Updates to the Alberta Drug Benefit List

Effective June 1, 2024

Alberta Government

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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 effective June 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
LIVTENCITY 200 MG TABLET	MARIBAVIR	00002530740	TAK
NYPOZI 0.3 MG / SYRINGE INJECTION	FILGRASTIM	00002520990	TNX
NYPOZI 0.48 MG / SYRINGE INJECTION	FILGRASTIM	00002521008	TNX
RYMTI 50 MG / ML INJECTION	ETANERCEPT	00002530295	LPC
RYMTI 50 MG / ML INJECTION	ETANERCEPT	00002530309	LPC
VYALEV 240 MG / ML / 12 MG / ML INJECTION	FOSLEVODOPA/ FOSCARBIDOPA	00002537702	ABV

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
GLATIRAMER ACETATE 20 MG / SYRINGE INJECTION	GLATIRAMER ACETATE	00002541440	MYP
M-DIENOGEST 2 MG TABLET	DIENOGEST	00002543613	MTR

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
AURO-ATOMOXETINE 10 MG CAPSULE	ATOMOXETINE HCL	00002471485	AUR
AURO-ATOMOXETINE 18 MG CAPSULE	ATOMOXETINE HCL	00002471493	AUR
AURO-ATOMOXETINE 25 MG CAPSULE	ATOMOXETINE HCL	00002471507	AUR
AURO-ATOMOXETINE 40 MG CAPSULE	ATOMOXETINE HCL	00002471515	AUR
AURO-ATOMOXETINE 60 MG CAPSULE	ATOMOXETINE HCL	00002471523	AUR
AURO-ATOMOXETINE 80 MG CAPSULE	ATOMOXETINE HCL	00002471531	AUR
AURO-ATOMOXETINE 100 MG CAPSULE	ATOMOXETINE HCL	00002471558	AUR

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

The following drug product(s) will be considered for coverage by Restricted Benefit / Special Authorization effective May 24, 2024 for patients covered under Alberta government-sponsored drug programs.

Trade Name / Strength / Form	Generic Description	DIN	MFR
PAXLOVID (20 TABLET COURSE - RENAL DOSING) 150 MG / 100 MG TABLET	NIRMATRELVIR/ RITONAVIR	00002527804	PFI
PAXLOVID (30 TABLET COURSE) 150 MG / 100 MG TABLET	NIRMATRELVIR/ RITONAVIR	00002524031	PFI

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

The following drug product(s) will be considered for coverage by Restricted Benefit / Special Authorization effective June 1, 2024 for patients covered under Alberta government-sponsored drug programs.

Trade Name / Strength / Form	Generic Description	DIN	MFR
AURO-MONTELUKAST 5 MG CHEWABLE TABLET	MONTELUKAST SODIUM	00002422875	AUR
JAMP TICAGRELOR 90 MG TABLET	TICAGRELOR	00002531801	JPC

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
AURO-MONTELUKAST 4 MG CHEWABLE TABLET	MONTELUKAST SODIUM	00002422867	AUR

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
AG-CITALOPRAM 40 MG TABLET	CITALOPRAM HYDROBROMIDE	00002339404	AGP
KETOROLAC TROMETHAMINE 30 MG / ML INJECTION	KETOROLAC TROMETHAMINE	00002523310	JPC
M-PREGABALIN 300 MG CAPSULE	PREGABALIN	00002541963	MTR
JAMP RIVAROXABAN 10 MG TABLET	RIVAROXABAN	00002516292	JPC
JAMP RIVAROXABAN 15 MG TABLET	RIVAROXABAN	00002516306	JPC
JAMP RIVAROXABAN 20 MG TABLET	RIVAROXABAN	00002516314	JPC

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, 2024. Please review the online **Interactive Drug Benefit List** for further information.*

Generic Description	Strength / Form	New LCA Price
DICLOFENAC SODIUM	100 MG SUSTAINED-RELEASE TABLET	0.6502
DIENOGEST	2 MG TABLET	0.5115
PERAMPANEL	2 MG TABLET	5.7128
PERAMPANEL	4 MG TABLET	5.7128
PERAMPANEL	6 MG TABLET	5.7128
PERAMPANEL	8 MG TABLET	5.7128
PERAMPANEL	10 MG TABLET	5.7128
PERAMPANEL	12 MG TABLET	5.7128

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until June 30, 2024. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-DICLO SR 100 MG SUSTAINED-RELEASE TABLET	DICLOFENAC SODIUM	00002091194	APX
ASPEN-DIENOGEST 2 MG TABLET	DIENOGEST	00002493055	APC
JAMP DIENOGEST 2 MG TABLET	DIENOGEST	00002498189	JPC
METOJECT SUBCUTANEOUS 17.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454769	MDX
METOJECT SUBCUTANEOUS 20 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454866	MDX
METOJECT SUBCUTANEOUS 22.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454777	MDX
SANDOZ DICLOFENAC SR 100 MG SUSTAINED-RELEASE TABLET	DICLOFENAC SODIUM	00002261944	SDZ
TARO-PERAMPANEL 2 MG TABLET	PERAMPANEL	00002522632	TAR
TARO-PERAMPANEL 4 MG TABLET	PERAMPANEL	00002522640	TAR
TARO-PERAMPANEL 6 MG TABLET	PERAMPANEL	00002522659	TAR
TARO-PERAMPANEL 8 MG TABLET	PERAMPANEL	00002522667	TAR
TARO-PERAMPANEL 10 MG TABLET	PERAMPANEL	00002522675	TAR
TARO-PERAMPANEL 12 MG TABLET	PERAMPANEL	00002522683	TAR

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
ALTACE HCT 2.5 MG / 12.5 MG TABLET	RAMIPRIL/ HYDROCHLOROTHIAZIDE	00002283131	VCL
ALTACE HCT 5 MG / 12.5 MG TABLET	RAMIPRIL/ HYDROCHLOROTHIAZIDE	00002283158	VCL
ALTACE HCT 5 MG / 25 MG TABLET	RAMIPRIL/ HYDROCHLOROTHIAZIDE	00002283174	VCL
ALTACE HCT 10 MG / 12.5 MG TABLET	RAMIPRIL/ HYDROCHLOROTHIAZIDE	00002283166	VCL
ALTACE HCT 10 MG / 25 MG TABLET	RAMIPRIL/ HYDROCHLOROTHIAZIDE	00002283182	VCL
CHAMPIX 0.5 MG TABLET	VARENICLINE TARTRATE	00002291177	PFI
CHAMPIX 1 MG TABLET	VARENICLINE TARTRATE	00002291185	PFI
CHAMPIX (STARTER PACK) 0.5 MG / 1 MG TABLET	VARENICLINE TARTRATE/ VARENICLINE TARTRATE	00002298309	PFI
MYLAN-NITRO 0.4 MG / DOSE SUBLINGUAL METERED DOSE SPRAY	NITROGLYCERIN	00002243588	MYP
SANDOZ OMEPRAZOLE 20 MG SUSTAINED-RELEASE CAPSULE	OMEPRAZOLE	00002296446	SDZ

PART 2

Drug Additions

CITALOPRAM HYDROBROMIDE

40 MG (BASE) ORAL TABLET

00002339404	**AG-CITALOPRAM**	**AGP**	$	**0.1332**
00002246057	**APO-CITALOPRAM**	**APX**	$	**0.1332**
00002275570	**AURO-CITALOPRAM**	**AUR**	$	**0.1332**
00002459922	**CCP-CITALOPRAM**	**CEL**	$	**0.1332**
00002353679	**CITALOPRAM**	**SNS**	$	**0.1332**
00002387964	**CITALOPRAM**	**SIV**	$	**0.1332**
00002430568	**CITALOPRAM**	**JPC**	$	**0.1332**
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	$	1.5828

DICLOFENAC SODIUM

100 MG ORAL SUSTAINED-RELEASE TABLET

00002091194	APO-DICLO SR	APX	***$ 0.3124***	$	0.6502
00002261944	SANDOZ DICLOFENAC SR	SDZ	***$ 0.3124***	$	0.6502

MAC pricing has been applied based on the LCA Price for 4 X 25 mg oral enteric-coated tablets.

KETOROLAC TROMETHAMINE

30 MG / ML INJECTION

00002239944	**KETOROLAC TROMETHAMINE**	**SDZ**	$	**3.0870**
00002244947	**KETOROLAC TROMETHAMINE**	**FKC**	$	**3.0870**
00002443376	**KETOROLAC TROMETHAMINE**	**JUN**	$	**3.0870**
00002523310	**KETOROLAC TROMETHAMINE**	**JPC**	$	**3.0870**

METHOTREXATE SODIUM

17.5 MG / SYR (BASE) INJECTION SYRINGE

00002491338	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**16.0000**
00002454769	**METOJECT SUBCUTANEOUS**	**MDX**	$	**16.0000**
00002539632	**PMS-METHOTREXATE**	**PMS**	$	**16.0000**

20 MG / SYR (BASE) INJECTION SYRINGE

☒ 00002422190	METHOTREXATE (0.8 ML SYRINGE)	PMS	$	11.2000
00002491346	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**17.5000**
00002454866	**METOJECT SUBCUTANEOUS**	**MDX**	$	**17.5000**
00002539640	**PMS-METHOTREXATE**	**PMS**	$	**17.5000**

22.5 MG / SYR (BASE) INJECTION SYRINGE

00002491354	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**17.5000**
00002454777	**METOJECT SUBCUTANEOUS**	**MDX**	$	**17.5000**
00002539659	**PMS-METHOTREXATE**	**PMS**	$	**17.5000**

MONTELUKAST SODIUM

4 MG (BASE) ORAL CHEWABLE TABLET

00002377608	**APO-MONTELUKAST**	**APX**	$	**0.2758**
00002422867	**AURO-MONTELUKAST**	**AUR**	$	**0.2758**
00002514877	**JAMP MONTELUKAST**	**JPC**	$	**0.2758**
00002399865	**MAR-MONTELUKAST**	**MAR**	$	**0.2758**
00002408627	**MINT-MONTELUKAST**	**MPI**	$	**0.2758**
00002382458	**MONTELUKAST**	**SIV**	$	**0.2758**
00002522101	**NAT-MONTELUKAST**	**NTP**	$	**0.2758**
00002354977	**PMS-MONTELUKAST**	**PMS**	$	**0.2758**
00002330385	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.2758**
00002355507	**TEVA-MONTELUKAST**	**TEV**	$	**0.2758**
00002243602	SINGULAIR	ORC	$	1.6450

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

5 MG (BASE) ORAL CHEWABLE TABLET

00002377616	**APO-MONTELUKAST**	**APX**	$	**0.3082**
00002422875	**AURO-MONTELUKAST**	**AUR**	$	**0.3082**
00002514885	**JAMP MONTELUKAST**	**JPC**	$	**0.3082**
00002399873	**MAR-MONTELUKAST**	**MAR**	$	**0.3082**
00002408635	**MINT-MONTELUKAST**	**MPI**	$	**0.3082**
00002379325	**MONTELUKAST**	**SNS**	$	**0.3082**
00002382466	**MONTELUKAST**	**SIV**	$	**0.3082**
00002522128	**NAT-MONTELUKAST**	**NTP**	$	**0.3082**
00002354985	**PMS-MONTELUKAST**	**PMS**	$	**0.3082**
00002330393	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.3082**
00002355515	**TEVA-MONTELUKAST**	**TEV**	$	**0.3082**
00002238216	SINGULAIR	ORC	$	1.8400

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility for Alberta Human Services clients.)

PREGABALIN

300 MG ORAL CAPSULE

00002449900	**ACH-PREGABALIN**	**AHI**	$	**0.4145**
00002480778	**AG-PREGABALIN**	**AGP**	$	**0.4145**
00002394294	**APO-PREGABALIN**	**APX**	$	**0.4145**
00002436019	**JAMP-PREGABALIN**	**JPC**	$	**0.4145**
00002541963	**M-PREGABALIN**	**MTR**	$	**0.4145**
00002494906	**NAT-PREGABALIN**	**NTP**	$	**0.4145**
00002479192	**NRA-PREGABALIN**	**NRA**	$	**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**

RIVAROXABAN

10 MG ORAL TABLET

00002470497	**APO-RIVAROXABAN**	**APX**	$	**0.7175**
00002516292	**JAMP RIVAROXABAN**	**JPC**	$	**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

15 MG ORAL TABLET

00002470500	**APO-RIVAROXABAN**	**APX**	$	**0.7175**
00002516306	**JAMP RIVAROXABAN**	**JPC**	$	**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

20 MG ORAL TABLET

00002470519	**APO-RIVAROXABAN**	**APX**	$	**0.7175**
00002516314	**JAMP RIVAROXABAN**	**JPC**	$	**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

TICAGRELOR

RESTRICTED BENEFIT - This product is a benefit for the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction when initiated in hospital and prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the initiating prescriber is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.)

90 MG ORAL TABLET

00002482630	**APO-TICAGRELOR**	**APX**	$	**0.3960**
00002531801	**JAMP TICAGRELOR**	**JPC**	$	**0.3960**
00002529769	**M-TICAGRELOR**	**MTR**	$	**0.3960**
00002492598	**TARO-TICAGRELOR**	**TAR**	$	**0.3960**
00002368544	BRILINTA	AZC	$	1.7041

PART 3

Special Authorization

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**
00002471485	**AURO-ATOMOXETINE**	**AUR**	$	**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**
00002471493	**AURO-ATOMOXETINE**	**AUR**	$	**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**
25 MG (BASE) ORAL CAPSULE				
00002318040	**APO-ATOMOXETINE**	**APX**	$	**0.6420**
00002445913	**ATOMOXETINE**	**SIV**	$	**0.6420**
00002467763	**ATOMOXETINE**	**SNS**	$	**0.6420**
00002471507	**AURO-ATOMOXETINE**	**AUR**	$	**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**

ATOMOXETINE HCL

40 MG (BASE) ORAL CAPSULE				
00002318059	**APO-ATOMOXETINE**	**APX**	$	**0.7369**
00002445948	**ATOMOXETINE**	**SIV**	$	**0.7369**
00002467771	**ATOMOXETINE**	**SNS**	$	**0.7369**
00002471515	**AURO-ATOMOXETINE**	**AUR**	$	**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**
00002471523	**AURO-ATOMOXETINE**	**AUR**	$	**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**
00002471531	**AURO-ATOMOXETINE**	**AUR**	$	**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**
00002471558	**AURO-ATOMOXETINE**	**AUR**	$	**1.3382**
00002506874	**JAMP ATOMOXETINE**	**JPC**	$	**1.3382**
00002386488	**SANDOZ ATOMOXETINE**	**SDZ**	$	**1.3382**

DIENOGEST

"For the management of pelvic pain associated with endometriosis in patients for whom one or more less costly hormonal options are either ineffective or not tolerated."

"Special authorization may be granted for 6 months."

"This Drug Product is eligible for auto-renewal."

2 MG ORAL TABLET				
00002493055	**ASPEN-DIENOGEST**	**APC**	$	**0.5115**
00002498189	**JAMP DIENOGEST**	**JPC**	$	**0.5115**
00002543613	**M-DIENOGEST**	**MTR**	$	**0.5115**
00002374900	VISANNE	BAI	$	2.1876

ETANERCEPT

Ankylosing Spondylitis

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

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

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

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

- Initial coverage may be approved for 50 mg per week for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

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

Following this assessment, continued coverage may be approved for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by an RA Specialist every 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 etanercept for Ankylosing Spondylitis must be completed using the Adalimumab/Certolizumab/Etanercept/Golimumab/Infliximab/Secukinumab for Ankylosing Spondylitis Special Authorization Request Form (ABC 60028).

Plaque Psoriasis

All Special Authorization requests for etanercept for patients weighing 63 kg or more will be assessed for coverage with an etanercept biosimilar. The originator drug, Enbrel, will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg.

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

ETANERCEPT

- Have a total PASI of 10 or more and a DLQI of more than 10, OR

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

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

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

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

-Initial coverage may be approved for up to 100 mg per week for 12 weeks.
-Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 12 weeks, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 12 weeks of therapy to determine response.
2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria:
- Greater than or equal to 75% reduction in PASI score, OR
- Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI

Following this assessment, continued coverage may be considered for 50 mg per week for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 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 etanercept 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).

ETANERCEPT

Polyarticular Juvenile Idiopathic Arthritis

All Special Authorization requests for etanercept for patients weighing 63 kg or more will be assessed for coverage with an etanercept biosimilar. The originator drug, Enbrel, will be approved for new etanercept starts for pediatric patients with Polyarticular Juvenile Idiopathic Arthritis or Plaque Psoriasis weighing less than 63 kg.

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

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

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

- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of abatacept) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from abatacept to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

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

Following this assessment, continued coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of 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

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2) The Pediatric RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the ACR Pedi 30,
3) Data from all of the six variables comprising the ACR Pedi 30 and the CHAQ scores must be reported in each request.

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

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

Psoriatic Arthritis

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

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

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

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

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

- Initial coverage may be approved for 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

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

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Following this assessment, continued coverage may be approved for 50 mg per week, for an initial period of 12 months and 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;
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above."

All requests (including renewal requests) for etanercept for Psoriatic Arthritis must be completed using the
Adalimumab/Certolizumab/Etanercept/Golimumab/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 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of etanercept per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12

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

Following this assessment, continued coverage may be approved for 50 mg per week, for 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 etanercept 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).

50 MG / ML INJECTION

☒	00002530295	RYMTI	LPC	$	236.1800
☒	00002530309	RYMTI	LPC	$	236.1800

FILGRASTIM

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

"Following induction and consolidation treatment for acute myeloid leukemia, for the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization."

"In patients with a diagnosis of congenital, cyclic or idiopathic neutropenia, to increase neutrophil counts and to reduce the incidence and duration of infection."

Please note for the first criterion: Coverage cannot be considered for palliative patients.

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

0.3 MG / SYR INJECTION SYRINGE				
☒ 00002520990	NYPOZI	TNX	$	138.5376
☒ 00002441489	GRASTOFIL (0.5 ML SYRINGE)	APX	$	138.5380
☒ 00002485575	NIVESTYM (0.5 ML SYRINGE)	PFI	$	144.3100
0.48 MG / SYR INJECTION SYRINGE				
☒ 00002454548	GRASTOFIL (0.8 ML SYRINGE)	APX	$	221.6600
☒ 00002521008	NYPOZI	TNX	$	221.6640
☒ 00002485583	NIVESTYM (0.8 ML SYRINGE)	PFI	$	230.9000

FOSLEVODOPA/ FOSCARBIDOPA

"Special authorization coverage may be provided for the treatment of patients with advanced levodopa-responsive Parkinson's disease (PD), who meet the following criteria:

1) The patient experiences severe disability associated with at least 25% of the waking day in the off state and/or ongoing, bothersome levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day). Time in the off state, frequency of motor fluctuations, and severity of associated disability should be assessed by a movement disorder subspecialist or neurologist with experience in managing advanced Parkinson's disease, and be based on an adequate and reliable account from longitudinal specialist care, clinical interview of a patient and/or care partner, or motor symptom diary.
2) The patient has received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response.
3) The patient has failed or is intolerant to adequate trials of each of the following adjunctive medications, if not contraindicated: maximally tolerated doses of levodopa in combination with carbidopa, a catechol-O-methyl transferase (COMT) inhibitor, a dopamine agonist, a monoamine oxidase (MAO-B) inhibitor, and amantadine.
4) The patient or caregiver are able to demonstrate correct understanding and use of the delivery system.
5) The patient does not have severe psychosis or dementia.
6) Foslevodopa/foscarbidopa should be prescribed by neurologists who are movement disorder subspecialists or who have expertise in managing advanced Parkinson's disease.

Initial coverage may be approved 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:
- The patient demonstrates a significant reduction in the time spent in the off state and/or in ongoing, bothersome levodopa-induced dyskinesias, along with an improvement in the related disability."

All requests for foslevodopa/foscarbidopa infusion (including renewal requests) must be completed using the Foslevodopa/Foscarbidopa Infusion or Levodopa/Carbidopa Intestinal Gel Special Authorization Request Form (ABC 60068).

240 MG / ML * 12 MG / ML INJECTION

00002537702	VYALEV	ABV	$	16.9810

GLATIRAMER ACETATE

20 MG / SYR INJECTION SYRINGE

☒ 00002460661 GLATECT PMS $ 32.4000

"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 glatiramer acetate per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

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

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

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

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

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

Continued coverage may be approved for up to 24 months. Patients may receive up to 100 days' supply of glatiramer acetate per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 24 Months

In order to be eligible for coverage, after an interruption in therapy greater than 24 months, the patient must meet the following criteria:
1) At least two relapses* during the previous 24 month period."

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

☒ 00002541440 GLATIRAMER ACETATE INJECTION MYP $ 37.9892

GLATIRAMER ACETATE

"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 glatiramer acetate per prescription at their pharmacy for the first 12 months of coverage.

Continued Coverage

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

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

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

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

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

Continued coverage may be approved for up to 24 months. Patients may receive up to 100 days' supply of glatiramer acetate per prescription at their pharmacy.

Restarting After an Interruption in Therapy Greater Than 24 Months

In order to be eligible for coverage, after an interruption in therapy greater than 24 months, the patient must meet the following criteria:
1) At least two relapses* during the previous 24 month period."

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

MARIBAVIR

"For the treatment of adult patients with post-transplant cytomegalovirus (CMV) infection/disease who are refractory* (with or without genotypic resistance) to 1 or more of the following antiviral drugs: valganciclovir, ganciclovir, foscarnet, or cidofovir.

Special authorization may be granted for 6 months.

Subsequent treatment with maribavir may be reimbursed for patients who have a recurrence of CMV viremia after a previous successful course of therapy with maribavir.

Treatment should be discontinued if any of the following occur:
- no change or an increase in CMV viral load after at least 2 weeks of maribavir treatment OR
- confirmed CMV genetic mutation associated with resistance to maribavir.

*Refractory to antiviral treatment is defined as: a lack of change in CMV viral load or increase in CMV viral load after at least 2 weeks of appropriately dosed treatment."

For coverage, this drug must be prescribed by or/in consultation with a Specialist in Transplant Medicine, Transplant Infectious Disease, Internal Medicine, or Infectious Diseases.

All requests (including retreatment requests) for maribavir must be completed using the Maribavir Special Authorization Request Form (ABC 60118).

200 MG ORAL TABLET

00002530740	LIVTENCITY	TAK	$	276.7857

MONTELUKAST SODIUM

(Refer to 48:10.24 of the Alberta Drug Benefit List for coverage of patients 6 to 18 years of age inclusive).

"For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:
a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, or
b) cannot operate inhaler devices."

"For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists."

"Special authorization for both criteria may be granted for 6 months."

In order to comply with the first criteria, information should indicate either
a) current use of inhaled steroids and contraindications or poor response to long-acting beta 2 agonists (e.g. salmeterol or formoterol) or,
b) the nature of the patient's difficulties with using inhaler devices.

In order to comply with the second criteria, information should include the nature of the patient's response to long-acting beta 2 agonists (e.g. salmeterol or formoterol).

All requests (including renewal requests) for montelukast 5 mg & 10 mg must be completed using the Montelukast Special Authorization Request Form (ABC 60039).

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

5 MG (BASE) ORAL CHEWABLE TABLET

00002377616	**APO-MONTELUKAST**	**APX**	$	**0.3082**
00002422875	**AURO-MONTELUKAST**	**AUR**	$	**0.3082**
00002514885	**JAMP MONTELUKAST**	**JPC**	$	**0.3082**
00002399873	**MAR-MONTELUKAST**	**MAR**	$	**0.3082**
00002408635	**MINT-MONTELUKAST**	**MPI**	$	**0.3082**
00002379325	**MONTELUKAST**	**SNS**	$	**0.3082**
00002382466	**MONTELUKAST**	**SIV**	$	**0.3082**
00002522128	**NAT-MONTELUKAST**	**NTP**	$	**0.3082**
00002354985	**PMS-MONTELUKAST**	**PMS**	$	**0.3082**
00002330393	**SANDOZ MONTELUKAST**	**SDZ**	$	**0.3082**
00002355515	**TEVA-MONTELUKAST**	**TEV**	$	**0.3082**
00002238216	SINGULAIR	ORC	$	1.8400

NIRMATRELVIR/ RITONAVIR

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of nirmatrelvir/ritonavir Drug Products.)

"Special authorization coverage may be provided for mild-to-moderate coronavirus disease 2019 (COVID-19) in adults with positive results of direct severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death.

Treatment with nirmatrelvir-ritonavir should be initiated as soon as possible after a diagnosis of COVID-19 has been made, and within 5 days of symptom onset in adult patients who have either of the following:

Severe immunosuppression such as:
-Solid organ transplant recipients
-Treatment for malignant hematologic condition
-Bone marrow, stem cell transplant or transplant-related immunosuppressant use
-Receipt of anti-CD20 agents or B-cell depleting agents (such as rituximab) in the previous 2 years.
-Severe primary immunodeficiencies including combined immunodeficiencies affecting T-cells, immune dysregulation (particularly familial hemophagocytic lymphohistiocytosis or those with type 1 interferon defects caused by a genetic primary immunodeficiency disorder or secondary to anti-interferon autoantibodies.
Moderate immunosuppression such as:
-Treatment for cancer including solid tumors.
-Significantly immunosuppressing drugs (e.g., biologic in the last three months, oral immune suppressing medication in the last months, oral steroid [20 mg/day of prednisone equivalent taken on an ongoing basis] in the last month, or immune-suppressing infusion or injection in the last three months).
-Advanced HIV infection
-Moderate primary immunodeficiencies- a primary immunodeficiency with a genetic cause at any time; or a primary immunodeficiency and immunoglobulin replacement therapy in the last year.
-Renal conditions (i.e., hemodialysis, peritoneal dialysis, glomerulonephritis and dispensing of a steroid, eGFR < 15 mL/min).

Coverage may be approved for up to 300 mg nirmatrelvir (two 150 mg tablets) with 100 mg ritonavir (one 100 mg tablet) twice daily for 5 days."

All requests for nirmatrelvir-ritonavir must be completed using the Nirmatrelvir-Ritonavir Special Authorization Request Form (ABC 60117).

150 MG * 100 MG ORAL TABLET

☒ 00002524031	PAXLOVID (30 TABLET COURSE)	PFI	$	42.9627
☒ 00002527804	PAXLOVID (20 TABLET COURSE - RENAL DOSING)	PFI	$	64.4440

PERAMPANEL

"For adjunctive therapy in patients with refractory partial-onset seizures or primary generalized tonic-clonic (PGTC) seizures who meet all of the following criteria:

- Are currently receiving two or more antiepileptic medications, AND
- Have failed or demonstrated intolerance to three other antiepileptic medications, AND
- Therapy must be initiated by a Neurologist.

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

Special authorization may be granted for six months.

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

Each of these products are eligible for auto-renewal"

2 MG ORAL TABLET				
00002522632	**TARO-PERAMPANEL**	**TAR**	$	**5.7128**
00002404516	FYCOMPA	EIS	$	10.3869
4 MG ORAL TABLET				
00002522640	**TARO-PERAMPANEL**	**TAR**	$	**5.7128**
00002404524	FYCOMPA	EIS	$	10.3869
6 MG ORAL TABLET				
00002522659	**TARO-PERAMPANEL**	**TAR**	$	**5.7128**
00002404532	FYCOMPA	EIS	$	10.3869
8 MG ORAL TABLET				
00002522667	**TARO-PERAMPANEL**	**TAR**	$	**5.7128**
00002404540	FYCOMPA	EIS	$	10.3869
10 MG ORAL TABLET				
00002522675	**TARO-PERAMPANEL**	**TAR**	$	**5.7128**
00002404559	FYCOMPA	EIS	$	10.3869
12 MG ORAL TABLET				
00002522683	**TARO-PERAMPANEL**	**TAR**	$	**5.7128**
00002404567	FYCOMPA	EIS	$	10.3869

TICAGRELOR

(Refer to 20:12.18 of the Alberta Drug Benefit List for coverage of ticagrelor when prescribed by a specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.)

For the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction, when initiated in hospital in consultation with a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA. Special authorization may be granted for 6 months.*

*Special Authorization is only required when the initiating prescriber is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery.

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

90 MG ORAL TABLET

00002482630	**APO-TICAGRELOR**	**APX**	$	**0.3960**
00002531801	**JAMP TICAGRELOR**	**JPC**	$	**0.3960**
00002529769	**M-TICAGRELOR**	**MTR**	$	**0.3960**
00002492598	**TARO-TICAGRELOR**	**TAR**	$	**0.3960**
00002368544	BRILINTA	AZC	$	1.7041