Updates to the Alberta Drug Benefit List

Effective February 1, 2024

Alberta Government

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Administered by Alberta Blue Cross
on behalf of Alberta Health.

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

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Special Authorization

The following drug product(s) will be considered for coverage by Special Authorization effective February 1, 2024 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
HADLIMA PUSHTOUCH (40 MG / 0.4 ML PEN) 40 MG / SYRINGE INJECTION	ADALIMUMAB	00002533480	SSB
HADLIMA (40 MG / 0.4 ML SYRINGE) 40 MG / SYRINGE INJECTION	ADALIMUMAB	00002533472	SSB
YUFLYMA (40 MG / 0.4 ML) 40 MG / SYRINGE INJECTION	ADALIMUMAB	00002523760	CHC
YUFLYMA (80 MG / 0.8 ML) 80 MG / SYRINGE INJECTION	ADALIMUMAB	00002535084	CHC
YUFLYMA (80 MG / 0.8 ML) 80 MG / SYRINGE INJECTION	ADALIMUMAB	00002535076	CHC
ZEPOSIA (INITIATION PACK) 0.23 MG / 0.46 MG CAPSULE	OZANIMOD HCL	00002506009	BMS
ZEPOSIA 0.92 MG CAPSULE	OZANIMOD HCL	00002505991	BMS

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-RIVAROXABAN 2.5 MG TABLET	RIVAROXABAN	00002541734	APX
PMS-RIVAROXABAN 2.5 MG TABLET	RIVAROXABAN	00002527537	PMS
REDDY-RIVAROXABAN 2.5 MG TABLET	RIVAROXABAN	00002524503	DRL
RIVAROXABAN 2.5 MG TABLET	RIVAROXABAN	00002541467	SIV
SANDOZ RIVAROXABAN 2.5 MG TABLET	RIVAROXABAN	00002537877	SDZ
TARO-RIVAROXABAN 2.5 MG TABLET	RIVAROXABAN	00002526786	TAR

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002470500	APX
APO-RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002470519	APX
ATOMOXETINE 10 MG CAPSULE	ATOMOXETINE HYDROCHLORIDE	00002467747	SNS
ATOMOXETINE 18 MG CAPSULE	ATOMOXETINE HYDROCHLORIDE	00002467755	SNS
ATOMOXETINE 25 MG CAPSULE	ATOMOXETINE HYDROCHLORIDE	00002467763	SNS
ATOMOXETINE 40 MG CAPSULE	ATOMOXETINE HYDROCHLORIDE	00002467771	SNS
ATOMOXETINE 60 MG CAPSULE	ATOMOXETINE HYDROCHLORIDE	00002467798	SNS

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
ATOMOXETINE 80 MG CAPSULE	ATOMOXETINE HYDROCHLORIDE	00002467801	SNS
ATOMOXETINE 100 MG CAPSULE	ATOMOXETINE HYDROCHLORIDE	00002467828	SNS
JAMP TROSPIUM 20 MG TABLET	TROSPIUM CHLORIDE	00002506661	JPC
PMS-RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002512068	PMS
PMS-RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002512076	PMS
REDDY-RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002472430	DRL
REDDY-RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002472422	DRL
RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002541483	SIV
RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002541491	SIV
SANDOZ RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002482231	SDZ
SANDOZ RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002482258	SDZ
TARO-RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002483815	TAR
TARO-RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002483823	TAR
TEVA-RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002507218	TEV
TEVA-RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002507226	TEV

Restricted Benefit(s)

Additional Brand(s) and/or Strength(s) of Drug Product(s) Available by Restricted Benefit

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002470497	APX
PMS-METHYLPHENIDATE CR 10 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002536943	PMS
PMS-METHYLPHENIDATE CR 15 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002536951	PMS
PMS-METHYLPHENIDATE CR 20 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002536978	PMS
PMS-METHYLPHENIDATE CR 30 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002536986	PMS
PMS-METHYLPHENIDATE CR 40 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002536994	PMS
PMS-METHYLPHENIDATE CR 50 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002537001	PMS

Additional Brand(s) and/or Strength(s) of Drug Product(s) Available by Restricted Benefit, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
PMS-METHYLPHENIDATE CR 60 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002537028	PMS
PMS-METHYLPHENIDATE CR 80 MG EXTENDED-RELEASE CAPSULE	METHYLPHENIDATE HYDROCHLORIDE	00002537036	PMS
PMS-RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002512041	PMS
REDDY-RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002472414	DRL
RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002541475	SIV
SANDOZ RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002482223	SDZ
TARO-RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002483807	TAR
TEVA-RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002507196	TEV

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
AURO-LURASIDONE 20 MG TABLET	LURASIDONE HYDROCHLORIDE	00002513986	AUR
AURO-LURASIDONE 40 MG TABLET	LURASIDONE HYDROCHLORIDE	00002513994	AUR
AURO-LURASIDONE 60 MG TABLET	LURASIDONE HYDROCHLORIDE	00002514001	AUR
AURO-LURASIDONE 80 MG TABLET	LURASIDONE HYDROCHLORIDE	00002514028	AUR
AURO-LURASIDONE 120 MG TABLET	LURASIDONE HYDROCHLORIDE	00002514036	AUR
AURO-VALGANCICLOVIR 50 MG / ML SUSPENSION	VALGANCICLOVIR HCL	00002535483	AUR
FLECAINIDE 50 MG TABLET	FLECAINIDE ACETATE	00002534800	SNS
FLECAINIDE 100 MG TABLET	FLECAINIDE ACETATE	00002534819	SNS
FLUCONAZOLE 50 MG TABLET	FLUCONAZOLE	00002534886	SIV
FLUCONAZOLE 100 MG TABLET	FLUCONAZOLE	00002534894	SIV
GLYCOPYRROLATE 0.2 MG / ML INJECTION	GLYCOPYRROLATE	00002382857	OMG
GLYCOPYRROLATE MULTIDOSE 0.2 MG / ML INJECTION	GLYCOPYRROLATE	00002382849	OMG
M-CITALOPRAM 20 MG TABLET	CITALOPRAM HYDROBROMIDE	00002467836	MTR
M-CITALOPRAM 40 MG TABLET	CITALOPRAM HYDROBROMIDE	00002467844	MTR
M-DORZOLAMIDE-TIMOLOL 2% / 0.5% OPHTHALMIC SOLUTION	DORZOLAMIDE HYDROCHLORIDE / TIMOLOL MALEATE	00002537796	MTR
METHOTREXATE INJECTION BP 7.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002422166	PMS

Added Product(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
METHOTREXATE INJECTION BP 10 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002422174	PMS
METHOTREXATE (0.6 ML SYRINGE) 15 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002422182	PMS
METHOTREXATE (0.8 ML SYRINGE) 20 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002422190	PMS
METHOTREXATE INJECTION BP 25 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002422204	PMS
MEZERA 500 MG DELAYED-RELEASE TABLET	MESALAZINE	00002524481	AVP
MINT-BETAHISTINE 8 MG TABLET	BETAHISTINE DIHYDROCHLORIDE	00002538121	MPI
MINT-BETAHISTINE 16 MG TABLET	BETAHISTINE DIHYDROCHLORIDE	00002538148	MPI
MINT-METFORMIN 500 MG TABLET	METFORMIN HYDROCHLORIDE	00002388766	MPI
MINT-METFORMIN 850 MG TABLET	METFORMIN HYDROCHLORIDE	00002388774	MPI
MINT-METRONIDAZOLE 250 MG TABLET	METRONIDAZOLE	00002535807	MPI
MIRTAZAPINE 15 MG TABLET	MIRTAZAPINE	00002532689	SNS
ONDANSETRON ODT 4 MG ORAL DISINTEGRATING TABLET / FILM	ONDANSETRON	00002524279	SNS
ONDANSETRON ODT 8 MG ORAL DISINTEGRATING TABLET / FILM	ONDANSETRON	00002524287	SNS
PMS-HYDROCHLOROTHIAZIDE 25 MG TABLET	HYDROCHLOROTHIAZIDE	00002247386	PMS
PMS-HYDROCHLOROTHIAZIDE 50 MG TABLET	HYDROCHLOROTHIAZIDE	00002247387	PMS
RISPERIDONE 0.25 MG TABLET	RISPERIDONE	00002533804	SIV
RISPERIDONE 0.5 MG TABLET	RISPERIDONE	00002533928	SIV
RISPERIDONE 1 MG TABLET	RISPERIDONE	00002533936	SIV
RISPERIDONE 2 MG TABLET	RISPERIDONE	00002533944	SIV
RISPERIDONE 3 MG TABLET	RISPERIDONE	00002533952	SIV
RISPERIDONE 4 MG TABLET	RISPERIDONE	00002533960	SIV
TEVA-RISPERIDONE 0.5 MG TABLET	RISPERIDONE	00002264188	TEV

New Established Interchangeable (IC) Grouping(s)

The following IC Grouping(s) have been established and LCA pricing will be applied effective March 1, 2024.

Generic Description	Strength / Form	New LCA Price
METHYLPHENIDATE HCL	10 MG EXTENDED-RELEASE CAPSULE	0.6993
METHYLPHENIDATE HCL	15 MG EXTENDED-RELEASE CAPSULE	1.0028
METHYLPHENIDATE HCL	20 MG EXTENDED-RELEASE CAPSULE	1.2923
METHYLPHENIDATE HCL	30 MG EXTENDED-RELEASE CAPSULE	1.7756
METHYLPHENIDATE HCL	40 MG EXTENDED-RELEASE CAPSULE	2.2620
METHYLPHENIDATE HCL	50 MG EXTENDED-RELEASE CAPSULE	2.7450
METHYLPHENIDATE HCL	60 MG EXTENDED-RELEASE CAPSULE	3.1943
METHYLPHENIDATE HCL	80 MG EXTENDED-RELEASE CAPSULE	4.2113
METRONIDAZOLE	250 MG TABLET	0.0572
RIVAROXABAN	2.5 MG TABLET	0.3550
RIVAROXABAN	10 MG TABLET	0.7175
RIVAROXABAN	15 MG TABLET	0.7175
RIVAROXABAN	20 MG TABLET	0.7175
VALGANCICLOVIR HCL	50 MG/ML SUSPENSION	2.0589

Least Cost Alternative (LCA) Price Change(s)

*The following established IC Grouping(s) are affected and a revised LCA price has been established. Groupings affected by a price decrease, will be effective March 1, 2024. Please review the online **Interactive Drug Benefit List** for further information.*

Generic Description	Strength / Form	New LCA Price
ACEBUTOLOL HCL	100 MG TABLET	0.1871
ACEBUTOLOL HCL	200 MG TABLET	0.2808
ACEBUTOLOL HCL	400 MG TABLET	0.5348
CLARITHROMYCIN	125 MG / 5 ML SUSPENSION	0.2388
CLARITHROMYCIN	250 MG / 5 ML SUSPENSION	0.4685
METRONIDAZOLE	250 MG TABLET	0.0572
TROSPIUM CHLORIDE	20 MG TABLET	0.4072

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until February 29, 2024. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-ACEBUTOLOL 100 MG TABLET	ACEBUTOLOL HCL	00002147602	APX
APO-ACEBUTOLOL 200 MG TABLET	ACEBUTOLOL HCL	00002147610	APX
APO-ACEBUTOLOL 400 MG TABLET	ACEBUTOLOL HCL	00002147629	APX
MAR-TROSPIUM 20 MG TABLET	TROSPIUM CHLORIDE	00002488353	MAR
METRONIDAZOLE 250 MG TABLET	METRONIDAZOLE	00000545066	AAP
KERENDIA 10 MG TABLET	FINERENONE	00002531917	BAI
KERENDIA 20 MG TABLET	FINERENONE	00002531925	BAI
SANDOZ MORPHINE SR 60 MG SUSTAINED-RELEASE TABLET	MORPHINE SULFATE	00002244792	SDZ
TARO-CLARITHROMYCIN 125 MG / 5 ML SUSPENSION	CLARITHROMYCIN	00002390442	TAR
TARO-CLARITHROMYCIN 250 MG / 5ML SUSPENSION	CLARITHROMYCIN	00002390450	TAR
TEVA-ACEBUTOLOL 100 MG TABLET	ACEBUTOLOL HCL	00002204517	TEV
TEVA-ACEBUTOLOL 200 MG TABLET	ACEBUTOLOL HCL	00002204525	TEV
TEVA-ACEBUTOLOL 400 MG TABLET	ACEBUTOLOL HCL	00002204533	TEV
TEVA-MORPHINE SR 60 MG SUSTAINED-RELEASE TABLET	MORPHINE SULFATE	00002302780	TEV

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 February 1, 2024, 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 March 1, 2024 claims will no longer pay for these product(s).

Trade Name / Strength / Form	Generic Description	DIN	MFR
ANDROCUR-DEPOT 100 MG / ML INJECTION	CYPROTERONE ACETATE	00000704423	PMS
AURO-AMOXICILLIN 25 MG / ML SUSPENSION	AMOXICILLIN TRIHYDRATE	00002458586	AUR
AURO-INDOMETHACIN 50 MG CAPSULE	INDOMETHACIN	00002499223	AUR
AURO-PRAVASTATIN 10 MG TABLET	PRAVASTATIN SODIUM	00002458977	AUR
AURO-PRAVASTATIN 20 MG TABLET	PRAVASTATIN SODIUM	00002458985	AUR
AURO-PRAVASTATIN 40 MG TABLET	PRAVASTATIN SODIUM	00002458993	AUR
CEFAZOLIN 1 G / VIAL INJECTION	CEFAZOLIN SODIUM	00002297205	APX
CEFAZOLIN 10 G / VIAL INJECTION	CEFAZOLIN SODIUM	00002297213	APX
CEFOXITIN 1 G / VIAL INJECTION	CEFOXITIN SODIUM	00002291711	APX

Discontinued Listing(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
CEFOXITIN 2 G / VIAL INJECTION	CEFOXITIN SODIUM	00002291738	APX
CEFTRIAXONE FOR INJECTION USP 1 G / VIAL INJECTION	CEFTRIAXONE SODIUM	00002292874	APX
CEFTRIAXONE FOR INJECTION USP 2 G / VIAL INJECTION	CEFTRIAXONE SODIUM	00002292882	APX
FRAGMIN 10,000 IU / ML INJECTION	DALTEPARIN SODIUM	00002132664	PFI
JAMP-IRBESARTAN 75 MG TABLET	IRBESARTAN	00002418193	JPC
JAMP-IRBESARTAN 150 MG TABLET	IRBESARTAN	00002418207	JPC
JAMP-IRBESARTAN 300 MG TABLET	IRBESARTAN	00002418215	JPC
JAMP-IRBESARTAN-HCTZ 300 MG / 12.5 MG TABLET	IRBESARTAN	00002418231	JPC
JAMP-IRBESARTAN-HCTZ 300 MG / 25 MG TABLET	IRBESARTAN	00002418258	JPC
JAMP-MONTELUKAST 5 MG CHEWABLE TABLET	MONTELUKAST SODIUM	00002442361	JPC
JAMP-ONDANSETRON (UNPRESERVED) 2 MG / ML INJECTION	ONDANSETRON HCL DIHYDRATE	00002420414	JPC
JAMP-ONDANSETRON (WITH PRESERVATIVE) 2 MG / ML INJECTION	ONDANSETRON HCL DIHYDRATE	00002420422	JPC
JAMP-RIZATRIPTAN IR 10 MG TABLET	RIZATRIPTAN BENZOATE	00002429241	JPC
JAMP-SERTRALINE 50 MG CAPSULE	SERTRALINE HCL	00002357151	JPC
LOESTRIN 1.5 / 30 (21 DAY) 1.5 MG / 0.03 MG ORAL TABLET	NORETHINDRONE ACETATE	00000297143	ALL
METHYLPREDNISOLONE SODIUM SUCCINATE 1 MG / VIAL INJECTION	METHYLPREDNISOLONE SODIUM SUCCINATE	00002241229	TEV
METHYLPREDNISOLONE SODIUM SUCCINATE 500 MG / VIAL INJECTION	METHYLPREDNISOLONE SODIUM SUCCINATE	00002231895	TEV
MINESTRIN 1 / 20 (21 DAY) 1 MG / 20 MCG TABLET	NORETHINDRONE ACETATE	00000315966	ALL
MINESTRIN 1 / 20 (28 DAY) 1 MG / 20 MCG TABLET	NORETHINDRONE ACETATE	00000343838	ALL
PRED MILD 0.12% OPHTHALMIC SUSPENSION	PREDNISOLONE ACETATE	00000299405	ALL
SKYRIZI 75 MG / SYRINGE INJECTION	RISANKIZUMAB	00002487454	ABV
STATEX 50 MG TABLET	MORPHINE SULFATE	00000675962	PAL
STERILE CEFAZOLIN SODIUM 10 G / VIAL INJECTION	CEFAZOLIN SODIUM	00002108135	TEV
TARO-WARFARIN 7.5 MG TABLET	WARFARIN SODIUM	00002242697	TAR

PART 2

Drug Additions

ACEBUTOLOL HCL

100 MG (BASE) ORAL TABLET

00002147602	**APO-ACEBUTOLOL**	**APX**	$	**0.1871**
00002204517	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.1871**

200 MG (BASE) ORAL TABLET

00002147610	**APO-ACEBUTOLOL**	**APX**	$	**0.2808**
00002204525	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.2808**

400 MG (BASE) ORAL TABLET

00002147629	**APO-ACEBUTOLOL**	**APX**	$	**0.5348**
00002204533	**TEVA-ACEBUTOLOL**	**TEV**	$	**0.5348**

BETAHISTINE DIHYDROCHLORIDE

8 MG ORAL TABLET

00002449145	**AURO-BETAHISTINE**	**AUR**	$	**0.0637**
00002519682	**M-BETAHISTINE**	**MTR**	$	**0.0637**
00002538121	**MINT-BETAHISTINE**	**MPI**	$	**0.0637**
00002280183	**TEVA-BETAHISTINE**	**TEV**	$	**0.0637**

16 MG ORAL TABLET

00002449153	**AURO-BETAHISTINE**	**AUR**	$	**0.1106**
00002466449	**BETAHISTINE**	**SNS**	$	**0.1106**
00002519690	**M-BETAHISTINE**	**MTR**	$	**0.1106**
00002538148	**MINT-BETAHISTINE**	**MPI**	$	**0.1106**
00002330210	**PMS-BETAHISTINE**	**PMS**	$	**0.1106**
00002280191	**TEVA-BETAHISTINE**	**TEV**	$	**0.1106**
00002243878	SERC	BGP	$	0.5282

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**
00002467836	**M-CITALOPRAM**	**MTR**	$	**0.1332**
00002371898	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429705	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409011	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002443880	**NATCO-CITALOPRAM**	**NTP**	$	**0.1332**
00002477645	**NRA-CITALOPRAM**	**NRA**	$	**0.1332**
00002248010	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002303264	**RIVA-CITALOPRAM**	**RIV**	$	**0.1332**
00002355272	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293218	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239607	CELEXA	LBC	$	1.5234
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**
00002467844	**M-CITALOPRAM**	**MTR**	$	**0.1332**
00002371901	**MAR-CITALOPRAM**	**MAR**	$	**0.1332**
00002429713	**MINT-CITALOPRAM**	**MPI**	$	**0.1332**
00002409038	**NAT-CITALOPRAM**	**NTP**	$	**0.1332**
00002443899	**NATCO-CITALOPRAM**	**NTP**	$	**0.1332**
00002477653	**NRA-CITALOPRAM**	**NRA**	$	**0.1332**
00002248011	**PMS-CITALOPRAM**	**PMS**	$	**0.1332**
00002303272	**RIVA-CITALOPRAM**	**RIV**	$	**0.1332**
00002355280	**SEPTA-CITALOPRAM**	**SEP**	$	**0.1332**
00002293226	**TEVA-CITALOPRAM**	**TEV**	$	**0.1332**
00002239608	CELEXA	LBC	$	1.5234

CLARITHROMYCIN

25 MG / ML ORAL SUSPENSION				
00002390442	**TARO-CLARITHROMYCIN**	**TAR**	$	**0.2388**
00002146908	BIAXIN	BGP	$	0.3180
50 MG / ML ORAL SUSPENSION				
00002390450	**TARO-CLARITHROMYCIN**	**TAR**	$	**0.4685**
00002244641	BIAXIN	BGP	$	0.6229

DORZOLAMIDE HCL/ TIMOLOL MALEATE

2 % (BASE) * 0.5 % (BASE) OPHTHALMIC SOLUTION				
00002299615	**APO-DORZO-TIMOP**	**APX**	$	**1.9887**
00002489635	**DORZOLAMIDE AND TIMOLOL**	**TGT**	$	**1.9887**
00002522020	**DORZOLAMIDE-TIMOLOL**	**JPC**	$	**1.9887**
00002457539	**JAMP DORZOLAMIDE-TIMOLOL**	**JPC**	$	**1.9887**
00002537796	**M-DORZOLAMIDE-TIMOLOL**	**MTR**	$	**1.9887**
00002437686	**MED-DORZOLAMIDE-TIMOLOL**	**GMP**	$	**1.9887**
00002441659	**RIVA-DORZOLAMIDE/TIMOLOL**	**RIV**	$	**1.9887**
00002344351	**SANDOZ DORZOLAMIDE/ TIMOLOL**	**SDZ**	$	**1.9887**
⊠ 00002258692	COSOPT PRESERVATIVE-FREE	ELV	$	2.7920
00002240113	COSOPT	ELV	$	6.8933

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

FLECAINIDE ACETATE

50 MG ORAL TABLET

00002275538	APO-FLECAINIDE	APX	$	0.1389
00002459957	AURO-FLECAINIDE	AUR	$	0.1389
00002534800	FLECAINIDE	SNS	$	0.1389
00002493705	JAMP FLECAINIDE	JPC	$	0.1389
00002476177	MAR-FLECAINIDE	MAR	$	0.1389
00002530066	NRA-FLECAINIDE	NRA	$	0.1389

100 MG ORAL TABLET

00002275546	APO-FLECAINIDE	APX	$	0.2779
00002459965	AURO-FLECAINIDE	AUR	$	0.2779
00002534819	FLECAINIDE	SNS	$	0.2779
00002493713	JAMP FLECAINIDE	JPC	$	0.2779
00002476185	MAR-FLECAINIDE	MAR	$	0.2779
00002530074	NRA-FLECAINIDE	NRA	$	0.2779

FLUCONAZOLE

50 MG ORAL TABLET

00002281260	ACT FLUCONAZOLE	TEV	$	1.2904
00002237370	APO-FLUCONAZOLE	APX	$	1.2904
00002517396	FLUCONAZOLE	SNS	$	1.2904
00002534886	FLUCONAZOLE	SIV	$	1.2904
00002245292	MYLAN-FLUCONAZOLE	MYP	$	1.2904
00002236978	NOVO-FLUCONAZOLE	TEV	$	1.2904
00002245643	PMS-FLUCONAZOLE	PMS	$	1.2904

100 MG ORAL TABLET

00002281279	ACT FLUCONAZOLE	TEV	$	2.2890
00002237371	APO-FLUCONAZOLE	APX	$	2.2890
00002517418	FLUCONAZOLE	SNS	$	2.2890
00002245293	MYLAN-FLUCONAZOLE	MYP	$	2.2890
00002236979	NOVO-FLUCONAZOLE	TEV	$	2.2890
00002245644	PMS-FLUCONAZOLE	PMS	$	2.2890
00002534894	FLUCONAZOLE	SIV	$	2.2891

GLYCOPYRROLATE

0.2 MG / ML INJECTION

00002039508	GLYCOPYRROLATE	SDZ	$	2.7825
00002382857	GLYCOPYRROLATE	OMG	$	2.7825
00002473879	GLYCOPYRROLATE (0.2 MG/1 ML)	STM	$	2.7825
00002473895	GLYCOPYRROLATE (0.4 MG/2 ML)	STM	$	2.7825
00002473887	GLYCOPYRROLATE (4 MG/20 ML)	STM	$	2.7825
00002382849	GLYCOPYRROLATE MULTIDOSE	OMG	$	2.7825

HYDROCHLOROTHIAZIDE

25 MG ORAL TABLET

00000326844	APO-HYDRO	APX	$	0.0157
00002360594	HYDROCHLOROTHIAZIDE	SNS	$	0.0157
00002247386	PMS-HYDROCHLOROTHIAZIDE	PMS	$	0.0157
00000021474	TEVA-HYDRAZIDE	TEV	$	0.0157

50 MG ORAL TABLET

00000312800	APO-HYDRO	APX	$	0.0217
00002360608	HYDROCHLOROTHIAZIDE	SNS	$	0.0217
00002247387	PMS-HYDROCHLOROTHIAZIDE	PMS	$	0.0217
00000021482	TEVA-HYDRAZIDE	TEV	$	0.0217

IPRATROPIUM BROMIDE

250 MCG / ML INHALATION SOLUTION

00002126222	**AA-IPRAVENT**	**AAP**	$	**0.3155**
00002231136	**PMS-IPRATROPIUM**	**PMS**	$	**0.3155**

LURASIDONE HCL

20 MG ORAL TABLET

00002513986	**AURO-LURASIDONE**	**AUR**	$	**1.2250**
00002516438	**JAMP LURASIDONE**	**JPC**	$	**1.2250**
00002505878	**PMS-LURASIDONE**	**PMS**	$	**1.2250**
00002521075	**SANDOZ LURASIDONE**	**SDZ**	$	**1.2250**
00002504499	**TARO-LURASIDONE**	**TAR**	$	**1.2250**
00002422050	LATUDA	SUN	$	4.2500

40 MG ORAL TABLET

00002513994	**AURO-LURASIDONE**	**AUR**	$	**1.2250**
00002516446	**JAMP LURASIDONE**	**JPC**	$	**1.2250**
00002505886	**PMS-LURASIDONE**	**PMS**	$	**1.2250**
00002521091	**SANDOZ LURASIDONE**	**SDZ**	$	**1.2250**
00002504502	**TARO-LURASIDONE**	**TAR**	$	**1.2250**
00002387751	LATUDA	SUN	$	4.2500

60 MG ORAL TABLET

00002514001	**AURO-LURASIDONE**	**AUR**	$	**1.2250**
00002516454	**JAMP LURASIDONE**	**JPC**	$	**1.2250**
00002505894	**PMS-LURASIDONE**	**PMS**	$	**1.2250**
00002521105	**SANDOZ LURASIDONE**	**SDZ**	$	**1.2250**
00002504510	**TARO-LURASIDONE**	**TAR**	$	**1.2250**
00002413361	LATUDA	SUN	$	4.2500

80 MG ORAL TABLET

00002514028	**AURO-LURASIDONE**	**AUR**	$	**1.2250**
00002516462	**JAMP LURASIDONE**	**JPC**	$	**1.2250**
00002505908	**PMS-LURASIDONE**	**PMS**	$	**1.2250**
00002521113	**SANDOZ LURASIDONE**	**SDZ**	$	**1.2250**
00002504529	**TARO-LURASIDONE**	**TAR**	$	**1.2250**
00002387778	LATUDA	SUN	$	4.2500

120 MG ORAL TABLET

00002514036	**AURO-LURASIDONE**	**AUR**	$	**1.2250**
00002516470	**JAMP LURASIDONE**	**JPC**	$	**1.2250**
00002505916	**PMS-LURASIDONE**	**PMS**	$	**1.2250**
00002521121	**SANDOZ LURASIDONE**	**SDZ**	$	**1.2250**
00002504537	**TARO-LURASIDONE**	**TAR**	$	**1.2250**
00002387786	LATUDA	SUN	$	4.2500

MESALAZINE

500 MG ORAL DELAYED-RELEASE TABLET

00002524481	MEZERA	AVP	$	0.6378

METFORMIN HCL

500 MG ORAL TABLET				
00002257726	**ACT METFORMIN**	**TEV**	$	**0.0247**
00002438275	**AURO-METFORMIN**	**AUR**	$	**0.0247**
00002380196	**JAMP-METFORMIN**	**JPC**	$	**0.0247**
00002378620	**MAR-METFORMIN**	**MAR**	$	**0.0247**
00002353377	**METFORMIN**	**SNS**	$	**0.0247**
00002385341	**METFORMIN FC**	**SIV**	$	**0.0247**
00002388766	**MINT-METFORMIN**	**MPI**	$	**0.0247**
00002536439	**NRA-METFORMIN**	**NRA**	$	**0.0247**
00002223562	**PMS-METFORMIN**	**PMS**	$	**0.0247**
00002520303	**PMSC-METFORMIN**	**PMS**	$	**0.0247**
00002531895	**PRZ-METFORMIN**	**PCI**	$	**0.0247**
00002246820	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.0247**
00002099233	GLUCOPHAGE	SAV	$	0.2716
850 MG ORAL TABLET				
00002257734	**ACT METFORMIN**	**TEV**	$	**0.0339**
00002438283	**AURO-METFORMIN**	**AUR**	$	**0.0339**
00002380218	**JAMP-METFORMIN**	**JPC**	$	**0.0339**
00002378639	**MAR-METFORMIN**	**MAR**	$	**0.0339**
00002353385	**METFORMIN**	**SNS**	$	**0.0339**
00002385368	**METFORMIN FC**	**SIV**	$	**0.0339**
00002388774	**MINT-METFORMIN**	**MPI**	$	**0.0339**
00002536447	**NRA-METFORMIN**	**NRA**	$	**0.0339**
00002242589	**PMS-METFORMIN**	**PMS**	$	**0.0339**
00002520311	**PMSC-METFORMIN**	**PMS**	$	**0.0339**
00002531909	**PRZ-METFORMIN**	**PCI**	$	**0.0339**
00002246821	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.0339**
00002162849	GLUCOPHAGE	SAV	$	0.3673

METHOTREXATE SODIUM

7.5 MG / SYR (BASE) INJECTION SYRINGE				
00002422166	METHOTREXATE INJECTION BP	PMS	$	5.6000
10 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422174	METHOTREXATE INJECTION BP	PMS	$	7.0000
☒ 00002454831	METOJECT SUBCUTANEOUS	MDX	$	29.6400
15 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422182	METHOTREXATE (0.6 ML SYRINGE)	PMS	$	8.4000
00002491311	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**24.5700**
00002454858	**METOJECT SUBCUTANEOUS**	**MDX**	$	**24.5700**
20 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422190	METHOTREXATE (0.8 ML SYRINGE)	PMS	$	11.2000
00002491346	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**26.2500**
00002454866	**METOJECT SUBCUTANEOUS**	**MDX**	$	**26.2500**
25 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422204	METHOTREXATE INJECTION BP	PMS	$	12.2000
00002491362	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**29.2500**
00002454874	**METOJECT SUBCUTANEOUS**	**MDX**	$	**29.2500**

METHYLPHENIDATE HCL

10 MG ORAL CONTROLLED-RELEASE CAPSULE

00002536943	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**0.6993**
00002277166	BIPHENTIN	ELV	$	0.7964

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

15 MG ORAL CONTROLLED-RELEASE CAPSULE

00002536951	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**1.0028**
00002277131	BIPHENTIN	ELV	$	1.1393

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

20 MG ORAL CONTROLLED-RELEASE CAPSULE

00002536978	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**1.2923**
00002277158	BIPHENTIN	ELV	$	1.4726

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

30 MG ORAL CONTROLLED-RELEASE CAPSULE

00002536986	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**1.7756**
00002277174	BIPHENTIN	ELV	$	2.0213

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

40 MG ORAL CONTROLLED-RELEASE CAPSULE

00002536994	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**2.2620**
00002277182	BIPHENTIN	ELV	$	2.5746

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

50 MG ORAL CONTROLLED-RELEASE CAPSULE

00002537001	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**2.7450**
00002277190	BIPHENTIN	ELV	$	3.1227

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

60 MG ORAL CONTROLLED-RELEASE CAPSULE

00002537028	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**3.1943**
00002277204	BIPHENTIN	ELV	$	3.6341

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

80 MG ORAL CONTROLLED-RELEASE CAPSULE

00002537036	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**4.2113**
00002277212	BIPHENTIN	ELV	$	4.7964

"For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as a restricted benefit for patients 6 years of age and older."

METRONIDAZOLE

250 MG ORAL TABLET

00000545066	**METRONIDAZOLE**	**AAP**	$	**0.0572**
00002535807	**MINT-METRONIDAZOLE**	**MPI**	$	**0.0572**

MIRTAZAPINE

15 MG ORAL TABLET

00002286610	**APO-MIRTAZAPINE**	**APX**	$	**0.0974**
00002411695	**AURO-MIRTAZAPINE**	**AUR**	$	**0.0974**
00002496666	**MIRTAZAPINE**	**SIV**	$	**0.0974**
00002532689	**MIRTAZAPINE**	**SNS**	$	**0.0974**
00002256096	**MYLAN-MIRTAZAPINE**	**MYP**	$	**0.0974**
00002273942	**PMS-MIRTAZAPINE**	**PMS**	$	**0.0974**
00002250594	**SANDOZ MIRTAZAPINE**	**SDZ**	$	**0.0974**

MORPHINE SULFATE

60 MG ORAL SUSTAINED-RELEASE TABLET

00002244792	**SANDOZ MORPHINE SR**	**SDZ**	$	**1.2180**
00002302780	**TEVA-MORPHINE SR**	**TEV**	$	**1.2180**
00002014300	MS CONTIN	PUR	$	2.1263

ONDANSETRON

4 MG ORAL DISINTEGRATING TABLET/FILM

00002511282	**AURO-ONDANSETRON ODT**	**AUR**	$	**3.2720**
00002514966	**MAR-ONDANSETRON ODT**	**MAR**	$	**3.2720**
00002487330	**MINT-ONDANSETRON ODT**	**MPI**	$	**3.2720**
00002481723	**ONDANSETRON ODT**	**SDZ**	$	**3.2720**
00002519232	**ONDANSETRON ODT**	**JPC**	$	**3.2720**
00002524279	**ONDANSETRON ODT**	**SNS**	$	**3.2720**
00002389983	**ONDISSOLVE ODF**	**TAK**	$	**3.2720**
00002519445	**PMS-ONDANSETRON ODT**	**PMS**	$	**3.2720**
00002239372	ZOFRAN ODT	SDZ	$	14.7040

8 MG ORAL DISINTEGRATING TABLET/FILM

00002511290	**AURO-ONDANSETRON ODT**	**AUR**	$	**4.9930**
00002514974	**MAR-ONDANSETRON ODT**	**MAR**	$	**4.9930**
00002487349	**MINT-ONDANSETRON ODT**	**MPI**	$	**4.9930**
00002481731	**ONDANSETRON ODT**	**SDZ**	$	**4.9930**
00002519240	**ONDANSETRON ODT**	**JPC**	$	**4.9930**
00002524287	**ONDANSETRON ODT**	**SNS**	$	**4.9930**
00002389991	**ONDISSOLVE ODF**	**TAK**	$	**4.9930**
00002519453	**PMS-ONDANSETRON ODT**	**PMS**	$	**4.9930**
00002239373	ZOFRAN ODT	SDZ	$	22.4370

RISPERIDONE

0.25 MG ORAL TABLET

00002282119	**APO-RISPERIDONE**	**APX**	$	**0.0878**
00002359529	**JAMP-RISPERIDONE**	**JPC**	$	**0.0878**
00002371766	**MAR-RISPERIDONE**	**MAR**	$	**0.0878**
00002359790	**MINT-RISPERIDONE**	**MPI**	$	**0.0878**
00002252007	**PMS-RISPERIDONE**	**PMS**	$	**0.0878**
00002328305	**RAN-RISPERIDONE**	**RAN**	$	**0.0878**
00002356880	**RISPERIDONE**	**SNS**	$	**0.0878**
00002533804	**RISPERIDONE**	**SIV**	$	**0.0878**
00002303655	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.0878**
00002282690	**TEVA-RISPERIDONE**	**TEV**	$	**0.0878**

0.5 MG ORAL TABLET

00002282127	**APO-RISPERIDONE**	**APX**	$	**0.1470**
00002359537	**JAMP-RISPERIDONE**	**JPC**	$	**0.1470**
00002371774	**MAR-RISPERIDONE**	**MAR**	$	**0.1470**
00002359804	**MINT-RISPERIDONE**	**MPI**	$	**0.1470**
00002252015	**PMS-RISPERIDONE**	**PMS**	$	**0.1470**
00002328313	**RAN-RISPERIDONE**	**RAN**	$	**0.1470**
00002356899	**RISPERIDONE**	**SNS**	$	**0.1470**
00002533928	**RISPERIDONE**	**SIV**	$	**0.1470**
00002303663	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.1470**
00002264188	**TEVA-RISPERIDONE**	**TEV**	$	**0.1470**

RISPERIDONE

1 MG ORAL TABLET				
00002282135	APO-RISPERIDONE	APX	$	0.2031
00002359545	JAMP-RISPERIDONE	JPC	$	0.2031
00002371782	MAR-RISPERIDONE	MAR	$	0.2031
00002359812	MINT-RISPERIDON	MPI	$	0.2031
00002252023	PMS-RISPERIDONE	PMS	$	0.2031
00002328321	RAN-RISPERIDONE	RAN	$	0.2031
00002356902	RISPERIDONE	SNS	$	0.2031
00002533936	RISPERIDONE	SIV	$	0.2031
00002279800	SANDOZ RISPERIDONE	SDZ	$	0.2031
00002264196	TEVA-RISPERIDONE	TEV	$	0.2031
2 MG ORAL TABLET				
00002282143	APO-RISPERIDONE	APX	$	0.4062
00002359553	JAMP-RISPERIDONE	JPC	$	0.4062
00002371790	MAR-RISPERIDONE	MAR	$	0.4062
00002359820	MINT-RISPERIDON	MPI	$	0.4062
00002252031	PMS-RISPERIDONE	PMS	$	0.4062
00002328348	RAN-RISPERIDONE	RAN	$	0.4062
00002356910	RISPERIDONE	SNS	$	0.4062
00002533944	RISPERIDONE	SIV	$	0.4062
00002279819	SANDOZ RISPERIDONE	SDZ	$	0.4062
00002264218	TEVA-RISPERIDONE	TEV	$	0.4062
3 MG ORAL TABLET				
00002282151	APO-RISPERIDONE	APX	$	0.6083
00002359561	JAMP-RISPERIDONE	JPC	$	0.6083
00002371804	MAR-RISPERIDONE	MAR	$	0.6083
00002359839	MINT-RISPERIDON	MPI	$	0.6083
00002252058	PMS-RISPERIDONE	PMS	$	0.6083
00002328364	RAN-RISPERIDONE	RAN	$	0.6083
00002356929	RISPERIDONE	SNS	$	0.6083
00002533952	RISPERIDONE	SIV	$	0.6083
00002279827	SANDOZ RISPERIDONE	SDZ	$	0.6083
00002264226	TEVA-RISPERIDONE	TEV	$	0.6083
4 MG ORAL TABLET				
00002282178	APO-RISPERIDONE	APX	$	0.8111
00002359588	JAMP-RISPERIDONE	JPC	$	0.8111
00002371812	MAR-RISPERIDONE	MAR	$	0.8111
00002359847	MINT-RISPERIDON	MPI	$	0.8111
00002252066	PMS-RISPERIDONE	PMS	$	0.8111
00002328372	RAN-RISPERIDONE	RAN	$	0.8111
00002356937	RISPERIDONE	SNS	$	0.8111
00002533960	RISPERIDONE	SIV	$	0.8111
00002279835	SANDOZ RISPERIDONE	SDZ	$	0.8111
00002264234	TEVA-RISPERIDONE	TEV	$	0.8111

RIVAROXABAN

10 MG ORAL TABLET

00002470497	**APO-RIVAROXABAN**	**APX**	$	**0.7175**
00002512041	**PMS-RIVAROXABAN**	**PMS**	$	**0.7175**
00002472414	**REDDY-RIVAROXABAN**	**DRL**	$	**0.7175**
00002541475	**RIVAROXABAN**	**SIV**	$	**0.7175**
00002482223	**SANDOZ RIVAROXABAN**	**SDZ**	$	**0.7175**
00002483807	**TARO-RIVAROXABAN**	**TAR**	$	**0.7175**
00002507196	**TEVA-RIVAROXABAN**	**TEV**	$	**0.7175**
00002316986	XARELTO	BAI	$	2.8700

RESTRICTED BENEFIT -This product is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total knee replacement surgery. Coverage is restricted to two 14-day courses of therapy per patient per year.

This product is a benefit for the prophylaxis of venous thromboembolic events in patients who have undergone elective total hip replacement surgery. Coverage is restricted to two 35-day courses of therapy per patient per year.

TELMISARTAN/ AMLODIPINE BESYLATE

80 MG * 5 MG ORAL TABLET

00002473488	**APO-TELMISARTAN-AMLODIPINE**	**APX**	$	**0.5472**
00002371049	TWYNSTA	BOE	$	0.7376

80 MG * 10 MG ORAL TABLET

00002473496	**APO-TELMISARTAN-AMLODIPINE**	**APX**	$	**0.5472**
00002371057	TWYNSTA	BOE	$	0.7376

VALGANCICLOVIR HCL

50 MG / ML ORAL SUSPENSION

00002535483	**AURO-VALGANCICLOVIR**	**AUR**	$	**2.0589**
00002306085	VALCYTE	CAG	$	2.8825

PART 3

Special Authorization

ADALIMUMAB

Ankylosing Spondylitis

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

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

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

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

-Initial coverage may be approved for 12 weeks as follows: An initial 40 mg dose, followed by additional 40 mg doses administered every two weeks for up to 12 weeks after the first dose.
-Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
-Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
-Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed at 12 weeks by an RA Specialist after the initial twelve weeks of therapy to determine response.
2) The RA Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
-Reduction of the BASDAI score by at least 50% of the pre-treatment value or by 2 or more units, AND
-Reduction of the Spinal Pain VAS by 2 cm or more.

Following this assessment, continued coverage may be approved for one 40 mg dose every other week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by an RA Specialist every 24 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

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

Hidradenitis Suppurativa

"Special authorization may be provided for the treatment of adult patients with active moderate to severe Hidradenitis Suppurativa who meet all of the following criteria:

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- A total abscess and nodule (AN) count of 3 or greater.
- Lesions in at least two distinct anatomical areas, one of which must be Hurley Stage II or III.
- An inadequate response to a 90-day trial of systemic antibiotics AND documented non response to conventional therapy.
For coverage, this drug must be initiated by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved for 12 weeks as follows: an initial dose of 160 mg, followed by one 80 mg dose two weeks later, then 40 mg every week beginning four weeks after the initial dose, for a total of eleven doses.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial approval period the patient must meet the following criteria:

1) The patient must be assessed by a Dermatology Specialist after 12 weeks of treatment to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:

- Greater than or equal to 50% reduction in AN count from pre-treatment baseline AND
- no increase in abscess count or draining fistula count relative to pre-treatment baseline.

Note: Treatment with adalimumab should be discontinued if there is insufficient improvement after 12 weeks of treatment.

Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every week for an additional period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 24 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for adalimumab for Hidradenitis Suppurativa must be completed using the Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form (ABC 60058).

Moderately to Severely Active Crohn's Disease

"Special authorization coverage may be approved for coverage of adalimumab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease in patients who meet the following criteria:

-Adalimumab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for adalimumab for coverage for the treatment of Moderately to Severely Active Crohn's Disease patients ('Specialist').
-Patients must be 18 years of age or older to be considered for coverage of adalimumab.
-Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
-Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of

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induction dosing (e.g. initial coverage period).
-Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Prior to initiation of adalimumab therapy for New Patients:
'New Patients' are patients who have never been treated with adalimumab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of adalimumab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; OR refractory to, or dependent on, glucocorticoids: following at least one tapering dosing schedule of 40mg/day, tapering by 5 mg each week to 20 mg then tapering by 2.5mg each week to zero, or similar.

AND
b) Immunosuppressive therapy as follows:
-Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
-6-mercaptopurine: minimum of 1mg/kg/day for a minimum of 3 months; OR
-Methotrexate: minimum of 15mg/week for a minimum of 3 months.
OR
-Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease

-New Patients must meet the criteria above prior to being considered for approval.
-All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

-Coverage for Induction dosing may only be approved for New Patients (those who have never been treated with adalimumab by any health care provider).
-'Induction Dosing' means a maximum of one 160 mg dose of adalimumab per New Patient at Week 0 followed by an 80 mg dose at Week 2.
-New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.
-As an interim measure, 40mg doses of adalimumab will be provided at weeks 4, 6, 8 and 10 to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.

Maintenance Dosing:

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'Maintenance Dosing' means one 40 mg dose of adalimumab per patient provided no more often than every other week starting at Week 4 for an initial period of 12 months with subsequent renewals of 24 months to:
-New Patients following the completion of Induction Dosing; OR
-Existing Patients, who are patients that are being treated, or have previously been treated, with adalimumab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:

-The New Patient must be assessed by a Specialist within 12 weeks after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease; AND
-The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's Disease.

Maintenance Dosing for Existing Patients:

-The patient must be assessed by a Specialist (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's Disease; AND
-these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 40 mg dose of adalimumab per patient provided no more often than every other week for a period of 24 months, if the following criteria are met at the end of each 24 month period:

-The New Patient or the Existing Patient must be assessed by a Specialist (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's Disease; AND
-For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's Disease; OR
-For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score."

All requests (including renewal requests) for adalimumab for Moderately to Severely Active Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Special Authorization Request Form (ABC 60031).

Plaque Psoriasis

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

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-Cyclosporine (6 weeks treatment); AND
-Phototherapy (unless restricted by geographic location)

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

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

-Initial coverage may be approved for an initial dose of 80 mg, followed by one 40 mg dose every other week beginning one week after the first dose, for a total of nine doses.
-Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
-Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
-Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

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

Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every other week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 24 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

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

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

Polyarticular Juvenile Idiopathic Arthritis

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 years of age and older who:
- Have 5 or more active joints (defined by either swelling or limitation of motion plus pain and/or tenderness), AND
- Are refractory to one or more disease modifying anti-rheumatic agents (DMARDS) conventionally used in children (minimum three month trial).

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"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary (Pediatric Rheumatology Specialist).

- Coverage may be approved for 24 mg per square meter body surface area (maximum dose 40 mg) every other week for 12 weeks.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of abatacept) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from abatacept to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric Rheumatology Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient is a responder that meets the following criteria (ACR Pedi 30):
- 30% improvement from baseline in at least three of the following six response variables, with worsening of 30% or more in no more than one of the six variables. The variables include:
i. global assessment of the severity of the disease by the Pediatric Rheumatology Specialist,
ii. global assessment of overall well-being by the patient or parent,
iii. number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),
iv. number of joints with limitation of motion,
v. functional ability based on CHAQ scores,
vi. ESR or CRP
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Following this assessment, continued coverage may be approved for 24 mg per square meter body surface area (maximum dose 40 mg) every other week, for a maximum of 12 months. After 12 months, in order to be considered for continued coverage, the patient must be re-assessed every 24 months by a Pediatric Rheumatology Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric Rheumatology Specialist to determine response, and
2) The Pediatric Rheumatology Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

Once a child with pJIA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for adalimumab for Polyarticular Juvenile

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Idiopathic Arthritis must be completed using the Adalimumab/Etanercept/Tocilizumab for Polyarticular Juvenile Idiopathic Arthritis Special Authorization Request Form (ABC 60011).

Psoriatic Arthritis

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to:

-Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
-An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

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

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

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

-Initial coverage may be approved for 40 mg administered every other week for 8 weeks.
-Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
-Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
-Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 weeks after, treatment with this biologic agent to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
-ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
-An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 40 mg every other week, for an initial period of 12 months with subsequent renewals of 24 months.
Ongoing coverage may be considered if the following criteria are met at the end of each 24-month period:
1) The patient has been assessed by an RA Specialist to determine response; and
2) The RA Specialist must confirm in writing that the patient has maintained a response

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to therapy as indicated by:
-Confirmation of maintenance of ACR20 or
-Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.

It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

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

Rheumatoid Arthritis

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

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

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

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

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

-Initial coverage may be approved for five doses as follows: An initial 40 mg dose, followed by additional 40 mg doses at 2, 4, 6 and 8 weeks after the first dose.
-Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
-Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
-Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
-Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

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For continued coverage beyond 5 doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial five doses to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
-ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
-An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 40 mg every other week for an initial period of 12 months and subsequent renewals of 24 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 24-month period:
1) The patient has been assessed by an RA Specialist to determine response;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
-Confirmation of maintenance of ACR20, or
-Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.

It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for adalimumab for Rheumatoid Arthritis must be completed using the Abatacept/Adalimumab/Anakinra/Baricitinib/Certolizumab/Etanercept/Golimumab/Infliximab/Sarilumab/Tocilizumab/Tofacitinib/Upadacitinib 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 160 mg, followed by an 80 mg

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dose at week 2, then one 40 mg dose at weeks 4, 6 and 8. As an interim measure, an additional 40 mg dose of adalimumab will be provided at week 10 to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below, for a total of six doses.

- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 8 and 12 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 40 mg every 2 weeks for an initial period of 12 months and subsequent renewals of 24 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 24-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of adalimumab therapy."

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

40 MG / SYR INJECTION SYRINGE

☒	00002511045	ABRILADA (40 MG/0.8 ML INJ PEN)	PFI	$	471.2700
☒	00002511053	ABRILADA (40 MG/0.8 ML INJ SYR)	PFI	$	471.2700
☒	00002459299	AMGEVITA (40 MG/0.8 ML INJ SYR)	AMG	$	471.2700
☒	00002459302	AMGEVITA 40 MG/0.8 ML AUTOINJECTOR PEN	AMG	$	471.2700
☒	00002533472	HADLIMA (40 MG/0.4 ML SYRINGE)	SSB	$	471.2700
☒	00002473100	HADLIMA (40 MG/0.8 ML INJ PEN)	SSB	$	471.2700
☒	00002473097	HADLIMA (40 MG/0.8 ML INJ SYR)	SSB	$	471.2700
☒	00002533480	HADLIMA PUSHTOUCH (40 MG/0.4 ML PEN)	SSB	$	471.2700
☒	00002502402	HULIO (40 MG/0.8 ML INJ PEN)	BBC	$	471.2700
☒	00002502399	HULIO (40 MG/0.8 ML INJ SYR)	BBC	$	471.2700
☒	00002492156	HYRIMOZ (40 MG/0.8 ML INJ PEN)	SDZ	$	471.2700
☒	00002492164	HYRIMOZ (40 MG/0.8 ML INJ SYR)	SDZ	$	471.2700
☒	00002502674	IDACIO (40 MG/0.8 ML INJ PEN)	FKC	$	471.2700
☒	00002502682	IDACIO (40 MG/0.8 ML INJ SYR)	FKC	$	471.2700
☒	00002523957	SIMLANDI (40 MG/0.4 ML AUTO-INJECTOR PEN)	JPC	$	471.2700
☒	00002523949	SIMLANDI (40 MG/0.4 ML INJ SYR)	JPC	$	471.2700
☒	00002523779	YUFLYMA (40 MG/0.4 ML INJ PEN)	CHC	$	471.2700

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✉	00002523760	YUFLYMA (40 MG/0.4 ML INJ SYR)	CHC	$	471.2700

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Hidradenitis Suppurativa

"Special authorization may be provided for the treatment of adult patients with active moderate to severe Hidradenitis Suppurativa who meet all of the following criteria:

- A total abscess and nodule (AN) count of 3 or greater.
- Lesions in at least two distinct anatomical areas, one of which must be Hurley Stage II or III.
- An inadequate response to a 90-day trial of systemic antibiotics AND documented non response to conventional therapy.
For coverage, this drug must be initiated by a Specialist in Dermatology ("Dermatology Specialist").

- Initial coverage may be approved for 12 weeks as follows: an initial dose of 160 mg, followed by one 80 mg dose two weeks later, then 40 mg every week beginning four weeks after the initial dose, for a total of eleven doses.
- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial approval period the patient must meet the following criteria:

1) The patient must be assessed by a Dermatology Specialist after 12 weeks of treatment to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:

- Greater than or equal to 50% reduction in AN count from pre-treatment baseline AND
- no increase in abscess count or draining fistula count relative to pre-treatment baseline.

Note: Treatment with adalimumab should be discontinued if there is insufficient improvement after 12 weeks of treatment.

Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every week for an additional period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 24 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

All requests (including renewal requests) for adalimumab for Hidradenitis Suppurativa must be completed using the Adalimumab for Hidradenitis Suppurativa Special Authorization Request Form (ABC 60058).

Moderately to Severely Active Crohn?s Disease

"Special authorization coverage may be approved for coverage of adalimumab for the reduction in signs and symptoms and induction and maintenance of clinical remission of Moderately to Severely Active Crohn's Disease in patients who meet the following criteria:

-Adalimumab must be prescribed by a Specialist in Gastroenterology or a physician appropriately trained by the University of Alberta or the University of Calgary and recognized as a prescriber by Alberta Blue Cross for adalimumab for coverage for the treatment of Moderately to Severely Active Crohn's Disease patients ('Specialist').
-Patients must be 18 years of age or older to be considered for coverage of adalimumab.
-Patients will be limited to receiving a one-month supply of adalimumab per prescription

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at their pharmacy.
-Patients may be allowed to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy (both primary loss of response and secondary loss of response) or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
-Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Prior to initiation of adalimumab therapy for New Patients:
'New Patients' are patients who have never been treated with adalimumab by any health care provider.

Moderately to Severely Active Crohn's Disease:

Prior to initiation of adalimumab therapy, New Patients must have a current Modified (without the physical exam) Harvey Bradshaw Index score of greater than or equal to 7 (New Patient's Baseline Score), AND be Refractory.

Refractory is defined as one or more of the following:
1) Serious adverse effects or reactions to the treatments specified below; OR
2) Contraindications (as defined in product monographs) to the treatments specified below; OR
3) Previous documented lack of effect at doses and for duration of all treatments specified below:
a) mesalamine: minimum of 3 grams/day for a minimum of 6 weeks; OR refractory to, or dependent on, glucocorticoids: following at least one tapering dosing schedule of 40mg/day, tapering by 5 mg each week to 20 mg then tapering by 2.5mg each week to zero, or similar.

AND
b) Immunosuppressive therapy as follows:
-Azathioprine: minimum of 2 mg/kg/day for a minimum of 3 months; OR
-6-mercaptopurine: minimum of 1mg/kg/day for a minimum of 3 months; OR
-Methotrexate: minimum of 15mg/week for a minimum of 3 months.
OR
-Immunosuppressive therapy discontinued at less than 3 months due to serious adverse effects or reactions.

Applications for coverage must include information regarding the dosages and duration of trial of each treatment the patient received, a description of any adverse effects, reactions, contraindications and/or lack of effect, as well as any other information requested by Alberta Blue Cross.

Coverage Criteria for Moderately to Severely Active Crohn's Disease

-New Patients must meet the criteria above prior to being considered for approval.
-All approvals are also subject to the following applicable criteria.

Induction Dosing for New Patients:

-Coverage for Induction dosing may only be approved for New Patients (those who have never been treated with adalimumab by any health care provider).
-'Induction Dosing' means a maximum of one 160 mg dose of adalimumab per New Patient at Week 0 followed by an 80 mg dose at Week 2.
-New Patients are eligible to receive Induction Dosing only once, after which time the Maintenance Dosing for New Patients and Continued Coverage for Maintenance Dosing criteria will apply.

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-As an interim measure, 40mg doses of adalimumab will be provided at weeks 4, 6, 8 and 10 to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below.

Maintenance Dosing:

'Maintenance Dosing' means one 40 mg dose of adalimumab per patient provided no more often than every other week starting at Week 4 for an initial period of 12 months with subsequent renewals of 24 months to:
-New Patients following the completion of Induction Dosing; OR
-Existing Patients, who are patients that are being treated, or have previously been treated, with adalimumab.

Maintenance Dosing for New Patients after Completion of Induction Dosing:

-The New Patient must be assessed by a Specialist within 12 weeks after the initiation of Induction Dosing to determine response by obtaining a Modified Harvey Bradshaw Index score for patients with Moderately to Severely Active Crohn's Disease; AND
-The Specialist must confirm the Modified Harvey Bradshaw Index score shows a decrease from the New Patient's Baseline Score of greater than or equal to 3 points for patients with Moderately to Severely Active Crohn's Disease.

Maintenance Dosing for Existing Patients:

-The patient must be assessed by a Specialist (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score (Existing Patient's Baseline Score) for Moderately to Severely Active Crohn's Disease; AND
-these measures must be provided to Alberta Blue Cross for assessment for continued coverage for maintenance dosing.

Continued Coverage for Maintenance Dosing:

Continued coverage may be considered for one 40 mg dose of adalimumab per patient provided no more often than every other week for a period of 24 months, if the following criteria are met at the end of each 24 month period:

-The New Patient or the Existing Patient must be assessed by a Specialist (within 2 months of the expiry of a patient's special authorization) at least 2 weeks after the day a dose of adalimumab was administered to the patient and prior to administration of the next dose to obtain: a Modified Harvey Bradshaw Index Score for Moderately to Severely Active Crohn's Disease; AND
-For New Patients: The Specialist must confirm that the patient has maintained a greater than or equal to 3 point decrease from the New Patient's Baseline Score for Moderately to Severely Active Crohn's Disease; OR
-For Existing Patients: The Specialist must confirm that the patient has maintained the Existing Patient's Baseline Score."

All requests (including renewal requests) for adalimumab for Moderately to Severely Active Crohn's Disease must be completed using the Adalimumab/Vedolizumab for Crohn's/Infliximab for Crohn's/Fistulizing Crohn's Special Authorization Request Form (ABC 60031).

PPlaque Psoriasis

"Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating psoriasis in patients who:
-Have a total PASI of 10 or more and a DLQI of more than 10, OR
-Who have significant involvement of the face, palms of the hands, soles of the feet or

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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)

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

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

-Initial coverage may be approved for an initial dose of 80 mg, followed by one 40 mg dose every other week beginning one week after the first dose, for a total of nine doses.
-Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
-Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
-Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
-Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

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

Following this assessment, continued coverage may be considered for one 40 mg dose of adalimumab every other week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 24 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

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

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

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and

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

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

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

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

Initial coverage may be approved for an initial dose of 160 mg, followed by an 80 mg dose at week 2, then one 40 mg dose at weeks 4, 6 and 8. As an interim measure, an additional 40 mg dose of adalimumab will be provided at week 10 to allow time to determine whether the New Patient meets coverage criteria for Maintenance Dosing below, for a total of six doses.

- Patients will be limited to receiving a one-month supply of adalimumab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond the initial coverage period, the patient must meet the following criteria:
1) The patient must be assessed by a Specialist between weeks 8 and 12 after the initiation of therapy to determine response.
2) The Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- a decrease in the partial Mayo score of greater than or equal to 2 points

Following this assessment, continued coverage may be approved for a dose of 40 mg every 2 weeks for an initial period of 12 months and subsequent renewals of 24 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 24-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of adalimumab therapy."

All requests (including renewal requests) for adalimumab for Ulcerative Colitis must be

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completed using the Adalimumab/Golimumab/Infliximab/Tofacitinib/Vedolizumab for Ulcerative Colitis Special Authorization Request Form (ABC 60008).

80 MG / SYR INJECTION SYRINGE

☒ 00002523965	SIMLANDI (80 MG/0.8 ML INJ SYR)	JPC	$	942.5400
☒ 00002535084	YUFLYMA (80 MG/0.8 ML INJ PEN)	CHC	$	942.5400
☒ 00002535076	YUFLYMA (80 MG/0.8 ML INJ SYR)	CHC	$	942.5400

ATOMOXETINE HCL

STEP THERAPY/SPECIAL AUTHORIZATION

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

FIRST-LINE DRUG PRODUCT(S): SHORT/LONG-ACTING METHYLPHENIDATE AND SHORT/LONG-ACTING AMPHETAMINE

For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years of age and older who are refractory to a short-/long-acting methylphenidate AND a short-/long-acting amphetamine.

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects or contraindications to treatments as defined in the product monographs.

Special authorization may be granted for 24 months.

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

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

All requests for atomoxetine must be completed using the Atomoxetine for Attention Deficit Hyperactivity Disorder (ADHD) Special Authorization Request Form (ABC 60109).

10 MG (BASE) ORAL CAPSULE

00002318024	**APO-ATOMOXETINE**	**APX**	$	**0.5106**
00002445883	**ATOMOXETINE**	**SIV**	$	**0.5106**
00002467747	**ATOMOXETINE**	**SNS**	$	**0.5106**
00002506807	**JAMP ATOMOXETINE**	**JPC**	$	**0.5106**
00002381028	**PMS-ATOMOXETINE**	**PMS**	$	**0.5106**
00002386410	**SANDOZ ATOMOXETINE**	**SDZ**	$	**0.5106**
00002314541	**TEVA-ATOMOXETINE**	**TEV**	$	**0.5106**

18 MG (BASE) ORAL CAPSULE

00002318032	**APO-ATOMOXETINE**	**APX**	$	**0.5748**
00002445905	**ATOMOXETINE**	**SIV**	$	**0.5748**
00002467755	**ATOMOXETINE**	**SNS**	$	**0.5748**
00002506815	**JAMP ATOMOXETINE**	**JPC**	$	**0.5748**
00002381036	**PMS-ATOMOXETINE**	**PMS**	$	**0.5748**
00002386429	**SANDOZ ATOMOXETINE**	**SDZ**	$	**0.5748**
00002314568	**TEVA-ATOMOXETINE**	**TEV**	$	**0.5748**

ATOMOXETINE HCL

25 MG (BASE) ORAL CAPSULE				
00002318040	**APO-ATOMOXETINE**	**APX**	$	**0.6420**
00002445913	**ATOMOXETINE**	**SIV**	$	**0.6420**
00002467763	**ATOMOXETINE**	**SNS**	$	**0.6420**
00002506823	**JAMP ATOMOXETINE**	**JPC**	$	**0.6420**
00002381044	**PMS-ATOMOXETINE**	**PMS**	$	**0.6420**
00002386437	**SANDOZ ATOMOXETINE**	**SDZ**	$	**0.6420**
00002314576	**TEVA-ATOMOXETINE**	**TEV**	$	**0.6420**
40 MG (BASE) ORAL CAPSULE				
00002318059	**APO-ATOMOXETINE**	**APX**	$	**0.7369**
00002445948	**ATOMOXETINE**	**SIV**	$	**0.7369**
00002467771	**ATOMOXETINE**	**SNS**	$	**0.7369**
00002506831	**JAMP ATOMOXETINE**	**JPC**	$	**0.7369**
00002381052	**PMS-ATOMOXETINE**	**PMS**	$	**0.7369**
00002386445	**SANDOZ ATOMOXETINE**	**SDZ**	$	**0.7369**
00002314584	**TEVA-ATOMOXETINE**	**TEV**	$	**0.7369**
60 MG (BASE) ORAL CAPSULE				
00002318067	**APO-ATOMOXETINE**	**APX**	$	**0.8092**
00002445956	**ATOMOXETINE**	**SIV**	$	**0.8092**
00002467798	**ATOMOXETINE**	**SNS**	$	**0.8092**
00002506858	**JAMP ATOMOXETINE**	**JPC**	$	**0.8092**
00002381060	**PMS-ATOMOXETINE**	**PMS**	$	**0.8092**
00002386453	**SANDOZ ATOMOXETINE**	**SDZ**	$	**0.8092**
00002314592	**TEVA-ATOMOXETINE**	**TEV**	$	**0.8092**
80 MG (BASE) ORAL CAPSULE				
00002318075	**APO-ATOMOXETINE**	**APX**	$	**1.2193**
00002467801	**ATOMOXETINE**	**SNS**	$	**1.2193**
00002506866	**JAMP ATOMOXETINE**	**JPC**	$	**1.2193**
00002386461	**SANDOZ ATOMOXETINE**	**SDZ**	$	**1.2193**
00002362511	**TEVA-ATOMOXETINE**	**TEV**	$	**1.2193**
100 MG (BASE) ORAL CAPSULE				
00002318083	**APO-ATOMOXETINE**	**APX**	$	**1.3382**
00002467828	**ATOMOXETINE**	**SNS**	$	**1.3382**
00002506874	**JAMP ATOMOXETINE**	**JPC**	$	**1.3382**
00002386488	**SANDOZ ATOMOXETINE**	**SDZ**	$	**1.3382**

FINERENONE

"Special authorization coverage may be provided as an adjunct to standard of care therapy to reduce the risk of end-stage kidney disease or cardiovascular death, fatal myocardial infarction or hospitalization for heart failure in adult patients with chronic kidney disease (CKD) and Type 2 diabetes (T2D), if the following criteria are met:

1) Patients must have:
- an estimated glomerular filtration rate (eGFR) level of at least 25 mL/min/1.73 m2, and
- an albuminuria level of at least 30 mg/g (or 3 mg/mmol)

2) Patients must not have:
- New York Heart Association [NYHA] class II to IV heart failure.

Coverage cannot be provided for use in combination with another mineralocorticoid receptor antagonist (MRA).

For coverage, this drug must be prescribed by a physician who has experience in the diagnosis and management of patients with CKD and T2D.

Special authorization may be granted for 6 months.

Note:
Consider discontinuation of finerenone if the patient has an eGFR less than 15 mL/min/1.73 m2 or urinary albumin-to-creatinine ratio (UACR) increase from baseline level while receiving finerenone."
All requests for finerenone must be completed using the finerenone Special Authorization Request Form (ABC 60111).

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

10 MG ORAL TABLET				
00002531917	KERENDIA	BAI	$	3.2565
20 MG ORAL TABLET				
00002531925	KERENDIA	BAI	$	3.2565

OZANIMOD HCL

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in patients 18 to 64 years of age inclusive 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 a 7-day dose escalation regimen (i.e., 0.23 mg once daily on days 1-4, then 0.46 mg once daily on days 5-7) followed by maintenance dosing of 0.92 mg once daily for 9 weeks. As an interim measure, coverage will be provided for additional doses of 0.92 mg daily for 2 weeks, to allow time to determine whether the patient meets criteria for continued coverage below.

- Patients will be limited to receiving a one-month supply of ozanimod per prescription at their pharmacy.
- Patients will not be permitted to switch back to ozanimod if they were deemed unresponsive to therapy.
- Patients will be permitted to switch from one agent to another if unresponsive to therapy, or due to serious adverse effects or contraindications.

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 10 weeks but no longer than 12 weeks of 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 0.92 mg 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;
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 ozanimod therapy.

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

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

OZANIMOD HCL

0.92 MG ORAL CAPSULE

00002505991	ZEPOSIA	BMS	$	68.4932

OZANIMOD HCL/ OZANIMOD HCL

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in patients 18 to 64 years of age inclusive 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 a 7-day dose escalation regimen (i.e., 0.23 mg once daily on days 1-4, then 0.46 mg once daily on days 5-7) followed by maintenance dosing of 0.92 mg once daily for 9 weeks. As an interim measure, coverage will be provided for additional doses of 0.92 mg daily for 2 weeks, to allow time to determine whether the patient meets criteria for continued coverage below.

- Patients will be limited to receiving a one-month supply of ozanimod per prescription at their pharmacy.
- Patients will not be permitted to switch back to ozanimod if they were deemed unresponsive to therapy.
- Patients will be permitted to switch from one agent to another if unresponsive to therapy, or due to serious adverse effects or contraindications.

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 10 weeks but no longer than 12 weeks of 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 0.92 mg 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;
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 ozanimod therapy.

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

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

OZANIMOD HCL/ OZANIMOD HCL

0.23 MG * 0.46 MG ORAL CAPSULE

00002506009	ZEPOSIA (INITIATION PACK)	BMS	$	68.4929

RIVAROXABAN

For use in combination with acetylsalicylic acid (ASA; 75 mg to 100 mg) for the prevention of stroke, myocardial infarction, and cardiovascular death, and for the prevention of acute limb ischemia and mortality in patients with concomitant coronary artery disease (CAD) and peripheral artery disease (PAD) as defined below.

Patients with CAD are defined as having one or more of the following:
1) myocardial infarction within the last 20 years
2) multi-vessel coronary disease (i.e., stenosis of greater than or equal to 50 per cent in two or more coronary arteries, or in one coronary territory if at least one other territory has been revascularized) with symptoms or history of stable or unstable angina
3) multi-vessel percutaneous coronary intervention
4) multi-vessel coronary artery bypass graft surgery.

For coverage, patients with CAD as defined above must also meet one of the following criteria:
- aged 65 years or older, or
- aged younger than 65 years with documented atherosclerosis or revascularization involving at least two vascular beds (coronary and other vascular) or at least two additional risk factors (current smoker, diabetes mellitus, estimated glomerular filtration rate less than 60 mL/min, heart failure, non-lacunar ischemic stroke 1 month or more ago).

Patients with PAD are defined as having one or more of the following:
1) previous aorto-femoral bypass surgery, limb bypass surgery, or percutaneous transluminal angioplasty revascularization of the iliac or infrainguinal arteries
2) previous limb or foot amputation for arterial vascular disease
3) history of intermittent claudication and one or more of the following:
- an anklebrachial index less than 0.90
- significant peripheral stenosis (greater than or equal to 50%) documented by angiography or by duplex ultrasound
4) previous carotid revascularization or asymptomatic carotid artery stenosis greater than or equal to 50%, as diagnosed by duplex ultrasound or angiography.

Exclusions from coverage:
- Patients who have CAD or PAD alone, OR;
- Patients with any one of the following characteristics:
1) at high risk of bleeding
2) a history of stroke within one month of treatment initiation or any history of hemorrhagic or lacunar stroke
3) severe heart failure with a known ejection fraction less than 30% or New York Heart Association (NYHA) class III or IV symptoms
4) an estimated glomerular filtration rate less than 15 mL/min
5) require dual antiplatelet therapy, other non-ASA antiplatelet therapy, or oral anticoagulant therapy.

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

All requests for rivaroxaban 2.5 mg must be completed using the Rivaroxaban 2.5 mg Special Authorization Request Form (ABC 60081).

2.5 MG ORAL TABLET

00002541734	**APO-RIVAROXABAN**	**APX**	$	**0.3550**
00002527537	**PMS-RIVAROXABAN**	**PMS**	$	**0.3550**
00002524503	**REDDY-RIVAROXABAN**	**DRL**	$	**0.3550**
00002541467	**RIVAROXABAN**	**SIV**	$	**0.3550**
00002537877	**SANDOZ RIVAROXABAN**	**SDZ**	$	**0.3550**
00002526786	**TARO-RIVAROXABAN**	**TAR**	$	**0.3550**
00002480808	XARELTO	BAI	$	1.4200

RIVAROXABAN

Non-Valvular Atrial Fibrillation

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage

Members of Alberta Government Sponsored Drug Plans who are at-risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following a Reasonable Trial on Warfarin; OR
- Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

At-risk patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Although the ROCKET-AF trial included patients with higher CHADS2 scores (greater than or equal to 2), other landmark studies with the other newer oral anticoagulants demonstrated a therapeutic benefit in patients with a CHADS2 score of 1. Coverage may be considered for an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.

Exclusion from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <30 mL/min) OR
- Greater than or equal to 75 years of age and without Documented Stable Renal Function; OR
- hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR
- prosthetic heart valves.

Definitions:
- Documented Stable Renal Function is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months (i.e. 30-49 mL/min for 15 mg once daily dosing or greater than or equal to 50 mL/Min for 20 mg once daily dosing).
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- Reasonable Trial on Warfarin is defined as at least 2 months of therapy.

OTHER CRITERIA:
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product monograph).
- Patients starting the Drug Product should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

Special Authorization may be granted for 24 months.

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

RIVAROXABAN

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

Venous Thromboembolic Events

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

OTHER CRITERIA:

The recommended dose of rivaroxaban for patients initiating DVT or PE treatment is 15 mg twice daily for 3 weeks, followed by 20 mg once daily.

Drug plan coverage for rivaroxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, rivaroxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for rivaroxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

15 MG ORAL TABLET

00002470500	**APO-RIVAROXABAN**	**APX**	$	**0.7175**
00002512068	**PMS-RIVAROXABAN**	**PMS**	$	**0.7175**
00002472430	**REDDY-RIVAROXABAN**	**DRL**	$	**0.7175**
00002541483	**RIVAROXABAN**	**SIV**	$	**0.7175**
00002482231	**SANDOZ RIVAROXABAN**	**SDZ**	$	**0.7175**
00002483815	**TARO-RIVAROXABAN**	**TAR**	$	**0.7175**
00002507218	**TEVA-RIVAROXABAN**	**TEV**	$	**0.7175**
00002378604	XARELTO	BAI	$	2.8700

RIVAROXABAN

Non-Valvular Atrial Fibrillation

SPECIAL AUTHORIZATION (step therapy approval process)

FIRST-LINE DRUG PRODUCT(S): WARFARIN

Coverage

Members of Alberta Government Sponsored Drug Plans who are at-risk with non-valvular atrial fibrillation (AF) who require the Drug Products for the prevention of stroke and systemic embolism AND in whom one of the following is also present:

- Inadequate Anticoagulation following a Reasonable Trial on Warfarin; OR
- Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

At-risk patients with atrial fibrillation are defined as those with a CHADS2 score of greater than or equal to 1. Although the ROCKET-AF trial included patients with higher CHADS2 scores (greater than or equal to 2), other landmark studies with the other newer oral anticoagulants demonstrated a therapeutic benefit in patients with a CHADS2 score of 1. Coverage may be considered for an antiplatelet regimen or oral anticoagulation for patients with a CHADS2 score of 1.

Exclusion from Coverage:
- Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <30 mL/min) OR
- Greater than or equal to 75 years of age and without Documented Stable Renal Function; OR
- hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis; OR
- prosthetic heart valves.

Definitions:
- Documented Stable Renal Function is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least 3 months (i.e. 30-49 mL/min for 15 mg once daily dosing or greater than or equal to 50 mL/Min for 20 mg once daily dosing).
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- Reasonable Trial on Warfarin is defined as at least 2 months of therapy.

OTHER CRITERIA:
- Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see Drug Product monograph).
- Patients starting the Drug Product should have ready access to appropriate medical services to manage a major bleeding event.
- There is currently no data to support that the Drug Product provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so Drug Product is not recommended in these populations.

Special Authorization may be granted for 24 months.

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

RIVAROXABAN

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

Venous Thromboembolic Events

SPECIAL AUTHORIZATION

COVERAGE:

"For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

OTHER CRITERIA:

The recommended dose of rivaroxaban for patients initiating DVT or PE treatment is 15 mg twice daily for 3 weeks, followed by 20 mg once daily.

Drug plan coverage for rivaroxaban is an alternative to heparin/warfarin for up to 6 months. When used for greater than 6 months, rivaroxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Special authorization may be granted for up to 6 months."

All requests for rivaroxaban must be completed using the Apixaban/Dabigatran/Edoxaban/Rivaroxaban Special Authorization Request Form (ABC 60019).

20 MG ORAL TABLET

00002470519	**APO-RIVAROXABAN**	**APX**	$	**0.7175**
00002512076	**PMS-RIVAROXABAN**	**PMS**	$	**0.7175**
00002472422	**REDDY-RIVAROXABAN**	**DRL**	$	**0.7175**
00002541491	**RIVAROXABAN**	**SIV**	$	**0.7175**
00002482258	**SANDOZ RIVAROXABAN**	**SDZ**	$	**0.7175**
00002483823	**TARO-RIVAROXABAN**	**TAR**	$	**0.7175**
00002507226	**TEVA-RIVAROXABAN**	**TEV**	$	**0.7175**
00002378612	XARELTO	BAI	$	2.8700

TROSPIUM CHLORIDE

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

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

"For patients who have failed on or are intolerant to solifenacin or tolterodine LA."

"Special authorization may be granted for 24 months."

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

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

All requests for trospium chloride must be completed using the darifenacin hydrobromide/Fesoterodine fumarate/Mirabegron/Trospium chloride Special Authorization Request Form (ABC 60088).

20 MG ORAL TABLET

00002506661	**JAMP TROSPIUM**	**JPC**	$	**0.4072**
00002488353	**MAR-TROSPIUM**	**MAR**	$	**0.4072**
00002275066	TROSEC	SUN	$	0.7820