Updates to the Alberta Drug Benefit List

Effective June 1, 2021

Alberta Government

Inquiries should be directed to:

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

Administered by Alberta Blue Cross
on behalf of Alberta Health.

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

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Special Authorization

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

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
SANDOZ DEFERASIROX (TYPE J) 90 MG TABLET	DEFERASIROX	00002489899	SDZ
SANDOZ DEFERASIROX (TYPE J) 180 MG TABLET	DEFERASIROX	00002489902	SDZ
SANDOZ DEFERASIROX (TYPE J) 360 MG TABLET	DEFERASIROX	00002489910	SDZ

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
AG-CYCLOBENZAPRINE 10 MG TABLET	CYCLOBENZAPRINE HCL	00002485419	AGP

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
AG-PREGABALIN 300 MG CAPSULE	PREGABALIN	00002480778	AGP
APO-FLUTICASONE HFA 250 MCG / DOSE METERED DOSE AEROSOL	FLUTICASONE PROPIONATE	00002510987	APX
JAMP-AMLODIPINE 5 MG TABLET	AMLODIPINE BESYLATE	00002357194	JPC
NRA-TELMISARTAN HCTZ 80 MG / 12.5 MG TABLET	TELMISARTAN/ HYDROCHLOROTHIAZIDE	00002504146	NRA
NRA-TELMISARTAN HCTZ 80 MG / 25 MG TABLET	TELMISARTAN/ HYDROCHLOROTHIAZIDE	00002504138	NRA
NRA-ZOPICLONE 5 MG TABLET	ZOPICLONE	00002477378	NRA
NRA-ZOPICLONE 7.5 MG TABLET	ZOPICLONE	00002477386	NRA
TRI-CIRA 21 0.18 MG / 0.035 MG / 0.215 MG / 0.035 MG / 0.25 MG / 0.035 MG TABLET	NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL	00002508087	APX

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 July 1, 2021. Please review the online **Interactive Drug Benefit List** for further information.*

Generic Description	Strength / Form	New LCA Price
CARBAMAZEPINE	200 MG ORAL SUSTAINED-RELEASE TABLET	0.2563
CARBAMAZEPINE	400 MG ORAL SUSTAINED-RELEASE TABLET	0.5126
DEFERASIROX	(TYPE J) 90 MG TABLET	2.6303
DEFERASIROX	(TYPE J) 180 MG TABLET	5.2610
DEFERASIROX	(TYPE J) 360 MG TABLET	10.5228
FLUTICASONE PROPIONATE	250 MCG / DOSE METERED DOSE AEROSOL	0.3752
NABILONE	1 MG CAPSULE	3.6669
NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL	(21 DAY) 0.18 MG / 0.035 MG / 0.215 MG / 0.035 MG / 0.25 MG / 0.035 MG ORAL TABLET	0.6852
TRAVOPROST	0.004% OPHTHALMIC SOLUTION	5.7520

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until June 30, 2021. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-TRAVOPROST Z 0.004% OPHTHALMIC SOLUTION	TRAVOPROST	00002415739	APX
FULPHILA (0.6 ML SYRINGE) 6 MG / SYRINGE INJECTION	PEGFILGRASTIM	00002484153	BGP
LAPELGA (0.6 ML SYRINGE) 6 MG / SYRINGE INJECTION	PEGFILGRASTIM	00002474565	APX
NORFLOXACIN 400 MG TABLET	NORFLOXACIN	00002229524	AAP
PLEGRIDY 63 MCG / 94 MCG / SYRINGE INJECTION	PEGINTERFERON BETA-1A	00002444402	BIO
PMS-CARBAMAZEPINE-CR 200 MG SUSTAINED-RELEASE TABLET	CARBAMAZEPINE	00002231543	PMS
PMS-CARBAMAZEPINE-CR 400 MG SUSTAINED-RELEASE TABLET	CARBAMAZEPINE	00002231544	PMS
PMS-NABILONE 1 MG CAPSULE	NABILONE	00002380919	PMS
SANDOZ CARBAMAZEPINE CR 200 MG SUSTAINED-RELEASE TABLET	CARBAMAZEPINE	00002261839	SDZ

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
SANDOZ CARBAMAZEPINE CR 400 MG SUSTAINED-RELEASE TABLET	CARBAMAZEPINE	00002261847	SDZ
SANDOZ TRAVOPROST 0.004% OPHTHALMIC SOLUTION	TRAVOPROST	00002413167	SDZ
TEVA-NABILONE 1 MG CAPSULE	NABILONE	00002384892	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 June 1, 2021, the listed product(s) will no longer be a benefit and where applicable, will not be considered for coverage by Special Authorization. A transition period will be applied and as of July 1, 2021 claims will no longer pay for these product(s).

Trade Name / Strength / Form	Generic Description	DIN	MFR
SANDOZ DILTIAZEM CD 120 MG ORAL CONTROLLED-DELIVERY CAPSULE	DILTIAZEM HCL	00002243338	SDZ
SANDOZ DILTIAZEM CD 180 MG ORAL CONTROLLED-DELIVERY CAPSULE	DILTIAZEM HCL	00002243339	SDZ
STATEX 5 MG RECTAL SUPPOSITORY	MORPHINE SULFATE	00000632228	PAL
STATEX 10 MG RECTAL SUPPOSITORY	MORPHINE SULFATE	00000632201	PAL

PART 2

Drug Additions

AMLODIPINE BESYLATE

5 MG (BASE) ORAL TABLET

00002297485	**ACT AMLODIPINE**	**APH**	$	**0.1343**
00002331284	**AMLODIPINE**	**SNS**	$	**0.1343**
00002385791	**AMLODIPINE**	**SIV**	$	**0.1343**
00002429217	**AMLODIPINE**	**JPC**	$	**0.1343**
00002419564	**AMLODIPINE BESYLATE**	**AHI**	$	**0.1343**
00002273373	**APO-AMLODIPINE**	**APX**	$	**0.1343**
00002397072	**AURO-AMLODIPINE**	**AUR**	$	**0.1343**
00002357194	**JAMP-AMLODIPINE**	**JPC**	$	**0.1343**
00002371715	**MAR-AMLODIPINE**	**MAR**	$	**0.1343**
00002362651	**MINT-AMLODIPINE**	**MPI**	$	**0.1343**
00002272113	**MYLAN-AMLODIPINE**	**MYP**	$	**0.1343**
00002476460	**NRA-AMLODIPINE**	**NRA**	$	**0.1343**
00002469030	**PHARMA-AMLODIPINE**	**PMS**	$	**0.1343**
00002321858	**RAN-AMLODIPINE**	**RAN**	$	**0.1343**
00002284383	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.1343**
00002357712	**SEPTA-AMLODIPINE**	**SEP**	$	**0.1343**
00000878928	NORVASC	UJC	$	1.4345

BUSPIRONE HCL

10 MG ORAL TABLET

00002211076	**APO-BUSPIRONE**	**APX**	$	**0.2713**
00002500213	**AURO-BUSPIRONE**	**AUR**	$	**0.2713**
00002231492	**NOVO-BUSPIRONE**	**TEV**	$	**0.2713**
00002230942	**PMS-BUSPIRONE**	**PMS**	$	**0.2713**

CARBAMAZEPINE

200 MG ORAL SUSTAINED-RELEASE TABLET

00002231543	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.2563**
00002261839	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.2563**
00000773611	TEGRETOL CR	NOV	$	0.4422

400 MG ORAL SUSTAINED-RELEASE TABLET

00002231544	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.5126**
00002261847	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.5126**
00000755583	TEGRETOL CR	NOV	$	0.8845

CYCLOBENZAPRINE HCL

RESTRICTED BENEFIT - Coverage is limited to 126 tablets per plan participant per year as an adjunct to rest and physical therapy for the treatment of acute muscle spasm.

10 MG ORAL TABLET

00002485419	**AG-CYCLOBENZAPRINE**	**AGP**	$	**0.1022**
00002177145	**APO-CYCLOBENZAPRINE**	**APX**	$	**0.1022**
00002348853	**AURO-CYCLOBENZAPRINE**	**AUR**	$	**0.1022**
00002287064	**CYCLOBENZAPRINE**	**SNS**	$	**0.1022**
00002424584	**CYCLOBENZAPRINE**	**SIV**	$	**0.1022**
00002495422	**FLEXERIL**	**ORI**	$	**0.1022**
00002357127	**JAMP-CYCLOBENZAPRINE**	**JPC**	$	**0.1022**
00002212048	**PMS-CYCLOBENZAPRINE**	**PMS**	$	**0.1022**
00002080052	**TEVA-CYCLOBENZAPRINE**	**TEV**	$	**0.1022**

FLUTICASONE PROPIONATE

250 MCG / DOSE INHALATION METERED DOSE AEROSOL

00002510987	**APO-FLUTICASONE HFA**	**APX**	$	**0.3752**
00002503131	**PMS-FLUTICASONE HFA**	**PMS**	$	**0.3752**
00002244293	FLOVENT HFA	GSK	$	0.7494

NABILONE

1 MG ORAL CAPSULE

00002380919	**PMS-NABILONE**	**PMS**	$	**3.6669**
00002384892	**TEVA-NABILONE**	**TEV**	$	**3.6669**
00000548375	CESAMET	VCL	$	6.9739

NORFLOXACIN

400 MG ORAL TABLET

00002229524	NORFLOXACIN	AAP	$	1.8586

NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL

0.18 MG * 0.035 MG * 0.215 MG * 0.035 MG * 0.25 MG * 0.035 MG ORAL TABLET

00002508087	**TRI-CIRA 21**	**APX**	$	**0.6852**
00002486296	**TRI-JORDYNA (21 DAY)**	**GLM**	$	**0.6852**

PREGABALIN

300 MG ORAL CAPSULE

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

TELMISARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET

00002419114	**ACH-TELMISARTAN HCTZ**	**AHI**	$	**0.2098**
00002456389	**AURO-TELMISARTAN HCTZ**	**AUR**	$	**0.2098**
00002389940	**JAMP TELMISARTAN-HCT**	**JPC**	$	**0.2098**
00002504146	**NRA-TELMISARTAN HCTZ**	**NRA**	$	**0.2098**
00002393557	**SANDOZ TELMISARTAN HCT**	**SDZ**	$	**0.2098**
00002390302	**TELMISARTAN HCTZ**	**SIV**	$	**0.2098**
00002395355	**TELMISARTAN/HCTZ**	**SNS**	$	**0.2098**
00002330288	**TEVA-TELMISARTAN HCTZ**	**TEV**	$	**0.2098**
00002244344	MICARDIS PLUS	BOE	$	1.2474

80 MG * 25 MG ORAL TABLET

00002419122	**ACH-TELMISARTAN HCTZ**	**AHI**	$	**0.2098**
00002456397	**AURO-TELMISARTAN HCTZ**	**AUR**	$	**0.2098**
00002389959	**JAMP TELMISARTAN-HCT**	**JPC**	$	**0.2098**
00002504138	**NRA-TELMISARTAN HCTZ**	**NRA**	$	**0.2098**
00002393565	**SANDOZ TELMISARTAN HCT**	**SDZ**	$	**0.2098**
00002390310	**TELMISARTAN HCTZ**	**SIV**	$	**0.2098**
00002395363	**TELMISARTAN/HCTZ**	**SNS**	$	**0.2098**
00002379252	**TEVA-TELMISARTAN HCTZ**	**TEV**	$	**0.2098**
00002318709	MICARDIS PLUS	BOE	$	1.2474

TRAVOPROST

0.004 % OPHTHALMIC SOLUTION

00002415739	**APO-TRAVOPROST Z**	**APX**	$	**5.7520**
00002413167	**SANDOZ TRAVOPROST**	**SDZ**	$	**5.7520**
00002318008	TRAVATAN Z	NOV	$	11.6960

ZOPICLONE

5 MG ORAL TABLET

00002245077	**APO-ZOPICLONE**	**APX**	$	**0.0990**
00002406969	**JAMP-ZOPICLONE**	**JPC**	$	**0.0990**
00002386771	**MAR-ZOPICLONE**	**MAR**	$	**0.0990**
00002391716	**MINT-ZOPICLONE**	**MPI**	$	**0.0990**
00002477378	**NRA-ZOPICLONE**	**NRA**	$	**0.0990**
00002243426	**PMS-ZOPICLONE**	**PMS**	$	**0.0990**
00002267918	**RAN-ZOPICLONE**	**RAN**	$	**0.0990**
00002246534	**RATIO-ZOPICLONE**	**TEV**	$	**0.0990**
00002344122	**ZOPICLONE**	**SNS**	$	**0.0990**
00002385821	**ZOPICLONE**	**SIV**	$	**0.0990**
00002216167	IMOVANE	SAV	$	1.0832

7.5 MG ORAL TABLET

00002218313	**APO-ZOPICLONE**	**APX**	$	**0.1250**
00002406977	**JAMP-ZOPICLONE**	**JPC**	$	**0.1250**
00002386798	**MAR-ZOPICLONE**	**MAR**	$	**0.1250**
00002391724	**MINT-ZOPICLONE**	**MPI**	$	**0.1250**
00002477386	**NRA-ZOPICLONE**	**NRA**	$	**0.1250**
00002240606	**PMS-ZOPICLONE**	**PMS**	$	**0.1250**
00002267926	**RAN-ZOPICLONE**	**RAN**	$	**0.1250**
00002242481	**RATIO-ZOPICLONE**	**TEV**	$	**0.1250**
00002008203	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.1250**
00002282445	**ZOPICLONE**	**SNS**	$	**0.1250**
00002385848	**ZOPICLONE**	**SIV**	$	**0.1250**
00001926799	IMOVANE	SAV	$	1.3677

PART 3

Special Authorization

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

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

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

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

Special authorization may be granted for 24 months."

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

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

90 MG ORAL TABLET

00002485265	**APO-DEFERASIROX (TYPE J)**	**APX**	$	**2.6303**
00002489899	**SANDOZ DEFERASIROX (TYPE J)**	**SDZ**	$	**2.6303**
00002507315	**TARO-DEFERASIROX (TYPE J)**	**TAR**	$	**2.6303**
00002452219	JADENU	NOV	$	10.5210

DEFERASIROX

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FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

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

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Special authorization may be granted for 24 months."

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

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

180 MG ORAL TABLET

00002485273	**APO-DEFERASIROX (TYPE J)**	**APX**	$	**5.2610**
00002489902	**SANDOZ DEFERASIROX (TYPE J)**	**SDZ**	$	**5.2610**
00002507323	**TARO-DEFERASIROX (TYPE J)**	**TAR**	$	**5.2610**
00002452227	JADENU	NOV	$	21.0440

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

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

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

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Special authorization may be granted for 24 months."

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

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

360 MG ORAL TABLET

00002485281	**APO-DEFERASIROX (TYPE J)**	**APX**	$	**10.5228**
00002489910	**SANDOZ DEFERASIROX (TYPE J)**	**SDZ**	$	**10.5228**
00002507331	**TARO-DEFERASIROX (TYPE J)**	**TAR**	$	**10.5228**
00002452235	JADENU	NOV	$	42.0910

PEGFILGRASTIM

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

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

Please note: Coverage cannot be considered for palliative patients.

6 MG / SYR INJECTION SYRINGE

☒ 00002484153	FULPHILA (0.6 ML SYRINGE)	BGP	$	1375.0000
☒ 00002474565	LAPELGA (0.6 ML SYRINGE)	APX	$	1375.0000
☒ 00002506238	NYVEPRIA (0.6 ML SYRINGE)	PFI	$	1375.0000
☒ 00002497395	ZIEXTENZO (0.6 ML SYRINGE)	SDZ	$	1424.6300

PEGINTERFERON BETA-1A/ PEGINTERFERON BETA-1A

"Special authorization coverage may be provided for the reduction of the frequency and severity of clinical relapses and reduction of the number and volume of active brain lesions, identified on MRI scans, in ambulatory patients with relapsing remitting multiple sclerosis.

Coverage

For coverage, this drug must be prescribed by a registered MS Neurologist. A current assessment must be completed by a registered MS Neurologist at every request.

To register to become an MS Neurologist please complete the Registration for MS Neurologist Status Form (ABC 60002).

Initial Coverage

1) The registered MS Neurologist must confirm a diagnosis of RRMS;

2) The patient must have active disease which is defined as at least two relapses* of MS during the previous two years or in the two years prior to starting an MS disease modifying therapy (DMT).

*A relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Onset of clinical relapses must be separated by a period of at least one month. At least one new T2 lesion or definite gadolinium-enhancing T1 MRI lesion (not questionable faint enhancement) obtained at least 90 days after initiation of the DMT and at least 90 days before or after a relapse may substitute for one clinical relapse.

3) The patient must be ambulatory with or without aid (The registered MS Neurologist must provide a current updated Expanded Disability Status Scale (EDSS) score less than or equal to 6.5).
Coverage may be approved for up to 12 months. Patients will be limited to receiving a one-month supply of peg-interferon beta-1a per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

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

1) The patient must be assessed by a registered MS Neurologist;

2) The registered MS Neurologist must confirm a diagnosis of RRMS;

3) The registered MS Neurologist must provide a current updated EDSS score. The patient must not have an EDSS score of 7.0 or above sustained for one year or more.

Coverage of this drug may be considered in a patient with a sustained EDSS score of 7.0 or above in exceptional circumstances. For MS DMT coverage to be considered, details of the exceptional circumstance must be provided in a letter from the registered MS Neurologist and accompany the Special Authorization Request Form.

Continued coverage may be approved for up to 12 months. Patients may receive up to 100 days' supply of peg-interferon beta-1a per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 12 Months

In order to be eligible for coverage, after an interruption in therapy greater than 12 months, the patient must meet the following criteria:

1) At least one relapse* per 12 month period; or

PEGINTERFERON BETA-1A/ PEGINTERFERON BETA-1A

2) At least two relapses* during the previous 24 month period."

All requests (including renewal requests) for interferon beta-1b must be completed using the Dimethyl Fumarate/Glatiramer Acetate/Interferon Beta-1a/Ocrelizumab/Peginterferon Beta-1a/Teriflunomide for RRMS/Interferon Beta-1b for SPMS or RRMS Special Authorization Request Form (ABC 60001).

63 MCG / SYR * 94 MCG / SYR INJECTION SYRINGE				
00002444402	PLEGRIDY	BIO	$	899.0730