Updates to the Alberta Drug Benefit List

Effective May 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 May 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
ENSPRYNG 120 ML / SYRINGE INJECTION	SATRALIZUMAB	00002499681	HLR
JAMTEKI (0.5 ML SYRINGE) 45 MG / SYRINGE INJECTION	USTEKINUMAB	00002543036	JPC
JAMTEKI (1 ML SYRINGE) 90 MG / SYRINGE INJECTION	USTEKINUMAB	00002543044	JPC
VIMIZIM 5 MG / ML INJECTION	ELOSULFASE ALFA	00002427184	BMI
WEZLANA (0.5 ML SYRINGE) 45 MG / SYRINGE INJECTION	USTEKINUMAB	00002544180	AMG
WEZLANA (0.5 ML VIAL) 45 MG / VIAL INJECTION	USTEKINUMAB	00002544202	AMG
WEZLANA (1 ML SYRINGE) 90 MG / SYRINGE INJECTION	USTEKINUMAB	00002544199	AMG

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
AURO-PIRFENIDONE 267 MG TABLET	PIRFENIDONE	00002537753	AUR
AURO-PIRFENIDONE 801 MG TABLET	PIRFENIDONE	00002537761	AUR
AURO-TOFACITINIB 10 MG TABLET	TOFACITINIB CITRATE	00002530015	AUR
TARO-TOFACITINIB 10 MG TABLET	TOFACITINIB CITRATE	00002511312	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
TEVA-SITAGLIPTIN MALATE 25 MG TABLET	SITAGLIPTIN	00002522705	TEV
TEVA-SITAGLIPTIN MALATE 50 MG TABLET	SITAGLIPTIN	00002522713	TEV
TEVA-SITAGLIPTIN MALATE 100 MG TABLET	SITAGLIPTIN	00002522721	TEV

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
SOLIRIS 300 MG / VIAL INJECTION	ECULIZUMAB	00002322285	APG
STELARA (0.5 ML VIAL OR SYRINGE) 45 MG INJECTION	USTEKINUMAB	00002320673	JAI
STELARA (1 ML SYRINGE) 90 MG / SYRINGE INJECTION	USTEKINUMAB	00002320681	JAI

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
ACT METHYLPHENIDATE ER 18 MG EXTENDED-RELEASE TABLET	METHYLPHENIDATE HCL	00002441934	TEV
ACT METHYLPHENIDATE ER 27 MG EXTENDED-RELEASE TABLET	METHYLPHENIDATE HCL	00002441942	TEV
ACT METHYLPHENIDATE ER 36 MG EXTENDED-RELEASE TABLET	METHYLPHENIDATE HCL	00002441950	TEV
ACT METHYLPHENIDATE ER 54 MG EXTENDED-RELEASE TABLET	METHYLPHENIDATE HCL	00002441969	TEV
NRA-ARIPIPRAZOLE 2 MG TABLET	ARIPIPRAZOLE	00002472201	NRA
NRA-ARIPIPRAZOLE 5 MG TABLET	ARIPIPRAZOLE	00002472228	NRA

Drug Product(s) Available by Restricted Benefit with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
ALMOTRIPTAN 12.5 MG TABLET	ALMOTRIPTAN MALATE	00002466821	SNS
MYLAN-ALMOTRIPTAN 6.25 MG TABLET	ALMOTRIPTAN MALATE	00002398435	MYP
MYLAN-ALMOTRIPTAN 12.5 MG TABLET	ALMOTRIPTAN MALATE	00002398443	MYP
SANDOZ ALMOTRIPTAN 12.5 MG TABLET	ALMOTRIPTAN MALATE	00002405334	SDZ
TEVA-ALMOTRIPTAN 12.5 MG TABLET	ALMOTRIPTAN MALATE	00002434849	TEV

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
AMOXICILLIN / CLAV 500 MG / 125 MG TABLET	AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM	00002536021	SNS
AMOXICILLIN / CLAV 875 MG / 125 MG TABLET	AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM	00002536048	SNS
APO-METHADONE 1 MG TABLET	METHADONE HCL	00002533642	APX
APO-METHADONE 5 MG TABLET	METHADONE HCL	00002533650	APX
APO-METHADONE 10 MG TABLET	METHADONE HCL	00002533669	APX
APO-METHADONE 25 MG TABLET	METHADONE HCL	00002533677	APX
AURO-CEFPROZIL 25 MG / ML SUSPENSION	CEFPROZIL	00002347261	AUR
AURO-CEFPROZIL 50 MG / ML SUSPENSION	CEFPROZIL	00002347288	AUR
AURO-CEPHALEXIN 50 MG / ML SUSPENSION	CEPHALEXIN	00002497751	AUR
CANDESARTAN/HCTZ 32 MG /12.5 MG TABLET	CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE	00002536064	SNS
CLONIDINE 0.025 MG TABLET	CLONIDINE HCL	00002540061	SIV
CLONIDINE 0.1 MG TABLET	CLONIDINE HCL	00002538490	SIV

Added Product(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
CLONIDINE 0.2 MG TABLET	CLONIDINE HCL	00002538504	SIV
FUROSEMIDE 10 MG / ML INJECTION	FUROSEMIDE	00002527502	JPC
GLYCOPYRROLATE 0.2 MG / ML INJECTION	GLYCOPYRROLATE	00002532379	JPC
HYDRALAZINE 10 MG TABLET	HYDRALAZINE HCL	00002539802	SNS
HYDRALAZINE 25 MG TABLET	HYDRALAZINE HCL	00002539810	SNS
HYDRALAZINE 50 MG TABLET	HYDRALAZINE HCL	00002539829	SNS
JAMP DICLOFENAC 0.1 % OPHTHALMIC SOLUTION	DICLOFENAC SODIUM	00002534525	JPC
JAMP GABAPENTIN 100 MG CAPSULE	GABAPENTIN	00002535246	JPC
JAMP GABAPENTIN 300 MG CAPSULE	GABAPENTIN	00002535254	JPC
JAMP GABAPENTIN 400 MG CAPSULE	GABAPENTIN	00002535262	JPC
JAMP SOLIFENACIN SUCCINATE 5 MG TABLET	SOLIFENACIN SUCCINATE	00002428911	JPC
JAMP SOLIFENACIN SUCCINATE 10 MG TABLET	SOLIFENACIN SUCCINATE	00002428938	JPC
JAMP TOPIRAMATE 100 MG TABLET	TOPIRAMATE	00002345269	JPC
LUPIN-TIOTROPIUM 18 MCG INHALATION CAPSULE	TIOTROPIUM BROMIDE MONOHYDRATE	00002537850	LPC
METOCLOPRAMIDE HYDROCHLORIDE 5 MG / ML INJECTION	METOCLOPRAMIDE HCL	00002537397	JPC
MINT-ENTACAPONE 200 MG TABLET	ENTACAPONE	00002535939	MPI
MINT-MEXILETINE 200 MG CAPSULE	MEXILETINE HCL	00002536854	MPI
MINT-TRIMEBUTINE 100 MG TABLET	TRIMEBUTINE MALEATE	00002538202	MPI
MINT-TRIMEBUTINE 200 MG TABLET	TRIMEBUTINE MALEATE	00002538210	MPI
NRA-ARIPIPRAZOLE 10 MG TABLET	ARIPIPRAZOLE	00002472244	NRA
NRA-ARIPIPRAZOLE 15 MG TABLET	ARIPIPRAZOLE	00002472252	NRA
NRA-ARIPIPRAZOLE 20 MG TABLET	ARIPIPRAZOLE	00002472260	NRA
NRA-ARIPIPRAZOLE 30 MG TABLET	ARIPIPRAZOLE	00002472279	NRA
NRA-EZETIMIBE 10 MG TABLET	EZETIMIBE	00002536420	NRA
NRA-TOPIRAMATE 25 MG TABLET	TOPIRAMATE	00002538466	NRA
NRA-TOPIRAMATE 100 MG TABLET	TOPIRAMATE	00002538458	NRA
NRA-TOPIRAMATE 200 MG TABLET	TOPIRAMATE	00002538474	NRA
OCTASA 800 MG DELAYED-RELEASE TABLET	MESALAZINE	00002465752	TAG
OCTASA 1600 MG DELAYED-RELEASE TABLET	MESALAZINE	00002529610	TAG
ONDANSETRON 4 MG TABLET	ONDANSETRON HCL DIHYDRATE	00002541424	SIV
ONDANSETRON 8 MG TABLET	ONDANSETRON HCL DIHYDRATE	00002541432	SIV

Added Product(s), continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
PMS-METHOTREXATE 10 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002539608	PMS
PMS-METHOTREXATE 12.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002539616	PMS
PMS-METHOTREXATE 15 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002539624	PMS
PMS-METHOTREXATE 17.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002539632	PMS
PMS-METHOTREXATE 20 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002539640	PMS
PMS-METHOTREXATE 22.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002539659	PMS
PMS-METHOTREXATE 25 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002539667	PMS
PRZ-K20 20 MEQ EXTENDED-RELEASE TABLET	POTASSIUM CHLORIDE (K+)	00080107649	PCI
UCERIS 2 MG / DOSE RECTAL FOAM	BUDESONIDE	00002498057	VCL

New Established Interchangeable (IC) Grouping(s)

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

Generic Description	Strength / Form	New LCA Price
CEFPROZIL	25 MG / ML SUSPENSION	0.0970
CEFPROZIL	50 MG / ML SUSPENSION	0.1938
METHADONE HCL	1 MG TABLET	0.1399
METHADONE HCL	5 MG TABLET	0.4659
METHADONE HCL	10 MG TABLET	0.7454
METHADONE HCL	25 MG TABLET	1.3850
METHOTREXATE SODIUM	10 MG / SYRINGE INJECTION	22.2300
METHOTREXATE SODIUM	12.5 MG / SYRINGE INJECTION	23.4000
METOCLOPRAMIDE HCL	5 MG / ML INJECTION	2.3748
MEXILETINE HCL	200 MG CAPSULE	0.9837
TIOTROPIUM BROMIDE MONOHYDRATE	18 MCG INHALATION CAPSULE	1.3715
TOFACITINIB CITRATE	10 MG TABLET	21.1718
TRIMEBUTINE MALEATE	100 MG TABLET	0.2939
TRIMEBUTINE MALEATE	200 MG TABLET	0.3600

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 June 1, 2024. Please review the online **Interactive Drug Benefit List** for further information.*

Generic Description	Strength / Form	New LCA Price
AZATHIOPRINE	50 MG TABLET	0.5185
METHYLPHENIDATE HCL	10 MG CONTROLLED-RELEASE CAPSULE	0.5128
METHYLPHENIDATE HCL	15 MG CONTROLLED-RELEASE CAPSULE	0.7354
METHYLPHENIDATE HCL	20 MG CONTROLLED-RELEASE CAPSULE	0.9477
METHYLPHENIDATE HCL	30 MG CONTROLLED-RELEASE CAPSULE	1.3021
METHYLPHENIDATE HCL	40 MG CONTROLLED-RELEASE CAPSULE	1.6588
METHYLPHENIDATE HCL	50 MG CONTROLLED-RELEASE CAPSULE	2.0130
METHYLPHENIDATE HCL	60 MG CONTROLLED-RELEASE CAPSULE	2.3425
METHYLPHENIDATE HCL	80 MG CONTROLLED-RELEASE CAPSULE	3.0883
METHOTREXATE SODIUM	15 MG / SYRINGE INJECTION	22.2300
METHOTREXATE SODIUM	17.5 MG / SYRINGE INJECTION	23.4000
METHOTREXATE SODIUM	20 MG / SYRINGE INJECTION	22.2300
METHOTREXATE SODIUM	22.5 MG / SYRINGE INJECTION	23.4000
METHOTREXATE SODIUM	25 MG / SYRINGE INJECTION	23.4000
VALGANCICLOVIR HCL	50 MG / ML SUSPENSION	1.5099

Product(s) with a Price Change

The following product(s) had a Price Change. The previous higher price will be recognized until May 31, 2024. For products within an established IC Grouping, the LCA price may apply.

Trade Name / Strength / Form	Generic Description	DIN	MFR
AURO-VALGANCICLOVIR 50 MG / ML SUSPENSION	VALGANCICLOVIR HCL	00002535483	AUR
APO-AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	00002242907	APX
APO-TRIMEBUTINE 100 MG TABLET	TRIMEBUTINE MALEATE	00002245663	APX
APO-TRIMEBUTINE 200 MG TABLET	TRIMEBUTINE MALEATE	00002245664	APX
METHOTREXATE SUBCUTANEOUS 15 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002491311	AHI

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
METHOTREXATE SUBCUTANEOUS 17.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002491338	AHI
METHOTREXATE SUBCUTANEOUS 20 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002491346	AHI
METHOTREXATE SUBCUTANEOUS 22.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002491354	AHI
METHOTREXATE SUBCUTANEOUS 25 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002491362	AHI
METOCLOPRAMIDE HYDROCHLORIDE 5 MG / ML INJECTION	METOCLOPRAMIDE HCL	00002185431	SDZ
METOJECT SUBCUTANEOUS 10 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454831	MDX
METOJECT SUBCUTANEOUS 12.5 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454750	MDX
METOJECT SUBCUTANEOUS 15 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454858	MDX
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
METOJECT SUBCUTANEOUS 25 MG / SYRINGE INJECTION	METHOTREXATE SODIUM	00002454874	MDX
NOVO-MEXILETINE 200 MG CAPSULE	MEXILETINE HCL	00002230360	TEV
PMS-METHYLPHENIDATE CR 10 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002536943	PMS
PMS-METHYLPHENIDATE CR 15 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002536951	PMS
PMS-METHYLPHENIDATE CR 20 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002536978	PMS
PMS-METHYLPHENIDATE CR 30 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002536986	PMS
PMS-METHYLPHENIDATE CR 40 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002536994	PMS
PMS-METHYLPHENIDATE CR 50 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002537001	PMS
PMS-METHYLPHENIDATE CR 60 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002537028	PMS

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
PMS-METHYLPHENIDATE CR 80 MG CONTROLLED-RELEASE CAPSULE	METHYLPHENIDATE HCL	00002537036	PMS
RAN-CEFPROZIL 25 MG / ML SUSPENSION	CEFPROZIL	00002329204	RAN
RAN-CEFPROZIL 50 MG / ML SUSPENSION	CEFPROZIL	00002293579	RAN
TEVA-AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	00002236819	TEV
TEVA-NAPROX EC 250 MG ENTERIC-COATED TABLET	NAPROXEN	00002243312	TEV
TOPAMAX SPRINKLE 25 MG CAPSULE	TOPIRAMATE	00002239908	JAI
VERMOX 100 MG ORAL CHEWABLE TABLET	MEBENDAZOLE	00000556734	JAI

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
ACCUPRIL 5 MG TABLET	QUINAPRIL	00001947664	PFI
ACCUPRIL 10 MG TABLET	QUINAPRIL	00001947672	PFI
ACCUPRIL 20 MG TABLET	QUINAPRIL	00001947680	PFI
ACCUPRIL 40 MG TABLET	QUINAPRIL	00001947699	PFI
ACCURETIC 10/12.5 10 MG / 12.5 MG TABLET	QUINAPRIL/ HYDROCHLOROTHIAZIDE	00002237367	PFI
ACCURETIC 20/12.5 20 MG / 12.5 MG TABLET	QUINAPRIL/ HYDROCHLOROTHIAZIDE	00002237368	PFI
ACCURETIC 20/25 20 MG / 25 MG TABLET	QUINAPRIL/ HYDROCHLOROTHIAZIDE	00002237369	PFI
APO-CARVEDILOL 25 MG TABLET	CARVEDILOL	00002247936	APX
MYLAN-VERAPAMIL 80 MG TABLET	VERAPAMIL HCL	00002237921	MYP
MYLAN-VERAPAMIL 120 MG TABLET	VERAPAMIL HCL	00002237922	MYP
PMS-CIPROFLOXACIN 250 MG TABLET	CIPROFLOXACIN HCL	00002248437	PMS
PMS-CIPROFLOXACIN 750 MG TABLET	CIPROFLOXACIN HCL	00002248439	PMS

PART 2

Drug Additions

ALMOTRIPTAN MALATE

This product is a benefit for patients 12 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older, and Criteria for Special Authorization of Select Drug Products in the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.).

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

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM

500 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002536021	**AMOXICILLIN/CLAV**	**SNS**	$	**0.3778**
00002243351	**APO-AMOXI CLAV**	**APX**	$	**0.3778**
00002471698	**AURO-AMOXICLAV**	**AUR**	$	**0.3778**
00002508257	**JAMP AMOXI CLAV**	**JPC**	$	**0.3778**
00002482576	**SANDOZ AMOXI-CLAV**	**SDZ**	$	**0.3778**
875 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002536048	**AMOXICILLIN/CLAV**	**SNS**	$	**0.5551**
00002245623	**APO-AMOXI CLAV**	**APX**	$	**0.5551**
00002471701	**AURO-AMOXICLAV**	**AUR**	$	**0.5551**
00002508265	**JAMP AMOXI CLAV**	**JPC**	$	**0.5551**
00002482584	**SANDOZ AMOXI-CLAV**	**SDZ**	$	**0.5551**

ARIPIPRAZOLE

2 MG ORAL TABLET

00002471086	**APO-ARIPIPRAZOLE**	**APX**	$	**0.8092**
00002506688	**ARIPIPRAZOLE**	**SNS**	$	**0.8092**
00002534320	**ARIPIPRAZOLE**	**SIV**	$	**0.8092**
00002460025	**AURO-ARIPIPRAZOLE**	**AUR**	$	**0.8092**
00002483556	**MINT-ARIPIPRAZOLE**	**MPI**	$	**0.8092**
00002472201	**NRA-ARIPIPRAZOLE**	**NRA**	$	**0.8092**
00002466635	**PMS-ARIPIPRAZOLE**	**PMS**	$	**0.8092**
00002473658	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**0.8092**
00002322374	ABILIFY	OTS	$	3.1618

ALBERTA HEALTH RESTRICTED BENEFIT

This Drug Product is a benefit for patients 13 to 17 years of age inclusive.

5 MG ORAL TABLET

00002471094	**APO-ARIPIPRAZOLE**	**APX**	$	**0.9046**
00002506718	**ARIPIPRAZOLE**	**SNS**	$	**0.9046**
00002534339	**ARIPIPRAZOLE**	**SIV**	$	**0.9046**
00002460033	**AURO-ARIPIPRAZOLE**	**AUR**	$	**0.9046**
00002483564	**MINT-ARIPIPRAZOLE**	**MPI**	$	**0.9046**
00002472228	**NRA-ARIPIPRAZOLE**	**NRA**	$	**0.9046**
00002466643	**PMS-ARIPIPRAZOLE**	**PMS**	$	**0.9046**
00002473666	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**0.9046**
00002322382	ABILIFY	OTS	$	3.5591

ALBERTA HEALTH RESTRICTED BENEFIT

This Drug Product is a benefit for patients 13 to 17 years of age inclusive.

10 MG ORAL TABLET

00002471108	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0754**
00002506726	**ARIPIPRAZOLE**	**SNS**	$	**1.0754**
00002534347	**ARIPIPRAZOLE**	**SIV**	$	**1.0754**
00002460041	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0754**
00002483572	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.0754**
00002472244	**NRA-ARIPIPRAZOLE**	**NRA**	$	**1.0754**
00002466651	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0754**
00002473674	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0754**
00002322390	ABILIFY	OTS	$	4.1016

15 MG ORAL TABLET

00002471116	**APO-ARIPIPRAZOLE**	**APX**	$	**1.2692**
00002506734	**ARIPIPRAZOLE**	**SNS**	$	**1.2692**
00002534355	**ARIPIPRAZOLE**	**SIV**	$	**1.2692**
00002460068	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.2692**
00002483580	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.2692**
00002472252	**NRA-ARIPIPRAZOLE**	**NRA**	$	**1.2692**
00002466678	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.2692**
00002473682	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.2692**
00002322404	ABILIFY	OTS	$	4.1016

20 MG ORAL TABLET

00002471124	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0017**
00002506750	**ARIPIPRAZOLE**	**SNS**	$	**1.0017**
00002534363	**ARIPIPRAZOLE**	**SIV**	$	**1.0017**
00002460076	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0017**
00002483599	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.0017**
00002472260	**NRA-ARIPIPRAZOLE**	**NRA**	$	**1.0017**
00002466686	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0017**
00002473690	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0017**
00002322412	ABILIFY	OTS	$	4.1016

ARIPIPRAZOLE

30 MG ORAL TABLET

00002471132	**APO-ARIPIPRAZOLE**	**APX**	$	**1.0017**
00002506785	**ARIPIPRAZOLE**	**SNS**	$	**1.0017**
00002534371	**ARIPIPRAZOLE**	**SIV**	$	**1.0017**
00002460084	**AURO-ARIPIPRAZOLE**	**AUR**	$	**1.0017**
00002483602	**MINT-ARIPIPRAZOLE**	**MPI**	$	**1.0017**
00002472279	**NRA-ARIPIPRAZOLE**	**NRA**	$	**1.0017**
00002466694	**PMS-ARIPIPRAZOLE**	**PMS**	$	**1.0017**
00002473704	**SANDOZ ARIPIPRAZOLE**	**SDZ**	$	**1.0017**
00002322455	ABILIFY	OTS	$	4.1016

AZATHIOPRINE

50 MG ORAL TABLET

00002242907	**APO-AZATHIOPRINE**	**APX**	$	**0.5185**
00002236819	**TEVA-AZATHIOPRINE**	**TEV**	$	**0.5185**
00000004596	IMURAN	APC	$	1.3353

BUDESONIDE

2 MG / DOSE RECTAL FOAM

00002498057	UCERIS	VCL	$	7.1400

CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE

32 MG * 12.5 MG ORAL TABLET

00002421046	**AURO-CANDESARTAN HCT**	**AUR**	$	**0.2156**
00002536064	**CANDESARTAN/HCTZ**	**SNS**	$	**0.2156**
00002473259	**JAMP CANDESARTAN-HCT**	**JPC**	$	**0.2156**
00002531259	**NRA-CANDESARTAN HCTZ**	**NRA**	$	**0.2156**
00002420732	**SANDOZ CANDESARTAN PLUS**	**SDZ**	$	**0.2156**
00002395568	**TEVA-CANDESARTAN/HCTZ**	**TEV**	$	**0.2156**
00002332922	ATACAND PLUS	AZC	$	1.4252

CEFPROZIL

25 MG / ML ORAL SUSPENSION

00002347261	**AURO-CEFPROZIL**	**AUR**	$	**0.0970**
00002329204	**RAN-CEFPROZIL**	**RAN**	$	**0.0970**

50 MG / ML ORAL SUSPENSION

00002347288	**AURO-CEFPROZIL**	**AUR**	$	**0.1938**
00002293579	**RAN-CEFPROZIL**	**RAN**	$	**0.1938**

CEPHALEXIN

50 MG / ML ORAL SUSPENSION

00002497751	**AURO-CEPHALEXIN**	**AUR**	$	**0.2573**
00002528444	**JAMP CEPHALEXIN**	**JPC**	$	**0.2573**
00002469189	**LUPIN-CEPHALEXIN**	**LPC**	$	**0.2573**
00000342092	**TEVA-CEPHALEXIN 250**	**TEV**	$	**0.2573**

CLONIDINE HCL

0.025 MG ORAL TABLET

00002540061	**CLONIDINE**	**SIV**	$	**0.0680**
00002528207	**JAMP CLONIDINE**	**JPC**	$	**0.0680**
00002524198	**MAR-CLONIDINE**	**MAR**	$	**0.0680**
00002534738	**MINT-CLONIDINE**	**MPI**	$	**0.0680**
00002516217	**SANDOZ CLONIDINE**	**SDZ**	$	**0.0680**
00002304163	**TEVA-CLONIDINE**	**TEV**	$	**0.0680**

0.1 MG ORAL TABLET

00002538490	**CLONIDINE**	**SIV**	$	**0.0679**
00002462192	**MINT-CLONIDINE**	**MPI**	$	**0.0679**
00002515784	**SANDOZ CLONIDINE**	**SDZ**	$	**0.0679**
00002046121	**TEVA-CLONIDINE**	**TEV**	$	**0.0679**

0.2 MG ORAL TABLET

00002538504	**CLONIDINE**	**SIV**	$	**0.1212**
00002462206	**MINT-CLONIDINE**	**MPI**	$	**0.1212**
00002515792	**SANDOZ CLONIDINE**	**SDZ**	$	**0.1212**
00002046148	**TEVA-CLONIDINE**	**TEV**	$	**0.1212**

DICLOFENAC SODIUM

0.1 % OPHTHALMIC SOLUTION

00002441020	**APO-DICLOFENAC OPHTHALMIC**	**APX**	$	**1.2397**
00002475065	**DICLOFENAC**	**PSL**	$	**1.2397**
00002534525	**JAMP DICLOFENAC**	**JPC**	$	**1.2397**
00002475197	**MINT-DICLOFENAC**	**MPI**	$	**1.2397**
00002454807	**SANDOZ DICLOFENAC OPHTHA**	**SDZ**	$	**1.2397**
00001940414	VOLTAREN OPHTHA	NOV	$	2.9280

ENTACAPONE

200 MG ORAL TABLET

00002535939	**MINT-ENTACAPONE**	**MPI**	$	**0.4010**
00002380005	**SANDOZ ENTACAPONE**	**SDZ**	$	**0.4010**
00002375559	**TEVA-ENTACAPONE**	**TEV**	$	**0.4010**

EZETIMIBE

10 MG ORAL TABLET

00002425610	**ACH-EZETIMIBE**	**AHI**	$	**0.1811**
00002475898	**AG-EZETIMIBE**	**AGP**	$	**0.1811**
00002427826	**APO-EZETIMIBE**	**APX**	$	**0.1811**
00002469286	**AURO-EZETIMIBE**	**AUR**	$	**0.1811**
00002429659	**EZETIMIBE**	**SIV**	$	**0.1811**
00002431300	**EZETIMIBE**	**SNS**	$	**0.1811**
00002460750	**GLN-EZETIMIBE**	**GLM**	$	**0.1811**
00002423235	**JAMP-EZETIMIBE**	**JPC**	$	**0.1811**
00002467437	**M-EZETIMIBE**	**MTR**	$	**0.1811**
00002422662	**MAR-EZETIMIBE**	**MAR**	$	**0.1811**
00002423243	**MINT-EZETIMIBE**	**MPI**	$	**0.1811**
00002481669	**NRA-EZETIMIBE**	**NRA**	$	**0.1811**
00002536420	**NRA-EZETIMIBE**	**NRA**	$	**0.1811**
00002416409	**PMS-EZETIMIBE**	**PMS**	$	**0.1811**
00002419548	**RAN-EZETIMIBE**	**RAN**	$	**0.1811**
00002416778	**SANDOZ EZETIMIBE**	**SDZ**	$	**0.1811**
00002354101	**TEVA-EZETIMIBE**	**TEV**	$	**0.1811**
00002247521	EZETROL	ORC	$	1.9900

FUROSEMIDE

10 MG / ML INJECTION

00000527033	**FUROSEMIDE**	**SDZ**	$	**0.6055**
00002461404	**FUROSEMIDE**	**STM**	$	**0.6055**
00002527502	**FUROSEMIDE**	**JPC**	$	**0.6055**
00002382539	**FUROSEMIDE INJECTION SDZ**	**SDZ**	$	**0.6055**

GABAPENTIN

100 MG ORAL CAPSULE

00002477912	**AG-GABAPENTIN**	**AGP**	$	**0.0416**
00002244304	**APO-GABAPENTIN**	**APX**	$	**0.0416**
00002321203	**AURO-GABAPENTIN**	**AUR**	$	**0.0416**
00002246314	**GABAPENTIN**	**SIV**	$	**0.0416**
00002353245	**GABAPENTIN**	**SNS**	$	**0.0416**
00002416840	**GABAPENTIN**	**AHI**	$	**0.0416**
00002535246	**JAMP GABAPENTIN**	**JPC**	$	**0.0416**
00002361469	**JAMP-GABAPENTIN**	**JPC**	$	**0.0416**
00002391473	**MAR-GABAPENTIN**	**MAR**	$	**0.0416**
00002408880	**MINT-GABAPENTIN**	**MPI**	$	**0.0416**
00002243446	**PMS-GABAPENTIN**	**PMS**	$	**0.0416**
00002244513	**TEVA-GABAPENTIN**	**TEV**	$	**0.0416**
00002084260	NEURONTIN	BGP	$	0.5260

300 MG ORAL CAPSULE

00002477920	**AG-GABAPENTIN**	**AGP**	$	**0.1012**
00002244305	**APO-GABAPENTIN**	**APX**	$	**0.1012**
00002321211	**AURO-GABAPENTIN**	**AUR**	$	**0.1012**
00002246315	**GABAPENTIN**	**SIV**	$	**0.1012**
00002353253	**GABAPENTIN**	**SNS**	$	**0.1012**
00002416859	**GABAPENTIN**	**AHI**	$	**0.1012**
00002535254	**JAMP GABAPENTIN**	**JPC**	$	**0.1012**
00002361485	**JAMP-GABAPENTIN**	**JPC**	$	**0.1012**
00002391481	**MAR-GABAPENTIN**	**MAR**	$	**0.1012**
00002408899	**MINT-GABAPENTIN**	**MPI**	$	**0.1012**
00002243447	**PMS-GABAPENTIN**	**PMS**	$	**0.1012**
00002244514	**TEVA-GABAPENTIN**	**TEV**	$	**0.1012**
00002084279	NEURONTIN	BGP	$	1.2587

400 MG ORAL CAPSULE

00002477939	**AG-GABAPENTIN**	**AGP**	$	**0.1206**
00002244306	**APO-GABAPENTIN**	**APX**	$	**0.1206**
00002321238	**AURO-GABAPENTIN**	**AUR**	$	**0.1206**
00002246316	**GABAPENTIN**	**SIV**	$	**0.1206**
00002353261	**GABAPENTIN**	**SNS**	$	**0.1206**
00002416867	**GABAPENTIN**	**AHI**	$	**0.1206**
00002535262	**JAMP GABAPENTIN**	**JPC**	$	**0.1206**
00002361493	**JAMP-GABAPENTIN**	**JPC**	$	**0.1206**
00002391503	**MAR-GABAPENTIN**	**MAR**	$	**0.1206**
00002408902	**MINT-GABAPENTIN**	**MPI**	$	**0.1206**
00002243448	**PMS-GABAPENTIN**	**PMS**	$	**0.1206**
00002244515	**TEVA-GABAPENTIN**	**TEV**	$	**0.1206**
00002084287	NEURONTIN	BGP	$	1.4999

GLYCOPYRROLATE

0.2 MG / ML INJECTION

00002039508	**GLYCOPYRROLATE**	**SDZ**	$	**2.7825**
00002382857	**GLYCOPYRROLATE**	**OMG**	$	**2.7825**
00002532379	**GLYCOPYRROLATE**	**JPC**	$	**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**

HYDRALAZINE HCL

10 MG ORAL TABLET

00000441619	**APO-HYDRALAZINE**	**APX**	$	**0.0355**
00002539802	**HYDRALAZINE**	**SNS**	$	**0.0355**
00002457865	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0355**
00002468778	**MINT-HYDRALAZINE**	**MPI**	$	**0.0355**

25 MG ORAL TABLET

00000441627	**APO-HYDRALAZINE**	**APX**	$	**0.0609**
00002539810	**HYDRALAZINE**	**SNS**	$	**0.0609**
00002457873	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0609**
00002468786	**MINT-HYDRALAZINE**	**MPI**	$	**0.0609**

50 MG ORAL TABLET

00000441635	**APO-HYDRALAZINE**	**APX**	$	**0.0956**
00002539829	**HYDRALAZINE**	**SNS**	$	**0.0956**
00002457881	**JAMP-HYDRALAZINE**	**JPC**	$	**0.0956**
00002468794	**MINT-HYDRALAZINE**	**MPI**	$	**0.0956**

MEBENDAZOLE

100 MG ORAL CHEWABLE TABLET

00000556734	VERMOX	JAI	$	6.3350

MESALAZINE

800 MG ORAL DELAYED-RELEASE TABLET

00002465752	OCTASA	TAG	$	1.1358

1,600 MG ORAL DELAYED-RELEASE TABLET

00002529610	OCTASA	TAG	$	2.3740

METHADONE HCL

1 MG ORAL TABLET

00002533642	**APO-METHADONE**	**APX**	$	**0.1399**
00002247698	METADOL	PAL	$	0.1865

5 MG ORAL TABLET

00002533650	**APO-METHADONE**	**APX**	$	**0.4659**
00002247699	METADOL	PAL	$	0.6212

10 MG ORAL TABLET

00002533669	**APO-METHADONE**	**APX**	$	**0.7454**
00002247700	METADOL	PAL	$	0.9939

25 MG ORAL TABLET

00002533677	**APO-METHADONE**	**APX**	$	**1.3850**
00002247701	METADOL	PAL	$	1.9021

METHOTREXATE SODIUM

10 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422174	METHOTREXATE INJECTION BP	PMS	$	7.0000
00002454831	**METOJECT SUBCUTANEOUS**	**MDX**	$	**22.2300**
00002539608	**PMS-METHOTREXATE**	**PMS**	$	**22.2300**
12.5 MG / SYR INJECTION SYRINGE				
00002454750	**METOJECT SUBCUTANEOUS**	**MDX**	$	**23.4000**
00002539616	**PMS-METHOTREXATE**	**PMS**	$	**23.4000**
15 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422182	METHOTREXATE (0.6 ML SYRINGE)	PMS	$	8.4000
00002491311	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**16.3800**
00002454858	**METOJECT SUBCUTANEOUS**	**MDX**	$	**16.3800**
00002539624	**PMS-METHOTREXATE**	**PMS**	$	**16.3800**
17.5 MG / SYR (BASE) INJECTION SYRINGE				
00002491338	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**16.0000**
00002539632	**PMS-METHOTREXATE**	**PMS**	$	**16.0000**
00002454769	METOJECT SUBCUTANEOUS	MDX	$	17.1600
20 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422190	METHOTREXATE (0.8 ML SYRINGE)	PMS	$	11.2000
00002491346	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**17.5000**
00002539640	**PMS-METHOTREXATE**	**PMS**	$	**17.5000**
00002454866	METOJECT SUBCUTANEOUS	MDX	$	17.9400
22.5 MG / SYR (BASE) INJECTION SYRINGE				
00002491354	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**17.5000**
00002539659	**PMS-METHOTREXATE**	**PMS**	$	**17.5000**
00002454777	METOJECT SUBCUTANEOUS	MDX	$	18.7200
25 MG / SYR (BASE) INJECTION SYRINGE				
☒ 00002422204	METHOTREXATE INJECTION BP	PMS	$	12.2000
00002491362	**METHOTREXATE SUBCUTANEOUS**	**AHI**	$	**19.5000**
00002454874	**METOJECT SUBCUTANEOUS**	**MDX**	$	**19.5000**
00002539667	**PMS-METHOTREXATE**	**PMS**	$	**19.5000**

METHYLPHENIDATE HCL

18 MG ORAL EXTENDED-RELEASE TABLET				
00002441934	ACT METHYLPHENIDATE ER	TEV	$	1.0493

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

27 MG ORAL EXTENDED-RELEASE TABLET				
00002441942	ACT METHYLPHENIDATE ER	TEV	$	1.2109

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

36 MG ORAL EXTENDED-RELEASE TABLET				
00002441950	ACT METHYLPHENIDATE ER	TEV	$	1.3726

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

54 MG ORAL EXTENDED-RELEASE TABLET				
00002441969	ACT METHYLPHENIDATE ER	TEV	$	1.6958

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

10 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002536943	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**0.5128**
00002277166	BIPHENTIN	ELV	$	0.8275

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

METHYLPHENIDATE HCL

15 MG ORAL CONTROLLED-RELEASE CAPSULE

00002536951	**PMS-METHYLPHENIDATE CR**	**PMS**	$	**0.7354**
00002277131	BIPHENTIN	ELV	$	1.1837

"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**	$	**0.9477**
00002277158	BIPHENTIN	ELV	$	1.5300

"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**	$	**1.3021**
00002277174	BIPHENTIN	ELV	$	2.1001

"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**	$	**1.6588**
00002277182	BIPHENTIN	ELV	$	2.6750

"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**	$	**2.0130**
00002277190	BIPHENTIN	ELV	$	3.2445

"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**	$	**2.3425**
00002277204	BIPHENTIN	ELV	$	3.7758

"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**	$	**3.0883**
00002277212	BIPHENTIN	ELV	$	4.9835

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

METOCLOPRAMIDE HCL

5 MG / ML INJECTION

00002185431	**METOCLOPRAMIDE HYDROCHLORIDE**	**SDZ**	$	**2.3748**
00002537397	**METOCLOPRAMIDE HYDROCHLORIDE**	**JPC**	$	**2.3748**

MEXILETINE HCL

200 MG ORAL CAPSULE

00002536854	**MINT-MEXILETINE**	**MPI**	$	**0.9837**
00002230360	**NOVO-MEXILETINE**	**TEV**	$	**0.9837**

NAPROXEN

250 MG ORAL ENTERIC-COATED TABLET

00002243312	TEVA-NAPROX EC	TEV	***$ 0.1068***	$	0.2049

MAC pricing has been applied based on the LCA price for 1 x 250 mg oral tablet.

ONDANSETRON HCL DIHYDRATE

4 MG (BASE) ORAL TABLET				
00002478927	**ACCEL-ONDANSETRON**	**ACP**	$	**2.5450**
00002458810	CCP-ONDANSETRON	CEL	$	2.6790
00002288184	APO-ONDANSETRON	APX	$	3.2720
00002313685	JAMP-ONDANSETRON	JPC	$	3.2720
00002371731	MAR-ONDANSETRON	MAR	$	3.2720
00002305259	MINT-ONDANSETRON	MPI	$	3.2720
00002297868	MYLAN-ONDANSETRON	MYP	$	3.2720
00002417839	NAT-ONDANSETRON	NTP	$	3.2720
00002421402	ONDANSETRON	SNS	$	3.2720
00002541424	ONDANSETRON	SIV	$	3.2720
00002258188	PMS-ONDANSETRON	PMS	$	3.2720
00002274310	SANDOZ ONDANSETRON	SDZ	$	3.2720
00002296349	TEVA-ONDANSETRON	TEV	$	3.2720
8 MG (BASE) ORAL TABLET				
00002478935	**ACCEL-ONDANSETRON**	**ACP**	$	**3.8840**
00002458802	CCP-ONDANSETRON	CEL	$	4.0880
00002288192	APO-ONDANSETRON	APX	$	4.9930
00002313693	JAMP-ONDANSETRON	JPC	$	4.9930
00002371758	MAR-ONDANSETRON	MAR	$	4.9930
00002305267	MINT-ONDANSETRON	MPI	$	4.9930
00002297876	MYLAN-ONDANSETRON	MYP	$	4.9930
00002417847	NAT-ONDANSETRON	NTP	$	4.9930
00002421410	ONDANSETRON	SNS	$	4.9930
00002541432	ONDANSETRON	SIV	$	4.9930
00002258196	PMS-ONDANSETRON	PMS	$	4.9930
00002274329	SANDOZ ONDANSETRON	SDZ	$	4.9930
00002296357	TEVA-ONDANSETRON	TEV	$	4.9930

POTASSIUM CHLORIDE (K+)

20 MEQ ORAL EXTENDED-RELEASE TABLET				
00080107649	PRZ-K20	PCI	$	0.1161

SOLIFENACIN SUCCINATE

5 MG ORAL TABLET

00002439344	**ACH-SOLIFENACIN SUCCINATE**	**AHI**	$	**0.3041**
00002446375	**AURO-SOLIFENACIN**	**AUR**	$	**0.3041**
00002428911	**JAMP SOLIFENACIN SUCCINATE**	**JPC**	$	**0.3041**
00002424339	**JAMP-SOLIFENACIN**	**JPC**	$	**0.3041**
00002529696	**M-SOLIFENACIN SUCCINATE**	**MTR**	$	**0.3041**
00002417723	**PMS-SOLIFENACIN**	**PMS**	$	**0.3041**
00002493039	**PRZ-SOLIFENACIN**	**PCI**	$	**0.3041**
00002399032	**SANDOZ SOLIFENACIN**	**SDZ**	$	**0.3041**
00002458241	**SOLIFENACIN**	**SNS**	$	**0.3041**
00002437988	**TARO-SOLIFENACIN**	**SPG**	$	**0.3041**
00002397900	**TEVA-SOLIFENACIN**	**TEV**	$	**0.3041**
00002277263	VESICARE	ASP	$	1.5135

10 MG ORAL TABLET

00002439352	**ACH-SOLIFENACIN SUCCINATE**	**AHI**	$	**0.3041**
00002446383	**AURO-SOLIFENACIN**	**AUR**	$	**0.3041**
00002428938	**JAMP SOLIFENACIN SUCCINATE**	**JPC**	$	**0.3041**
00002424347	**JAMP-SOLIFENACIN**	**JPC**	$	**0.3041**
00002529718	**M-SOLIFENACIN SUCCINATE**	**MTR**	$	**0.3041**
00002417731	**PMS-SOLIFENACIN**	**PMS**	$	**0.3041**
00002493047	**PRZ-SOLIFENACIN**	**PCI**	$	**0.3041**
00002399040	**SANDOZ SOLIFENACIN**	**SDZ**	$	**0.3041**
00002458268	**SOLIFENACIN**	**SNS**	$	**0.3041**
00002437996	**TARO-SOLIFENACIN**	**SPG**	$	**0.3041**
00002397919	**TEVA-SOLIFENACIN**	**TEV**	$	**0.3041**
00002277271	VESICARE	ASP	$	1.5135

TIOTROPIUM BROMIDE MONOHYDRATE

18 MCG INHALATION CAPSULE

00002537850	**LUPIN-TIOTROPIUM**	**LPC**	$	**1.3715**
00002246793	**SPIRIVA**	**BOE**	$	**1.3715**

TOPIRAMATE

25 MG ORAL TABLET				
00002395738	**ACH-TOPIRAMATE**	**AHI**	$	**0.2433**
00002475936	**AG-TOPIRAMATE**	**AGP**	$	**0.2433**
00002279614	**APO-TOPIRAMATE**	**APX**	$	**0.2433**
00002345803	**AURO-TOPIRAMATE**	**AUR**	$	**0.2433**
00002287765	**GLN-TOPIRAMATE**	**GLM**	$	**0.2433**
00002345250	**JAMP TOPIRAMATE**	**JPC**	$	**0.2433**
00002435608	**JAMP-TOPIRAMATE**	**JPC**	$	**0.2433**
00002315645	**MINT-TOPIRAMATE**	**MPI**	$	**0.2433**
00002263351	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.2433**
00002538466	**NRA-TOPIRAMATE**	**NRA**	$	**0.2433**
00002262991	**PMS-TOPIRAMATE**	**PMS**	$	**0.2433**
00002248860	**TEVA-TOPIRAMATE**	**TEV**	$	**0.2433**
00002356856	**TOPIRAMATE**	**SNS**	$	**0.2433**
00002389460	**TOPIRAMATE**	**SIV**	$	**0.2433**
00002230893	TOPAMAX	JAI	$	1.8000
100 MG ORAL TABLET				
00002395746	**ACH-TOPIRAMATE**	**AHI**	$	**0.4583**
00002475944	**AG-TOPIRAMATE**	**AGP**	$	**0.4583**
00002279630	**APO-TOPIRAMATE**	**APX**	$	**0.4583**
00002345838	**AURO-TOPIRAMATE**	**AUR**	$	**0.4583**
00002287773	**GLN-TOPIRAMATE**	**GLM**	$	**0.4583**
00002345269	**JAMP TOPIRAMATE**	**JPC**	$	**0.4583**
00002435616	**JAMP-TOPIRAMATE**	**JPC**	$	**0.4583**
00002315653	**MINT-TOPIRAMATE**	**MPI**	$	**0.4583**
00002263378	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.4583**
00002538458	**NRA-TOPIRAMATE**	**NRA**	$	**0.4583**
00002263009	**PMS-TOPIRAMATE**	**PMS**	$	**0.4583**
00002248861	**TEVA-TOPIRAMATE**	**TEV**	$	**0.4583**
00002356864	**TOPIRAMATE**	**SNS**	$	**0.4583**
00002389487	**TOPIRAMATE**	**SIV**	$	**0.4583**
00002230894	TOPAMAX	JAI	$	3.3700
200 MG ORAL TABLET				
00002395754	**ACH-TOPIRAMATE**	**AHI**	$	**0.6748**
00002279649	**APO-TOPIRAMATE**	**APX**	$	**0.6748**
00002345846	**AURO-TOPIRAMATE**	**AUR**	$	**0.6748**
00002287781	**GLN-TOPIRAMATE**	**GLM**	$	**0.6748**
00002345277	**JAMP TOPIRAMATE**	**JPC**	$	**0.6748**
00002435624	**JAMP-TOPIRAMATE**	**JPC**	$	**0.6748**
00002315661	**MINT-TOPIRAMATE**	**MPI**	$	**0.6748**
00002263386	**MYLAN-TOPIRAMATE**	**MYP**	$	**0.6748**
00002538474	**NRA-TOPIRAMATE**	**NRA**	$	**0.6748**
00002263017	**PMS-TOPIRAMATE**	**PMS**	$	**0.6748**
00002248862	**TEVA-TOPIRAMATE**	**TEV**	$	**0.6748**
00002356872	**TOPIRAMATE**	**SNS**	$	**0.6748**
00002230896	TOPAMAX	JAI	$	4.9890
25 MG ORAL CAPSULE				
00002239908	TOPAMAX SPRINKLE	JAI	$	1.7540

TRIMEBUTINE MALEATE

100 MG ORAL TABLET				
00002245663	**APO-TRIMEBUTINE**	**APX**	$	**0.2939**
00002538202	**MINT-TRIMEBUTINE**	**MPI**	$	**0.2939**
200 MG ORAL TABLET				
00002245664	**APO-TRIMEBUTINE**	**APX**	$	**0.3600**
00002538210	**MINT-TRIMEBUTINE**	**MPI**	$	**0.3600**

VALGANCICLOVIR HCL

50 MG / ML	**ORAL**	**SUSPENSION**			
00002535483	**AURO-VALGANCICLOVIR**		**AUR**	$	**1.5099**
00002306085	VALCYTE		CAG	$	2.9949

PART 3

Special Authorization

ECULIZUMAB

Eligibility Criteria for Eculizumab Coverage

IIn order to maintain the integrity of the ADBL, and having regard to the financial and social implications of covering eculizumab for the treatment of paroxysmal nocturnal hemoglobinuria (PNH), the following special authorization criteria must be satisfied.

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

The patient must:
1) Be diagnosed with PNH in accordance with the requirements specified in the Clinical Criteria for eculizumab;
2) Have Alberta government-sponsored drug coverage;
3) Meet the Registration Requirements;
4) Satisfy the Clinical Criteria for eculizumab (initial or continued coverage, as appropriate); AND
5) Meet the criteria specified in Contraindications to Coverage and Discontinuance of Coverage.

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

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

Registration Requirements

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

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

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

ECULIZUMAB

Clinical Criteria

Patients with insufficient initial response or who have failed treatment with ravulizumab at the Health Canada-recommended dosage are not eligible for reimbursement of eculizumab.

In addition to meeting Sections 1 and Sections 2 herein, to be considered for coverage of eculizumab, a patient must be assessed by a Specialist in Hematology (i.e. a physician who holds specialty certification in Hematology from the Royal College of Physicians and Surgeons of Canada) and meet all of the following clinical criteria (initial or continued coverage, as appropriate).

a. Clinical Criteria - Initial Coverage
All of the following Clinical Criteria must be established on the basis of evidence to the satisfaction of the Minister or the Minister's delegate for initial coverage:

1) The diagnosis of PNH must have been established by flow cytometry and/or a FLAER test. The proportion of circulating cells of each type which are GPI-deficient and hence of the PNH clone is quantitated by flow cytometry. Patients must have a:
- PNH granulocyte or monocyte clone size equal to or greater than 10%, AND
- Raised LDH (value at least 1.5 times the upper limit of normal for the reporting laboratory).

2) Patients with a granulocyte or monocyte clone size equal to or greater than 10% also require AT LEAST ONE of the following:
- Thrombosis: Evidence that the patient has had a thrombotic or embolic event which required the institution of therapeutic anticoagulant therapy;
- Transfusions: Evidence that the patient has been transfused with at least four (4) units of red blood cells in the last twelve (12) months;
- Anemia: Evidence that the patient has chronic or recurrent anemia where causes other than hemolysis have been excluded and demonstrated by more than one measure of less than or equal to 70 g/L or by more than one measure of less than or equal to 100 g/L with concurrent symptoms of anemia;
- Pulmonary insufficiency: Evidence that the patient has debilitating shortness of breath and/or chest pain resulting in limitation of normal activity (New York Heart Association Class III) and/or established diagnosis of pulmonary arterial hypertension, where causes other than PNH have been excluded;
- Renal insufficiency: Evidence that the patient has a history of renal insufficiency, demonstrated by an eGFR less than or equal to 60 mL/min/1.73 m^2, where causes other than PNH have been excluded; OR
- Smooth muscle spasm: Evidence that the patient has recurrent episodes of severe pain requiring hospitalisation and/or narcotic analgesia, where causes other than PNH have been excluded.

AND

3) All patients must receive meningococcal immunization with a quadravalent vaccine (A, C, Y and W135) at least two (2) weeks prior to receiving the first dose of eculizumab. Treating physicians will be required to submit confirmation of meningococcal immunizations in order for their patients to continue to be eligible for treatment with eculizumab. Pneumococcal immunization with a 23-valent polysaccharide vaccine and a 13-valent conjugate vaccine, and a Haemophilus influenza type b (Hib) vaccine must be given according to current clinical guidelines. All patients must be monitored and reimmunized according to current clinical guidelines for vaccine use.

b. Clinical Criteria - Continued Coverage
All of the following Clinical Criteria must be established on the basis of evidence to the satisfaction of the Minister or the Minister's delegate for continued coverage:
1) Patient eligibility must be reviewed six (6) months after commencing therapy and every six (6) months thereafter;

AND

ECULIZUMAB

2) Continued eligibility will be subject to the assessment of evidence, in accordance with the following monitoring requirements, which demonstrates:
- Clinical improvement in the patient, OR
- Stabilization of the patient's condition;

Monitoring requirements;

The patient's Specialist in Hematology must provide the following monitoring information every six (6) months:
- Lactate dehydrogenase (LDH);
- Full blood count and reticulocytes;
- Transfusion history for previous six months;
- Iron studies;
- Urea, electrolytes and eGFR;
- Recent clinical history; AND
- Any other information requested by the Minister, the Minister's delegate, or an Expert Advisor.

The patient's Specialist in Hematology must provide the following monitoring information every twelve (12) months:
- Confirmation that the patient has been immunized or reimmunized (meningococcal, pneumococcal 23-valent, pneumococcal 13-valent and Hib) according to current clinical guidelines for vaccine use;
- Progress reports on the clinical symptoms that formed the basis of initial eligibility;
- Quality of life, through clinical narrative;
- Granulocyte or monocyte clone size (by flow cytometry): AND
- Any other information requested by the Minister, the Minister's delegate, or an Expert Advisor.

c. Contraindications to Coverage

- Small clone size - granulocyte and monocyte clone sizes below 10%;
- Aplastic anaemia with two or more of the following: neutrophil count below 0.5 x 10^9/L, platelet count below 20 x 10^9/L, reticulocytes below 25 x 10^9/L, or severe bone marrow hypocellularity;
- Patients with a presence of another life threatening or severe disease where the long term prognosis is unlikely to be influenced by therapy (for example acute myeloid leukaemia or high-risk myelodysplastic syndrome); OR
- The presence of another medical condition that in the opinion of the Minister or Minister's delegate might reasonably be expected to compromise a response to therapy.

d. Discontinuation of Coverage

Coverage may be discontinued where one or more of the following situations apply:
- The patient or the patient's Specialist in Hematology fails to comply adequately with treatment or measures, including monitoring requirements, taken to evaluate the effectiveness of the therapy;
- There is a failure to provide the Minister, the Minister's delegate, or an Expert Advisor with information as required or as requested;
- If in the opinion of the Minister or the Minister's delegate, therapy fails to relieve the symptoms of disease that originally resulted in the patient being approved by the Minister or the Minister's delegate;
- The patient has (or develops) a condition referred to in Contraindications to Coverage.

The patient's Specialist in Hematology will be advised if their patient is at risk of being withdrawn from treatment for failure to comply with the above requirements or other perceived "non-compliance" and given a reasonable period of time to respond prior to coverage being discontinued.

Process for Eculizumab Coverage

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

ECULIZUMAB

completed and submitted:

- An Eculizumab/Pegcetacoplan/Ravulizumab for Paroxysmal Nocturnal Hemoglobinuria Special Authorization Request Form completed by the patient's Specialist in Hematology;
- An Eculizumab/Pegcetacoplan/Ravulizumab Consent Form completed by the patient, or a patient's parent/guardian/legal representative, and the patients Specialist in Hematology (for any initial coverage application); AND
- Any other documentation that may be required by the Minister or the Minister's delegate.

a. Expert Review

Once the Minister or the Minister's delegate has confirmed that the patient meets the Registration Requirement or granted a waiver of the Registration Requirement, the Application will be given to one or more Expert Advisors for review.

The Application, together with the recommendation or recommendations of the Expert Advisor(s), is then forwarded to the Minister or the Minister's delegate for a decision regarding coverage.

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

Approval of Coverage

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

Initial coverage may be approved for a period of up to six (6) months as follows: One dose of 600 mg of eculizumab administered weekly for the first four (4) weeks of treatment (total of four 600 mg doses), followed by one dose of 900 mg of eculizumab administered every two (2) weeks from week five (5) of treatment (total of eleven 900 mg doses).

Continued coverage may be approved for up to one dose of 900 mg of eculizumab administered every two (2) weeks, for a period of six (6) months (total of thirteen 900 mg doses). If the patient restarts treatment after a lapse in therapy, continued coverage may be approved for a period of up to six (6) months as follows: One dose of 600 mg of eculizumab administered weekly for the first four (4) weeks of treatment (total of four 600 mg doses), followed by one dose of 900 mg of eculizumab administered every two (2) weeks from week five (5) of treatment (total of eleven 900 mg doses).

If a patient is approved for coverage, prescriptions for eculizumab must be written by a Specialist in Hematology. To avoid wastage, prescription quantities are limited to a two week supply. Extended quantity and vacation supplies are not permitted. The Government is not responsible and will not pay for costs associated with wastage or improper storage of eculizumab.

Approval of coverage is granted for a specific period, to a maximum of six (6) months. If continued treatment is necessary, it is the responsibility of the patient or patient's parent/guardian/legal representative and the Specialist in Hematology to submit a new Application to re-apply for eculizumab coverage, and receive a decision thereon, prior to the expiry date of the authorization period.

Coverage will not be approved when any complement inhibitors are to be used in combination except in the first 4 weeks of treatment with pegcetacoplan. Patients will not be permitted to switch back to a previously trialed complement inhibitor if they were deemed unresponsive to therapy.

Withdrawal

ECULIZUMAB

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

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

300 MG / VIAL INJECTION

00002322285	SOLIRIS	APG	$ 6675.3000

ELOSULFASE ALFA

"For the treatment of mucopolysaccharidosis type IVA (MPS IVA) confirmed by diagnostic testing through enzymatic assay for N-acetylgalactosamine-6-sulfate sulfatase (GALNS) activity in peripheral blood leukocytes or fibroblasts (excluding multiple sulfatase deficiency) AND *mutation analysis of GALNS when the following criteria are met:

*Note: not all MPS IVA patients will have 2 known pathogenic alleles identified and that parental mutation analysis to establish the phase of mutations should be performed.

I. Treatment should be provided under the care of a specialist with experience in the diagnosis and management of MPS IVA.

AND

II. Patients must have the following baseline evaluations completed prior to initiating therapy on elosulfase alfa:

- Detailed medical history documenting surgeries, medical admissions, subspecialty assessments
- Orthopedic evaluation including spinal and cranial MRI, skeletal x-rays appropriate to age and clinical disease
- Mobility measure: 6 Minute Walking Test (6MWT) and Stair Climb test (if appropriate for age and disease status)
- Respiratory function testing including sleep study (age appropriate)
- Age appropriate quality of life measure (such as HAQ, PODCI, EQ5D5L or SF36)
- Documentation of mobility aide requirement
- Requirement for respiratory aides including ventilation status and changes in respiratory support requirements
- Ophthalmologic and ENT assessment
- Urine keratin sulfate (KS) determination: specific KS determination is preferred over total glycosaminoglycans (GAGs)
- GALNS enzyme activity determination and Morquio A gene mutation analysis (both enzyme analysis and mutation analysis are recommended to ensure that the primary diagnosis is correct)
- Cardiac echocardiogram

AND

III. Patient will not be eligible for coverage of elosulfase alfa if any of the following apply (Exclusion Criteria):

- The patient is diagnosed with an additional progressive life limiting condition where treatment would not provide long term benefit (such as cancer or multiple sclerosis)
- The patient has a forced vital capacity (FVC) of less than 0.3 litres and requires continuous ventilator assistance
- The patient/family is unwilling to comply with the associated monitoring criteria
- The patient/family is unwilling to attend clinics for assessment and treatment purposes

Initial coverage may be approved at a dosage of 2 mg/kg once weekly for a period of 12 months. Patients will be limited to receiving a two-week supply of elosulfase alfa per prescription at their pharmacy.

Ongoing coverage may be considered for 2 mg/kg once weekly for a period of 12 months only if the following criteria are met:

I. The patient demonstrates at least 3 of the 5 following treatment effects at the end of each 12-month period:

- 6 MWT or Stair Climb test stabilized at or improved by at least 5% of baseline measure
- FVC or FEV-1 stabilized at or improved by at least 5% of baseline measure or remaining within 2SD of normal for age

ELOSULFASE ALFA

- Improvement or no change (if minimal effect) in age appropriate quality of life measure
- Reduction of urine KSs of 20%
- Stability of cardiac ejection fraction reduction (within 5% of baseline)

AND

II. It is confirmed that none of the following applies to the patient (Discontinuation Criteria):

- Is unable to tolerate infusions due to infusion related adverse events that cannot be resolved
- Requires continuous respiratory support
- Has missed more than 6 infusions in a 12-month interval, unless for medically related issues
- Meets any one of the Exclusion Criteria outlined above."

All requests (including renewal requests) for elosulfase alfa must be completed using the Elosulfase Alfa Special Authorization Request Form (ABC XXXXX).

5 MG / VIAL INJECTION

00002427184	VIMIZIM	BMI	$ 1091.0900

PIRFENIDONE

"Initial approval criteria:

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

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

Initial renewal criteria (at 6 months):

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

Approval period: 6 months

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

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

Approval period: 12 months

Exclusion Criteria:

Combination use of pirfenidone and nintedanib will not be funded.

Notes:

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

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

267 MG ORAL TABLET

00002537753	**AURO-PIRFENIDONE**	**AUR**	$	**3.3560**
00002514702	**JAMP PIRFENIDONE**	**JPC**	$	**3.3560**
00002531526	**PMS-PIRFENIDONE**	**PMS**	$	**3.3560**
00002488507	**SANDOZ PIRFENIDONE**	**SDZ**	$	**3.3560**
00002464489	ESBRIET	HLR	$	13.4240

801 MG ORAL TABLET

00002537761	**AURO-PIRFENIDONE**	**AUR**	$	**10.0680**
00002514710	**JAMP PIRFENIDONE**	**JPC**	$	**10.0680**
00002531534	**PMS-PIRFENIDONE**	**PMS**	$	**10.0680**
00002488515	**SANDOZ PIRFENIDONE**	**SDZ**	$	**10.0680**
00002464500	ESBRIET	HLR	$	40.2720

SATRALIZUMAB

"Special authorization coverage may be provided for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult and adolescent patients (aged 12 years and above) who are anti-aquaporin-4 (AQP4) antibody positive and who meet ALL of the following criteria:

-Refractory to or intolerant of an adequate trial of rituximab for NMOSD (note that if rituximab is not appropriate for the patient, an adequate trial of another preventative treatment including but not limited to other monoclonal antibodies, azathioprine, mycophenolate or other immunosuppressants must have been used), and
-The patient must have had at least one relapse of NMOSD in the previous 12 months, and
-The patient has an Expanded Disability Status Scale (EDSS) score of less than or equal to 6.5.

For coverage, this drug must be prescribed by a Neurologist.

Initial coverage may be approved for 120 mg of satralizumab at weeks 0, 2 and 4, followed by 120 mg every four weeks.

Patients will be limited to receiving three doses of satralizumab per prescription at their pharmacy during the initial four weeks, then one dose per prescription thereafter.

Coverage may be provided for 12 months.

For continued coverage beyond the initial 12 months, the following criteria must be met:
-The Neurologist must provide a current updated EDSS score. The patient must have an EDSS score of less than 8.0 at each renewal.

Following this assessment, continued coverage may be approved for 120 mg every four weeks. Continued coverage may be approved for up to 6 months.

Satralizumab should not be initiated during a NMOSD relapse episode."

All requests (including renewal requests) for satralizumab must be completed using the Satralizumab Special Authorization Request Form (ABC XXXXX).

120 ML / SYR	**INJECTION**	**SYRINGE**		
00002499681	ENSPRYNG		HLR	$ 9450.0000

SITAGLIPTIN

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

FIRST-LINE DRUG PRODUCT(S): METFORMIN
SECOND-LINE DRUG PRODUCT(S): SULFONYLUREAS
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:
- a sufficient trial (i.e. a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

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
CA - Prior adverse reaction
CB - Previous treatment failure
CJ - Product is not effective

All requests for sitagliptin must be completed using the DPP-4/SGLT2 Inhibitors/GLP-1 Receptor Agonist Special Authorization Request Form (ABC 60012).

25 MG ORAL TABLET

00002512475	**ACH-SITAGLIPTIN**	**AHI**	$	**0.8197**
00002508656	**APO-SITAGLIPTIN MALATE**	**APX**	$	**0.8197**
00002529866	**AURO-SITAGLIPTIN**	**AUR**	$	**0.8197**
00002534134	**JAMP SITAGLIPTIN**	**JPC**	$	**0.8197**
00002504049	**SANDOZ SITAGLIPTIN**	**SDZ**	$	**0.8197**
00002529033	**SITAGLIPTIN**	**SIV**	$	**0.8197**
00002531631	**TARO-SITAGLIPTIN FUMARATE**	**TAR**	$	**0.8197**
00002522705	**TEVA-SITAGLIPTIN MALATE**	**TEV**	$	**0.8197**
00002388839	JANUVIA	MFC	$	3.2229

50 MG ORAL TABLET

00002512483	**ACH-SITAGLIPTIN**	**AHI**	$	**0.8197**
00002508664	**APO-SITAGLIPTIN MALATE**	**APX**	$	**0.8197**
00002529874	**AURO-SITAGLIPTIN**	**AUR**	$	**0.8197**
00002534142	**JAMP SITAGLIPTIN**	**JPC**	$	**0.8197**
00002504057	**SANDOZ SITAGLIPTIN**	**SDZ**	$	**0.8197**
00002529041	**SITAGLIPTIN**	**SIV**	$	**0.8197**
00002531658	**TARO-SITAGLIPTIN FUMARATE**	**TAR**	$	**0.8197**
00002522713	**TEVA-SITAGLIPTIN MALATE**	**TEV**	$	**0.8197**
00002388847	JANUVIA	MFC	$	3.2229

SITAGLIPTIN

100 MG ORAL TABLET

00002512491	**ACH-SITAGLIPTIN**	**AHI**	$	**0.8197**
00002508672	**APO-SITAGLIPTIN MALATE**	**APX**	$	**0.8197**
00002529882	**AURO-SITAGLIPTIN**	**AUR**	$	**0.8197**
00002534150	**JAMP SITAGLIPTIN**	**JPC**	$	**0.8197**
00002504065	**SANDOZ SITAGLIPTIN**	**SDZ**	$	**0.8197**
00002529068	**SITAGLIPTIN**	**SIV**	$	**0.8197**
00002531666	**TARO-SITAGLIPTIN FUMARATE**	**TAR**	$	**0.8197**
00002522721	**TEVA-SITAGLIPTIN MALATE**	**TEV**	$	**0.8197**
00002303922	JANUVIA	MFC	$	3.2229

TOFACITINIB CITRATE

Ulcerative Colitis

"Special authorization coverage may be provided for the reduction in signs and symptoms and induction and maintenance of clinical remission of Ulcerative Colitis in adult patients (18 years of age or older) with active disease (characterized by a partial Mayo score >4 prior to initiation of biologic therapy) and who are refractory or intolerant to:

- mesalamine: minimum of 4 grams/day for a minimum of 4 weeks; AND
- corticosteroids (failure to respond to prednisone 40 mg daily for 2 weeks, or; steroid dependent i.e. failure to taper off steroids without recurrence of disease or disease requiring a second dose of steroids within 12 months of previous dose).

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

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

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

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

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

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

Following this assessment, continued coverage may be approved for a dose of 5 mg twice daily for a period of 12 months. Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:
1) The patient has been assessed by a Specialist in Gastroenterology to determine response;
2) The Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- a decrease in the partial Mayo score of greater than or equal to 2 points from the score prior to initiation of tofacitinib therapy.

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

Note: For patients who showed a response to induction therapy then experienced secondary loss of response while on maintenance dosing with 5 mg, the maintenance

TOFACITINIB CITRATE

dose may be adjusted from 5 mg to 10 mg by making an additional special authorization request to Alberta Blue Cross for the increased dose.

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

10 MG (BASE) ORAL TABLET

00002530015	**AURO-TOFACITINIB**	**AUR**	$	**21.1718**
00002511312	**TARO-TOFACITINIB**	**TAR**	$	**21.1718**
00002480786	XELJANZ	PFI	$	43.7833

USTEKINUMAB

45 MG / VIAL INJECTION

00002544202	WEZLANA (0.5 ML VIAL)	AMG	$ 2755.8800

Plaque Psoriasis

Effective May 1, 2024, all new Special Authorization requests for the treatment Plaque Psoriasis, for ustekinumab-naive patients will be assessed for coverage with an ustekinumab biosimilar. The originator drug, Stelara, will not be approved for new ustekinumab starts for patients with Plaque Psoriasis; patients currently on the originator drug for the treatment of Plaque Psoriasis, must switch to the biosimilar prior to November 1, 2024 in order to maintain coverage for the molecule through their Alberta government sponsored drug plan. During the switching period, both the originator drug and biosimilar(s) will be covered. As of November 1, 2024, the authorization will only cover the biosimilar(s).

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

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:

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

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

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

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

-Initial coverage may be approved for three doses of ustekinumab 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose 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. the initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 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 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks for a period of 12 months. [Note: For patients who have an incomplete response, consideration may be given to treating as often as every 8 weeks]. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as

USTEKINUMAB

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 ustekinumab 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).

USTEKINUMAB

45 MG INJECTION VIAL OR SYRINGE

00002320673	STELARA (0.5 ML VIAL OR SYRINGE)	JAI	$ 4465.5800

Effective May 1, 2024, all new Special Authorization requests for the treatment of Plaque Psoriasis, for ustekinumab-naive patients will be assessed for coverage with an ustekinumab biosimilar. The originator drug, Stelara, will not be approved for new ustekinumab starts for patients with Plaque Psoriasis; patients currently on the originator drug for the treatment of Plaque Psoriasis, must switch to the biosimilar prior to November 1, 2024 in order to maintain coverage for the molecule through their Alberta government sponsored drug plan. During the switching period, both the originator drug and biosimilar(s) will be covered. As of November 1, 2024, the authorization will only cover the biosimilar(s).

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

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory to 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 three doses of 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose 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, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 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 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

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

USTEKINUMAB

All requests (including renewal requests) for ustekinumab 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).

For this product - pricing has been established on a per vial or syringe basis.

USTEKINUMAB

45 MG / SYR INJECTION SYRINGE

✉	00002544180	WEZLANA (0.5 ML SYRINGE)	AMG	$ 2755.8800

Plaque Psoriasis

Effective May 1, 2024, all new Special Authorization requests for the treatment Plaque Psoriasis, for ustekinumab-naive patients will be assessed for coverage with an ustekinumab biosimilar. The originator drug, Stelara, will not be approved for new ustekinumab starts for patients with Plaque Psoriasis; patients currently on the originator drug for the treatment of Plaque Psoriasis, must switch to the biosimilar prior to November 1, 2024 in order to maintain coverage for the molecule through their Alberta government sponsored drug plan. During the switching period, both the originator drug and biosimilar(s) will be covered. As of November 1, 2024, the authorization will only cover the biosimilar(s).

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

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:

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

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

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

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

-Initial coverage may be approved for three doses of ustekinumab 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose 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. the initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 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 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks for a period of 12 months. [Note: For patients who have an incomplete response, consideration may be given to treating as often as every 8 weeks]. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as

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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 ustekinumab 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).

☒ 00002543036 JAMTEKI (0.5 ML SYRINGE) JPC $ 2755.8840

Plaque Psoriasis

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

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:

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

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

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

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

-Initial coverage may be approved for three doses of ustekinumab 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose 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. the initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 weeks of therapy to determine response.

USTEKINUMAB

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 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks for a period of 12 months. [Note: For patients who have an incomplete response, consideration may be given to treating as often as every 8 weeks]. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

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

All requests (including renewal requests) for ustekinumab 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).

USTEKINUMAB

90 MG / SYR INJECTION SYRINGE

☒ 00002544199 WEZLANA (1 ML SYRINGE) AMG $ 2755.8800

Plaque Psoriasis

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

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:

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

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

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

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

-Initial coverage may be approved for three doses of ustekinumab 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose 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. the initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 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 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks for a period of 12 months. [Note: For patients who have an incomplete response, consideration may be given to treating as often as every 8 weeks]. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as

USTEKINUMAB

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 ustekinumab 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).

✉ 00002543044 JAMTEKI (1 ML SYRINGE) JPC $ 2755.8840

Plaque Psoriasis

Effective May 1, 2024, all new Special Authorization requests for the treatment Plaque Psoriasis, for ustekinumab-naive patients will be assessed for coverage with an ustekinumab biosimilar. The originator drug, Stelara, will not be approved for new ustekinumab starts for patients with Plaque Psoriasis; patients currently on the originator drug for the treatment of Plaque Psoriasis, must switch to the biosimilar prior to November 1, 2024 in order to maintain coverage for the molecule through their Alberta government sponsored drug plan. During the switching period, both the originator drug and biosimilar(s) will be covered. As of November 1, 2024, the authorization will only cover the biosimilar(s).

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

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory or intolerant to:

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

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

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

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

-Initial coverage may be approved for three doses of ustekinumab 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose 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. the initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For continued coverage, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 weeks of therapy to determine response.

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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 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks for a period of 12 months. [Note: For patients who have an incomplete response, consideration may be given to treating as often as every 8 weeks]. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

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

All requests (including renewal requests) for ustekinumab 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).

☒ 00002320681 STELARA (1 ML SYRINGE) JAI $ 4465.5800

Effective May 1, 2024, all new Special Authorization requests for the treatment of Plaque Psoriasis, for ustekinumab-naive patients will be assessed for coverage with an ustekinumab biosimilar. The originator drug, Stelara, will not be approved for new ustekinumab starts for patients with Plaque Psoriasis; patients currently on the originator drug for the treatment of Plaque Psoriasis, must switch to the biosimilar prior to November 1, 2024 in order to maintain coverage for the molecule through their Alberta government sponsored drug plan. During the switching period, both the originator drug and biosimilar(s) will be covered. As of November 1, 2024, the authorization will only cover the biosimilar(s).

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

- Have a total PASI of 10 or more and a DLQI of more than 10, OR
- Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND
- Who are refractory to 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 three doses of 45 mg (90 mg for patients weighing greater than 100 kg) at weeks 0, 4 and 16.
- Patients will be limited to receiving one dose 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

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(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, the patient must meet all of the following criteria:
1) The patient must be assessed by a Dermatology Specialist after the initial 16 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 45 mg (90 mg for patients weighing greater than 100 kg) every 12 weeks for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above."

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

All requests (including renewal requests) for ustekinumab 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).