Updates to the Alberta Drug Benefit List

Effective September 1, 2021

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 for patients covered under Alberta government-sponsored drug programs.

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
AG-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002432684	AGP
AG-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002432692	AGP

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
AURO-ZOLMITRIPTAN 2.5 MG TABLET	ZOLMITRIPTAN	00002481030	AUR
MEROPENEM FOR INJECTION 1 G / VIAL INJECTION	MEROPENEM	00002493349	STM

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-DARIFENACIN 7.5 MG EXTENDED-RELEASE TABLET	DARIFENACIN HYDROBROMIDE	00002452510	APX
APO-DARIFENACIN 15 MG EXTENDED-RELEASE TABLET	DARIFENACIN HYDROBROMIDE	00002452529	APX

Drug Product(s) with Changes to Criteria for Coverage

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002362260	APX
APO-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002362279	APX
APO-RIVASTIGMINE 1.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002336715	APX
APO-RIVASTIGMINE 3 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002336723	APX
APO-RIVASTIGMINE 4.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002336731	APX
APO-RIVASTIGMINE 6 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002336758	APX
ARICEPT 5 MG TABLET	DONEPEZIL HCL	00002232043	PFI
ARICEPT 10 MG TABLET	DONEPEZIL HCL	00002232044	PFI
AURO-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002400561	AUR
AURO-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002400588	AUR

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
AURO-GALANTAMINE ER 8 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002425157	AUR
AURO-GALANTAMINE ER 16 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002425165	AUR
AURO-GALANTAMINE ER 24 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002425173	AUR
BIO-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002412853	BMD
BIO-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002412861	BMD
DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002475278	RIV
DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002420597	SIV
DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002426846	SNS
DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002475286	RIV
DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002420600	SIV
DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002426854	SNS
DONEPEZIL HYDROCHLORIDE 5 MG TABLET	DONEPEZIL HCL	00002402645	AHI
DONEPEZIL HYDROCHLORIDE 10 MG TABLET	DONEPEZIL HCL	00002402653	AHI
EXELON 1.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242115	NOV
EXELON 2 MG / ML ORAL SOLUTION	RIVASTIGMINE HYDROGEN TARTRATE	00002245240	NOV
EXELON 3 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242116	NOV
EXELON 4.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242117	NOV
EXELON 6 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002242118	NOV
GALANTAMINE ER 8 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002443015	SNS
GALANTAMINE ER 16 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002443023	SNS
GALANTAMINE ER 24 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002443031	SNS
JAMP RIVASTIGMINE 1.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002485362	JPC
JAMP RIVASTIGMINE 3 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002485370	JPC
JAMP RIVASTIGMINE 4.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002485389	JPC
JAMP RIVASTIGMINE 6 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002485397	JPC
JAMP-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002416948	JPC
JAMP-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002416956	JPC
MAR-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002402092	MAR
MAR-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002402106	MAR
MED-RIVASTIGMINE 1.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002401614	GMP

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
MED-RIVASTIGMINE 3 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002401622	GMP
MED-RIVASTIGMINE 4.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002401630	GMP
MED-RIVASTIGMINE 6 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002401649	GMP
MINT-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002408600	MPI
MINT-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002408619	MPI
MYLAN-GALANTAMINE ER 8 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002339439	MYP
MYLAN-GALANTAMINE ER 16 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002339447	MYP
MYLAN-GALANTAMINE ER 24 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002339455	MYP
NAT-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002439557	NTP
NAT-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002439565	NTP
PMS-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002322331	PMS
PMS-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002322358	PMS
PMS-GALANTAMINE ER 8 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002398370	PMS
PMS-GALANTAMINE ER 16 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002398389	PMS
PMS-GALANTAMINE ER 24 MG EXTENDED-RELEASE CAPSULE	GALANTAMINE HYDROBROMIDE	00002398397	PMS
RAN-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002381508	RAN
RAN-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002381516	RAN
RIXIMYO 10 MG / ML INJECTION	RITUXIMAB	00002498316	SDZ
SANDOZ DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002328666	SDZ
SANDOZ DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002328682	SDZ
SANDOZ RIVASTIGMINE 1.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002324563	SDZ
SANDOZ RIVASTIGMINE 3 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002324571	SDZ
SANDOZ RIVASTIGMINE 4.5 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002324598	SDZ
SANDOZ RIVASTIGMINE 6 MG CAPSULE	RIVASTIGMINE HYDROGEN TARTRATE	00002324601	SDZ
SEPTA DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002428482	SEP
SEPTA DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002428490	SEP
TEVA-DONEPEZIL 5 MG TABLET	DONEPEZIL HCL	00002340607	TEV
TEVA-DONEPEZIL 10 MG TABLET	DONEPEZIL HCL	00002340615	TEV

Restricted Benefit(s)

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
RIVA-CYCLOBENZAPRINE 10 MG TABLET	CYCLOBENZAPRINE HCL	00002242079	RIV

Added Product(s)

Trade Name / Strength / Form	Generic Description	DIN	MFR
AG-ZOPICLONE 7.5 MG TABLET	ZOPICLONE	00002475847	AGP
HYDROMORPHONE HCL HP 50 MG / ML INJECTION	HYDROMORPHONE HCL	00002469413	STM
JAMP-AMLODIPINE 2.5 MG TABLET	AMLODIPINE BESYLATE	00002357186	JPC
JAMP-HYDROCORTISONE ACETATE / UREA 1 % / 10% TOPICAL CREAM	HYDROCORTISONE ACETATE/ UREA	00080061501	JPC
JAMP-METHADONE CONCENTRATE 10 MG / ML ORAL LIQUID	METHADONE HCL	00002495783	JPC
MINT-LEVETIRACETAM 250 MG TABLET	LEVETIRACETAM	00002442388	MPI
MINT-LEVETIRACETAM 500 MG TABLET	LEVETIRACETAM	00002442396	MPI
MINT-LEVETIRACETAM 750 MG TABLET	LEVETIRACETAM	00002442418	MPI
ONDANSETRON (PRESERVED) 2 MG / ML INJECTION	ONDANSETRON HCL DIHYDRATE	00002462257	STM
RIVA-CLARITHROMYCIN 500 MG TABLET	CLARITHROMYCIN	00002346532	RIV
SIMVASTATIN 5 MG TABLET	SIMVASTATIN	00002284723	SNS
SIMVASTATIN 10 MG TABLET	SIMVASTATIN	00002284731	SNS
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	00002284758	SNS
SIMVASTATIN 40 MG TABLET	SIMVASTATIN	00002284766	SNS
SIMVASTATIN 80 MG TABLET	SIMVASTATIN	00002284774	SNS
TARO-BUDESONIDE 0.125 MG / ML INHALATION SUSPENSION	BUDESONIDE	00002494264	TAR
TARO-BUDESONIDE 0.25 MG / ML INHALATION SUSPENSION	BUDESONIDE	00002494272	TAR
TARO-BUDESONIDE 0.5 MG / ML INHALATION SUSPENSION	BUDESONIDE	00002494280	TAR

New Established Interchangeable (IC) Grouping(s)

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

Generic Description	Strength / Form	New LCA Price
BUDESONIDE	0.25 MG / ML INHALATION SUSPENSION	0.3593

New Established Interchangeable (IC) Grouping(s), continued

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

Generic Description	Strength / Form	New LCA Price
DARIFENACIN HYDROBROMIDE	7.5 MG EXTENDED-RELEASE TABLET	1.2087
DARIFENACIN HYDROBROMIDE	15 MG EXTENDED-RELEASE TABLET	1.2087
HYDROMORPHONE HCL	50 MG / ML INJECTION	6.9525
MEROPENEM	1 G / VIAL INJECTION	18.4450

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

Generic Description	Strength / Form	New LCA Price
BUDESONIDE	0.125 MG / ML INHALATION SUSPENSION	0.1143
BUDESONIDE	0.5 MG / ML INHALATION SUSPENSION	0.4559
DEFERASIROX	125 MG DISPERSIBLE TABLET FOR SUSPENSION	5.2408
DEFERASIROX	250 MG DISPERSIBLE TABLET FOR SUSPENSION	10.4820
DEFERASIROX	500 MG DISPERSIBLE TABLET FOR SUSPENSION	20.9649
MEDROXYPROGESTERONE ACETATE	2.5 MG TABLET	0.1183
MORPHINE SULFATE	15 MG SUSTAINED-RELEASE TABLET	0.4145

Product(s) with a Price Change

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
APO-DEFERASIROX 125 MG DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002461544	APX
APO-DEFERASIROX 250 MG DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002461552	APX
APO-DEFERASIROX 500 MG DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002461560	APX
APO-MEDROXY 2.5 MG TABLET	MEDROXYPROGESTERONE ACETATE	00002244726	APX
PMS-METHOTREXATE 2.5 MG TABLET	METHOTREXATE	00002170698	PMS
SANDOZ DEFERASIROX 125 MG DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002464454	SDZ

Product(s) with a Price Change, continued

Trade Name / Strength / Form	Generic Description	DIN	MFR
SANDOZ DEFERASIROX 250 MG DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002464462	SDZ
SANDOZ DEFERASIROX 500 MG DISPERSIBLE TABLET FOR SUSPENSION	DEFERASIROX	00002464470	SDZ
SANDOZ MORPHINE SR 15 MG SUSTAINED-RELEASE TABLET	MORPHINE SULFATE	00002244790	SDZ
TEVA-BUDESONIDE 0.125 MG / ML INHALATION SUSPENSION	BUDESONIDE	00002465949	TEV
TEVA-BUDESONIDE 0.5 MG / ML INHALATION SUSPENSION	BUDESONIDE	00002465957	TEV
TEVA-MEDROXYPROGESTERONE 2.5 MG TABLET	MEDROXYPROGESTERONE ACETATE	00002221284	TEV
TEVA-MORPHINE SR 15 MG SUSTAINED-RELEASE TABLET	MORPHINE SULFATE	00002302764	TEV

Discontinued Listing(s)

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

Trade Name / Strength / Form	Generic Description	DIN	MFR
MAR-OLANZAPINE ODT 10 MG DISINTEGRATING TABLET	OLANZAPINE	00002389096	MAR
PMS-ATORVASTATIN 80 MG TABLET	ATORVASTATIN CALCIUM	00002399407	PMS
SANDOZ CLOPIDOGREL 75 MG TABLET	CLOPIDOGREL BISULFATE	00002359316	SDZ
SANDOZ METOPROLOL SR 200 MG SUSTAINED-RELEASE TABLET	METOPROLOL TARTRATE	00002303418	SDZ

PART 2

Drug Additions

AMLODIPINE BESYLATE

2.5 MG (BASE) ORAL TABLET

00002385783	**AMLODIPINE**	**SIV**	$	**0.0767**
00002492199	**AMLODIPINE**	**JPC**	$	**0.0767**
00002419556	**AMLODIPINE BESYLATE**	**AHI**	$	**0.0767**
00002357186	**JAMP-AMLODIPINE**	**JPC**	$	**0.0767**
00002371707	**MAR-AMLODIPINE**	**MAR**	$	**0.0767**
00002476452	**NRA-AMLODIPINE**	**NRA**	$	**0.0767**
00002469022	**PHARMA-AMLODIPINE**	**PMS**	$	**0.0767**
00002295148	**PMS-AMLODIPINE**	**PMS**	$	**0.0767**
00002330474	**SANDOZ AMLODIPINE**	**SDZ**	$	**0.0767**

BUDESONIDE

0.125 MG / ML INHALATION SUSPENSION

00002494264	**TARO-BUDESONIDE**	**TAR**	$	**0.1143**
00002465949	**TEVA-BUDESONIDE**	**TEV**	$	**0.1143**
00002229099	PULMICORT NEBUAMP	AZC	$	0.2375

0.25 MG / ML INHALATION SUSPENSION

00002494272	**TARO-BUDESONIDE**	**TAR**	$	**0.3593**
00001978918	PULMICORT NEBUAMP	AZC	$	0.4750

0.5 MG / ML INHALATION SUSPENSION

00002494280	**TARO-BUDESONIDE**	**TAR**	$	**0.4559**
00002465957	**TEVA-BUDESONIDE**	**TEV**	$	**0.4559**
00001978926	PULMICORT NEBUAMP	AZC	$	0.9473

CLARITHROMYCIN

500 MG ORAL TABLET

00002442485	**CLARITHROMYCIN**	**SIV**	$	**0.8318**
00002247574	**PMS-CLARITHROMYCIN**	**PMS**	$	**0.8318**
00002361434	**RAN-CLARITHROMYCIN**	**RAN**	$	**0.8318**
00002346532	**RIVA-CLARITHROMYCIN**	**RIV**	$	**0.8318**
00002266547	**SANDOZ CLARITHROMYCIN**	**SDZ**	$	**0.8318**
00002126710	BIAXIN BID	BGP	$	3.3271

CYCLOBENZAPRINE HCL

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

10 MG ORAL TABLET

00002485419	**AG-CYCLOBENZAPRINE**	**AGP**	$	**0.1022**
00002177145	**APO-CYCLOBENZAPRINE**	**APX**	$	**0.1022**
00002348853	**AURO-CYCLOBENZAPRINE**	**AUR**	$	**0.1022**
00002287064	**CYCLOBENZAPRINE**	**SNS**	$	**0.1022**
00002424584	**CYCLOBENZAPRINE**	**SIV**	$	**0.1022**
00002495422	**FLEXERIL**	**ORI**	$	**0.1022**
00002357127	**JAMP-CYCLOBENZAPRINE**	**JPC**	$	**0.1022**
00002212048	**PMS-CYCLOBENZAPRINE**	**PMS**	$	**0.1022**
00002242079	**RIVA-CYCLOBENZAPRINE**	**RIV**	$	**0.1022**
00002080052	**TEVA-CYCLOBENZAPRINE**	**TEV**	$	**0.1022**

HYDROCORTISONE ACETATE/ UREA

1 % * 10 % TOPICAL CREAM

☒ 00080061501	JAMP-HYDROCORTISONE ACETATE/UREA	JPC	$	0.0915
☒ 00000681989	DERMAFLEX HC	PAL	$	0.1880

HYDROMORPHONE HCL

50 MG / ML INJECTION

00002469413	**HYDROMORPHONE HCL HP**	**STM**	$	**6.9525**
00002146126	**HYDROMORPHONE HP 50**	**SDZ**	$	**6.9525**

LEVETIRACETAM

250 MG ORAL TABLET

00002274183	**ACT LEVETIRACETAM**	**APH**	$	**0.3210**
00002285924	**APO-LEVETIRACETAM**	**APX**	$	**0.3210**
00002375249	**AURO-LEVETIRACETAM**	**AUR**	$	**0.3210**
00002403005	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.3210**
00002353342	**LEVETIRACETAM**	**SNS**	$	**0.3210**
00002399776	**LEVETIRACETAM**	**AHI**	$	**0.3210**
00002442531	**LEVETIRACETAM**	**SIV**	$	**0.3210**
00002454653	**LEVETIRACETAM**	**PMS**	$	**0.3210**
00002442388	**MINT-LEVETIRACETAM**	**MPI**	$	**0.3210**
00002440202	**NAT-LEVETIRACETAM**	**NTP**	$	**0.3210**
00002499193	**NRA-LEVETIRACETAM**	**NRA**	$	**0.3210**
00002482274	**RIVA-LEVETIRACETAM**	**RIV**	$	**0.3210**
00002461986	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.3210**
00002247027	KEPPRA	UCB	$	1.7252

500 MG ORAL TABLET

00002274191	**ACT LEVETIRACETAM**	**APH**	$	**0.3911**
00002285932	**APO-LEVETIRACETAM**	**APX**	$	**0.3911**
00002375257	**AURO-LEVETIRACETAM**	**AUR**	$	**0.3911**
00002403021	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.3911**
00002353350	**LEVETIRACETAM**	**SNS**	$	**0.3911**
00002399784	**LEVETIRACETAM**	**AHI**	$	**0.3911**
00002442558	**LEVETIRACETAM**	**SIV**	$	**0.3911**
00002454661	**LEVETIRACETAM**	**PMS**	$	**0.3911**
00002442396	**MINT-LEVETIRACETAM**	**MPI**	$	**0.3911**
00002440210	**NAT-LEVETIRACETAM**	**NTP**	$	**0.3911**
00002499207	**NRA-LEVETIRACETAM**	**NRA**	$	**0.3911**
00002482282	**RIVA-LEVETIRACETAM**	**RIV**	$	**0.3911**
00002461994	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.3911**
00002247028	KEPPRA	UCB	$	2.1213

750 MG ORAL TABLET

00002274205	**ACT LEVETIRACETAM**	**APH**	$	**0.5416**
00002285940	**APO-LEVETIRACETAM**	**APX**	$	**0.5416**
00002375265	**AURO-LEVETIRACETAM**	**AUR**	$	**0.5416**
00002403048	**JAMP-LEVETIRACETAM**	**JPC**	$	**0.5416**
00002353369	**LEVETIRACETAM**	**SNS**	$	**0.5416**
00002399792	**LEVETIRACETAM**	**AHI**	$	**0.5416**
00002442566	**LEVETIRACETAM**	**SIV**	$	**0.5416**
00002454688	**LEVETIRACETAM**	**PMS**	$	**0.5416**
00002442418	**MINT-LEVETIRACETAM**	**MPI**	$	**0.5416**
00002440229	**NAT-LEVETIRACETAM**	**NTP**	$	**0.5416**
00002499215	**NRA-LEVETIRACETAM**	**NRA**	$	**0.5416**
00002482290	**RIVA-LEVETIRACETAM**	**RIV**	$	**0.5416**
00002462001	**SANDOZ LEVETIRACETAM**	**SDZ**	$	**0.5416**
00002247029	KEPPRA	UCB	$	2.9371

MEDROXYPROGESTERONE ACETATE

2.5 MG ORAL TABLET

00002244726	**APO-MEDROXY**	**APX**	$	**0.1183**
00002221284	**TEVA-MEDROXYPROGESTERONE**	**TEV**	$	**0.1183**

MEROPENEM

RESTRICTED BENEFIT - This product is a benefit when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

(Refer to Section 3 - Criteria for Special Authorization of Select Drug Products of the Alberta Drug Benefit List for eligibility when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

1 G / VIAL INJECTION

00002378795	**MEROPENEM**	**SDZ**	$	**18.4450**
00002493349	**MEROPENEM FOR INJECTION**	**STM**	$	**18.4450**

METHADONE HCL

10 MG / ML ORAL LIQUID

☒ 00002495783	JAMP-METHADONE CONCENTRATE	JPC	$	0.0525
☒ 00002481979	METHADONE HYDROCHLORIDE	SDZ	$	0.0525
☒ 00002495880	ODAN-METHADONE (UNFLAVOURED)	ODN	$	0.0525
☒ 00002394596	METHADOSE	MAL	$	0.1125
☒ 00002394618	METHADOSE SUGAR FREE	MAL	$	0.1125
☒ 00002244290	METADOL-D	PAL	$	0.1500
☒ 00002241377	METADOL CONCENTRATE	PAL	$	0.4198

METHOTREXATE

2.5 MG ORAL TABLET

00002182963	**APO-METHOTREXATE**	**APX**	$	**0.6325**
00002170698	**PMS-METHOTREXATE**	**PMS**	$	**0.6325**

MORPHINE SULFATE

15 MG ORAL SUSTAINED-RELEASE TABLET

00002244790	**SANDOZ MORPHINE SR**	**SDZ**	$	**0.4145**
00002302764	**TEVA-MORPHINE SR**	**TEV**	$	**0.4145**
00002015439	MS CONTIN	PUR	$	0.7700

ONDANSETRON HCL DIHYDRATE

2 MG / ML (BASE) INJECTION

00002420422	**JAMP-ONDANSETRON (WITH PRESERVATIVE)**	**JPC**	$	**3.4552**
00002279436	**ONDANSETRON (PRESERVED)**	**SDZ**	$	**3.4552**
00002462257	**ONDANSETRON (PRESERVED)**	**STM**	$	**3.4552**
00002274418	**ONDANSETRON HYDROCHLORIDE DIHYDRATE (PRESERVED)**	**SDZ**	$	**3.4552**

SIMVASTATIN

5 MG ORAL TABLET

00002480050	**AG-SIMVASTATIN**	**AGP**	$	**0.1023**
00002247011	**APO-SIMVASTATIN**	**APX**	$	**0.1023**
00002405148	**AURO-SIMVASTATIN**	**AUR**	$	**0.1023**
00002375591	**JAMP-SIMVASTATIN**	**JPC**	$	**0.1023**
00002372932	**MINT-SIMVASTATIN**	**MPI**	$	**0.1023**
00002469979	**PHARMA-SIMVASTATIN**	**PMS**	$	**0.1023**
00002329131	**RAN-SIMVASTATIN**	**RAN**	$	**0.1023**
00002284723	**SIMVASTATIN**	**SNS**	$	**0.1023**
00002386291	**SIMVASTATIN**	**SIV**	$	**0.1023**
00002250144	**TEVA-SIMVASTATIN**	**TEV**	$	**0.1023**

10 MG ORAL TABLET

00002480069	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2023
00002247012	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2023
00002405156	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2023
00002375605	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2023
00002375044	MAR-SIMVASTATIN	MAR	***$ 0.1354***	$	0.2023
00002372940	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2023
00002469987	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2023
00002329158	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2023
00002284731	SIMVASTATIN	SNS	***$ 0.1354***	$	0.2023
00002386305	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2023
00002250152	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2023
00000884332	ZOCOR	ORC	***$ 0.1354***	$	2.2268

MAC pricing will be applied based on the LCA Price for Rosuvastatin Calcium 1 x 10 mg tablet or the LCA Price of Atorvastatin 1 x 20 mg tablet whichever is lower.

20 MG ORAL TABLET

00002480077	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2501
00002247013	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2501
00002405164	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2501
00002375613	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2501
00002375052	MAR-SIMVASTATIN	MAR	***$ 0.1354***	$	0.2501
00002372959	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2501
00002469995	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2501
00002329166	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2501
00002284758	SIMVASTATIN	SNS	***$ 0.1354***	$	0.2501
00002386313	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2501
00002250160	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2501
00000884340	ZOCOR	ORC	***$ 0.1354***	$	2.7521

MAC pricing will be applied based on the LCA Price for Rosuvastatin Calcium 1 x 10 mg tablet or the LCA Price of Atorvastatin 1 x 20 mg tablet whichever is lower.

40 MG ORAL TABLET

00002480085	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2501
00002247014	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2501
00002405172	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2501
00002375621	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2501
00002375060	MAR-SIMVASTATIN	MAR	***$ 0.1354***	$	0.2501
00002372967	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2501
00002470004	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2501
00002329174	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2501
00002284766	SIMVASTATIN	SNS	***$ 0.1354***	$	0.2501
00002386321	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2501
00002250179	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2501
00000884359	ZOCOR	ORC	***$ 0.1354***	$	2.7521

MAC pricing will be applied based on the LCA Price for Rosuvastatin Calcium 1 x 10 mg tablet or the LCA Price of Atorvastatin 1 x 20 mg tablet whichever is lower.

SIMVASTATIN

80 MG ORAL TABLET

00002480093	AG-SIMVASTATIN	AGP	***$ 0.1354***	$	0.2501
00002247015	APO-SIMVASTATIN	APX	***$ 0.1354***	$	0.2501
00002405180	AURO-SIMVASTATIN	AUR	***$ 0.1354***	$	0.2501
00002375648	JAMP-SIMVASTATIN	JPC	***$ 0.1354***	$	0.2501
00002372975	MINT-SIMVASTATIN	MPI	***$ 0.1354***	$	0.2501
00002470012	PHARMA-SIMVASTATIN	PMS	***$ 0.1354***	$	0.2501
00002329182	RAN-SIMVASTATIN	RAN	***$ 0.1354***	$	0.2501
00002284774	SIMVASTATIN	SNS	***$ 0.1354***	$	0.2501
00002386348	SIMVASTATIN	SIV	***$ 0.1354***	$	0.2501
00002250187	TEVA-SIMVASTATIN	TEV	***$ 0.1354***	$	0.2501

MAC pricing will be applied based on the LCA Price for Rosuvastatin Calcium 1 x 10 mg tablet or the LCA Price of Atorvastatin 1 x 20 mg tablet whichever is lower.

ZOLMITRIPTAN

RESTRICTED BENEFIT - This product is a benefit for patients 18 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 of the Alberta Human Services Drug Benefit Supplement for eligibility in Alberta Human Services clients.)

2.5 MG ORAL TABLET

00002481030	**AURO-ZOLMITRIPTAN**	**AUR**	$	**3.5375**
00002458780	**CCP-ZOLMITRIPTAN**	**CEL**	$	**3.5375**
00002477106	**JAMP ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002421623	**JAMP-ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002419521	**MINT-ZOLMITRIPTAN**	**MPI**	$	**3.5375**
00002421534	**NAT-ZOLMITRIPTAN**	**NTP**	$	**3.5375**
00002324229	**PMS-ZOLMITRIPTAN**	**PMS**	$	**3.5375**
00002362988	**SANDOZ ZOLMITRIPTAN**	**SDZ**	$	**3.5375**
00002313960	**TEVA-ZOLMITRIPTAN**	**TEV**	$	**3.5375**
00002238660	ZOMIG	AZC	$	14.9600

ZOPICLONE

7.5 MG ORAL TABLET

00002475847	**AG-ZOPICLONE**	**AGP**	$	**0.1250**
00002218313	**APO-ZOPICLONE**	**APX**	$	**0.1250**
00002406977	**JAMP-ZOPICLONE**	**JPC**	$	**0.1250**
00002386798	**MAR-ZOPICLONE**	**MAR**	$	**0.1250**
00002391724	**MINT-ZOPICLONE**	**MPI**	$	**0.1250**
00002477386	**NRA-ZOPICLONE**	**NRA**	$	**0.1250**
00002240606	**PMS-ZOPICLONE**	**PMS**	$	**0.1250**
00002267926	**RAN-ZOPICLONE**	**RAN**	$	**0.1250**
00002242481	**RATIO-ZOPICLONE**	**TEV**	$	**0.1250**
00002282445	**ZOPICLONE**	**SNS**	$	**0.1250**
00002385848	**ZOPICLONE**	**SIV**	$	**0.1250**
00001926799	IMOVANE	SAV	$	1.3677

PART 3

Special Authorization

DARIFENACIN HYDROBROMIDE

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

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

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

"Special authorization may be granted for 24 months."

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

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

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

7.5 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002452510	**APO-DARIFENACIN**	**APX**	$	**1.2087**
00002273217	ENABLEX	SLP	$	1.6222
15 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002452529	**APO-DARIFENACIN**	**APX**	$	**1.2087**
00002273225	ENABLEX	SLP	$	1.6222

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

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

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

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

Special authorization may be granted for 24 months."

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

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

125 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461544	**APO-DEFERASIROX**	**APX**	$	**5.2408**
00002464454	**SANDOZ DEFERASIROX**	**SDZ**	$	**5.2408**
00002287420	EXJADE	NOV	$	10.6625

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

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

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

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

Special authorization may be granted for 24 months."

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

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

250 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461552	**APO-DEFERASIROX**	**APX**	$	**10.4820**
00002464462	**SANDOZ DEFERASIROX**	**SDZ**	$	**10.4820**
00002287439	EXJADE	NOV	$	21.3257

DEFERASIROX

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

FIRST-LINE DRUG PRODUCT(S): DEFEROXAMINE

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

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

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

Special authorization may be granted for 24 months."

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

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

500 MG ORAL DISPERSIBLE TABLET FOR SUSPENSION

00002461560	**APO-DEFERASIROX**	**APX**	$	**20.9649**
00002464470	**SANDOZ DEFERASIROX**	**SDZ**	$	**20.9649**
00002287447	EXJADE	NOV	$	42.6532

DONEPEZIL HCL

"For the treatment of Alzheimer's disease in patients who meet the following criteria:
- a Mini Mental State Exam (MMSE) score between 10-26, or
- a St. Louis University Mental Status Examination (SLUMS) score between 6-26, or
- a Rowland Universal Dementia Assessment Scale (RUDAS) score between 9-22, or
- an InterRAI-Cognitive Performance Scale score between 1-4

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

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

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

Renewal requests may be considered for patients where an updated score while on this drug meets the following criteria:
- MMSE score is 10 or higher, or
- SLUMS score is 6 or higher, or
- RUDAS score is 9 or higher, or
- InterRAI-Cognitive Performance Scale is 4 or lower."

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

5 MG ORAL TABLET

00002432684	**AG-DONEPEZIL**	**AGP**	$	**0.4586**
00002362260	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400561	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412853	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420597	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426846	**DONEPEZIL**	**SNS**	$	**0.4586**
00002475278	**DONEPEZIL**	**RIV**	$	**0.4586**
00002402645	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002416948	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402092	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002408600	**MINT-DONEPEZIL**	**MPI**	$	**0.4586**
00002439557	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322331	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381508	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328666	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428482	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340607	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232043	ARICEPT	PFI	$	5.0779

DONEPEZIL HCL

10 MG ORAL TABLET

00002432692	**AG-DONEPEZIL**	**AGP**	$	**0.4586**
00002362279	**APO-DONEPEZIL**	**APX**	$	**0.4586**
00002400588	**AURO-DONEPEZIL**	**AUR**	$	**0.4586**
00002412861	**BIO-DONEPEZIL**	**BMD**	$	**0.4586**
00002420600	**DONEPEZIL**	**SIV**	$	**0.4586**
00002426854	**DONEPEZIL**	**SNS**	$	**0.4586**
00002475286	**DONEPEZIL**	**RIV**	$	**0.4586**
00002402653	**DONEPEZIL HYDROCHLORIDE**	**AHI**	$	**0.4586**
00002416956	**JAMP-DONEPEZIL**	**JPC**	$	**0.4586**
00002402106	**MAR-DONEPEZIL**	**MAR**	$	**0.4586**
00002408619	**MINT-DONEPEZIL**	**MPI**	$	**0.4586**
00002439565	**NAT-DONEPEZIL**	**NTP**	$	**0.4586**
00002322358	**PMS-DONEPEZIL**	**PMS**	$	**0.4586**
00002381516	**RAN-DONEPEZIL**	**RAN**	$	**0.4586**
00002328682	**SANDOZ DONEPEZIL**	**SDZ**	$	**0.4586**
00002428490	**SEPTA DONEPEZIL**	**SEP**	$	**0.4586**
00002340615	**TEVA-DONEPEZIL**	**TEV**	$	**0.4586**
00002232044	ARICEPT	PFI	$	5.0779

GALANTAMINE HYDROBROMIDE

"For the treatment of Alzheimer's disease in patients who meet the following criteria:
- a Mini Mental State Exam (MMSE) score between 10-26, or
- a St. Louis University Mental Status Examination (SLUMS) score between 6-26, or
- a Rowland Universal Dementia Assessment Scale (RUDAS) score between 9-22, or
- an InterRAI-Cognitive Performance Scale score between 1-4

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

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

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

Renewal requests may be considered for patients where an updated score while on this drug meets the following criteria:
- MMSE score is 10 or higher, or
- SLUMS score is 6 or higher, or
- RUDAS score is 9 or higher, or
- InterRAI-Cognitive Performance Scale is 4 or lower."

All requests (including renewal requests) for galantamine hydrobromide must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request From (ABC 60034).

8 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002425157	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443015	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339439	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398370	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**

16 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002425165	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443023	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339447	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398389	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**

GALANTAMINE HYDROBROMIDE

24 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE

00002425173	**AURO-GALANTAMINE ER**	**AUR**	$	**1.2463**
00002443031	**GALANTAMINE ER**	**SNS**	$	**1.2463**
00002339455	**MYLAN-GALANTAMINE ER**	**MYP**	$	**1.2463**
00002398397	**PMS-GALANTAMINE ER**	**PMS**	$	**1.2463**

MEROPENEM

(Refer to Section 1 - Restricted Benefits of the Alberta Drug Benefit List for coverage of the product when prescribed by a Specialist in Infectious Diseases or Hematology, or a designated prescriber.)

"1) For second-line therapy of infections due to gram-negative organisms producing inducible beta-lactamases or extended spectrum beta-lactamases where there is resistance to first-line agents or

2) For therapy for infections involving multi-resistant Pseudomonas aeruginosa, where there is documented susceptibility to meropenem or

3) For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."*

*Special Authorization is only required when the prescriber prescribing the medication is not a Specialist in Infectious Diseases or Hematology, or a designated prescriber.

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. Also, where applicable, the specialist in Infectious Diseases that recommended this drug is required.

1 G / VIAL INJECTION

00002378795	**MEROPENEM**	**SDZ**	$	**18.4450**
00002493349	**MEROPENEM FOR INJECTION**	**STM**	$	**18.4450**

RITUXIMAB

10 MG / ML INJECTION

☒ 00002498316 RIXIMYO SDZ $ 29.7000

Rheumatoid Arthritis

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

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

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

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

- Initial coverage may be approved for a dose of 1000 mg of rituximab administered at 0 and 2 weeks (total of 2 - 1000 mg doses).
- Patients will be limited to receiving one dose of rituximab per prescription at their pharmacy.
- Patients will be permitted to switch from one biologic agent to another (with the exception of anakinra) following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period).
- Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.
- Patients will not be permitted to switch from anakinra to other biologic agents except under exceptional circumstances.
- Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

For coverage for an additional two-dose course of therapy, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after each course of therapy, between 16 and 24 weeks after receiving the initial dose of each course of therapy, to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- An improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place] following the initial course of rituximab; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places] following the initial course of rituximab.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above, AND
3) The patient must have residual disease or disease activity returning to a level above a DAS28 score of 2.6.

Subsequent courses of therapy cannot be considered prior to 24 weeks elapsing from the initial dose of the previous course of therapy."

All requests (including renewal requests) for rituximab for Rheumatoid Arthritis must be completed using the Rituximab for Rheumatoid Arthritis Special Authorization Request Form (ABC 60046).

Granulomatosis with polyangiitis (GPA) or Microscopic Polyangiitis (MPA)

"For use in combination with glucocorticoids for the induction of remission of severely active granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis) or microscopic polyangiitis (MPA) in adult patients who have:
- Severe active disease that is life- or organ-threatening. The organ(s) and how the organ(s) is (are) threatened must be specified;
AND

RITUXIMAB

- A positive serum assay for either proteinase 3-ANCA (anti-neutrophil cytoplasmic antibody) or myeloperoxidase-ANCA. A copy of the lab report must be provided; AND
- Cyclophosphamide cannot be used for ONE of the following reasons:
a) The patient has failed a minimum of six intravenous pulses of cyclophosphamide; OR
b) The patient has failed three months of oral cyclophosphamide therapy; OR
c) The patient has a severe intolerance or an allergy to cyclophosphamide; OR
d) Cyclophosphamide is contraindicated; OR
e) The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide.

- Coverage may be approved for a maximum of 375 mg per square metre of body surface area weekly for 4 weeks.
- Patients will be limited to receiving two doses of rituximab per prescription at their pharmacy.
- For relapse following a remission, coverage may be provided for patients who experience a flare of severe active disease that is life- or organ-threatening; or, who experience worsening symptoms in 2 or more organs even if not life-threatening. Note: For relapse following a rituximab-induced remission, additional coverage may be approved no sooner than 6 months after previous rituximab treatment."

All requests (including renewal requests) for rituximab for Granulomatosis with Polyangiitis (GPA) or Microscopic Polyangiitis (MPA) must be completed using the Rituximab for Granulomatosis with Polyangiitis/Microscopic Polyangiitis Special Authorization Request Form (ABC 60018).

RIVASTIGMINE HYDROGEN TARTRATE

"For the treatment of Alzheimers disease in patients who meet the following criteria:
- a Mini Mental State Exam (MMSE) score between 10-26, or
- a St. Louis University Mental Status Examination (SLUMS) score between 6-26, or
- a Rowland Universal Dementia Assessment Scale (RUDAS) score between 9-22, or
- an InterRAI-Cognitive Performance Scale score between 1-4

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

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

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

Renewal requests may be considered for patients where an updated score while on this drug meets the following criteria:
- MMSE score is 10 or higher, or
- SLUMS score is 6 or higher, or
- RUDAS score is 9 or higher, or
- InterRAI-Cognitive Performance Scale is 4 or lower."

All requests (including renewal requests) for rivastigmine hydrogen tartrate must be completed using the Donepezil/Galantamine/Rivastigmine Special Authorization Request From (ABC 60034).

1.5 MG (BASE) ORAL CAPSULE				
00002336715	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485362	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401614	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324563	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242115	EXELON	NOV	$	2.8425
3 MG (BASE) ORAL CAPSULE				
00002336723	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485370	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401622	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324571	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242116	EXELON	NOV	$	2.8425
4.5 MG (BASE) ORAL CAPSULE				
00002336731	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485389	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401630	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324598	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242117	EXELON	NOV	$	2.8425
6 MG (BASE) ORAL CAPSULE				
00002336758	**APO-RIVASTIGMINE**	**APX**	$	**0.6514**
00002485397	**JAMP RIVASTIGMINE**	**JPC**	$	**0.6514**
00002401649	**MED-RIVASTIGMINE**	**GMP**	$	**0.6514**
00002324601	**SANDOZ RIVASTIGMINE**	**SDZ**	$	**0.6514**
00002242118	EXELON	NOV	$	2.8425
2 MG / ML (BASE) ORAL SOLUTION				
00002245240	EXELON	NOV	$	1.4945

ZOLMITRIPTAN

(Refer to 28:32.28 of the Alberta Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using zolmitriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

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

2.5 MG ORAL TABLET

00002481030	**AURO-ZOLMITRIPTAN**	**AUR**	$	**3.5375**
00002458780	**CCP-ZOLMITRIPTAN**	**CEL**	$	**3.5375**
00002477106	**JAMP ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002421623	**JAMP-ZOLMITRIPTAN**	**JPC**	$	**3.5375**
00002419521	**MINT-ZOLMITRIPTAN**	**MPI**	$	**3.5375**
00002421534	**NAT-ZOLMITRIPTAN**	**NTP**	$	**3.5375**
00002324229	**PMS-ZOLMITRIPTAN**	**PMS**	$	**3.5375**
00002362988	**SANDOZ ZOLMITRIPTAN**	**SDZ**	$	**3.5375**
00002313960	**TEVA-ZOLMITRIPTAN**	**TEV**	$	**3.5375**
00002238660	ZOMIG	AZC	$	14.9600