "RESTRICTED BENEFIT" and is followed by an explanation of the restriction. For eligible drug products, please refer to the applicable PTCs in the *HSDBS*.

00:00:02	Diabetes Supplies
02:00	Pediatric Cough and Cold Preparations
04:02	Pediatric Antihistamines
12:92	Miscellaneous Autonomic Drugs
20:04.04	Antianemia Drugs (Iron Preparations)
28:08.04.92	Analgesics and Antipyretics Nonsteroidal Anti-Inflammatory Agents (Other Nonsteroidal Anti-Inflammatory Agents)
28:16.08.04	Psychotherapeutic Agents Antipsychotics (Atypical Antipsychotics)
56:12	Cathartics & Laxatives
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88:16	Vitamin D
88:28	Multivitamin Preparations
88:28:01	Multivitamin Preparations (Vitamins & Minerals)

Example:

LORATADINE

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

1 MG / ML ORAL SYRUP

00002241523 CLARITIN

BIC

\$ 0.0542

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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 and/or Alberta Human Services 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* or the *Alberta Human Services Drug Benefit Supplement* are contraindicated or inappropriate because of the clinical condition of the patient.
4. The particular brand of drug is considered essential in the care of a patient, where the LCA price policy would otherwise apply. Coverage of a specific brand may be considered where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with alternate brands in an interchangeable grouping. Coverage of a brand name product will **not** be considered in situations where the interchangeable grouping includes a pseudo-generic to the brand name drug.
5. A particular drug product or dosage form of a drug is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the product level. Coverage may be considered only where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with the drug product which establishes the MAC pricing.

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

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

Auto-Renewal Process

Selected drug products are eligible for the following auto-renewal process (for eligibility, see the Special Authorization criteria for each drug product).

1. For initial approval, a special authorization request must be submitted. If approval is granted, it will be effective for the Approval Period outlined in the drug product's Special Authorization criteria.
2. As long as the patient has submitted a claim for the drug product within the preceding Approval Period (example: within the preceding 6 months), approval will be automatically renewed for a further Approval Period (example: a further 6 months). There is no need for the prescriber to

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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* or the *Supplement*.
2. Drug products **not yet reviewed** by Alberta Health and/or Alberta Human Services. 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* or the *Supplement*.
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.

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. Special authorization request forms can be found in *Alberta Drug Benefit List*.

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

SECTION 2

Price Policy

PRICE POLICY

Price Policy

The [Price Policy](#) is stated in the *Alberta Drug Benefit List*.

Additional Units of Issue for Pricing

Units of issue for pricing in the *Supplement* are defined in the Policies and Guidelines Section 1 of the *List*. The following are additional units of issue that apply to the *Supplement*.

Dosage Form	Unit of Issue Priced in HSDBS
Buccal Spray	Dose
Oral Gum	Piece
Oral Pudding.....	Gram
Rectal Pediatric Enema	Enema
Rectal Pediatric Suppository.....	Suppository
Topical Cream/Vaginal Cream	Kit
Topical Rinse.....	Millilitre
Topical Shampoo.....	Millilitre
Vaginal Tablet/Topical Cream.....	Kit

Excluded Drug Products

Drugs Used in the Treatment of Infertility

All drug products used for the **treatment of infertility** are **excluded** as benefits for Alberta Human Services clients and are **not** eligible for special authorization for this indication.

Other Exclusions from the *ADBL*

The following molecules (all brands, forms, routes, and strengths) in the current *Alberta Drug Benefit List* are **excluded** as benefits for Alberta Human Services clients **unless coverage has been granted through Special Authorization**. (Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the *Supplement* for more information.)

Generic Description	Strength / Form
almotriptan malate	6.25 mg & 12.5 mg tablet
naratriptan hcl	1 mg & 2.5 mg tablet
rizatriptan benzoate	5 mg & 10 mg disintegrating tablet
rizatriptan benzoate	5 mg & 10 mg tablet
sumatriptan hemisulfate	5 mg/dose & 20 mg/dose nasal unit dose spray
sumatriptan succinate	50 mg & 100 mg tablet
sumatriptan succinate	6 mg/syringe injection
zolmitriptan	2.5 mg dispersible tablet
zolmitriptan	2.5 mg tablet
zolmitriptan	5 mg/dose nasal unit dose spray

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CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

The drug products listed in this section may be considered for coverage by special authorization for patients covered under Alberta Health-sponsored drug programs. (For Alberta Human Services clients, the special authorization criteria for coverage can be found in the Criteria for Special Authorization of Select Drug Products section of the *Alberta Human Services Drug Benefit Supplement*.)

Special Authorization Policy

DRUG PRODUCTS ELIGIBLE FOR CONSIDERATION BY SPECIAL AUTHORIZATION

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

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

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

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

AUTO-RENEWAL PROCESS

Selected drug products are eligible for the following auto-renewal process (for eligibility, see the Special Authorization criteria for each drug product).

1. For initial approval, a special authorization request must be submitted. If approval is granted, it will be effective for the Approval Period outlined in the drug product's Special Authorization criteria
2. As long as the patient has submitted a claim for the drug product within the preceding Approval Period (example: within the preceding 6 months), approval will be automatically renewed for a further Approval Period (example: a further 6 months). There is no need for the prescriber to submit a new request as the automated real-time claims adjudication system will read the patient's claims history to determine if a claim has been made within the preceding Approval Period.
3. If the patient does not make a claim for the drug product during the Approval Period, the approval will lapse and a new special authorization request must be submitted.

STEP THERAPY APPROVAL PROCESS

Select drug products are eligible for coverage via the step therapy process, outlined below.

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

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

DRUG PRODUCTS NOT ELIGIBLE FOR CONSIDERATION BY SPECIAL AUTHORIZATION

The following categories of drug products are **not** eligible for special authorization:

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

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

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

Drug products not yet reviewed may encompass new pharmaceutical products, new strengths of products already listed, reformulated products and new interchangeable (generic) products.

3. Drug products that have **completed the review** process and are **not included** on the *List*.
4. Most drugs available through Health Canada's Special Access Program.
5. Drug products when prescribed for cosmetic indications.
6. Nonprescription or over-the-counter drug products are generally not eligible.

Criteria for Coverage

Wording that appears within quotation marks (“ ”) in this section is the official special authorization criteria, as recommended by the Alberta Health Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health. Wording that is not enclosed in quotation marks outlines specific information required to interpret criteria, guidelines for submitting requests and/or information regarding conditions under which coverage cannot be provided.

Products Available through Health Canada's Special Access Program

PEMOLINE

“For the treatment of attention deficit hyperactivity disorder where approval has been provided by Health Canada's Special Access Program.”

37.5 MG	ORAL TABLET
DIN N/A*	CYLERT
75 MG	ORAL TABLET
DIN N/A*	CYLERT

**As Cylert has been withdrawn from market, the DINs are no longer valid. Where authorizations for Cylert have been granted, coverage for this product will be provided under PIN 00000999917.*

Other Products

The remaining drug products in this section are listed alphabetically according to the generic ingredient name of the drug. These products can be found on the following pages.

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ALMOTRIPTAN MALATE

"For the treatment of acute migraine attacks in patients where other standard therapy has failed. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy.

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

6.25 MG (BASE)	ORAL TABLET			
00002398435	MYLAN-ALMOTRIPTAN	MYP	\$	7.0433
12.5 MG (BASE)	ORAL TABLET			
00002466821	ALMOTRIPTAN	SNS	\$	2.3478
00002398443	MYLAN-ALMOTRIPTAN	MYP	\$	2.3478
00002405334	SANDOZ ALMOTRIPTAN	SDZ	\$	2.3478
00002434849	TEVA-ALMOTRIPTAN	TEV	\$	2.3478

INFANT FORMULA

"For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the infant formulas which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement). Information is required regarding the patient's diagnosis, previous infant formulas utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other infant formulas."

ORAL POWDER

<input checked="" type="checkbox"/>	00000999543	PURAMINO A+	MJO	\$	0.1275
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"For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the infant formulas which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement). Information is required regarding the patient's diagnosis, previous infant formulas utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other infant formulas."

<input checked="" type="checkbox"/>	00000999568	NEOCATE WITH DHA & ARA	NUN	\$	0.1598
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"For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the infant formulas which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement). Information is required regarding the patient's diagnosis, previous infant formulas utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other infant formulas."

NARATRIPTAN HCL

"For the treatment of acute migraine attacks in patients where other standard therapy has failed. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy.

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

1 MG (BASE)	ORAL TABLET			
00002314290	TEVA-NARATRIPTAN	TEV	\$	12.4993
00002237820	AMERGE	GSK	\$	15.5050
2.5 MG (BASE)	ORAL TABLET			
00002322323	SANDOZ NARATRIPTAN	SDZ	\$	6.1436
00002314304	TEVA-NARATRIPTAN	TEV	\$	6.1436
00002237821	AMERGE	GSK	\$	16.3428

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

NUTRITIONAL PRODUCT

For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the nutritional products which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement).

Information is required regarding the patient's diagnosis, previous nutritional products utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other nutritional products.

ORAL LIQUID

<input checked="" type="checkbox"/>	00000999402	BOOST FRUIT FLAVOURED BEVERAGE	NHN	\$	0.0076
<input checked="" type="checkbox"/>	00000999890	ISOSOURCE 1.0 HP	NHN	\$	0.0088
<input checked="" type="checkbox"/>	00000999886	ISOSOURCE FIBRE 1.0 HP	NHN	\$	0.0090
<input checked="" type="checkbox"/>	00000999416	JEVITY 1.2 CAL	ABN	\$	0.0128
<input checked="" type="checkbox"/>	00000999475	JEVITY 1.5 CAL	ABN	\$	0.0147
<input checked="" type="checkbox"/>	00000999430	TWOCAL HN	ABN	\$	0.0150

ORAL PUDDING

<input checked="" type="checkbox"/>	00000999404	ENSURE	ABN	\$	0.0111
<input checked="" type="checkbox"/>	00000999440	BOOST	NHN	\$	0.0135

NUTRITIONAL PRODUCT (ADULT MEAL REPLACEMENT)

For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the nutritional products which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement).

Information is required regarding the patient's diagnosis, previous nutritional products utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other nutritional products.

ORAL LIQUID

<input checked="" type="checkbox"/>	00000999427	BOOST HIGH PROTEIN	NHN	\$	0.0081
<input checked="" type="checkbox"/>	00000999845	ENSURE PROTEIN MAX	ABN	\$	0.0082

NUTRITIONAL PRODUCT (ADULT)

For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the nutritional products which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement).

Information is required regarding the patient's diagnosis, previous nutritional products utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other nutritional products.

ORAL LIQUID

<input checked="" type="checkbox"/>	00000999944	PEPTAMEN	NHN	\$	0.0283
<input checked="" type="checkbox"/>	00000999435	PEPTAMEN WITH PREBIO 1	NHN	\$	0.0283
<input checked="" type="checkbox"/>	00000999927	MCT OIL	NHN	\$	0.0379
<input checked="" type="checkbox"/>	00000999421	PEPTAMEN 1.5	NHN	\$	0.0405
<input checked="" type="checkbox"/>	00000999467	PEPTAMEN AF 1.2	NHN	\$	0.0446

ORAL POWDER

<input checked="" type="checkbox"/>	00000999935	SCANDISHAKE	AXC	\$	0.0395
<input checked="" type="checkbox"/>	00000999929	TOLEREX	NHN	\$	0.0509
<input checked="" type="checkbox"/>	00000999444	DUOCAL	NUN	\$	0.0724
<input checked="" type="checkbox"/>	00000999415	BENEPROTEIN	NHN	\$	0.0753
<input checked="" type="checkbox"/>	00000999983	VIVONEX T.E.N.	NHN	\$	0.0851
<input checked="" type="checkbox"/>	00000999405	VIVONEX PLUS	NHN	\$	0.0860

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

NUTRITIONAL PRODUCT (PEDIATRIC)

For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the nutritional products which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement).

Information is required regarding the patient's diagnosis, previous nutritional products utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other nutritional products.

ORAL LIQUID

<input checked="" type="checkbox"/>	00000999426	COMPLEAT PEDIATRIC	NHN	\$	0.0107
<input checked="" type="checkbox"/>	00000999434	PEDIASURE PLUS WITH FIBRE	ABN	\$	0.0115
<input checked="" type="checkbox"/>	00000999853	COMPLEAT PEDIATRIC 1.5	NHN	\$	0.0159
<input checked="" type="checkbox"/>	00000999565	KETOCAL	NUN	\$	0.0261
<input checked="" type="checkbox"/>	00000999408	PEPTAMEN JUNIOR	NHN	\$	0.0283
<input checked="" type="checkbox"/>	00000999391	NEOCATE SPLASH	NUN	\$	0.0306
<input checked="" type="checkbox"/>	00000999553	PEPTAMEN JUNIOR 1.5	NHN	\$	0.0421

ORAL POWDER

<input checked="" type="checkbox"/>	00000999559	MODULEN IBD	NHN	\$	0.0697
<input checked="" type="checkbox"/>	00000999445	KETOCAL	NUN	\$	0.1158
<input checked="" type="checkbox"/>	00000999876	PURAMINO A+ JUNIOR	MJO	\$	0.1219
<input checked="" type="checkbox"/>	00000999447	NEOCATE JUNIOR	NUN	\$	0.1313
<input checked="" type="checkbox"/>	00000999560	NEOCATE JUNIOR WITH FIBRE	NUN	\$	0.1313
<input checked="" type="checkbox"/>	00000999422	VIVONEX PEDIATRIC	NHN	\$	0.1404

NUTRITIONAL PRODUCTS

For use in patients who are unable to tolerate, have failed, or have nutritional requirements which cannot be met with the nutritional products which are unrestricted benefits (listed in PTC 40:20 of the Alberta Human Services Drug Benefit Supplement).

Information is required regarding the patient's diagnosis, previous nutritional products utilized and the patient's response to therapy, and/or the nutritional requirement which cannot be met with other nutritional products.

ORAL LIQUID

<input checked="" type="checkbox"/>	00000999864	KETOVIE 3:1	CAM	\$	0.0242
<input checked="" type="checkbox"/>	00000999866	KETOVIE 4:1	CAM	\$	0.0242
<input checked="" type="checkbox"/>	00000999840	KETOVIE 4:1 UNFLAVORED	CAM	\$	0.0262
<input checked="" type="checkbox"/>	00000999606	KETOVIE 4:1 PLANT BASED PROTEIN	CAM	\$	0.0322
<input checked="" type="checkbox"/>	00000999865	KETOVIE PEPTIDE 4:1	CAM	\$	0.0322

ORAL POWDER

<input checked="" type="checkbox"/>	00000999841	EQUACARE JUNIOR	CAM	\$	0.0952
<input checked="" type="checkbox"/>	00000999605	ESSENTIAL CARE JUNIOR	CAM	\$	0.1244

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

RIZATRIPTAN BENZOATE

"For the treatment of acute migraine attacks in patients where other standard therapy has failed. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy.

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

5 MG (BASE) ORAL TABLET			
00002393468	APO-RIZATRIPTAN	APX	\$ 7.4100
00002429233	JAMP-RIZATRIPTAN IR	JPC	\$ 7.4100
10 MG (BASE) ORAL TABLET			
00002381702	ACT RIZATRIPTAN	TEV	\$ 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	ORC	\$ 16.6980
5 MG (BASE) ORAL DISINTEGRATING TABLET			
00002483270	ACCEL-RIZATRIPTAN ODT	ACP	\$ 2.8150
00002458764	CCP-RIZATRIPTAN ODT	CEL	\$ 2.9633
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	ORC	\$ 16.6980
10 MG (BASE) ORAL DISINTEGRATING TABLET			
00002483289	ACCEL-RIZATRIPTAN ODT	ACP	\$ 2.8150
00002458772	CCP-RIZATRIPTAN ODT	CEL	\$ 2.9633
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	ORC	\$ 16.6980

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

SUMATRIPTAN HEMISULFATE

"For the treatment of acute migraine attacks in patients where other standard therapy has failed. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy.

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

5 MG / DOSE (BASE)	NASAL UNIT DOSE SPRAY			
00002230418	IMITREX	GSK	\$	16.1979
20 MG / DOSE (BASE)	NASAL UNIT DOSE SPRAY			
00002230420	IMITREX	GSK	\$	16.6655

SUMATRIPTAN SUCCINATE

"For the treatment of acute migraine attacks in patients where other standard therapy has failed. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy.

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

50 MG (BASE)	ORAL TABLET			
00002268388	APO-SUMATRIPTAN	APX	\$	2.7732
00002268914	MYLAN-SUMATRIPTAN	MYP	\$	2.7732
00002256436	PMS-SUMATRIPTAN	PMS	\$	2.7732
00002286521	SUMATRIPTAN	SNS	\$	2.7732
00002385570	SUMATRIPTAN DF	SIV	\$	2.7732
00002286823	TEVA-SUMATRIPTAN DF	TEV	\$	2.7732
00002212153	IMITREX DF	GSK	\$	16.5813
100 MG (BASE)	ORAL TABLET			
00002268396	APO-SUMATRIPTAN	APX	\$	3.0549
00002268922	MYLAN-SUMATRIPTAN	MYP	\$	3.0549
00002256444	PMS-SUMATRIPTAN	PMS	\$	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	\$	18.2665
6 MG / SYR (BASE)	INJECTION SYRINGE			
00002361698	TARO-SUMATRIPTAN (0.5 ML)	TAR	\$	38.7582
00002212188	IMITREX (0.5 ML)	GSK	\$	48.9100

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

ZOLMITRIPTAN

"For the treatment of acute migraine attacks in patients where other standard therapy has failed. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy.

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

2.5 MG ORAL TABLET

00002481030	AURO-ZOLMITRIPTAN	AUR	\$	3.5375
00002458780	CCP-ZOLMITRIPTAN	CEL	\$	3.5375
00002477106	JAMP ZOLMITRIPTAN	JPC	\$	3.5375
00002421623	JAMP-ZOLMITRIPTAN	JPC	\$	3.5375
00002419521	MINT-ZOLMITRIPTAN	MPI	\$	3.5375
00002421534	NAT-ZOLMITRIPTAN	NTP	\$	3.5375
00002362988	SANDOZ ZOLMITRIPTAN	SDZ	\$	3.5375
00002313960	TEVA-ZOLMITRIPTAN	TEV	\$	3.5375
00002238660	ZOMIG	AZC	\$	15.1246

2.5 MG ORAL DISPERSIBLE TABLET

00002428237	JAMP-ZOLMITRIPTAN ODT	JPC	\$	1.7532
00002428474	SEPTA-ZOLMITRIPTAN-ODT	SEP	\$	1.7532
00002243045	ZOMIG RAPIMELT	AZC	\$	15.1246

5 MG / DOSE NASAL UNIT DOSE SPRAY

00002248993	ZOMIG	AZC	\$	15.1246
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SECTION 3

Criteria for 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 Alberta Human Services clients.

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.

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



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 HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
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

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
00002492008	NRA-CIPROFLOXACIN	NRA	\$	0.5025
00002248438	PMS-CIPROFLOXACIN	PMS	\$	0.5025
00002303736	RAN-CIPROFLOX	RAN	\$	0.5025
00002248757	SANDOZ CIPROFLOXACIN	SDZ	\$	0.5025

ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

CIPROFLOXACIN HCL

750 MG (BASE) ORAL TABLET

00002247341	ACT CIPROFLOXACIN	APH	\$	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

ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

LEVOFLOXACIN

250 MG ORAL TABLET

00002315424	ACT LEVOFLOXACIN	TEV	\$	1.2038
00002284707	APO-LEVOFLOXACIN	APX	\$	1.2038
00002298635	SANDOZ LEVOFLOXACIN	SDZ	\$	1.2038

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

For the treatment of

- 1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or
- 2) Community acquired pneumonia in patients with co-morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking); or
- 3) Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or
- 4) Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with beta-lactam (penicillin and cephalosporin) allergy; or
- 5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

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

ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

LEVOFLOXACIN

500 MG ORAL TABLET

00002315432	ACT LEVOFLOXACIN	TEV	\$	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 HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

LEVOFLOXACIN

750 MG ORAL TABLET

00002315440	ACT LEVOFLOXACIN	TEV	\$	4.8478
00002325942	APO-LEVOFLOXACIN	APX	\$	4.8478
00002298651	SANDOZ LEVOFLOXACIN	SDZ	\$	4.8478

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

For the treatment of

- 1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or
- 2) Community acquired pneumonia in patients with co-morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking); or
- 3) Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or
- 4) Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with beta-lactam (penicillin and cephalosporin) allergy; or
- 5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

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

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
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				
00002478137	AG-MOXIFLOXACIN	AGP	\$	1.5230
00002404923	APO-MOXIFLOXACIN	APX	\$	1.5230
00002432242	AURO-MOXIFLOXACIN	AUR	\$	1.5230
00002443929	JAMP-MOXIFLOXACIN	JPC	\$	1.5230
00002447061	JAMP-MOXIFLOXACIN	JPC	\$	1.5230
00002472791	M-MOXIFLOXACIN	MTR	\$	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

SECTION 4

Rare Diseases Drug Coverage Program

RARE DISEASES DRUG COVERAGE PROGRAM

Selected drug products used in the treatment of rare diseases may be considered for coverage for individuals covered under Alberta government-sponsored drug programs. The Minister of Health makes the final decisions regarding coverage under this Program, and may list a drug product under this section when the Minister considers it in the public interest to do so.¹

RARE DISEASES DRUG COVERAGE

In order to be eligible for the Rare Diseases Drug Coverage Program, an individual must:

- have Alberta government-sponsored drug coverage;
 - be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five years unless:
 - the individual is less than five years of age at the date of the application, then the individual's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years;
- OR
- the individual has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for a drug product listed in this section in the province of origin by a provincial or territorial government sponsored drug plan, and the individual has been registered in the Alberta Health Care Insurance Plan (the individual must provide supporting documentation from the province of origin to prove prior coverage).
- meet the clinical criteria for a rare disease drug product published on the *List*;
 - have a *Rare Diseases Drug Coverage Application* form ("Application") submitted on their behalf to Alberta Blue Cross by the individual's "Rare Disease Specialist";
 - have the Application reviewed and approved for coverage by the Alberta Rare Diseases Clinical Review Panel ("Review Panel")
 - complete the required forms, and consent to and acknowledge that
 - approval for initial and continued coverage is conditional upon clinical outcomes;
 - regular monitoring of the individual's clinical outcomes will be required, and
 - that coverage will be discontinued if there is inadequate response or the individual's condition deteriorates as outlined in the withdrawal criteria established in relation to a specific rare diseases drug product and/or as assessed by the Review Panel.

Contraindications

In addition to meeting the above criteria, the individual must not have the following contraindications:

- Significant illness, not including one of the rare diseases, likely to substantially alter or reduce life expectancy.

¹ Section 1 of the ADBL does not apply to the Rare Diseases Drug Coverage Program

Rare Diseases Drugs Eligible for Coverage

Drug products approved by Health Canada for the treatment of Rare Diseases may be considered for coverage in accordance with this section.

Rare Diseases are genetic, lysosomal storage disorders occurring at a rate of less than one per 50,000 for the Canadian population for a specific disease (as determined by Alberta Health).

As of April 1, 2009, drug products for the treatment of the following rare diseases are currently under consideration for coverage:

- Gaucher's disease
- Fabry disease
- MPS-I (Hurler/Hurler Scheie)
- Hunter disease
- Pompe disease

Alberta Rare Diseases Clinical Review Panel

The Alberta Rare Diseases Clinical Review Panel ("Review Panel") is a review panel composed of specialists treating rare diseases and other health professionals with clinical expertise, appointed by the Minister of Health.

The Review Panel's functions include:

- Providing advice to Alberta Health regarding the Rare Diseases Drug Coverage Program;
- Reviewing and applying clinical knowledge and skills to individual applications for Rare Diseases Drug Coverage; and
- Providing advice to the Expert Committee on Drug Evaluation and Therapeutics regarding drug products under consideration for coverage under this section, clinical criteria for rare diseases drug products and identifying appropriate "Rare Disease Specialists".

Process for Rare Diseases Drug Coverage

Participating "Rare Disease Specialists" must complete a Rare Diseases Drug Coverage Application form for each individual. The form must be the one specific to the rare diseases drug product being requested. The completed application may be forwarded to Alberta Blue Cross by mail or by facsimile.

To be considered for Rare Diseases Drug Coverage, the "Rare Disease Specialist" must confirm the individual (or individual's parent/guardian/legal representative) has been provided with information regarding the Rare Diseases Drug Coverage Program and have completed the required forms.

Alberta Blue Cross, in providing administrative support to the Review Panel, receives and screens each application for completeness, then forwards to Alberta Health to confirm that the individual has met the Alberta Health Care Insurance Plan registration requirement (please see above).

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

**ALBERTA HUMAN SERVICES DRUG BENEFIT SUPPLEMENT
RARE DISEASES DRUG COVERAGE PROGRAM**

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.

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

PART 2

Pharmacologic – Therapeutic Classification of Drugs

00:00 NON-CLASSIFIED DRUGS

00:00.02

(DIABETES SUPPLIES)**DIABETES SUPPLIES**

<input checked="" type="checkbox"/>	00000990024	BLOOD GLUCOSE METER	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000990072	BLOOD KETONE TEST STRIPS	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000999941	BLOOD LETTING LANCET	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000990058	GLUCOSE CALIBRATION SOLUTION	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000990045	INFUSION SETS (TUBING & NEEDLE)	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000990057	INSULIN CARTRIDGES / RESERVOIRS	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"/>	00000999942	LANCING DEVICE	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000999957	URINE KETONE TEST STRIPS	XXX	\$	0.0000
<input checked="" type="checkbox"/>	00000444992	CARESENS N MULTI TEST STRIPS	SEN	\$	0.5000

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

<input checked="" type="checkbox"/>	00000444996	FIRST CANADIAN HEALTH SPIRIT TEST STRIPS	ARP	\$	0.5000
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This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

<input checked="" type="checkbox"/>	00000444982	GE200 TEST STRIPS	BNE	\$	0.5100
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This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

<input checked="" type="checkbox"/>	00000444995	MEDISURE TEST STRIPS	MDS	\$	0.6800
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This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

<input checked="" type="checkbox"/>	00000444984	ACCU-CHEK GUIDE TEST STRIPS	RDC	\$	0.6813
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This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

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

00:00 NON-CLASSIFIED DRUGS

00:00.02

(DIABETES SUPPLIES)**DIABETES SUPPLIES**

to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444988 FREESTYLE PRECISION TEST STRIPS ABD \$ 0.6890

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444987 FREESTYLE LITE TEST STRIPS ABD \$ 0.6900

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444994 ONE TOUCH ULTRA TEST STRIPS LIF \$ 0.6943

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444993 ONE TOUCH VERIO TEST STRIPS LIF \$ 0.6943

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444990 CONTOUR NEXT TEST STRIPS ADC \$ 0.6989

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

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

00:00 NON-CLASSIFIED DRUGS

00:00.02

(DIABETES SUPPLIES)**DIABETES SUPPLIES**

00000444989 CONTOUR TEST STRIPS ADC \$ 0.6989

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444998 RAPID RESPONSE GLUCO-MD TEST STRIPS BTN \$ 0.7000

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444986 ACCU-CHEK AVIVA TEST STRIPS RDC \$ 0.7125

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444985 ACCU-CHEK COMPACT TEST STRIPS RDC \$ 0.7125

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

00000444983 ACCU-CHEK MOBILE TEST STRIPS RDC \$ 0.7125

This product is a benefit for patients with diabetes when purchased from a licensed pharmacy.

Eligible individuals will have coverage for eligible blood glucose test strips for each benefit year up to a maximum of:

- 3,000 strips for patients with diabetes who are currently and regularly using insulin, OR
- 400 strips for patients treated with diabetes medications with high risk of hypoglycemia, OR
- 200 strips for patients treated with diabetes medications with low risk of hypoglycemia, OR
- 200 strips for patients treated by diet and/or exercise.

02:00 PEDIATRIC COUGH AND COLD PREPARATIONS

02:00

DEXTROMETHORPHAN HBR/ PSEUDOEPHEDRINE HCL

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 17 years of age inclusive.

1.5 MG / ML * 3 MG / ML ORAL LIQUID

00002044013	ROBITUSSIN CHILDRENS COUGH AND COLD GKC		\$	0.0524
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04:00 ANTIHISTAMINE DRUGS

04:02

PEDIATRIC ANTIHISTAMINES**CYPROHEPTADINE HCL**

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

4 MG ORAL TABLET

00002332248	CYPROHEPTADINE	JPC	\$	0.8334
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DESLORATADINE

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

0.5 MG / ML ORAL SYRUP

00002247193	AERIUS KIDS	BIC	\$	0.0725
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DIPHENHYDRAMINE HCL

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

2.5 MG / ML ORAL ELIXIR

00002298503	DIPHENHYDRAMINE	JPC	\$	0.0459
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LORATADINE

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

1 MG / ML ORAL SYRUP

00002241523	CLARITIN	BIC	\$	0.0569
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08:00 ANTI-INFECTIVE AGENTS

08:14.08

ANTIFUNGALS**(AZOLES)****FLUCONAZOLE**

150 MG ORAL CAPSULE

00002241895	APO-FLUCONAZOLE-150	APX	\$	3.9400
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<input checked="" type="checkbox"/>	00002432471	JAMP-FLUCONAZOLE	JPC	\$	3.9400
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<input checked="" type="checkbox"/>	00002428792	MAR-FLUCONAZOLE-150	MAR	\$	3.9400
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<input checked="" type="checkbox"/>	00002433702	PRIVA-FLUCONAZOLE	PMI	\$	3.9400
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12:00 AUTONOMIC DRUGS

12:92

MISCELLANEOUS AUTONOMIC DRUGS**BUPROPION HCL**

150 MG ORAL SUSTAINED-RELEASE TABLET

<input checked="" type="checkbox"/>	00002238441	ZYBAN	VCL	\$	1.0591
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12:00 AUTONOMIC DRUGS**12:92 MISCELLANEOUS AUTONOMIC DRUGS****NICOTINE**

RESTRICTED BENEFIT - Coverage is limited to a lifetime maximum of \$500.00 per participant for all over the counter smoking cessation products listed in the Alberta Human Services Drug Benefit Supplement.

1 MG / DOSE BUCCAL SPRAY

<input checked="" type="checkbox"/>	00080054636	NIC-HIT	EUP	\$	0.0550
<input checked="" type="checkbox"/>	00080038858	NICORETTE QUICKMIST	MCL	\$	0.2142

2 MG / DOSE BUCCAL SPRAY

	00080060452	NIC-HIT	EUP	\$	0.0625
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2 MG ORAL GUM

	00002091933	NICORETTE	JJI	\$	0.3060
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4 MG ORAL GUM

	00002091941	NICORETTE	JJI	\$	0.3060
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10 MG INHALATION CARTRIDGE

	00002241742	NICORETTE INHALER	JJI	\$	0.7650
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7 MG/DAY TRANSDERMAL PATCH

<input checked="" type="checkbox"/>	00001943057	HABITROL 7 MG/DAY	GKC	\$	2.6786
<input checked="" type="checkbox"/>	00002241227	TRANSDERMAL NICOTINE 7 MG/DAY	GKC	\$	2.7257
<input checked="" type="checkbox"/>	00002093111	NICODERM 7 MG/DAY	JJI	\$	3.7652

14 MG/DAY TRANSDERMAL PATCH

<input checked="" type="checkbox"/>	00001943065	HABITROL 14 MG/DAY	GKC	\$	2.6786
<input checked="" type="checkbox"/>	00002241226	TRANSDERMAL NICOTINE 14 MG/DAY	GKC	\$	2.7257
<input checked="" type="checkbox"/>	00002093138	NICODERM 14 MG/DAY	JJI	\$	3.7652

21 MG/DAY TRANSDERMAL PATCH

<input checked="" type="checkbox"/>	00001943073	HABITROL 21 MG/DAY	GKC	\$	2.6786
<input checked="" type="checkbox"/>	00002241228	TRANSDERMAL NICOTINE 21 MG/DAY	GKC	\$	2.7257
<input checked="" type="checkbox"/>	00002093146	NICODERM 21 MG/DAY	JJI	\$	3.7652

20:00 BLOOD FORMULATION, COAGULATION AND THROMBOSIS**20:04.04 ANTIANEMIA DRUGS
(IRON PREPARATIONS)****FERROUS FUMARATE**

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

60 MG / ML ORAL SUSPENSION

<input checked="" type="checkbox"/>	00080029822	JAMP-FERROUS FUMARATE	JPC	\$	0.0821
<input checked="" type="checkbox"/>	00001923439	PALAFER	VCL	\$	0.0900

FERROUS SULFATE

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

30 MG / ML ORAL LIQUID

	00080008295	JAMP FERROUS SULFATE	JPC	\$	0.0272
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30 MG / ML ORAL SYRUP

	00000758469	FERODAN	ODN	\$	0.0272
	00000017884	FER-IN-SOL	MJO	\$	0.0519

75 MG / ML ORAL DROPS

	00002237385	FERODAN INFANT	ODN	\$	0.1432
<input checked="" type="checkbox"/>	00080008309	JAMP FERROUS SULFATE INFANT DROPS	JPC	\$	0.1432
	00000762954	FER-IN-SOL	MJO	\$	0.2558

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04.92 ANALGESICS AND ANTIPYRETICS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS
(OTHER NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

IBUPROFEN

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

20 MG / ML ORAL SUSPENSION

<input checked="" type="checkbox"/>	00002242365	CHILDREN'S MOTRIN	MCL	\$	0.0477
<input checked="" type="checkbox"/>	00002232297	CHILDREN'S ADVIL	GKC	\$	0.0662

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.92 ANALGESICS AND ANTIPYRETICS
(MISCELLANEOUS ANALGESICS AND ANTIPYRETICS)

ACETAMINOPHEN**500 MG ORAL TABLET**

<input checked="" type="checkbox"/>	00002355299	JAMP-ACETAMINOPHEN BLAZON	JPC	\$	0.0271
<input checked="" type="checkbox"/>	00001939122	JAMP-ACETAMINOPHEN EXTRA STRENGTH	JPC	\$	0.0271
<input checked="" type="checkbox"/>	00002252813	ACETAMINOPHEN EXTRA STRENGTH	CEL	\$	0.0285
	00002229977	APO-ACETAMINOPHEN (CAPLET)	APX	\$	0.0285
	00000482323	NOVO GESIC FORTE	TEV	\$	0.0285
	00000559407	TYLENOL EXTRA STRENGTH	MCL	\$	0.1213
	00000723908	TYLENOL EXTRA-STRENGTH (CAPLET)	MCL	\$	0.1213

32 MG / ML ORAL SOLUTION

	00002027798	PEDIATRIX	TEV	\$	0.0434
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16 MG / ML ORAL SYRUP

	00000884553	CHILDRENS TEMPRA	PAL	\$	0.0413
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32 MG / ML ORAL SYRUP

	00000875996	TEMPRA D.S.	PAL	\$	0.0413
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80 MG / ML ORAL DROPS

	00002027801	PEDIATRIX	TEV	\$	0.1510
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120 MG RECTAL SUPPOSITORY

	00002230434	ACET 120	PPH	\$	0.9600
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325 MG RECTAL SUPPOSITORY

	00002230436	ACET 325	PPH	\$	0.9600
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650 MG RECTAL SUPPOSITORY

	00002230437	ACET 650	PPH	\$	0.9600
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28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
 ANTIPSYCHOTICS
 (ATYPICAL ANTIPSYCHOTICS)

ARIPIPIRAZOLE**2 MG ORAL TABLET**

00002471086	APO-ARIPIPIRAZOLE	APX	\$	0.8092
00002460025	AURO-ARIPIPIRAZOLE	AUR	\$	0.8092
00002483556	MINT-ARIPIPIRAZOLE	MPI	\$	0.8092
00002466635	PMS-ARIPIPIRAZOLE	PMS	\$	0.8092
00002473658	SANDOZ ARIPIPIRAZOLE	SDZ	\$	0.8092
00002322374	ABILIFY	OTS	\$	3.1618

ALBERTA HUMAN SERVICES RESTRICTED BENEFIT

This Drug Product is a benefit for Alberta Human Services clients 13 years of age and older.

5 MG ORAL TABLET

00002471094	APO-ARIPIPIRAZOLE	APX	\$	0.9046
00002460033	AURO-ARIPIPIRAZOLE	AUR	\$	0.9046
00002483564	MINT-ARIPIPIRAZOLE	MPI	\$	0.9046
00002466643	PMS-ARIPIPIRAZOLE	PMS	\$	0.9046
00002473666	SANDOZ ARIPIPIRAZOLE	SDZ	\$	0.9046
00002322382	ABILIFY	OTS	\$	3.5591

ALBERTA HUMAN SERVICES RESTRICTED BENEFIT

This Drug Product is a benefit for Alberta Human Services clients 13 years of age and older.

10 MG ORAL TABLET

00002471108	APO-ARIPIPIRAZOLE	APX	\$	1.0754
00002506726	ARIPIPIRAZOLE	SNS	\$	1.0754
00002460041	AURO-ARIPIPIRAZOLE	AUR	\$	1.0754
00002483572	MINT-ARIPIPIRAZOLE	MPI	\$	1.0754
00002466651	PMS-ARIPIPIRAZOLE	PMS	\$	1.0754
00002473674	SANDOZ ARIPIPIRAZOLE	SDZ	\$	1.0754
00002322390	ABILIFY	OTS	\$	4.1016

RESTRICTED BENEFIT - This product is a benefit for Alberta Human Services clients 13 years of age and older.

15 MG ORAL TABLET

00002471116	APO-ARIPIPIRAZOLE	APX	\$	1.2692
00002460068	AURO-ARIPIPIRAZOLE	AUR	\$	1.2692
00002483580	MINT-ARIPIPIRAZOLE	MPI	\$	1.2692
00002466678	PMS-ARIPIPIRAZOLE	PMS	\$	1.2692
00002473682	SANDOZ ARIPIPIRAZOLE	SDZ	\$	1.2692
00002322404	ABILIFY	OTS	\$	4.1016

RESTRICTED BENEFIT - This product is a benefit for Alberta Human Services clients 13 years of age and older.

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:16.08.04 PSYCHOTHERAPEUTIC AGENTS
ANTIPSYCHOTICS
(ATYPICAL ANTIPSYCHOTICS)

ARIPIIPRAZOLE**20 MG ORAL TABLET**

00002471124	APO-ARIPIIPRAZOLE	APX	\$	1.0017
00002460076	AURO-ARIPIIPRAZOLE	AUR	\$	1.0017
00002483599	MINT-ARIPIIPRAZOLE	MPI	\$	1.0017
00002466686	PMS-ARIPIIPRAZOLE	PMS	\$	1.0017
00002473690	SANDOZ ARIPIIPRAZOLE	SDZ	\$	1.0017
00002322412	ABILIFY	OTS	\$	4.1016

RESTRICTED BENEFIT - This product is a benefit for Alberta Human Services clients 13 years of age and older.

30 MG ORAL TABLET

00002471132	APO-ARIPIIPRAZOLE	APX	\$	1.0017
00002460084	AURO-ARIPIIPRAZOLE	AUR	\$	1.0017
00002483602	MINT-ARIPIIPRAZOLE	MPI	\$	1.0017
00002466694	PMS-ARIPIIPRAZOLE	PMS	\$	1.0017
00002473704	SANDOZ ARIPIIPRAZOLE	SDZ	\$	1.0017
00002322455	ABILIFY	OTS	\$	4.1016

RESTRICTED BENEFIT - This product is a benefit for Alberta Human Services clients 13 years of age and older.

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:12 REPLACEMENT PREPARATIONS

SODIUM CHLORIDE/ POTASSIUM CHLORIDE (K+)(CL-)/ SODIUM CITRATE,ACID/ DEXTROSE

470 MG / G * 300 MG / G * 530 MG / G * 3.56 G / G ORAL POWDER

00001931563	GASTROLYTE	SAV	\$	0.1622
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SODIUM CHLORIDE/ SODIUM CITRATE,ACID/ DEXTROSE/ POTASSIUM CITRATE (K+)

470 MG * 530 MG * 3.56 G * 390 MG ORAL POWDER PACKET

00080027403	JAMP REHYDRALYTE	JPC	\$	0.7010
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SODIUM/ POTASSIUM/ CHLORIDE/ CITRATE/ DEXTROSE

0.045 MEQ / ML * 0.02 MEQ / ML * 0.035 MEQ / ML * 0.03 MEQ / ML * 0.025 G / ML ORAL LIQUID

00002219883	PEDIATRIC ELECTROLYTE	PPH	\$	0.0074
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SODIUM/ POTASSIUM/ CHLORIDE/ CITRATE/ ZINC/ DEXTROSE

0.045 MEQ / ML * 0.02 MEQ / ML * 0.035 MEQ / ML * 0.014 MEQ / ML * 0.0078 MG / ML * 0.025 G / ML ORAL SOLUTION

00080072902	PEDIALYTE (UNFLAVOURED)	ABN	\$	0.0074
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0.045 MEQ / ML * 0.02 MEQ / ML * 0.035 MEQ / ML * 0.0255 MEQ / ML * 0.0078 MG / ML * 0.025 G / ML ORAL SOLUTION

00080074173	PEDIALYTE (FLAVOURED)	ABN	\$	0.0074
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40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE**40:20 CALORIC AGENTS****INFANT FORMULA****ORAL LIQUID**

00000999449	ALIMENTUM	ABN	\$	0.0066
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ORAL POWDER

<input checked="" type="checkbox"/>	00000999788	SIMILAC ALIMENTUM	ABN	\$	0.0381
<input checked="" type="checkbox"/>	00000999465	SIMILAC NEOSURE	ABN	\$	0.0403
<input checked="" type="checkbox"/>	00000999564	ENFAMIL ENFACARE A+	MJO	\$	0.0422
<input checked="" type="checkbox"/>	00000999520	NUTRAMIGEN A+ HYPOALLERGENIC	MJO	\$	0.0457

NUTRITIONAL PRODUCT**ORAL LIQUID**

<input checked="" type="checkbox"/>	00000999889	ISOSOURCE 1.2	NHN	\$	0.0065
<input checked="" type="checkbox"/>	00000999895	ISOSOURCE FIBRE 1.2	NHN	\$	0.0077
<input checked="" type="checkbox"/>	00000999888	ISOSOURCE 1.5	NHN	\$	0.0078
<input checked="" type="checkbox"/>	00000999896	ISOSOURCE FIBRE 1.5	NHN	\$	0.0078
<input checked="" type="checkbox"/>	00000999877	ISOSOURCE 2.0	NHN	\$	0.0112
<input checked="" type="checkbox"/>	00000999938	JEVITY 1 CAL	ABN	\$	0.0112

NUTRITIONAL PRODUCT (ADULT MEAL REPLACEMENT)**ORAL LIQUID**

<input checked="" type="checkbox"/>	00000999932	BOOST 1.5 PLUS CALORIES	NHN	\$	0.0069
<input checked="" type="checkbox"/>	00000999920	BOOST	NHN	\$	0.0081
<input checked="" type="checkbox"/>	00000999921	BOOST PLUS CALORIES	NHN	\$	0.0081
<input checked="" type="checkbox"/>	00000999902	ENSURE PLUS	ABN	\$	0.0082
<input checked="" type="checkbox"/>	00000999901	ENSURE REGULAR	ABN	\$	0.0082
<input checked="" type="checkbox"/>	00000999409	RESOURCE 2.0	NHN	\$	0.0090

NUTRITIONAL PRODUCT (ADULT)**ORAL LIQUID**

<input checked="" type="checkbox"/>	00000999966	COMPLEAT	NHN	\$	0.0085
<input checked="" type="checkbox"/>	00000999856	COMPLEAT 1.5	NHN	\$	0.0118

NUTRITIONAL PRODUCT (DIABETIC)**ORAL LIQUID**

<input checked="" type="checkbox"/>	00000999413	RESOURCE DIABETIC	NHN	\$	0.0073
<input checked="" type="checkbox"/>	00000999940	GLUCERNA	ABN	\$	0.0081

ORAL LIQUID

00000999483	BOOST DIABETIC	NHN	\$	0.0081
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NUTRITIONAL PRODUCT (PEDIATRIC)**ORAL LIQUID**

<input checked="" type="checkbox"/>	00000999418	NUTREN JUNIOR	NHN	\$	0.0070
<input checked="" type="checkbox"/>	00000999419	NUTREN JUNIOR FIBRE W PREBIO 1	NHN	\$	0.0070
<input checked="" type="checkbox"/>	00000999458	RESOURCE KID ESSENTIALS 1.5 CAL	NHN	\$	0.0102
<input checked="" type="checkbox"/>	00000999933	PEDIASURE	ABN	\$	0.0105
<input checked="" type="checkbox"/>	00000990029	PEDIASURE FIBRE	ABN	\$	0.0105
<input checked="" type="checkbox"/>	00000989998	PEDIASURE PEPTIDE 1 CAL	ABN	\$	0.0106

NUTRITIONAL PRODUCT (RENAL)**ORAL LIQUID**

<input checked="" type="checkbox"/>	00000999545	NEPRO	ABN	\$	0.0091
<input checked="" type="checkbox"/>	00000990056	NOVASOURCE RENAL	NHN	\$	0.0093
<input checked="" type="checkbox"/>	00000999414	SUPLENA	ABN	\$	0.0097

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS**52:02 ANTIALLERGIC AGENTS****SODIUM CROMOGLYCATE**

Not a benefit for Alberta Human Services Group 19824 and Group 20403 clients.

2% OPHTHALMIC SOLUTION

00002230621	OPTICROM	ALL	\$	1.0130
00002009277	CROMOLYN	PPH	\$	1.0998

52:00 EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS**52:92 MISCELLANEOUS EENT DRUGS****SODIUM CHLORIDE**

0.9% NASAL SOLUTION

00080024901	SALINEX (DROPS)	EXP	\$	0.1650
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56:00 GASTROINTESTINAL DRUGS**56:08 ANTIDIARRHEA AGENTS****LOPERAMIDE HCL**

2 MG ORAL TABLET

00002228351	PMS-LOPERAMIDE (CAPLET)	PMS	\$	0.0952
00002132591	TEVA-LOPERAMIDE (CAPLET)	TEV	\$	0.0952

0.13 MG / ML ORAL SOLUTION

00002291800	IMODIUM	MCL	\$	0.0368
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56:00 GASTROINTESTINAL DRUGS**56:12 CATHARTICS AND LAXATIVES****BISACODYL**

5 MG ORAL ENTERIC-COATED TABLET

00000254142	DULCOLAX	SAV	\$	0.1950
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10 MG RECTAL SUPPOSITORY

<input checked="" type="checkbox"/> 00002361450	BISACODYL	JPC	\$	0.4681
00000003875	DULCOLAX	SAV	\$	1.1800

DOCUSATE SODIUM

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

4 MG / ML ORAL SYRUP

00000870226	RATIO-DOCUSATE SODIUM	TEV	\$	0.0220
00002086018	COLACE	WSB	\$	0.0231

10 MG / ML ORAL DROPS

00002090163	COLACE	WSB	\$	0.1858
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GLYCERIN

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

RECTAL PEDIATRIC SUPPOSITORY

00001926047	GLYCERIN INFANT	WSB	\$	0.1872
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56:00 GASTROINTESTINAL DRUGS**56:12 CATHARTICS AND LAXATIVES****POLYETHYLENE GLYCOL/ POTASSIUM CHLORIDE (K+)/
SODIUM SULFATE/ SODIUM CHLORIDE/ SODIUM
BICARBONATE**

238.18 G / G * 3.05 G / G * 22.96 G / G * 5.85 G / G * 6.76 G / G	ORAL POWDER		
00000777838	PEG-LYTE	PPH	\$ 0.0805
RESTRICTED BENEFIT - This product is a benefit for patients 18 years of age and older for bowel cleansing prior to procedures (such as colonoscopy). Coverage is restricted to a total of 840g (i.e. 3 fills of 280g) per patient per year.			

**POLYETHYLENE GLYCOL/ SODIUM SULFATE/ SODIUM
BICARBONATE/ SODIUM CHLORIDE/ POTASSIUM CHLORIDE
(K+)**

238.8 G / G * 22.7 G / G * 6.7 G / G * 5.8 G / G * 3 G / G	ORAL POWDER		
00000677442	COLYTE	PPH	\$ 0.0805
RESTRICTED BENEFIT - This product is a benefit for patients 18 years of age and older for bowel cleansing prior to procedures (such as colonoscopy). Coverage is restricted to a total of 840g (i.e. 3 fills of 280g) per patient per year.			

SODIUM PHOSPHATE/ SODIUM ACID PHOSPHATE

10.4 G / ENM * 3.9 G / ENM	RECTAL ENEMA		
00002231170	ENE-MED	HJS	\$ 1.9500
00000009911	FLEET ENEMA	CBF	\$ 3.8800
10.4 G / ENM * 3.9 G / ENM	RECTAL PEDIATRIC ENEMA		
00000108065	FLEET ENEMA PEDIATRIC (65 ML)	CBF	\$ 3.9000
RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.			

56:00 GASTROINTESTINAL DRUGS**56:16 DIGESTANTS****LACTASE**

3,000 UNIT	ORAL TABLET		
00002230653	LACTAID	MCL	\$ 0.1422
4,500 UNIT	ORAL TABLET		
00002230654	EXTRA STRENGTH LACTAID	MCL	\$ 0.2142
9,000 UNIT	ORAL TABLET		
<input checked="" type="checkbox"/> 00080070358	JAMP-LACTASE ENZYME	JPC	\$ 0.2928
<input checked="" type="checkbox"/> 00002231507	LACTAID ULTRA (CAPLET)	MCL	\$ 0.3556
3,000 UNIT	ORAL CHEWABLE TABLET		
00002239139	JAMP-LACTASE ENZYME	JPC	\$ 0.1036
4,500 UNIT	ORAL CHEWABLE TABLET		
00080018706	JAMP-LACTASE ENZYME	JPC	\$ 0.1283

56:00 GASTROINTESTINAL DRUGS**56:22.08 ANTIEMETICS
(ANTI-HISTAMINES)****DIMENHYDRINATE**

50 MG	ORAL TABLET		
00002245416	JAMP-DIMENHYDRINATE	JPC	\$ 0.0473

84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.08 ANTI-INFECTIVES
ANTIFUNGALS
(AZOLES)

CLOTRIMAZOLE**1% TOPICAL CREAM**

00002239432	CANESTEN EXTERNAL CREAM REFILL	BIC	\$	0.4080
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1% VAGINAL CREAM

<input checked="" type="checkbox"/>	00000812366	CLOTRIMADERM	TAR	\$	0.2220
<input checked="" type="checkbox"/>	00002150891	CANESTEN 6	BIC	\$	0.2560

2% VAGINAL CREAM

<input checked="" type="checkbox"/>	00000812374	CLOTRIMADERM	TAR	\$	0.4440
<input checked="" type="checkbox"/>	00002150905	CANESTEN 3	BIC	\$	0.5224

10% VAGINAL CREAM

00002150883	CANESTEN 1	BIC	\$	2.7680
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CLOTRIMAZOLE/ CLOTRIMAZOLE**1% * 10% TOPICAL/VAGINAL CREAM/CREAM**

00002230509	CANESTEN 1 CREAM COMBI-PAK	BIC	\$	15.1200
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200 MG * 1% VAGINAL/TOPICAL TABLET/CREAM

00002264099	CANESTEN 3 COMFORTAB COMBI-PAK	BIC	\$	14.2600
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500 MG * 1% VAGINAL/TOPICAL TABLET/CREAM

00002264102	CANESTEN 1 COMFORTAB COMBI-PAK	BIC	\$	15.1200
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MICONAZOLE NITRATE**2% VAGINAL CREAM**

00002231106	MICOZOLE	TAR	\$	0.2829
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84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.08.28 ANTI-INFECTIVES
ANTIFUNGALS
(POLYENES)

NYSTATIN

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

100,000 UNIT / G TOPICAL CREAM

00000716871	NYADERM	TAR	\$	0.0733
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84:00 SKIN AND MUCOUS MEMBRANE AGENTS

84:04.12 ANTI-INFECTIVES
(SCABICIDES AND PEDICULICIDES)

DIMETHICONE**50% TOPICAL SOLUTION**

00002373785	NYDA	GXP	\$	0.4484
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ISOPROPYL MYRISTATE**50% TOPICAL SOLUTION**

00002279592	RESULTZ	ARA	\$	0.1022
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84:00 SKIN AND MUCOUS MEMBRANE AGENTS**84:04.12 ANTI-INFECTIVES
(SCABICIDES AND PEDICULICIDES)****PERMETHRIN****5% TOPICAL CREAM**

00002219905 NIX DERMAL GKC \$ 0.4977

5% TOPICAL LOTION

00002231348 KWELLADA-P MTC \$ 0.5053

10 MG / ML TOPICAL RINSE

00000771368 NIX CREME IPH \$ 0.1907

00002231480 KWELLADA-P CREME MTC \$ 0.2328

PYRETHRINS/ PIPERONYL BUTOXIDE**0.33% * 3% TOPICAL SHAMPOO**

00002125447 R & C SHAMPOO WITH CONDITIONER MTC \$ 0.1558

88:00 VITAMINS**88:16 VITAMIN D****VITAMIN D3**

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

400 UNIT / ML ORAL DROPS 00080003038 JAMP-VITAMIN D JPC \$ 0.1697 00000762881 D-VI-SOL INFANT MJO \$ 0.1996 00080019649 D3-DOL JPC \$ 5.3892**88:00 VITAMINS****88:28 MULTIVITAMIN PREPARATIONS****VITAMIN A ACETATE/ THIAMINE MONONITRATE/ RIBOFLAVIN
(VITAMIN B2)/ PYRIDOXINE HCL/ CYANOCOBALAMIN/ SODIUM
ASCORBATE/ VITAMIN D/ FOLIC ACID/ NIACINAMIDE
(NICOTINAMIDE)**

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

**1,600 UNIT (BASE) * 1.5 MG * 1.5 MG * 1 MG * 3 MCG * 50 MG * 400 UNIT * 0.1 MG * 8 MG ORAL
CHEWABLE TABLET**

00002247975 FLINTSTONES MULTI VITAMINS W EXTRA C BIC \$ 0.1362

VITAMIN A PALMITATE/ VITAMIN D/ ASCORBIC ACID

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

2,500 UNIT / ML (BASE) * 667 UNIT / ML * 50 MG / ML ORAL DROPS

00000762903 TRI-VI-SOL MJO \$ 0.2346

**VITAMIN A PALMITATE/ VITAMIN D/ SODIUM ASCORBATE/
THIAMINE HCL/ RIBOFLAVIN (VITAMIN B2)/ NIACINAMIDE
(NICOTINAMIDE)**

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age inclusive.

1,500 UNIT / ML * 400 UNIT / ML * 30 MG / ML * 0.5 MG / ML * 0.6 MG / ML * 4 MG / ML ORAL DROPS

00000762946 POLY-VI-SOL MJO \$ 0.2346

88:00 VITAMINS

88:28.01 MULTIVITAMIN PREPARATIONS
(VITAMINS & MINERALS)

**BETA CAROTENE/ BIOTIN/ CALCIUM CARBONATE/ CHROMIUM
CHLORIDE/ COPPER CITRATE/ FOLIC ACID/ POTASSIUM
IODIDE/ IRON/ MAGNESIUM OXIDE/ MANGANESE/ SODIUM
MOLYBDATE/ NIACINAMIDE (NICOTINAMIDE)/ CALCIUM D-
PANTOTHENATE/ RIBOFLAVIN (VITAMIN B2)/ SODIUM
SELENATE/ THIAMINE MONONITRATE/ VITAMIN A ACETATE/
CYANOCOBALAMIN/ PYRIDOXINE HCL/ ASCORBIC ACID/
VITAMIN D/ VITAMIN E (DL-ALPHA TOCOPHERYL ACETATE)/
ZINC OXIDE**

5,400 MCG * 24 MCG * 250 MG * 9 MCG * 0.3 MG * 600 MCG * 225 MCG * 24 MG * 50 MG * 1.2 MG * 28 MCG * 8
MG * 3.6 MG * 0.9 MG * 17 MCG * 0.9 MG * 462 MCG * 2.8 MCG * 1.4 MG * 70 MG * 15 MCG * 4.8 MG * 2.4 MG
ORAL TABLET

00080082297 NESTLE MATERNA NES \$ 0.1762

**VITAMIN A ACETATE/ THIAMINE MONONITRATE/ RIBOFLAVIN
(VITAMIN B2)/ PYRIDOXINE HCL/ CYANOCOBALAMIN/ SODIUM
ASCORBATE/ VITAMIN D/ FOLIC ACID/ NIACINAMIDE
(NICOTINAMIDE)/ FERROUS FUMARATE**

RESTRICTED BENEFIT - This product is a benefit for patients up to 17 years of age
inclusive.

1,600 UNIT (BASE) * 1.5 MG * 1.5 MG * 1 MG * 3 MCG * 50 MG * 400 UNIT * 0.1 MG * 8 MG * 4 MG (BASE)
ORAL CHEWABLE TABLET

00002247995 FLINTSTONES MULTI VITAMINS PLUS IRON BIC \$ 0.1362

92:00 MISCELLANEOUS THERAPEUTIC AGENTS

92:00

INSTANT FOOD THICKENER

ORAL POWDER

<input checked="" type="checkbox"/>	00000999455	CONSIST-RITE	DFI	\$	0.0188
<input checked="" type="checkbox"/>	00000999453	RESOURCE THICKENUP	NHN	\$	0.0233
<input checked="" type="checkbox"/>	00000999561	RESOURCE THICKENUP CLEAR	NHN	\$	0.3192

Appendices

Abbreviations

Pharmaceutical Manufacturers

Appendix 1 Pharmaceutical Manufacturers

A

ABD Abbott Diabetes Care
ABN Abbott Nutrition
ACP Accel Pharma Inc.
ADC Ascensia Diabetes Care
AGP Angita Pharma Inc.
ALL Allergan Inc.
APH Actavis Pharma Company
APX Apotex Inc.
ARA Aralez Pharmaceuticals Inc.
ARP Ara Pharmaceuticals Inc.
AUR Auro Pharma Inc.
AXC Aptalis Pharma Canada Inc.
AZC Astrazeneca Canada Inc.

B

BAI Bayer Inc.
BIC Bayer Inc. Consumer Care
BNE Bionime USA Corporation
BTN BTNX Inc.

C

CAM Cambrooke Therapeutics
CBF C.B. Fleet Company Inc.
CEL Cellchem Pharmaceuticals Inc.

D

DFI Donmar Foods Incorporated

E

EUP Euro-Pharm
EXP Exzell Pharma

G

GKC GlaxoSmithKline Consumer Healthcare
GMP Generic Medical Partners Inc
GSK GlaxoSmithKline
GXP G Pohl Boskamp GMBH & Co/Pediapharm Inc

H

HJS H.J. Sutton/Quality Home Products

I

IPH Insight Pharmaceuticals LLC

J

JJI Johnson & Johnson Inc.
JPC Jamp Pharma Corporation

L

LIF Lifescan Canada

M

MAR Marcan Pharmaceuticals Inc
MCL McNeil Consumer Healthcare
MDS MediSure Canada Inc.
MJO Mead Johnson Nutrition (Canada) Co.
MPI Mint Pharmaceuticals Inc.
MTC MedTech Products Inc.
MTR Mantra Pharma Inc.
MYP Viatrix Canada (Mylan Pharmaceuticals ULC)

N

NES Nestle Canada Inc.
NHN Nestle Health Science
NRA Nora Pharma Inc
NTP Natco Pharma (Canada) Inc.
NUN Nutricia North America

O

ODN Odan Laboratories Ltd.
ORC Organon Canada Inc.
OTS Otsuka Canada Pharmaceutical Inc.

P

PAL Paladin Labs Inc.
PMI Pharmapar Inc.
PMS Pharmascience Inc.
PPH Pendopharm Inc.

R

RAN Ranbaxy Pharmaceuticals Canada Inc
RDC Roche Diabetes Care

S

SAV Sanofi-Aventis
SDZ Sandoz Canada Inc.
SEN I-SENS USA
SEP Septa Pharmaceuticals Inc.
SIV Sivem Pharmaceuticals ULC
SNS Sanis Health Inc.

T

TAR Taro Pharmaceuticals Inc.
TEV Teva Canada Limited

V

VCL Bausch Health

W

WSB ANB Canada/Boyd Pharmaceuticals Inc.

X

XXX Miscellaneous Manufacturers

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