Updates to the Alberta Drug Benefit List

Effective August 1, 2021

Alberta Government

Inquiries should be directed to:

Pharmacy Services
Alberta Blue Cross
10009 108 Street NW
Edmonton AB T5J 3C5

Telephone Number: (780) 498-8370 (Edmonton)
(403) 294-4041 (Calgary)
1-800-361-9632 (Toll Free)

FAX Number: (780) 498-8406
1-877-305-9911 (Toll Free)

Website: https://www.alberta.ca/drug-benefit-list-and-drug-review-process.aspx

Administered by Alberta Blue Cross
on behalf of Alberta Health.

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

Table of Contents

Special Authorization

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

New Drug Product(s) Available by Special Authorization

Trade Name / Strength / Form	Generic Description	DIN	MFR
KANUMA 20 MG / VIAL INJECTION	SEBELIPASE ALFA	00002469596	APG
ORKAMBI 125 MG / 100 MG TABLET	IVACAFTOR/ LUMACAFTOR	00002463040	VER
ORKAMBI 125 MG / 200 MG TABLET	IVACAFTOR/ LUMACAFTOR	00002451379	VER
ORKAMBI 125 MG / 100 MG GRANULE	IVACAFTOR/ LUMACAFTOR	00002483831	VER
ORKAMBI 188 MG / 150 MG GRANULE	IVACAFTOR/ LUMACAFTOR	00002483858	VER

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACH-LACOSAMIDE 50 MG TABLET	LACOSAMIDE	00002489287	AHI
ACH-LACOSAMIDE 100 MG TABLET	LACOSAMIDE	00002489295	AHI
ACH-LACOSAMIDE 150 MG TABLET	LACOSAMIDE	00002489309	AHI
ACH-LACOSAMIDE 200 MG TABLET	LACOSAMIDE	00002489317	AHI
DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002475278	RIV
DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002475286	RIV
JAMP PIRFENIDONE 267 MG CAPSULE	PIRFENIDONE	00002509938	JPC
SANDOZ PIRFENIDONE 267 MG TABLET	PIRFENIDONE	00002488507	SDZ
SANDOZ PIRFENIDONE 801 MG TABLET	PIRFENIDONE	00002488515	SDZ

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
COSENTYX 150 MG / ML INJECTION SYRINGE	SECUKINUMAB	00002438070	NOV
KALYDECO 150 MG TABLET	IVACAFTOR	00002397412	VER
XELJANZ 5 MG TABLET	TOFACITINIB CITRATE	00002423898	PFI
XELJANZ XR 11 MG EXTENDED-RELEASE TABLET	TOFACITINIB CITRATE	00002470608	PFI

Restricted Benefit(s)

New Drug Product(s) Available by Restricted Benefit

Effective August 1, 2021, plan members may be eligible for coverage up to $2,400 each benefit year for eligible diabetes supplies purchased from a licensed pharmacy based on their method of diabetes management. Eligible diabetes supplies include needles, syringes, lancets, blood glucose, blood ketone and urine testing strips.

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACCU-CHEK AVIVA BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444986	RDC
ACCU-CHEK COMPACT BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444985	RDC
ACCU-CHEK GUIDE BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444984	RDC
ACCU-CHEK MOBILE BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444983	RDC
BLOOD KETONE TEST STRIPS	DIABETES SUPPLIES	00000990072	XXX
CARESENS N MULTI BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444992	SEN
CONTOUR BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444989	ADC
CONTOUR NEXT BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444990	ADC
FIRST CANADIAN HEALTH SPIRIT BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444996	ARP
FREESTYLE LITE BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444987	ABD
FREESTYLE PRECISION BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444988	ABD
GE200 BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444982	BNE
MEDISURE BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444995	MDS
ONE TOUCH ULTRA BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444994	LIF
ONE TOUCH VERIO BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444993	LIF
RAPID RESPONSE GLUCO-MD BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000444998	BTN

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
BLOOD LETTING LANCET	DIABETES SUPPLIES	00000999941	XXX
INSULIN PEN NEEDLES	DIABETES SUPPLIES	00000999985	XXX

Drug Product(s) with Changes to Criteria for Coverage, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
INSULIN SYRINGES	DIABETES SUPPLIES	00000999952	XXX
URINE TEST STRIPS	DIABETES SUPPLIES	00000999957	XXX

Drug Product(s) with Changes to Benefit Status

The following drug product(s) previously covered as regular benefits will now be covered as restricted benefits effective August 1, 2021.

Trade Name / Strength / Form	Generic Description	DIN	MFR
HUMALOG 100 UNIT / ML INJECTION	INSULIN LISPRO	00002229704	LIL
HUMALOG CARTRIDGE 100 UNIT / ML INJECTION	INSULIN LISPRO	00002229705	LIL
HUMALOG KWIKPEN 100 UNIT / ML INJECTION	INSULIN LISPRO	00002403412	LIL

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
AA-TELMISARTAN-AMLODIPINE 80 MG / 5 MG TABLET	TELMISARTAN/ AMLODIPINE BESYLATE	00002473488	AAP
AA-TELMISARTAN-AMLODIPINE 80 MG / 10 MG TABLET	TELMISARTAN/ AMLODIPINE BESYLATE	00002473496	AAP
ACH-PREGABALIN 25 MG CAPSULE	PREGABALIN	00002449838	AHI
ACH-PREGABALIN 50 MG CAPSULE	PREGABALIN	00002449846	AHI
ACH-PREGABALIN 75 MG CAPSULE	PREGABALIN	00002449854	AHI
ACH-PREGABALIN 300 MG CAPSULE	PREGABALIN	00002449900	AHI
ADMELOG 100 UNIT / ML INJECTION	INSULIN LISPRO	00002469901	SAV
ADMELOG CARTRIDGE 100 UNIT / ML INJECTION	INSULIN LISPRO	00002469898	SAV
ADMELOG PEN 100 UNIT / ML INJECTION	INSULIN LISPRO	00002469871	SAV
ATORVASTATIN 10 MG TABLET	ATORVASTATIN CALCIUM	00002475022	RIV
ATORVASTATIN 20 MG TABLET	ATORVASTATIN CALCIUM	00002475030	RIV
ATORVASTATIN 40 MG TABLET	ATORVASTATIN CALCIUM	00002475049	RIV
ATORVASTATIN 80 MG TABLET	ATORVASTATIN CALCIUM	00002475057	RIV
INCLUNOX (0.3 ML SYRINGE) 30 MG / ML INJECTION SYRINGE	ENOXAPARIN SODIUM	00002507501	SDZ
JAMP-VALACYCLOVIR 500 MG TABLET	VALACYCLOVIR	00002440598	JPC
M-AZITHROMYCIN 250 MG TABLET	AZITHROMYCIN	00002502038	MTR

Added Product(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
M-ESCITALOPRAM 10 MG TABLET	ESCITALOPRAM	00002471418	MTR
M-PREGABALIN 25 MG CAPSULE	PREGABALIN	00002467291	MTR
M-PREGABALIN 50 MG CAPSULE	PREGABALIN	00002467305	MTR
M-PREGABALIN 75 MG CAPSULE	PREGABALIN	00002467313	MTR
M-PREGABALIN 150 MG CAPSULE	PREGABALIN	00002467321	MTR
NOROMBY 30 MG / SYRINGE INJECTION	ENOXAPARIN SODIUM	00002506459	JUN
NOROMBY 40 MG / SYRINGE INJECTION	ENOXAPARIN SODIUM	00002506467	JUN
NOROMBY 60 MG / SYRINGE INJECTION	ENOXAPARIN SODIUM	00002506475	JUN
NOROMBY 80 MG / SYRINGE INJECTION	ENOXAPARIN SODIUM	00002506483	JUN
NOROMBY 100 MG / SYRINGE INJECTION	ENOXAPARIN SODIUM	00002506491	JUN
NOROMBY 120 MG / SYRINGE INJECTION	ENOXAPARIN SODIUM	00002506505	JUN
NOROMBY 150 MG / SYRINGE INJECTION	ENOXAPARIN SODIUM	00002506513	JUN
OLMESARTAN / HCTZ 20 MG / 12.5 MG TABLET	OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE	00002509601	SNS
OLMESARTAN / HCTZ 40 MG / 12.5 MG TABLET	OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE	00002509636	SNS
OLMESARTAN / HCTZ 40 MG / 25 MG TABLET	OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE	00002509628	SNS
RIVA-ALENDRONATE 70 MG TABLET	ALENDRONATE SODIUM	00002270889	RIV
RIVA-AMIODARONE 200 MG TABLET	AMIODARONE HCL	00002247217	RIV
RIVA-AZITHROMYCIN 250 MG TABLET	AZITHROMYCIN	00002275309	RIV
RIVA-CITALOPRAM 20 MG TABLET	CITALOPRAM HYDROBROMIDE	00002303264	RIV
RIVA-CITALOPRAM 40 MG TABLET	CITALOPRAM HYDROBROMIDE	00002303272	RIV
RIVA-FINASTERIDE 5 MG TABLET	FINASTERIDE	00002455013	RIV
RIVA-RISEDRONATE 35 MG TABLET	RISEDRONATE SODIUM	00002341077	RIV

New Established Interchangeable (IC) Grouping(s)

The following IC Grouping(s) have been established and LCA pricing will be applied effective September 1, 2021.

Generic Description	Strength / Form	New LCA Price
PIRFENIDONE	267 MG CAPSULE	6.7120
PIRFENIDONE	267 MG TABLET	6.7120
PIRFENIDONE	801 MG TABLET	20.7401
TELMISARTAN/ AMLODIPINE BESYLATE	80 MG / 5 MG TABLET	0.5472
TELMISARTAN/ AMLODIPINE BESYLATE	80 MG / 10 MG TABLET	0.5472

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until August 31, 2021. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
RAN-CEFPROZIL 250 MG TABLET	CEFPROZIL	00002293528	RAN
SALAGEN 5 MG TABLET	PILOCARPINE HCL	00002216345	AMD
ZIEXTENZO (0.6 ML SYRINGE) 6 MG INJECTION SYRINGE	PEGFILGRASTIM	00002497395	SDZ

Discontinued Listing(s)

Notification of discontinuation has been received from the manufacturer(s). The Alberta government-sponsored drug programs previously covered the following drug product(s). Effective August 1, 2021, the listed product(s) will no longer be a benefit and where applicable, will not be considered for coverage by Special Authorization. A transition period will be applied and as of September 1, 2021 claims will no longer pay for these product(s).

Trade Name / Strength / Form	Generic Description	DIN	MFR
ASACOL 800 800 MG ENTERIC-COATED TABLET	MESALAZINE	00002267217	ALL
BIAXIN XL 500 MG EXTENDED-RELEASE TABLET	CLARITHROMYCIN	00002244756	BGP
HP-PAC (KIT) 30 MG / 500 MG / 500 MG TABLET / CAPSULE	LANSOPRAZOLE/ AMOXICILLIN TRIHYDRATE/ CLARITHROMYCIN	00002238525	BGP
NORPROLAC 0.15 MG TABLET	QUINAGOLIDE	00002223775	FEI
SANDOZ DILTIAZEM CD 240 MG CONTROLLED-DELIVERY CAPSULE	DILTIAZEM HCL	00002243340	SDZ
TEVA-LOSARTAN/HCTZ 50 MG / 12.5 MG TABLET	LOSARTAN POTASSIUM/ HYDROCHLOROTHIAZIDE	00002358263	TEV

Product(s) Removed from the Alberta Drug Benefit List

The Alberta government-sponsored drug programs previously covered the following drug product(s). Effective August 1, 2021, the listed product(s) will no longer be a benefit. A transition period will be applied and as of September 1, 2021 claims will no longer pay for this product.

Trade Name / Strength / Form	Generic Description	DIN	MFR
BLOOD GLUCOSE TEST STRIPS	DIABETES SUPPLIES	00000999955	XXX

PART 2

Drug Additions

ALENDRONATE SODIUM

70 MG ORAL TABLET

00002485184	**AG-ALENDRONATE**	**AGP**	$	**2.1014**
00002299712	**ALENDRONATE**	**SIV**	$	**2.1014**
00002352966	**ALENDRONATE**	**SNS**	$	**2.1014**
00002381494	**ALENDRONATE SODIUM**	**AHI**	$	**2.1014**
00002248730	**APO-ALENDRONATE**	**APX**	$	**2.1014**
00002388553	**AURO-ALENDRONATE**	**AUR**	$	**2.1014**
00002385031	**JAMP-ALENDRONATE**	**JPC**	$	**2.1014**
00002394871	**MINT-ALENDRONATE**	**MPI**	$	**2.1014**
00002284006	**PMS-ALENDRONATE-FC**	**PMS**	$	**2.1014**
00002270889	**RIVA-ALENDRONATE**	**RIV**	$	**2.1014**
00002288109	**SANDOZ ALENDRONATE**	**SDZ**	$	**2.1014**
00002261715	**TEVA-ALENDRONATE**	**TEV**	$	**2.1014**
00002245329	FOSAMAX	MFC	$	11.0114

AMIODARONE HCL

200 MG ORAL TABLET

00002364336	**AMIODARONE**	**SNS**	$	**0.3706**
00002385465	**AMIODARONE**	**SIV**	$	**0.3706**
00002246194	**APO-AMIODARONE**	**APX**	$	**0.3706**
00002242472	**PMS-AMIODARONE**	**PMS**	$	**0.3706**
00002247217	**RIVA-AMIODARONE**	**RIV**	$	**0.3706**
00002243836	**SANDOZ AMIODARONE**	**SDZ**	$	**0.3706**
00002239835	**TEVA-AMIODARONE**	**TEV**	$	**0.3706**

ATORVASTATIN CALCIUM

10 MG (BASE) ORAL TABLET				
00002457741	**ACH-ATORVASTATIN**	**AHI**	$	**0.1743**
00002478145	**AG-ATORVASTATIN**	**AGP**	$	**0.1743**
00002295261	**APO-ATORVASTATIN**	**APX**	$	**0.1743**
00002475022	**ATORVASTATIN**	**RIV**	$	**0.1743**
00002411350	**ATORVASTATIN-10**	**SIV**	$	**0.1743**
00002407256	**AURO-ATORVASTATIN**	**AUR**	$	**0.1743**
00002391058	**JAMP-ATORVASTATIN**	**JPC**	$	**0.1743**
00002454017	**MAR-ATORVASTATIN**	**MAR**	$	**0.1743**
00002479508	**MINT-ATORVASTATIN**	**MPI**	$	**0.1743**
00002392933	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.1743**
00002476517	**NRA-ATORVASTATIN**	**NRA**	$	**0.1743**
00002399377	**PMS-ATORVASTATIN**	**PMS**	$	**0.1743**
00002477149	**PMS-ATORVASTATIN**	**PMS**	$	**0.1743**
00002313707	**RAN-ATORVASTATIN**	**RAN**	$	**0.1743**
00002417936	**REDDY-ATORVASTATIN**	**DRL**	$	**0.1743**
00002324946	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.1743**
00002310899	**TEVA-ATORVASTATIN**	**TEV**	$	**0.1743**
00002230711	LIPITOR	UJC	$	1.8588
20 MG (BASE) ORAL TABLET				
00002457768	**ACH-ATORVASTATIN**	**AHI**	$	**0.2179**
00002478153	**AG-ATORVASTATIN**	**AGP**	$	**0.2179**
00002295288	**APO-ATORVASTATIN**	**APX**	$	**0.2179**
00002475030	**ATORVASTATIN**	**RIV**	$	**0.2179**
00002411369	**ATORVASTATIN-20**	**SIV**	$	**0.2179**
00002407264	**AURO-ATORVASTATIN**	**AUR**	$	**0.2179**
00002391066	**JAMP-ATORVASTATIN**	**JPC**	$	**0.2179**
00002454025	**MAR-ATORVASTATIN**	**MAR**	$	**0.2179**
00002479516	**MINT-ATORVASTATIN**	**MPI**	$	**0.2179**
00002392941	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2179**
00002476525	**NRA-ATORVASTATIN**	**NRA**	$	**0.2179**
00002399385	**PMS-ATORVASTATIN**	**PMS**	$	**0.2179**
00002477157	**PMS-ATORVASTATIN**	**PMS**	$	**0.2179**
00002313715	**RAN-ATORVASTATIN**	**RAN**	$	**0.2179**
00002417944	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2179**
00002324954	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2179**
00002310902	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2179**
00002230713	LIPITOR	UJC	$	2.3234
40 MG (BASE) ORAL TABLET				
00002457776	**ACH-ATORVASTATIN**	**AHI**	$	**0.2342**
00002478161	**AG-ATORVASTATIN**	**AGP**	$	**0.2342**
00002295296	**APO-ATORVASTATIN**	**APX**	$	**0.2342**
00002475049	**ATORVASTATIN**	**RIV**	$	**0.2342**
00002411377	**ATORVASTATIN-40**	**SIV**	$	**0.2342**
00002407272	**AURO-ATORVASTATIN**	**AUR**	$	**0.2342**
00002391074	**JAMP-ATORVASTATIN**	**JPC**	$	**0.2342**
00002454033	**MAR-ATORVASTATIN**	**MAR**	$	**0.2342**
00002479524	**MINT-ATORVASTATIN**	**MPI**	$	**0.2342**
00002392968	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2342**
00002476533	**NRA-ATORVASTATIN**	**NRA**	$	**0.2342**
00002399393	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002477165	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002313723	**RAN-ATORVASTATIN**	**RAN**	$	**0.2342**
00002417952	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2342**
00002324962	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2342**
00002310910	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2342**
00002230714	LIPITOR	UJC	$	2.4973

ATORVASTATIN CALCIUM

80 MG (BASE) ORAL TABLET

00002457784	**ACH-ATORVASTATIN**	**AHI**	$	**0.2342**
00002478188	**AG-ATORVASTATIN**	**AGP**	$	**0.2342**
00002295318	**APO-ATORVASTATIN**	**APX**	$	**0.2342**
00002475057	**ATORVASTATIN**	**RIV**	$	**0.2342**
00002411385	**ATORVASTATIN-80**	**SIV**	$	**0.2342**
00002407280	**AURO-ATORVASTATIN**	**AUR**	$	**0.2342**
00002391082	**JAMP-ATORVASTATIN**	**JPC**	$	**0.2342**
00002454041	**MAR-ATORVASTATIN**	**MAR**	$	**0.2342**
00002392976	**MYLAN-ATORVASTATIN**	**MYP**	$	**0.2342**
00002476541	**NRA-ATORVASTATIN**	**NRA**	$	**0.2342**
00002399407	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002477173	**PMS-ATORVASTATIN**	**PMS**	$	**0.2342**
00002313758	**RAN-ATORVASTATIN**	**RAN**	$	**0.2342**
00002417960	**REDDY-ATORVASTATIN**	**DRL**	$	**0.2342**
00002324970	**SANDOZ ATORVASTATIN**	**SDZ**	$	**0.2342**
00002310929	**TEVA-ATORVASTATIN**	**TEV**	$	**0.2342**
00002243097	LIPITOR	UJC	$	2.4973

AZITHROMYCIN

250 MG ORAL TABLET

00002480700	**AG-AZITHROMYCIN**	**AGP**	$	**0.9410**
00002415542	**APO-AZITHROMYCIN Z**	**APX**	$	**0.9410**
00002330881	**AZITHROMYCIN**	**SNS**	$	**0.9410**
00002442434	**AZITHROMYCIN**	**SIV**	$	**0.9410**
00002452308	**JAMP-AZITHROMYCIN**	**JPC**	$	**0.9410**
00002502038	**M-AZITHROMYCIN**	**MTR**	$	**0.9410**
00002452324	**MAR-AZITHROMYCIN**	**MAR**	$	**0.9410**
00002267845	**NOVO-AZITHROMYCIN**	**TEV**	$	**0.9410**
00002479680	**NRA-AZITHROMYCIN**	**NRA**	$	**0.9410**
00002261634	**PMS-AZITHROMYCIN**	**PMS**	$	**0.9410**
00002275309	**RIVA-AZITHROMYCIN**	**RIV**	$	**0.9410**
00002265826	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**0.9410**
00002212021	ZITHROMAX	PFI	$	5.2318

BUPROPION HCL

100 MG ORAL SUSTAINED-RELEASE TABLET

00002391562	**BUPROPION SR**	**SNS**	$	**0.1547**
00002275074	**ODAN BUPROPION SR**	**ODN**	$	**0.1547**

150 MG ORAL SUSTAINED-RELEASE TABLET

00002391570	**BUPROPION SR**	**SNS**	$	**0.2297**
00002275082	**ODAN BUPROPION SR**	**ODN**	$	**0.2297**

CEFPROZIL

250 MG ORAL TABLET

00002293528	RAN-CEFPROZIL	RAN	$	1.0220

CITALOPRAM HYDROBROMIDE

20 MG (BASE) ORAL TABLET				
00002246056	**APO-CITALOPRAM**	**APX**	$	**0.1332**
00002275562	**AURO-CITALOPRAM**	**AUR**	$	**0.1332**
00002459914	**CCP-CITALOPRAM**	**CEL**	$	**0.1332**
00002353660	**CITALOPRAM**	**SNS**	$	**0.1332**
00002387956	**CITALOPRAM**	**SIV**	$	**0.1332**
00002430541	**CITALOPRAM**	**JPC**	$	**0.1332**
00002371898	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429705	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409011	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002248010	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002285622	**RAN-CITALO**	**RAN**	$	**0.1332**
00002303264	**RIVA-CITALOPRAM**	**RIV**	$	**0.1332**
00002248170	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.1332**
00002355272	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293218	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239607	CELEXA	LBC	$	1.4654
40 MG (BASE) ORAL TABLET				
00002246057	**APO-CITALOPRAM**	**APX**	$	**0.1332**
00002275570	**AURO-CITALOPRAM**	**AUR**	$	**0.1332**
00002459922	**CCP-CITALOPRAM**	**CEL**	$	**0.1332**
00002353679	**CITALOPRAM**	**SNS**	$	**0.1332**
00002387964	**CITALOPRAM**	**SIV**	$	**0.1332**
00002430568	**CITALOPRAM**	**JPC**	$	**0.1332**
00002371901	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429713	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409038	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002248011	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002303272	**RIVA-CITALOPRAM**	**RIV**	$	**0.1332**
00002248171	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.1332**
00002355280	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293226	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239608	CELEXA	LBC	$	1.4654

DIABETES SUPPLIES

STRIP

00000444989	CONTOUR	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

DIABETES SUPPLIES

☒ 00000990072 BLOOD KETONE TEST STRIPS XXX $ 0.0000

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000999941 BLOOD LETTING LANCET XXX $ 0.0000

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000999985 INSULIN PEN NEEDLES XXX $ 0.0000

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000999952 INSULIN SYRINGES XXX $ 0.0000

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000999957 URINE TEST STRIPS XXX $ 0.0000

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444992 CARESENS N MULTI SEN $ 0.5000

DIABETES SUPPLIES

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444992 CARESENS N MULTI 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444992 CARESENS N MULTI 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444996 FIRST CANADIAN HEALTH SPIRIT ARP $ 0.5000

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444996 FIRST CANADIAN HEALTH SPIRIT ARP $ 0.5000

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444996 FIRST CANADIAN HEALTH SPIRIT ARP $ 0.5000

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

DIABETES SUPPLIES

pharmacy.

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444982	GE200	BNE	$	0.5100

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444982	GE200	BNE	$	0.5100

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444982	GE200	BNE	$	0.5100

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444995	MEDISURE	MDS	$	0.6800

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444995	MEDISURE	MDS	$	0.6800

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

DIABETES SUPPLIES

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444995 MEDISURE MDS $ 0.6800

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444984 ACCU-CHEK GUIDE RDC $ 0.6813

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444984 ACCU-CHEK GUIDE RDC $ 0.6813

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444984 ACCU-CHEK GUIDE RDC $ 0.6813

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

Eligible individuals will have coverage for eligible diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444988 FREESTYLE PRECISION 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 diabetes supplies for each benefit year

DIABETES SUPPLIES

up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444988 FREESTYLE PRECISION 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444988 FREESTYLE PRECISION 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444987 FREESTYLE LITE 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444987 FREESTYLE LITE 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444987 FREESTYLE LITE 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 diabetes supplies for each benefit year up to a maximum of:

DIABETES SUPPLIES

-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444994 ONE TOUCH ULTRA 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444994 ONE TOUCH ULTRA 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444994 ONE TOUCH ULTRA 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444993 ONE TOUCH VERIO 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444993 ONE TOUCH VERIO 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR

DIABETES SUPPLIES

-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444993 ONE TOUCH VERIO 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444989 CONTOUR 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444989 CONTOUR 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444990 CONTOUR NEXT 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444990 CONTOUR NEXT 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR

DIABETES SUPPLIES

-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

00000444990	CONTOUR NEXT	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

00000444998	RAPID RESPONSE GLUCO-MD	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

00000444998	RAPID RESPONSE GLUCO-MD	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

00000444998	RAPID RESPONSE GLUCO-MD	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

00000444986	ACCU-CHEK AVIVA	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR

DIABETES SUPPLIES

-$160 for patients treated by diet and/or exercise.

⌧ 00000444986 ACCU-CHEK AVIVA 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444986 ACCU-CHEK AVIVA 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444985 ACCU-CHEK COMPACT 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444985 ACCU-CHEK COMPACT 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

⌧ 00000444985 ACCU-CHEK COMPACT 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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

DIABETES SUPPLIES

☒ 00000444983	ACCU-CHEK MOBILE	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444983	ACCU-CHEK MOBILE	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

☒ 00000444983	ACCU-CHEK MOBILE	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 diabetes supplies for each benefit year up to a maximum of:
-$2,400 for patients with diabetes who are currently and regularly using insulin, OR
-$320 for patients treated with diabetes medications with high risk of hypoglycemia, OR
-$160 for patients treated with diabetes medications with low risk of hypoglycemia, OR
-$160 for patients treated by diet and/or exercise.

ENOXAPARIN SODIUM

30 MG / SYR INJECTION SYRINGE				
☒ 00002507501	INCLUNOX (0.3 ML SYRINGE)	SDZ	$	4.9620
☒ 00002506459	NOROMBY	JUN	$	5.2920
☒ 00002509075	REDESCA (0.3 ML SYRINGE)	VLP	$	5.3500
40 MG / SYR INJECTION SYRINGE				
☒ 00002507528	INCLUNOX (0.4 ML SYRINGE)	SDZ	$	6.6160
☒ 00002506467	NOROMBY	JUN	$	7.0560
☒ 00002509083	REDESCA (0.4 ML SYRINGE)	VLP	$	7.0800
60 MG / SYR INJECTION SYRINGE				
☒ 00002507536	INCLUNOX (0.6 ML SYRINGE)	SDZ	$	9.9240
☒ 00002506475	NOROMBY	JUN	$	10.5840
☒ 00002509091	REDESCA (0.6 ML SYRINGE)	VLP	$	10.6300
80 MG / SYR INJECTION SYRINGE				
☒ 00002507544	INCLUNOX (0.8 ML SYRINGE)	SDZ	$	13.2320
☒ 00002506483	NOROMBY	JUN	$	14.1120
☒ 00002509105	REDESCA (0.8 ML SYRINGE)	VLP	$	14.1600
100 MG / SYR INJECTION SYRINGE				
☒ 00002507552	INCLUNOX (1 ML SYRINGE)	SDZ	$	16.5400
☒ 00002506491	NOROMBY	JUN	$	17.6400
☒ 00002509113	REDESCA (1 ML SYRINGE)	VLP	$	17.7100

ENOXAPARIN SODIUM

120 MG / SYR INJECTION SYRINGE

☒ 00002507560	INCLUNOX HP (0.8 ML SYRINGE)	SDZ	$	19.8480
☒ 00002506505	NOROMBY	JUN	$	21.1680
☒ 00002509148	REDESCA HP (0.8 ML SYRINGE)	VLP	$	21.2400

150 MG / SYR INJECTION SYRINGE

☒ 00002507579	INCLUNOX HP (1 ML SYRINGE)	SDZ	$	24.8100
☒ 00002506513	NOROMBY	JUN	$	26.4600
☒ 00002509156	REDESCA HP (1 ML SYRINGE)	VLP	$	26.5500

ESCITALOPRAM

10 MG ORAL TABLET

00002434652	**ACH-ESCITALOPRAM**	**AHI**	$	**0.3109**
00002295016	**APO-ESCITALOPRAM**	**APX**	$	**0.3109**
00002397358	**AURO-ESCITALOPRAM**	**AUR**	$	**0.3109**
00002429039	**ESCITALOPRAM**	**SIV**	$	**0.3109**
00002430118	**ESCITALOPRAM**	**SNS**	$	**0.3109**
00002429780	**JAMP-ESCITALOPRAM**	**JPC**	$	**0.3109**
00002471418	**M-ESCITALOPRAM**	**MTR**	$	**0.3109**
00002423480	**MAR-ESCITALOPRAM**	**MAR**	$	**0.3109**
00002407418	**MINT-ESCITALOPRAM**	**MPI**	$	**0.3109**
00002309467	**MYLAN-ESCITALOPRAM**	**MYP**	$	**0.3109**
00002440296	**NAT-ESCITALOPRAM**	**NTP**	$	**0.3109**
00002476851	**NRA-ESCITALOPRAM**	**NRA**	$	**0.3109**
00002469243	**PMS-ESCITALOPRAM**	**PMS**	$	**0.3109**
00002303949	**PMSC-ESCITALOPRAM**	**PMS**	$	**0.3109**
00002385481	**RAN-ESCITALOPRAM**	**RAN**	$	**0.3109**
00002364077	**SANDOZ ESCITALOPRAM**	**SDZ**	$	**0.3109**
00002318180	**TEVA-ESCITALOPRAM**	**TEV**	$	**0.3109**
00002263238	CIPRALEX	LBC	$	1.8795

20 MG ORAL TABLET

00002434660	**ACH-ESCITALOPRAM**	**AHI**	$	**0.3310**
00002295024	**APO-ESCITALOPRAM**	**APX**	$	**0.3310**
00002397374	**AURO-ESCITALOPRAM**	**AUR**	$	**0.3310**
00002429047	**ESCITALOPRAM**	**SIV**	$	**0.3310**
00002430126	**ESCITALOPRAM**	**SNS**	$	**0.3310**
00002429799	**JAMP-ESCITALOPRAM**	**JPC**	$	**0.3310**
00002471426	**M-ESCITALOPRAM**	**MTR**	$	**0.3310**
00002423502	**MAR-ESCITALOPRAM**	**MAR**	$	**0.3310**
00002407434	**MINT-ESCITALOPRAM**	**MPI**	$	**0.3310**
00002309475	**MYLAN-ESCITALOPRAM**	**MYP**	$	**0.3310**
00002440318	**NAT-ESCITALOPRAM**	**NTP**	$	**0.3310**
00002476878	**NRA-ESCITALOPRAM**	**NRA**	$	**0.3310**
00002469251	**PMS-ESCITALOPRAM**	**PMS**	$	**0.3310**
00002303965	**PMSC-ESCITALOPRAM**	**PMS**	$	**0.3310**
00002385503	**RAN-ESCITALOPRAM**	**RAN**	$	**0.3310**
00002364085	**SANDOZ ESCITALOPRAM**	**SDZ**	$	**0.3310**
00002318202	**TEVA-ESCITALOPRAM**	**TEV**	$	**0.3310**
00002263254	CIPRALEX	LBC	$	2.0067

FINASTERIDE

5 MG ORAL TABLET

00002365383	**APO-FINASTERIDE**	**APX**	$	**0.4138**
00002405814	**AURO-FINASTERIDE**	**AUR**	$	**0.4138**
00002355043	**FINASTERIDE**	**AHI**	$	**0.4138**
00002445077	**FINASTERIDE**	**SNS**	$	**0.4138**
00002447541	**FINASTERIDE**	**SIV**	$	**0.4138**
00002357224	**JAMP-FINASTERIDE**	**JPC**	$	**0.4138**
00002389878	**MINT-FINASTERIDE**	**MPI**	$	**0.4138**
00002310112	**PMS-FINASTERIDE**	**PMS**	$	**0.4138**
00002455013	**RIVA-FINASTERIDE**	**RIV**	$	**0.4138**
00002322579	**SANDOZ FINASTERIDE**	**SDZ**	$	**0.4138**
00002348500	**TEVA-FINASTERIDE**	**TEV**	$	**0.4138**
00002010909	PROSCAR	MFC	$	2.0816

HYDROCORTISONE/ CINCHOCAINE HCL/ FRAMYCETIN SULFATE/ ESCULIN

5 MG * 5 MG * 10 MG * 10 MG RECTAL SUPPOSITORY

00002242528	**ODAN PROCTOMYXIN HC**	**ODN**	$	**0.6000**
00002247882	**PROCTOL**	**ODN**	$	**0.6000**

INSULIN LISPRO

100 UNIT / ML INJECTION

☒ 00002469901	ADMELOG	SAV	$	2.2700
☒ 00002469898	ADMELOG CARTRIDGE	SAV	$	3.0000
☒ 00002469871	ADMELOG PEN	SAV	$	3.0000

OLMESARTAN MEDOXOMIL/ HYDROCHLOROTHIAZIDE

20 MG * 12.5 MG ORAL TABLET

00002468948	**ACH-OLMESARTAN HCTZ**	**AHI**	$	**0.3019**
00002443112	**ACT OLMESARTAN HCT**	**APH**	$	**0.3019**
00002453606	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.3019**
00002476487	**AURO-OLMESARTAN HCTZ**	**AUR**	$	**0.3019**
00002475707	**GLN-OLMESARTAN HCTZ**	**GLM**	$	**0.3019**
00002509601	**OLMESARTAN/HCTZ**	**SNS**	$	**0.3019**
00002319616	OLMETEC PLUS	MFC	$	1.1607

40 MG * 12.5 MG ORAL TABLET

00002468956	**ACH-OLMESARTAN HCTZ**	**AHI**	$	**0.3019**
00002443120	**ACT OLMESARTAN HCT**	**APH**	$	**0.3019**
00002453614	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.3019**
00002476495	**AURO-OLMESARTAN HCTZ**	**AUR**	$	**0.3019**
00002475715	**GLN-OLMESARTAN HCTZ**	**GLM**	$	**0.3019**
00002509636	**OLMESARTAN/HCTZ**	**SNS**	$	**0.3019**
00002319624	OLMETEC PLUS	MFC	$	1.1607

40 MG * 25 MG ORAL TABLET

00002468964	**ACH-OLMESARTAN HCTZ**	**AHI**	$	**0.3019**
00002443139	**ACT OLMESARTAN HCT**	**APH**	$	**0.3019**
00002453622	**APO-OLMESARTAN/HCTZ**	**APX**	$	**0.3019**
00002476509	**AURO-OLMESARTAN HCTZ**	**AUR**	$	**0.3019**
00002475723	**GLN-OLMESARTAN HCTZ**	**GLM**	$	**0.3019**
00002509628	**OLMESARTAN/HCTZ**	**SNS**	$	**0.3019**
00002319632	OLMETEC PLUS	MFC	$	1.1607

PILOCARPINE HCL

5 MG ORAL TABLET

00002509571	JAMP PILOCARPINE	JPC	$	0.7321
00002496119	M-PILOCARPINE	MTR	$	0.7321
00002216345	SALAGEN	AMD	$	0.7321

PREGABALIN

25 MG ORAL CAPSULE

00002449838	ACH-PREGABALIN	AHI	$	0.1481
00002480727	AG-PREGABALIN	AGP	$	0.1481
00002394235	APO-PREGABALIN	APX	$	0.1481
00002433869	AURO-PREGABALIN	AUR	$	0.1481
00002435977	JAMP-PREGABALIN	JPC	$	0.1481
00002467291	M-PREGABALIN	MTR	$	0.1481
00002423804	MINT-PREGABALIN	MPI	$	0.1481
00002494841	NAT-PREGABALIN	NTP	$	0.1481
00002479117	NRA-PREGABALIN	NRA	$	0.1481
00002359596	PMS-PREGABALIN	PMS	$	0.1481
00002403692	PREGABALIN	SIV	$	0.1481
00002405539	PREGABALIN	SNS	$	0.1481
00002392801	RAN-PREGABALIN	RAN	$	0.1481
00002390817	SANDOZ PREGABALIN	SDZ	$	0.1481
00002361159	TEVA-PREGABALIN	TEV	$	0.1481

50 MG ORAL CAPSULE

00002449846	ACH-PREGABALIN	AHI	$	0.2324
00002480735	AG-PREGABALIN	AGP	$	0.2324
00002394243	APO-PREGABALIN	APX	$	0.2324
00002433877	AURO-PREGABALIN	AUR	$	0.2324
00002435985	JAMP-PREGABALIN	JPC	$	0.2324
00002467305	M-PREGABALIN	MTR	$	0.2324
00002423812	MINT-PREGABALIN	MPI	$	0.2324
00002494868	NAT-PREGABALIN	NTP	$	0.2324
00002479125	NRA-PREGABALIN	NRA	$	0.2324
00002359618	PMS-PREGABALIN	PMS	$	0.2324
00002403706	PREGABALIN	SIV	$	0.2324
00002405547	PREGABALIN	SNS	$	0.2324
00002392828	RAN-PREGABALIN	RAN	$	0.2324
00002390825	SANDOZ PREGABALIN	SDZ	$	0.2324
00002361175	TEVA-PREGABALIN	TEV	$	0.2324

75 MG ORAL CAPSULE

00002449854	ACH-PREGABALIN	AHI	$	0.3007
00002480743	AG-PREGABALIN	AGP	$	0.3007
00002394251	APO-PREGABALIN	APX	$	0.3007
00002433885	AURO-PREGABALIN	AUR	$	0.3007
00002435993	JAMP-PREGABALIN	JPC	$	0.3007
00002467313	M-PREGABALIN	MTR	$	0.3007
00002424185	MINT-PREGABALIN	MPI	$	0.3007
00002494876	NAT-PREGABALIN	NTP	$	0.3007
00002479133	NRA-PREGABALIN	NRA	$	0.3007
00002359626	PMS-PREGABALIN	PMS	$	0.3007
00002403714	PREGABALIN	SIV	$	0.3007
00002405555	PREGABALIN	SNS	$	0.3007
00002392836	RAN-PREGABALIN	RAN	$	0.3007
00002390833	SANDOZ PREGABALIN	SDZ	$	0.3007
00002361183	TEVA-PREGABALIN	TEV	$	0.3007

PREGABALIN

150 MG ORAL CAPSULE

00002480751	**AG-PREGABALIN**	**AGP**	$	**0.4145**
00002394278	**APO-PREGABALIN**	**APX**	$	**0.4145**
00002433907	**AURO-PREGABALIN**	**AUR**	$	**0.4145**
00002436000	**JAMP-PREGABALIN**	**JPC**	$	**0.4145**
00002467321	**M-PREGABALIN**	**MTR**	$	**0.4145**
00002424207	**MINT-PREGABALIN**	**MPI**	$	**0.4145**
00002494884	**NAT-PREGABALIN**	**NTP**	$	**0.4145**
00002479168	**NRA-PREGABALIN**	**NRA**	$	**0.4145**
00002359634	**PMS-PREGABALIN**	**PMS**	$	**0.4145**
00002403722	**PREGABALIN**	**SIV**	$	**0.4145**
00002405563	**PREGABALIN**	**SNS**	$	**0.4145**
00002392844	**RAN-PREGABALIN**	**RAN**	$	**0.4145**
00002390841	**SANDOZ PREGABALIN**	**SDZ**	$	**0.4145**
00002361205	**TEVA-PREGABALIN**	**TEV**	$	**0.4145**

300 MG ORAL CAPSULE

00002449900	**ACH-PREGABALIN**	**AHI**	$	**0.4145**
00002480778	**AG-PREGABALIN**	**AGP**	$	**0.4145**
00002394294	**APO-PREGABALIN**	**APX**	$	**0.4145**
00002436019	**JAMP-PREGABALIN**	**JPC**	$	**0.4145**
00002494906	**NAT-PREGABALIN**	**NTP**	$	**0.4145**
00002359642	**PMS-PREGABALIN**	**PMS**	$	**0.4145**
00002403730	**PREGABALIN**	**SIV**	$	**0.4145**
00002405598	**PREGABALIN**	**SNS**	$	**0.4145**
00002392860	**RAN-PREGABALIN**	**RAN**	$	**0.4145**
00002390868	**SANDOZ PREGABALIN**	**SDZ**	$	**0.4145**
00002361248	**TEVA-PREGABALIN**	**TEV**	$	**0.4145**

RISEDRONATE SODIUM

35 MG ORAL TABLET

00002353687	**APO-RISEDRONATE**	**APX**	$	**1.9787**
00002406306	**AURO-RISEDRONATE**	**AUR**	$	**1.9787**
00002368552	**JAMP-RISEDRONATE**	**JPC**	$	**1.9787**
00002302209	**PMS-RISEDRONATE**	**PMS**	$	**1.9787**
00002370255	**RISEDRONATE**	**SNS**	$	**1.9787**
00002411407	**RISEDRONATE-35**	**SIV**	$	**1.9787**
00002341077	**RIVA-RISEDRONATE**	**RIV**	$	**1.9787**
00002327295	**SANDOZ RISEDRONATE**	**SDZ**	$	**1.9787**
00002298392	**TEVA-RISEDRONATE**	**TEV**	$	**1.9787**
00002246896	ACTONEL	ALL	$	11.6009

TELMISARTAN/ AMLODIPINE BESYLATE

80 MG * 5 MG ORAL TABLET

00002473488	**AA-TELMISARTAN-AMLODIPINE**	**AAP**	$	**0.5472**
00002371049	TWYNSTA	BOE	$	0.7296

80 MG * 10 MG ORAL TABLET

00002473496	**AA-TELMISARTAN-AMLODIPINE**	**AAP**	$	**0.5472**
00002371057	TWYNSTA	BOE	$	0.7296

VALACYCLOVIR

500 MG ORAL TABLET

00002295822	**APO-VALACYCLOVIR (CAPLET)**	**APX**	$	**0.6198**
00002405040	**AURO-VALACYCLOVIR**	**AUR**	$	**0.6198**
00002440598	**JAMP-VALACYCLOVIR**	**JPC**	$	**0.6198**
00002441454	**JAMP-VALACYCLOVIR**	**JPC**	$	**0.6198**
00002351579	**MYLAN-VALACYCLOVIR (CAPLET)**	**MYP**	$	**0.6198**
00002298457	**PMS-VALACYCLOVIR (CAPLET)**	**PMS**	$	**0.6198**
00002347091	**SANDOZ VALACYCLOVIR**	**SDZ**	$	**0.6198**
00002357534	**TEVA-VALACYCLOVIR**	**TEV**	$	**0.6198**
00002442000	**VALACYCLOVIR**	**SIV**	$	**0.6198**
00002454645	**VALACYCLOVIR**	**SNS**	$	**0.6198**
00002219492	VALTREX (CAPLET)	GSK	$	3.6158

PART 3

Special Authorization

DONEPEZIL HCL

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

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

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

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

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

All requests (including renewal requests) for donepezil HCI must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request Form (ABC 60034).

5 MG ORAL TABLET

00002362260	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400561	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412853	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420597	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426846	**DONEPEZIL**	**SNS**	$	**0.4586**
00002475278	**DONEPEZIL**	**RIV**	$	**0.4586**
00002402645	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002416948	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402092	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002408600	**MINT-DONEPEZIL**	**MPI**	$	**0.4586**
00002439557	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322331	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381508	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328666	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428482	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340607	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232043	ARICEPT	PFI	$	5.0779

10 MG ORAL TABLET

00002362279	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400588	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412861	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420600	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426854	**DONEPEZIL**	**SNS**	$	**0.4586**
00002475286	**DONEPEZIL**	**RIV**	$	**0.4586**
00002402653	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002416956	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402106	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002408619	**MINT-DONEPEZIL**	**MPI**	$	**0.4586**
00002439565	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322358	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381516	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328682	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428490	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340615	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232044	ARICEPT	PFI	$	5.0779

IVACAFTOR

"For the treatment of cystic fibrosis (CF) in patients age six (6) years and older who have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R; and

For the treatment of cystic fibrosis (CF) in patients aged 18 and older with an R117H mutation in the CFTR gene.

For coverage, this drug must be prescribed by a prescriber affiliated with one of the following Alberta Cystic Fibrosis Clinics:
- Cystic Fibrosis Clinic, Adult: Kaye Edmonton Clinic
- Cystic Fibrosis Services - Adult Outpatient: Foothills Medical Centre
- Cystic Fibrosis Clinic, Pediatric: Stollery Children's Hospital
- Pediatric Cystic Fibrosis Clinic: Alberta Children's Hospital

Initial coverage may be approved for up to 150 mg every 12 hours for 6 months. Patients will be limited to receiving a one-month supply per prescription at their pharmacy.

Coverage cannot be provided when intended for use in combination with other CFTR modulators.

Renewal Criteria

The sweat chloride test will be repeated at the next routine review appointment after starting ivacaftor to determine whether sweat chloride levels are reducing and to check compliance with the drug regimen. The sweat chloride level will then be re-checked 6 months after starting treatment to determine whether the full reduction (as detailed below) has been achieved. Thereafter sweat chloride levels will be checked annually.

For continued coverage of up to 150mg every 12 hours beyond the initial 6-month authorization, the patient will be considered to have responded to treatment if either:

a) The patient's sweat chloride test falls below 60mmoL/L; OR
b) The patient's sweat chloride test falls by at least 30%

In cases where the baseline sweat chloride test is already below 60mmoL/L, the patient will be considered to have responded to treatment if either:

c) The patient's sweat chloride test falls by at least 30%; OR
d) The patient demonstrates a sustained absolute improvement in FEV1 of at least 5%. In this instance FEV1 will be compared with the baseline pre-treatment level one month and three months after starting treatment.

Following this assessment, continued coverage of up to 150 mg every 12 hours may be approved for a period of 12 months. Patients will be limited to receiving a one-month supply per prescription at their pharmacy.

If the expected reduction in sweat chloride does not occur, the patient's CF clinician will first explore any challenges in following the recommended dosing schedule for ivacaftor. The patient's sweat chloride will then be retested around one week later and funding discontinued if the patient does not meet the above criteria."

All requests (including renewal requests) for ivacaftor must be completed using the Ivacaftor Special Authorization Request Form (ABC 60004).

150 MG ORAL TABLET

00002397412	KALYDECO	VER	$	420.0000

IVACAFTOR/ LUMACAFTOR

"For the treatment of cystic fibrosis (CF) in patients age two (2) years and older who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene who have demonstrated adherence to their prescribed cystic fibrosis therapeutic regimen and who have ONE or more of the following:

Experienced one (1) or more pulmonary exacerbation(s) per year requiring IV antibiotics;
OR
Experienced three (3) or more pulmonary exacerbations per year requiring therapy with oral antibiotics;
OR
For patients 6 -11 years of age: the patient has a decline of absolute FEV1 % predicted of greater than or equal to 5 percentage points within a 12 month period, sustained over at least 4 months, in spite of optimized medical therapies;
OR
For patient 12 years of age and older: the patient has a baseline FEV1 of <70% predicted, who has an absolute decline in FEV1 of greater than or equal to 5%, within a 12 month period, sustained over at least 4 months, in spite of optimized medical therapies;
OR
For patient 12 years of age and older: the patient has a baseline FEV1 of greater than or equal to 70% predicted who have an absolute decline in FEV1 of greater than or equal to 10% predicted within a 12 month period, sustained over at least 4 months, in spite of optimized medical therapies.

For initial coverage, the following pre-treatment information must be provided:
1) Number of days treated with oral and IV antibiotics for pulmonary exacerbations in the previous 6 months; AND/OR number of pulmonary exacerbations requiring oral and IV antibiotics in the previous 6 months; AND
2) Number of CF related hospitalizations in the previous 6 months; AND
3) Baseline Body Mass Index (BMI); AND
For patients aged 6 years and older:
4) Baseline measurement of FEV1 % predicted (within the last 30 days), AND
5) Change in FEV1 demonstrating decline in FEV1 % predicted prior to starting therapy (as defined above);

This drug must be prescribed by a prescriber affiliated with one of the following Alberta Cystic Fibrosis Clinics:
- Cystic Fibrosis Clinic, Adult: Kaye Edmonton Clinic
- Cystic Fibrosis Services - Adult Outpatient: Foothills Medical Centre
- Cystic Fibrosis Clinic, Pediatric: Stollery Children's Hospital
- Pediatric Cystic Fibrosis Clinic: Alberta Children's Hospital

For coverage, dosing will be approved as follows:
Patients 2-5 years of age: up to one packet of granules (containing lumacaftor 150 mg and ivacaftor 188 mg) every 12 hours.
Patients 6-11 years of age: 2 tablets (each containing lumacaftor 100 mg and ivacaftor 125 mg) every 12 hours.
Patients 12 years of age and older: 2 tablets (each containing lumacaftor 200 mg and ivacaftor 125 mg) every 12 hours.
Patients will be limited to receiving a one-month supply per prescription at their pharmacy.

Initial coverage may be approved for 6 months.
Subsequent renewal of coverage may be approved for 12 months.

For continued coverage, the patient must meet the following criteria:
1) Patient continues to adhere to their prescribed cystic fibrosis therapeutic regimen; AND
2) Patient has demonstrated at least ONE of the following:
-Reduction in the total number of days for which the patient received treatment with oral and/or IV antibiotics for pulmonary exacerbations compared with the 6 month period prior to initiating treatment; OR
-Reduction in the total number of pulmonary exacerbations requiring oral and IV antibiotics

IVACAFTOR/ LUMACAFTOR

compared with the 6 month period prior to initiating treatment; OR
-Reduction in the number of CF related hospitalizations compared with the 6 month period prior to initiating treatment; OR
-Maintenance or increase in BMI compared with the baseline BMI assessment; OR
-For patients aged 6 years and older: No decline in FEV1 % predicted compared with the baseline FEV1 assessment.

Coverage cannot be provided for lumacaftor/ivacaftor for the following:
1) When intended for use in combination with other CFTR modulators; OR
2) Patient is currently receiving invasive mechanical ventilation via endotracheal tube or tracheostomy tube; OR
3) Patient is the previous recipient of a double lung transplant."

All requests (including renewal requests) for lumacaftor/ivacaftor must be completed using the Lumacaftor/Ivacaftor Special Authorization Request Form (ABC 60090).

125 MG * 100 MG ORAL TABLET				
00002463040	ORKAMBI	VER	$	170.5357
125 MG * 200 MG ORAL TABLET				
00002451379	ORKAMBI	VER	$	170.5357
125 MG * 100 MG ORAL GRANULE				
00002483831	ORKAMBI	VER	$	341.0714
188 MG * 150 MG ORAL GRANULE				
00002483858	ORKAMBI	VER	$	341.0714

LACOSAMIDE

"For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

For the purpose of administering these criteria failure is defined as inability to achieve satisfactory seizure control.

Special authorization may be granted for six months.

Coverage cannot be provided for brivaracetam, eslicarbazepine, lacosamide or perampanel when these medications are intended for use in combination."

Each of these products is eligible for auto-renewal.

50 MG ORAL TABLET

00002489287	**ACH-LACOSAMIDE**	**AHI**	$	**0.6313**
00002475332	**AURO-LACOSAMIDE**	**AUR**	$	**0.6313**
00002488388	**JAMP-LACOSAMIDE**	**JPC**	$	**0.6313**
00002487802	**MAR-LACOSAMIDE**	**MAR**	$	**0.6313**
00002490544	**MINT-LACOSAMIDE**	**MPI**	$	**0.6313**
00002499568	**NRA-LACOSAMIDE**	**NRA**	$	**0.6313**
00002478196	**PHARMA-LACOSAMIDE**	**PMS**	$	**0.6313**
00002474670	**SANDOZ LACOSAMIDE**	**SDZ**	$	**0.6313**
00002472902	**TEVA-LACOSAMIDE**	**TEV**	$	**0.6313**
00002357615	VIMPAT	UCB	$	2.4093

100 MG ORAL TABLET

00002489295	**ACH-LACOSAMIDE**	**AHI**	$	**0.8750**
00002475340	**AURO-LACOSAMIDE**	**AUR**	$	**0.8750**
00002488396	**JAMP-LACOSAMIDE**	**JPC**	$	**0.8750**
00002487810	**MAR-LACOSAMIDE**	**MAR**	$	**0.8750**
00002490552	**MINT-LACOSAMIDE**	**MPI**	$	**0.8750**
00002499576	**NRA-LACOSAMIDE**	**NRA**	$	**0.8750**
00002478218	**PHARMA-LACOSAMIDE**	**PMS**	$	**0.8750**
00002474689	**SANDOZ LACOSAMIDE**	**SDZ**	$	**0.8750**
00002472910	**TEVA-LACOSAMIDE**	**TEV**	$	**0.8750**
00002357623	VIMPAT	UCB	$	3.4477

150 MG ORAL TABLET

00002489309	**ACH-LACOSAMIDE**	**AHI**	$	**1.1763**
00002475359	**AURO-LACOSAMIDE**	**AUR**	$	**1.1763**
00002488418	**JAMP-LACOSAMIDE**	**JPC**	$	**1.1763**
00002487829	**MAR-LACOSAMIDE**	**MAR**	$	**1.1763**
00002490560	**MINT-LACOSAMIDE**	**MPI**	$	**1.1763**
00002499584	**NRA-LACOSAMIDE**	**NRA**	$	**1.1763**
00002478226	**PHARMA-LACOSAMIDE**	**PMS**	$	**1.1763**
00002474697	**SANDOZ LACOSAMIDE**	**SDZ**	$	**1.1763**
00002472929	**TEVA-LACOSAMIDE**	**TEV**	$	**1.1763**
00002357631	VIMPAT	UCB	$	4.4862

LACOSAMIDE

200 MG ORAL TABLET

00002489317	**ACH-LACOSAMIDE**	**AHI**	$	**1.4500**
00002475367	**AURO-LACOSAMIDE**	**AUR**	$	**1.4500**
00002488426	**JAMP-LACOSAMIDE**	**JPC**	$	**1.4500**
00002487837	**MAR-LACOSAMIDE**	**MAR**	$	**1.4500**
00002490579	**MINT-LACOSAMIDE**	**MPI**	$	**1.4500**
00002499592	**NRA-LACOSAMIDE**	**NRA**	$	**1.4500**
00002478234	**PHARMA-LACOSAMIDE**	**PMS**	$	**1.4500**
00002474700	**SANDOZ LACOSAMIDE**	**SDZ**	$	**1.4500**
00002472937	**TEVA-LACOSAMIDE**	**TEV**	$	**1.4500**
00002357658	VIMPAT	UCB	$	5.5247

PEGFILGRASTIM

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

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

Please note: Coverage cannot be considered for palliative patients.

6 MG / SYR INJECTION SYRINGE

☒ 00002484153	FULPHILA (0.6 ML SYRINGE)	BGP	$	1375.0000
☒ 00002474565	LAPELGA (0.6 ML SYRINGE)	APX	$	1375.0000
☒ 00002506238	NYVEPRIA (0.6 ML SYRINGE)	PFI	$	1375.0000
☒ 00002497395	ZIEXTENZO (0.6 ML SYRINGE)	SDZ	$	1375.0000

PIRFENIDONE

"Initial approval criteria:

Adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF):
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.
-All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded.
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.
- Patient is under the care of a physician with experience in IPF.

Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests)

Initial renewal criteria (at 6 months):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 6 months

Second and subsequent renewals (at 12 months and thereafter):

Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

Patients who have experienced intolerance or failure to pirfenidone or nintedanib will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria."

All requests for pirfenidone must be completed using the Nintedanib/Pirfenidone Special Authorization Request Form (ABC 60051).

267 MG ORAL TABLET				
00002488507	**SANDOZ PIRFENIDONE**	**SDZ**	$	**6.7120**
00002464489	ESBRIET	HLR	$	13.4240
801 MG ORAL TABLET				
00002488515	**SANDOZ PIRFENIDONE**	**SDZ**	$	**20.1360**
00002464500	ESBRIET	HLR	$	40.2720
267 MG ORAL CAPSULE				
00002509938	**JAMP PIRFENIDONE**	**JPC**	$	**6.7120**
00002393751	ESBRIET	HLR	$	13.6251

SEBELIPASE ALFA

1. ELIGIBILITY CRITERIA FOR SEBELIPASE ALFA COVERAGE

In order to maintain the integrity of the ADBL, and having regard to the financial and social implications of covering sebelipase alfa for the treatment of lysosomal acid lipase (LAL) deficiency, the following special authorization criteria must be satisfied.

In order to be eligible for sebelipase alfa coverage for the treatment of LAL deficiency, a patient must have submitted a completed Application and have satisfied all of the following requirements:

The patient must:
1) Be diagnosed with LAL deficiency in accordance with the requirements specified in the Clinical Criteria for sebelipase alfa;
2) Have Alberta government-sponsored drug coverage;
3) Meet the Registration Requirements; AND
4) Satisfy the Clinical Criteria for sebelipase alfa (initial or continued coverage, as appropriate).

There is no guarantee that any application, whether for initial or continued coverage, will be approved. Depending on the circumstances of each case, the Minister or the Minister's delegate may:
- approve an Application;
- approve an Application with conditions;
- deny an Application;
- discontinue an approved Application; OR
- defer an Application pending the provision of further supporting information.

The process for review and approval is explained in further detail below.

2. REGISTRATION REQUIREMENTS

If the patient is a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of one (1) year prior to an application for coverage unless:
- the patient is less than one (1) year of age at the date of the application, then the patient's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of one (1) year; OR
- the patient has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for sebelipase alfa in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for sebelipase alfa as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

If the patient is not a citizen or permanent resident of Canada, the patient must be continuously registered in the Alberta Health Care Insurance Plan for a minimum of five (5) years prior to an application for coverage unless:
- the patient is less than five years of age at the date of the application, then the patient's parent/guardian/legal representative must be registered continuously in the Alberta Health Care Insurance Plan for a minimum of five years; OR
- the patient has moved to Alberta from another province or territory in Canada (the "province of origin"), and immediately prior to moving to Alberta, was covered for sebelipase alfa in the province of origin by a provincial or territorial government sponsored drug plan, (or the province of origin provided equivalent coverage for sebelipase alfa as does Alberta) and the patient has been registered in the Alberta Health Care Insurance Plan (the patient must provide supporting documentation from the province of origin to prove prior coverage).

The Minister reserves the right to modify or waive the Registration Requirements applicable to a given patient if the patient or the patient's parent/guardian/legal representative can establish to the satisfaction of the Minister that the patient has not moved to Alberta for the sole/primary purpose of obtaining coverage of sebelipase alfa.

SEBELIPASE ALFA

3. CLINICAL CRITERIA

"For the treatment of lysosomal acid lipase (LAL) deficiency in patients who have:
- documented biochemical evidence of deficient LAL activity (a copy of the lab report must be provided),
- two documented pathogenic mutations in the LIPA gene (a copy of the lab report must be provided),
- onset of clinical manifestations of LAL deficiency before six months of age.

For coverage, this drug must be prescribed by a specialist with experience in the diagnosis and management of LAL deficiency.

Coverage may be approved for up to 3 mg/kg once weekly as an intravenous infusion. Patients will be limited to receiving a 4-week supply of sebelipase alfa per prescription at their pharmacy.

Special authorization may be granted 12 months.

Renewal of coverage for sebelipase alfa may be continued for patients who do not experience any of the following adverse events from sebelipase alfa: hypersensitivity reactions (including anaphylaxis, hypotension, or fever), which cannot be managed with standard treatment, and/or have a significant impact on the patient's quality of life, or are life-threatening."

All requests (including renewal requests) for sebelipase alfa must be completed using the Sebelipase Alfa Special Authorization Request Form (ABC 60089).

4. PROCESS FOR SEBELIPASE ALFA COVERAGE

For both initial and continued coverage the following documents (the Application) must be completed and submitted:

- A Sebelipase Alfa Special Authorization Request Form completed by the patient's Specialist; AND
- Any other documentation that may be required by the Minister or the Minister's delegate.

The Application is forwarded to the Minister or the Minister's delegate to confirm that the patient meets the Registration Requirement or grant a waiver of the Registration Requirement, and thereafter render a decision regarding coverage.

After the Minister or Minister's delegate has rendered a decision, the patient's Specialist and the patient or patient's parent/guardian/legal representative will be notified by letter of the Minister's decision.

5. APPROVAL OF COVERAGE

The Minister or the Minister's delegate's decision in respect of an Application will specify the effective date of sebelipase alfa, if coverage is approved.

Initial or continued coverage may be approved for a period of up to twelve (12) months for up to 3 mg/kg once weekly as an intravenous infusion.

If a patient is approved for coverage, prescriptions for sebelipase alfa must be written by a specialist with experience in the diagnosis and management of LAL deficiency. To avoid wastage, prescription quantities are limited to a four-week supply. Extended quantity and vacation supplies are not permitted. The Government is not responsible and will not pay for costs associated with wastage or improper storage of sebelipase alfa.

Approval of coverage is granted for a specific period, to a maximum of twelve (12) months. If continued treatment is necessary, it is the responsibility of the patient or patient's parent/guardian/legal representative and the Specialist to submit a new Application to re-apply

SEBELIPASE ALFA

for sebelipase alfa coverage, and receive a decision thereon, prior to the expiry date of the authorization period.

6. WITHDRAWAL

Therapy may be withdrawn at the request of the patient or the patient's parent/guardian/legal representative at any time. Notification of withdrawal from therapy must be made by the Specialist or patient in writing.

Applications, withdrawal requests, and any other information to be provided must be sent to Clinical Drug Services, Alberta Blue Cross.

20 MG / VIAL INJECTION

00002469596	KANUMA	APG	$ 8546.0000

SECUKINUMAB

Plaque Psoriasis

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

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

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

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

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

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

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

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

SECUKINUMAB

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

Psoriatic Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).
Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

Initial coverage may be approved for 16 weeks as follows:
- Four weekly doses of 150 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8, 12 and 16. A dose of 300 mg (given as 2 subcutaneous injections of 150 mg each) may be considered for anti-TNF alpha inadequate responders.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond eight doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial eight doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be considered for one 150 mg (or 300 mg for anti-TNF alpha inadequate responders) dose of secukinumab every month for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;

SECUKINUMAB

2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for secukinumab for Psoriatic Arthritis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Ixekizumab/Secukinumab for Psoriatic Arthritis Special Authorization Request Form (ABC 60029).

Ankylosing Spondylitis

"Special authorization coverage may be provided for the reduction in the signs and symptoms of severely active Ankylosing Spondylitis, as defined by the Modified New York criteria for Ankylosing Spondylitis, in adult patients (18 years of age or older) who have active disease as demonstrated by:

- a BASDAI greater than or equal to 4 units, demonstrated on 2 occasions at least 8 weeks apart AND
- a Spinal Pain VAS of greater than or equal to 4 cm (on a 0-10 cm scale), demonstrated on 2 occasions at least 8 weeks apart AND
- who are refractory or intolerant to treatment with 2 or more NSAIDS each taken for a minimum of 4 weeks at maximum tolerated or recommended doses.

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

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

Initial coverage may be approved for 16 weeks as follows:
- Four weekly doses of 150 mg of secukinumab at weeks 0, 1, 2 and 3, followed by monthly dosing at weeks 4, 8, 12 and 16.
- Patients will be limited to receiving two doses of secukinumab per prescription at their pharmacy during the initial 3 weeks, then one dose per prescription thereafter.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond eight doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial eight doses to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
- Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be considered for one 150 mg dose of

SECUKINUMAB

secukinumab every month for a period of 12 months. [Note: For patients who continue to have active Ankylosing Spondylitis, a monthly maintenance dosage of 300 mg may be considered.] Ongoing coverage may be considered if the patient is re-assessed by an RA Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for secukinumab for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

150 MG / ML INJECTION SYRINGE				
00002438070	COSENTYX	NOV	$	840.0000

TOFACITINIB CITRATE

Rheumatoid Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for three months as follows:
- Tofacitinib 5 mg tablet: one tablet twice daily.
- Tofacitinib 11 mg extended-release tablet: one tablet daily.
- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond three months, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three months to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 5 mg twice daily or 11 mg once daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, or
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be

TOFACITINIB CITRATE

rounded to the correct number of decimal places as indicated above.

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent or other Janus kinase (JAK) inhibitors."

All requests (including renewal requests) for tofacitinib for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Baricitinib/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:
- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

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

Immunosuppressive therapy as follows may also be initiated if in the clinician's judgment a trial is warranted:
i) Azathioprine: minimum of 2 mg/kg/day for a minimum of 2 months; OR
ii) 6-mercaptopurine: minimum of 1 mg/kg/day for a minimum of 2 months

For coverage, this drug must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross ('Specialist').

Initial coverage may be approved for an initial dose of 10 mg twice daily for 8 weeks. As an interim measure, coverage will be provided for additional doses of 5 mg twice daily for 4 weeks, to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.

- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist after 8 weeks but no longer than 12 weeks after treatment to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 5 mg twice daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;

TOFACITINIB CITRATE

2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of tofacitinib therapy.

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent."

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg, the maintenance dose may be adjusted from 5 mg to 10 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

All requests (including renewal requests) for tofacitinib for Ulcerative Colitis must be completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

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

TOFACITINIB CITRATE

Rheumatoid Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory or intolerant to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

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

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

- Initial coverage may be approved for three months as follows:
- Tofacitinib 5 mg tablet: one tablet twice daily.
- Tofacitinib 11 mg extended-release tablet: one tablet daily.
- Patients will be limited to receiving a one-month supply of tofacitinib per prescription at their pharmacy.
- Patients will not be permitted to switch back to tofacitinib if they were deemed unresponsive to therapy.

For continued coverage beyond three months, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three months to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 5 mg twice daily or 11 mg once daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, or
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be

TOFACITINIB CITRATE

rounded to the correct number of decimal places as indicated above.

Coverage cannot be provided for tofacitinib when intended for use in combination with a biologic agent or other Janus kinase (JAK) inhibitors."

All requests (including renewal requests) for tofacitinib for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Baricitinib/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib for Rheumatoid Arthritis Special Authorization Request Form (ABC 60027).

11 MG (BASE)	ORAL	EXTENDED-RELEASE TABLET			
00002470608	XELJANZ XR		PFI	$	47.9178