



P.E.I. Pharmacare Formulary

Inquiries should be directed to:
PEI Pharmacare Department of Health and Wellness P.O. Box 2000, 20 Fitzroy St. Charlottetown, PEI C1A 7N8

Telephone inquiries should be directed to:	
Patient Eligibility Prescriber Eligibility Medication Eligibility Pharmacy Eligibility Pharmacist Eligibility Claim Inquiries Special Authorization Drug Status Formulary Inquiries	1-902-368-4947 Charlottetown 1-877-577-3737 Toll Free in PEI 1-902-368-4905 Fax
Technical Support Help Desk for Community Pharmacies	628-3772 Charlottetown 1-877-201-6771 Toll Free in PEI 7:00 am to 12:00 midnight 7 days per week
PEI Insulin Pump Program Diabetes Glucose Sensor Program P.O. Box 2000 Charlottetown, PE C1A 7N8	1-902-213-4825 Phone 1-833-335-0538 Toll Free in PEI diabetesadminofficer@ihis.org Email

Statements within this document are not intended to override or modify the provisions within an enactment or Minister authority.

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THE FORMULARY

The Prince Edward Island Pharmacare Formulary is a listing of therapeutically effective medications approved for coverage through the following programs:

HIV Drug Program	High Cost Drug Program
Catastrophic Drug Program	Institutional Pharmacy Program
Community Mental Health Drug Program	National Pharmacare Program
Children in Care Program	Nursing Home Drug Program
Cystic Fibrosis Drug Program	Phenylketonuria (PKU) Program
Diabetes Drug Program	Seniors Drug Program
Erythropoietin Program	Sexually Transmitted Infections Program
Family Health Benefit Drug Program	Smoking Cessation Drug Program
Financial Assistance Drug Program	Substance Use Harm Reduction Drug Program
Generic Drug Program	Transplant Drug Program
Growth Hormone Drug Program	Tuberculosis Drug Program
Hepatitis Drug Program	

It is compiled on behalf of the Minister of Health and Wellness based upon recommendations from either the Atlantic or Canadian Expert Drug Advisory Committees, or the Joint Oncology Drug Review Committee.

Medications in the Formulary are listed by Therapeutic Categories developed by the American Society of Hospital Pharmacists.

The PEI Pharmacare Formulary is not to be used to determine interchangeability of therapeutic products.

The PEI Pharmacare Formulary may be downloaded from the Department of Health and Wellness website at – [PEI Pharmacare Formulary \(princeedwardisland.ca\)](http://princeedwardisland.ca)

NATIONAL PHARMACARE PROGRAM

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
Delivered Through PEI Pharmacies			
National Pharmacare Program (National)	Persons eligible for PEI Medicare, with a valid PEI Health Card	Oral diabetes medications and insulin products as identified in the Formulary. Contraception products (oral, injectable, vaginal ring, implant, emergency contraception and intrauterine devices (IUD's)) as identified in the Formulary.	No fee.

PRINCE EDWARD ISLAND DRUG PROGRAMS

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
Programs Delivered Through PEI Community Retail Pharmacies			
Children-In-Care Program (W)	Persons in temporary or permanent custody of the Director of Child Welfare	All prescription medications. Non-prescription medications approved under the Financial Assistance Program.	No fee.
Generic Drug Program (G)	Persons less than 65 years of age with no private drug insurance	Approved generic prescription medications.	Maximum of \$19.95 per prescription. As part of Prescription Care, copays for eligible medications (identified in the formulary with ⑤) will be \$5 per prescription.

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
Diabetes Drug Program (D)	Persons eligible for PEI Medicare, diagnosed with diabetes, and registered with the program.	Approved insulin products as listed in the Formulary, and not eligible under the National Pharmacare Program.	\$10.00 per 10 mL vial of insulin. \$20.00 per box of insulin cartridges. As part of Prescription Care, copays for eligible medications (identified in the formulary with ⑤) will be \$5 per vial or cartridge.
		Approved oral diabetes medications as listed in the Formulary, and not eligible under the National Pharmacare Program	\$11.00 per prescription. As part of Prescription Care, copays for eligible medications (identified in the formulary with ⑤) will be \$5 per prescription
		Approved urine testing materials (Diastix and Ketostix – no prescription required)	\$11.00 per dispense
		Blood Glucose test strips eligibility and limits (no prescription required):	
		1) Patient has used insulin within 150 days	1) \$11.00 per dispense; maximum of 100 strips per 25 days.
	2) Non-insulin dependent diabetes patients on medications with a high risk of hypoglycemia	2) \$11.00 per dispense; maximum of 100 strips per dispense up to 300 strips annually	

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
		3) Non-insulin dependent diabetes patients on medications with a low risk of hypoglycemia	3) \$11.00 per dispense; maximum of 100 strips per dispense up to 200 strips annually
		Approved glucagon devices. Patients must have used insulin within 150 days (no prescription required for up to 2 units in 12 months).	As part of Prescription Care, copays will be \$5 per unit
Financial Assistance Drug Program (W)	Persons eligible under the Social Assistance Act and Regulations.	Approved prescription and non-prescription medications.	No fee.
Family Health Benefit Drug Program (F)	Families (parents, guardians, and children under 25 years of age) eligible for PEI Medicare, with at least one child under 25 years of age who is still attending school full time, and a total annual net family income less than \$24,800, plus \$3,000 for each additional child. Families must apply for coverage on an annual basis and provide income information to the program.	Approved prescription medications.	The pharmacy professional fee for each prescription obtained. As part of Prescription Care, copays for eligible medications (identified in the formulary with ⑤) will be \$5 per prescription.
High Cost Drug Program (M)	Persons eligible for PEI Medicare and approved for coverage for one or more of the	Approved high-cost medications.	An income-based portion of the medication cost plus the pharmacy professional fee for

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
	medications included in the program. Patients must apply for coverage on an annual basis and provide income information to the program.		each prescription obtained.
Nursing Home Drug Program (N)	Residents in private nursing homes eligible for coverage under the Social Assistance Act.	Approved prescription and non-prescription medications.	No fee.
Substance Use Harm Reduction Drug Program (L)	Persons eligible for PEI Medicare and assessed by a medical practitioner or nurse practitioner and determined to require treatment for an opioid use disorder or alcohol use disorder	Approved prescription medications.	No fee.
Smoking Cessation Drug Program (Z)	Persons eligible for PEI Medicare and having received smoking cessation counselling through Primary Care. For more information, please visit www.princeedwardisland.ca/quitsmoking	12 weeks of approved prescription or non-prescription medications.	No fee.
Seniors Drug Program (S)	Persons eligible for PEI Medicare and 65 years of age or older. Eligibility is effective upon a person becoming 65 years of age.	Approved prescription medications.	First \$8.25 of the medication cost plus the first \$7.69 of the pharmacy dispensing fee for each prescription obtained. As part of Prescription Care, copays for eligible medications (identified in the formulary with ⑤) will

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
			be \$5 per prescription
Catastrophic Drug Program (Q)	PEI permanent residents with a PEI Health card whose household members have up to date tax filings and are experiencing out of pocket eligible drug expenses that exceed their annual household limit. Eligible drug expenses are expenses incurred for drugs designated as having coverage under the Catastrophic Drug Program- (Q) listed on the PEI formulary.	Out of pocket costs for eligible drug expenses	This is an income based program. Once an applicant's out of pocket eligible drug expenses exceed the annual household limit the program will cover any further eligible drug expenses in the program year.
Sexually Transmitted Infections (STI) Program (V)	Persons diagnosed with a sexually transmitted infection or identified contacts of a person diagnosed with a sexually transmitted infection	Approved antibiotics	No fee.
Programs Delivered Through the Provincial Pharmacy Note: Beneficiaries are responsible for arranging for and paying for delivery of medications obtained through the Provincial Pharmacy.			
HIV Drug Program (A)	Persons diagnosed as HIV positive, diagnosed with AIDS, or with a non work related needle-stick injury and no private insurance; and registered with the program through the Chief Health Officer.	Approved antiretroviral agents and adjunctive therapies.	No fee.

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
Community Mental Health Drug Program (B)	Approved long-term psychiatric patients living in the community.	Approved long- acting injectable antipsychotic medications provided through an approved out- patient psychiatric program.	No fee.
Cystic Fibrosis Drug Program (C)	Persons eligible for PEI Medicare, diagnosed with cystic fibrosis, and who are registered with the program.	Approved prescription and non-prescription medications.	No fee.
Growth Hormone Drug Program (Y)	Children eligible for PEI Medicare, with a proven growth hormone deficiency or Turners Syndrome, and who are registered with the program.	Approved growth hormone supplements.	No fee.
Hepatitis Drug Program (H)	Persons diagnosed with hepatitis.	Approved prescription medications.	No fee
Institutional Pharmacy Program (N)	Residents in government manors.	Approved prescription and non-prescription medications.	No fee.
Phenylketonuria (PKU) Program (P)	Persons eligible for PEI Medicare, diagnosed with phenylketonuria, and who are registered with the program.	Special low protein formula. Up to \$3600 annually for low protein food items.	No fee.
Transplant Drugs Program (T)	Persons eligible for PEI Medicare, who received a bone marrow or solid organ transplant and are registered with the program.	Approved immunosuppressant Medications.	No fee.

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
Tuberculosis (TB) Drug Program (X)	Persons diagnosed with tuberculosis or who have been in close contact with a person diagnosed with tuberculosis, and who have registered with the program through the Chief Health Officer.	Approved antibiotics	No fee.
Programs Delivered Through Hospitals			
Erythropoietin Program (E)	Persons eligible for PEI Medicare, have been diagnosed with chronic renal failure or are receiving kidney dialysis.	Approved erythropoietin injections	No fee.

PEI Diabetes Glucose Sensor Program

Program	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
Program Delivered Through Community Retail Pharmacies			
Diabetes Glucose Sensor Program	Persons eligible for PEI Medicare, diagnosed with diabetes, eligible for program enrollment and registered with the program Glucose Sensor Program	Approved diabetes glucose sensors and transmitters. See Appendix F	This is an income based program. Fee per dispense period is based on household income to a maximum coverage of \$2,400 per program year.

PEI Diabetes Insulin Pump Program

Program	Beneficiaries	Benefits	Fee
Programs Delivered Through Approved Vendors (who have entered into an agreement with Department of Health and Wellness) See Appendix D For Approved Vendors			
Insulin Pump Program	Persons eligible for PEI Medicare, diagnosed with type 1 diabetes, who meet the eligibility requirements and are registered with the program Insulin Pump Program	Insulin pump and pump supplies from the approved vendors list (see appendix D) The following list details the supplies that are eligible for coverage under the PEI Insulin Pump Program: • Insulin pump (one pump every 5 years) • Infusion sets (maximum of 140 sets per year) • Reservoirs (maximum of 140 per year) • Site inserts (maximum of one replacement device per year) • Skin adhesive wipes (maximum of 150 per year) • Sterile transparent dressings (maximum of 200 per year)	An income-based program. Funding through the program varies depending on household income and private health insurance coverage

PEI Ostomy Supplies Program

Program	Beneficiaries	Benefits	Fee
Programs Delivered Through Ostomy Supply Vendors See Appendix E For Eligible Supplies			
Ostomy Supplies Program	Persons eligible for PEI Medicare, with permanent abdominal ostomies who meet requirements Ostomy Supplies Program	Ostomy supplies (see Appendix E for examples) Coverage is in the form of reimbursement, and will be based on the patient's household income. Coverage is not retroactive. Patients must be enrolled in the Ostomy Supplies Program at the time of ostomy supply purchase to be eligible for reimbursement. The following list details the categories that are eligible for coverage under the PEI Ostomy Supplies Program: • Skin wafers • Ostomy pouches • Adhesive removers • Skin barrier wipes • Stoma powders, pastes, and barrier rings • Ostomy belts Appendix E	An income-based program. Funding through the program varies depending on household income and private health insurance coverage Ostomy Supplies Program

PRESCRIPTION CARE

As of June 1st, 2023, under the joint federal-provincial *Prescription Care* Initiative, copays for commonly prescribed, eligible medications will be reduced to \$5 for residents covered under Seniors Drug, Family Health Benefit, Generic Drug and Diabetes Drug programs.

Medications eligible for the \$5 copay are identified in the formulary with a ⑤ preceding the non-proprietary or generic name.

FORMULARY REVIEW PROCESS

The coverage of new pharmaceutical products, new dosage forms and new strengths of existing products, and new uses for existing products must be approved on the authority of the Minister of Health and Wellness. The approval is based, in part, upon review by and recommendations received from either the Canadian Expert Drug Advisory Committee (CEDAC) as part of the national Common Drug Review (CDR) process, the Atlantic Expert Advisory Committee (AEAC) or the pan-Canadian Oncology Drug Review (pCODR). Prioritization of listing for products is under the direction of the Provincial Drugs and Therapeutics (PD&T) Committee.

The membership of these committees includes practicing physicians, pharmacists, and experts in drug evaluation. They review and evaluate scientific and economic information on new pharmaceutical products and make a recommendation to participating federal, provincial, and territorial government drug programs on whether a drug should be listed as a program benefit, including any conditions and/or criteria for coverage.

The Drug review process involves the following steps:

Health Canada Approval

Before a manufacturer can sell a drug in Canada, they must receive Health Canada approval. Health Canada assesses the drug's safety, efficacy (usually compared to taking no drug at all) and quality of the manufacturing process used to make the drug. When a drug has met all the regulatory requirements, Health Canada issues a Notice of Compliance (NOC) and/or a Drug Identification Number (DIN).

Information on the Health Canada drug review process is available [here](#).

Canadian Drug Expert Committee Review

PEI is a participant in the national Canadian Drug Expert Committee (CDEC) process. CDEC provides participating federal, provincial, and territorial drug benefit programs with a systematic review of the best available clinical evidence, a critique of manufacturer-submitted pharmacoeconomic studies, and a formulary listing recommendation made by the CDEC.

Submissions for new chemical entities, new combination products, and resubmissions related to these products should be filed with the CEDAC Directorate. Information on the CEDAC requirements and procedures are posted at: www.cadth.ca

Pan Canadian Oncology Drug Review

PEI is a participant in the pan-Canadian Oncology Drug Review (pCODR) process. This process provides participating federal, provincial and territorial drug benefit programs with a systematic review of the best available clinical evidence, and a formulary listing recommendation for oncology medications by an Expert Advisory Committee.

Submissions for new oncology medications and re-submissions related to these products should be directed through this process. For more information on pCODR, please reference the following web site:

<https://cadth.ca/pcodr>

Atlantic Common Drug Review

PEI is a participant in the Atlantic Common Drug Review (ACDR). The ACDR provides the provincial drug benefit programs in New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island with a systematic review of the best available clinical evidence, and a formulary listing recommendation made by the Atlantic Expert Advisory Committee (AEAC), for drugs that do not fall under the mandate of CEDAC or pCODR.

Submissions for new single source products that do not contain new chemical entities, line extensions, new indications for products released prior to CEDAC, and resubmissions for products reviewed prior to CEDAC should be sent to the drug programs within each of the four Atlantic provinces. The Prince Edward Island copy should be sent to:

PEI Pharmacare
Department of Health and Wellness
P.O. Box 2000, 20 Fitzroy St.
Charlottetown, PE C1A 7N8

Products are normally reviewed in the order of receipt of complete submissions. However, there can be exceptions to this. There is no fast tracking of products or pre-NOC reviews.

Information on the ACDR requirements and procedures is available [here](#).

pan-Canadian Pharmaceutical Alliance (pCPA)

Price negotiations are conducted through the pCPA to achieve greater value for publicly funded drug plans. All brand name drugs reviewed through the Canadian Expert Drug Advisory Committee (CEDAC) and pan-Canadian Oncology Drug Review (pCODR) are considered for negotiation. Generic drugs are considered for negotiation through the pCPA Tiered Pricing Framework.

Information on pCPA is available [here](#).

Provincial Drug and Therapeutics Committee

Prioritization of listing for products is under the guidance of the PD&T Committee. The prioritized list is based on expert advisory committees' recommendation and other factors such as drug plan mandates, jurisdictional priorities, budget impact, and resources. This list is submitted to the Department of Health and Wellness where final formulary listing decision is under the framework of the Drug Cost Assistance Act and Regulations.

Drug formulary listing decisions for PEI Pharmacare are announced in a Bulletin which is posted on the PEI Pharmacare webpage.

Biosimilars

Health Canada authorizes biosimilars for sale. It is recognized that there are no expected clinically meaningful differences in efficacy and safety between a biosimilar and the biologic drug that was already authorized for sale.

When a biosimilar version of a drug is added to the PEI Pharmacare formulary:

- The originator biologic will be delisted at the end of the switching period identified for the drug.
- To maintain Pharmacare coverage, a patient must switch to a biosimilar before the originator biologic is delisted.

Maximum Reimbursable Price List

The process for adding medications to the PEI Pharmacare Maximum Reimbursable Price (MRP) list has been revised effective August 1, 2019.

Submission Types:

A manufacturer may file a submission for a generic drug if:

1. The originator brand and strength of the drug is listed on the PEI Pharmacare Formulary.
2. The originator brand of the drug is listed on the PEI Pharmacare Formulary, but not the strength of the generic drug being submitted.
3. The originator brand is not listed but a generic brand of the drug is listed on the PEI Pharmacare Formulary.
4. The generic product was previously listed on the PEI Pharmacare Formulary and was delisted or was withdrawn from the market and is being re-introduced.
5. PEI Pharmacare requests a submission for a generic drug that is being considered for listing.
6. There is a change in DIN for a generic drug that is listed on the PEI Pharmacare Formulary.

A manufacturer must file a new submission for a generic drug if:

7. There is a change in product ownership for a generic product that is listed on the PEI Pharmacare Formulary.

In cases where none of the submission types described above apply, or if there is doubt as to whether a submission should be made, please contact PEI Pharmacare by email at pharmservices@ihis.org for guidance.

Submission Requirements (MRP List)

Submissions filed by manufacturers to have a generic drug product listed on the PEI Pharmacare Formulary must include the requirements outlined below. PEI Pharmacare may request additional information from the manufacturer, Health Canada, or any other source, or take other factors into consideration when reviewing the submission.

The following information must be contained in the submission and should be compiled in the following order:

1. **Cover Letter or Executive Summary.**
 - Indicate which of the submission types is being filed.
 - The names and contact information (email and phone number) for the primary and backup contact(s) who can be contacted regarding the submission. The manufacturer may designate the consultant(s) preparing the submission as primary and/or backup contact(s). Any changes in contacts should be communicated as soon as possible, by emailing pharmservices@ihis.org

- Additional information can be included in the Cover Letter. Please limit this to an explanation of unexpected situations or unusual features of a particular submission. For example, if any strengths of a product listed in the NOC will not be marketed, include this information as a comment in the Cover Letter.
- An electronic signature is acceptable.

2. **Submission Summary Form**

- Include the completed form as part of the whole PDF file and also as a separate attachment in MS Word format.

3. **Copy of the Notice of Compliance (NOC)** issued by Health Canada or, for drug products without a Notice of Compliance, the Drug Notification Form.

4. Copy of the Health Canada approved **Product Monograph**.

5. **Price**

- Indicate the submitted price in the Submission Summary Form.
- Confirm that the price has been submitted to the pan-Canadian Pharmaceutical Alliance (pCPA) Centralized Price Confirmation Process.

6. a) **Drug Notification Form**

b) A signed letter stating that the manufacturer is able to supply the drug product in quantities sufficient to meet the anticipated demand in the province.

7. **A signed letter authorizing unrestricted communication** regarding the drug product between PEI Pharmacare and

- Other federal, provincial, and territorial (F/P/T) drug programs
- F/P/T health authorities and related facilities
- Health Canada
- Patented Medicine Prices Review Board (PMPRB)
- Canada's Drug Agency (CDA-AMC)

All submissions for the addition of products to the PEI Pharmacare Maximum Reimbursable Price (MRP) list must be made by email to pharmservices@ihis.org

The subject of all email submissions must be "MRP List Submission".

The email must contain the following attachments:

- A single Portable Document Format (PDF) document that contains all the submission requirements with appropriate bookmarks for each component of the submission
- Submission Summary form (in MS Word format)

Submissions must not be made until there is product ready for sale and shipment to PEI pharmacies.

Pre-Notice of Compliance (NOC) submissions will not be accepted.

Products will not be listed until pCPA pricing is received.

Email submissions must not exceed 5 megabytes in size. Submissions may be sent as compressed

“zip” files.

An email confirmation will be sent to manufacturers to notify them that submissions are considered to be complete and to confirm availability and pricing. Questions regarding the submission will also be sent to manufacturers by email.

Submissions will be reviewed by drug program staff.

Bookmark Names:

The following are suggested bookmark names:

- Cover Letter
- Submission Summary
- Notice of Compliance (or Product License for NHPs)
- Drug Notification Form
- Product Monograph
- Unrestricted Sharing of Information Letter
- Notification of Changes Letter

SUBMISSION REQUIREMENTS (BRAND PRODUCTS)

Manufacturers must complete the CDR, pCODR, pCPA, and ACDR process (as applicable) prior to submitting to PEI Pharmacare for consideration of listing a brand drug. All submissions should be made by email only. The email should contain an attachment in Portable Document Format (PDF) that contains all of the submission requirements with appropriate bookmarks for each component of the submission. Due to technical limitations individual email submissions must not exceed 5 megabytes in size. Submissions may be sent as compressed “zip” files.

Submission Requirements

The following information must be contained in the submission and should be compiled in the following order:

1. Cover Letter or Executive Summary.
 - The names and contact information (email and phone number) for the primary and backup contact(s) who can be contacted regarding the submission. The manufacturer may designate the consultant(s) preparing the submission as primary and/or backup contact(s). Any changes in contacts should be communicated as soon as possible, by emailing pharmservices@ihis.org
 - Additional information can be included in the Cover Letter. Please limit this to an explanation of unexpected situations or unusual features of a particular submission. For example, if any strengths of a product listed in the NOC will not be marketed, include this information as a comment in the Cover Letter.
 - An electronic signature is acceptable.
2. Copy of the Notice of Compliance (NOC) issued by Health Canada.
3. Copy of the Health Canada approved Product Monograph.
4.
 - a) Drug Notification Form
 - b) Current price for all marketed dosage forms and strengths.
5. A signed letter stating that the manufacturer is able to supply the drug product in quantities sufficient to meet the anticipated demand in the province.
6. A signed letter authorizing unrestricted communication regarding the drug product between PEI Pharmacare and
 - a. Other federal, provincial, and territorial (F/P/T) drug programs
 - b. F/P/T health authorities and related facilities
 - c. Health Canada
 - d. Patented Medicine Prices Review Board (PMPRB)
 - e. Canada’s Drug Agency (CDA/AMC)
7. A Budget Impact Analysis (BIA).

For More Information

For more information on the submission process, please contact PEI Pharmacare at pharmservices@ihis.org.

PRODUCT DELETIONS

Except where the manufacture of a product is discontinued or approval for sale of a product in Canada is withdrawn, the deletion of products from the Formulary must be approved on the authority of the Minister of Health and Wellness.

SPECIAL AUTHORIZATION DRUG STATUS

Under the HIV, Diabetes, Family Health Benefit, Financial Assistance, Generic Drug Program, High Cost Drugs, Institutional Pharmacy, National Pharmacare, Nursing Home, Seniors, Transplant, and Catastrophic Drug Programs, certain drug products may be considered for Special Authorization (SA) coverage under the following circumstances:

1. Therapeutic alternatives listed in the Formulary are contraindicated or have been found to be ineffective; or
2. Drugs for which there is no alternative listed in the Formulary.

SA coverage will not be considered for medications that have not yet been reviewed for coverage by the Atlantic Expert Advisory Committee (AEAC), the Canadian Expert Drug Advisory Committee (CEDAC), the pan-Canadian Oncology Drug Review (pCODR) or that have received a negative recommendation from one of these expert advisory committees.

SA coverage will normally only be approved for the treatment of indications and in dosages listed in the official product monograph approved by Health Canada and published in the most recent edition of the Compendium of Pharmaceuticals and Specialities (CPS).

See Appendix A for further detail regarding the SA process.

"NO-SUBSTITUTION" PRESCRIPTIONS

Both generic and brand name products are manufactured under the same standards of good manufacturing practice, and only those brands which meet accepted standards of equivalence are accepted in Prince Edward Island.

Patients must pay the pharmacy the standard co-pay, plus any cost difference between the brand name requested and the price paid by government for the least expensive generic product.

EXTEMPORANEOUS PREPARATIONS

Extemporaneous preparations are defined as a drug or mixture of drugs prepared or compounded in a pharmacy according to the orders of a prescriber.

To be eligible as a benefit, extemporaneous preparations must:

1. Be specifically tailored to a prescription;
2. Contain one or more medications presently listed as a benefit under the Program for which the person is eligible and all of which are considered a therapeutic benefit in the concentrations and manner used (subject to the review procedure for SA coverage, if deemed appropriate); and
3. Not duplicate the formulation of a manufactured drug product, dilute or alter its formulation, as to result in a product of equivalent therapeutic advantage or one which offers no clear therapeutic advantage relative to a listed benefit.

Claims for extemporaneous preparations are to be submitted electronically using the major ingredient DIN and the appropriate CPhA compound type code.

EXCLUSIONS

The following are excluded as benefits under PEI Pharmacare:

- All benefits a person is entitled to under any other provincial or federal program (e.g. Workers Compensation, Veterans Affairs Canada, Non-Insured Health Benefits, the Canadian Armed Forces Drug Benefit Program, Correctional Service Canada, Interim Federal Health Program, etc.) or legislation.
- Drugs not authorized for sale and use in Canada (e.g. drugs obtained through Health Canada's Special Access Program, experimental or investigational drugs).
- The following classes of products, except for those specifically listed in the Formulary:
 - Over-the-counter (OTC) or non-prescription medications (some programs)
 - Dietary and nutritional supplements (e.g. Ensure, Boost)
 - Weight loss products
 - Cannabis and cannabis products
 - Soaps, cleansers, and shampoos
 - Oral ergoloid mesylates (i.e. Hydergine)
 - Peripheral vasodilators (e.g. Arlidin)
 - Combination anti-spasmodic/sedative products (e.g. Donnatal, Librax, Stelabid)
 - Combination sedative/analgesic products (e.g. Fiorinal, Tecnal)
 - Allergy serums
 - Products for the treatment of impotence or infertility.
 - Diagnostic agents (except diabetes)
 - Prostheses, medical devices (exception IUDs) and appliances, and medical supplies, including first aid supplies and syringes

PRESCRIPTION QUANTITIES

Maximum days' supply is based on the negotiated Pharmacy Service Contract between the Province and the PEI Pharmacists' Association. Coverage is limited to a maximum 90-day supply unless otherwise noted.

Pharmacare limits coverage to a maximum 30-day supply for:

- Narcotic medications, controlled medications, targeted medications, antibiotics, antifungals, sedatives and sleeping pills;
- Non-oral medications;
- Any high cost medication. For this purpose, a high cost medication is defined as a medication eligible for coverage under the High Cost Drug Program;
- Medications requiring a special authorization request for coverage.

Some medications may differ from this day's supply standard. In this case, the maximum day supply will be noted within the formulary drug listing and, if applicable, the special authorization criteria.

Program	Maximum Allowable Days' Supply
Cystic Fibrosis Drug Program	60 30 - drugs under SA coverage
Diabetes Drug Program	25 – test strips
Diabetes Glucose Sensor Program	28 – Libre sensors, 30 - Dexcom sensors 35 - Medtronic sensors 90 - Dexcom transmitter 365 – Medtronic transmitter
Growth Hormone Drug Program	30
Hepatitis Drug Program	30
High Cost Drug Program	30, unless otherwise specified in criteria for drug(s).
HIV Drug Program	60
National Pharmacare Program	90 – oral diabetes medication, contraceptives 30 – insulins
Smoking Cessation Drug Program	28 days – OTC Drugs ; 28 days – Prescription drugs
Substance Use Harm Reduction Drug Program	Up to 30 days
Transplant Drugs Program	60
Tuberculosis Drug Program	60

COORDINATION OF BENEFITS

Claims submitted for a medication listed under the National Pharmacare Program (NPP) are a single payer of first resort. Coordination of benefits is not required for submission of NPP claims.

For all other Pharmacare Programs, coordination of benefits allows one to claim under a private insurance plan and PEI Pharmacare for up to the reasonable and customary amount of the covered expense. A claim must be submitted to private insurance before PEI Pharmacare. If the claim is not submitted electronically to the private insurance plan, it should not be adjudicated through PEI Pharmacare electronically. The client may submit a request for reimbursement to Pharmacare after payment through the private insurance plan.

When benefits are coordinated, the eligible cost reimbursed by Pharmacare is based on the initial cost of the prescription, not the cost remaining after payment through the private insurance. If one's private insurance reimburses more than the amount eligible through Pharmacare, the remaining prescription costs are not eligible for coverage through Pharmacare.

STANDARDIZATION OF PACKAGE SIZES

To ensure claims are paid correctly, please use the following guidelines when calculating quantities for each claim and ensure your cost per unit is correct in your system.

FORM	QUANTITY	FORM	QUANTITY
Aerosols	Per dose	Nasal sprays	Per dose
Auto-injectors	Per auto-injector	Nebules	Per mL
Capsules	Per capsule	Ointments	Per gram
Creams	Per gram	Oral Contraceptives	Per tablet
Enemas	Per gm/per mL	Patches	Per patch
Gels	Per gram	Powders	Per gram
Inhalers	Per dose	Powder injectables	Per vial
Insulins (vials, pens, cartridges)	Per mL	Pre-filled syringes	Per syringe
Kits	Per kit	Sensor (glucose)	Per sensor
Liquid Injectables	Per mL	Suppositories	Per supp
Liquids	Per mL	Tablets	Per tablet
		Test Strips	Per strip

LEGEND

08:12.16 ANTIBIOTICS PENICILLINS ¹

AMOXICILLIN ²

250MG CAPSULE ³

00406724 ⁴	NOVAMOXIN ⁵	TEV ⁶	CFGNQSW ⁷
00628115	APO-AMOXI	APX	CFGNQSW
02352710	AMOXICILLIN	SNS	CFGNQSW
02388073	AURO-AMOXICILLIN	ARO	CFGNQSW
02401495	AMOXICILLIN	SIV	CFGNQSW
02433060	JAMP-AMOXICILLIN	JPC	CFGNQSW

CEFPROZIL

[SEE APPENDIX A](#) FOR SA CRITERIA ⁸

250MG TABLET

02293528	TARO-CEFPROZIL (SA) ⁸	RAN	FGNQSW

LATANOPROST

50UG/ML OPHTHALMIC SOLUTION

02231493	XALATAN	UJC	FNQSW
02254786	TEVA-LATANOPROST	TEV	FGNQSW
02296527	APO-LATANOPROST	APX	FGNQSW
02341085	RIVA-LATANOPROST	RIV	FGNQSW
02367335	SANDOZ-LATANOPROST	SDZ	FGNQSW
02373041	GD-LATANOPROST	GMD	FGNQSW
02426935	MED-LATANOPROST	GMP	FGNQSW
02453355	JAMP-LATANOPROST	JPC	FGNQSW
02489570	LATANOPROST	TLG	FGNQSW

Note: The provincial drug programs will only pay for one 2.5 mL bottle of Latanoprost per patient every 30 days. Patients are responsible for the entire prescription cost of any Latanoprost required beyond this. ⁹

Legend Key:

1. Pharmacological-Therapeutic sub-classification
2. Non-proprietary or generic name of the drug.
3. Drug strength and dosage form.
4. Drug Identification Number (DIN) assigned by Health Canada, or a Pseudo-Identification Number (PDIN) assigned by PEI Pharmacare for billing purposes only.
5. Brand name of the drug
6. Three letter identification codes are assigned to each manufacturer. The codes are listed in the Formulary.
7. Drug programs for which the product is considered to be a benefit:

National – National Pharmacare Program	N	Nursing Home/Institutional
A HIV Drug Program	P	Phenylketonuria (PKU) Program
B Community Mental Health Drug Program	Q	Catastrophic Drug Program
C Cystic Fibrosis Drug Program	S	Seniors Drug Program
D Diabetes Drug Program	T	Transplant Drug Program
E Erythropoietin Program	V	Sexually Transmitted Infections Program
F Family Health Benefit Drug Program	W	Financial Assistance Program / Children-In-Care Program
G Generic Drug Program	X	Tuberculosis (TB) Drug Program
H Hepatitis Drug Program	Y	Growth Hormone Program
L Substance Use Harm Reduction Program	Z	Smoking Cessation Drug Program
M High Cost Drug Program		

8. This product requires Special Authorization Status (SA) approval (see Appendix A for SA criteria).
9. Special note regarding the product(s) listed in this section.

04:00.00 ANTIHISTAMINES

CETIRIZINE

10MG TABLET

02223554	REACTINE	MCL	NW
02231603	APO-CETIRIZINE	APX	NW
02451778	JAMP-CETIRIZINE	JPC	NW
02517566	CETIRIZINE EXTRA STRENGTH	JPC	NW

20MG TABLET

02315963	PMS-CETIRIZINE	PMS	FGNQSW
02427141	MAR-CETIRIZINE	MAR	FGNQSW
02453363	APO-CETIRIZINE	APX	FGNQSW
02512025	M-CETIRIZINE	MRA	FGNQSW
02515695	CETIRIZINE	SNS	FGNQSW
02517353	JAMP-CETIRIZINE	JPC	FGNQSW
02528681	TEVA-CETIRIZINE	TEV	FGNQSW
02534126	CETIRIZINE	SIV	FGNQSW

DIPHENHYDRAMINE HCL

25MG CAPSULE

00757683	PDP-DIPHENHYDRAMINE	PEN	NW

50MG CAPSULE

00757691	PDP-DIPHENHYDRAMINE	PEN	NW

12.5MG/5ML ELIXIR

02019736	BENADRYL	MCL	NW
02298503	DIPHENHYDRAMINE HCL	JPC	NW

50MG/ML INTRAMUSCULAR INJECTION

00596612	DIPHENHYDRAMINE	SDZ	NW

LORATADINE

10MG TABLET

00782696	CLARITIN	BAY	W
02243880	APO-LORATADINE	APX	W

04:04.16 PIPERAZINE DERIVATIVES

FLUNARIZINE HCL

5MG CAPSULE

02246082	FLUNARIZINE	AAA	FGNQSW

08:08.00 ANTHELMINTICS

MEBENDAZOLE

100MG TABLET

00556734 VERMOX

JAN FNQW

PRAZIQUANTEL

600MG TABLET

02230897 BILTRICIDE

BAY FNQSW

PYRANTEL PAMOATE

125MG TABLET

01944363 COMBANTRIN
02380617 JAMP-PYRANTEL PAMOATE
02535467 RIVA-PYRANTEL PAMOATE

MCL NW
JPC NW
RIV NW

08:12.02 ANTIBIOTICS AMINOGLYCOSIDES

GENTAMICIN SULFATE

80MG/2ML INJECTION SOLUTION (2ML)

02242652 GENTAMICIN

SDZ FGNQSW

TOBRAMYCIN

80MG/2ML INJECTION SOLUTION

02241210 TOBRAMYCIN INJECTION USP
02502372 TOBRAMYCIN SULFATE
02533103 TOBRAMYCIN

SDZ CFGNQSW
STE CFGNQSW
JPC CFGNQSW

08:12.04 ANTIBIOTICS ANTIFUNGALS

FLUCONAZOLE

50MG TABLET

02236978 TEVA-FLUCONAZOLE
02237370 APO-FLUCONAZOLE
02245292 MYLAN-FLUCONAZOLE
02245643 PMS-FLUCONAZOLE
02281260 ACT-FLUCONAZOLE
02517396 FLUCONAZOLE

TEV AFGNQSW
APX AFGNQSW
MYL AFGNQSW
PMS AFGNQSW
TEV AFGNQSW
SNS AFGNQSW

02534886	FLUCONAZOLE	SIV	AFGNQSW
100MG TABLET			
02236979	TEV-FLUCONAZOLE	TEV	AFGNQSW
02237371	APO-FLUCONAZOLE	APX	AFGNQSW
02245293	MYLAN-FLUCONAZOLE	MYL	AFGNQSW
02245644	PMS-FLUCONAZOLE	PMS	AFGNQSW
02281279	ACT-FLUCONAZOLE	TEV	AFGNQSW
02517418	FLUCONAZOLE	SNS	AFGNQSW
02534894	FLUCONAZOLE	SIV	AFGNQSW

150MG CAPSULE			
02141442	DIFLUCAN ONE	PFI	AFNQSW
02241895	APO-FLUCONAZOLE	APX	AFGNQSW
02428792	MAR-FLUCONAZOLE	MAR	AFGNQSW
02432471	JAMP-FLUCONAZOLE	JPC	AFGNQSW
02521229	FLUCONAZOLE-150	SNS	AFGNQSW
02547864	JAMP-FLUCONAZOLE	JPC	AFGNQSW

ISAVUCONAZOLE

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG CAPSULE			
02483971	CRESEMBA (SA)	AVI	NMQW

ITRACONAZOLE

100MG CAPSULE			
02047454	SPORANOX	JAN	FNQSW
02462559	MINT-ITRACONAZOLE	MNT	FGNQSW

10MG/ML ORAL SOLUTION			
02495988	ODAN ITRACONAZOLE (SA)	ODN	FGNQSW

KETOCONAZOLE

200MG TABLET			
02231061	TEVA-KETOCONAZOLE	TEV	AFGNQSW
02237235	APO-KETOCONAZOLE	APX	AFGNQSW

08:12.06 ANTIBIOTICS CEPHALOSPORINS

CEFADROXIL

500MG CAPSULE			
02235134	TEVA-CEFADROXIL	TEV	FGNQSW
02240774	APO-CEFADROXIL	APX	FGNQSW
02544792	JAMP-CEFADROXIL	JPC	FGNQSW

CEFIXIME

400MG TABLET

00868981 SUPRAX
02432773 AURO-CEFIXIME

ODN **FNQSVW**
ARO **FGNQSVW**

100MG/5ML ORAL SUSPENSION

00868965 SUPRAX
02468689 AURO-CEFIXIME

ODN **FNQSW**
ARO **FGNQSW**

CEFPROZIL

250MG TABLET

02293528 TARO-CEFPROZIL

TAR **FGNQSW**

500MG TABLET

02293536 TARO-CEFPROZIL
02347253 AURO-CEFPROZIL

TAR **FGNQSW**
ARO **FGNQSW**

25MG/ML ORAL SUSPENSION

02329204 TARO-CEFPROZIL
02347261 AURO-CEFPROZIL

TAR **FGNQSW**
ARO **FGNQSW**

50MG/ML ORAL SUSPENSION

02293579 TARO-CEFPROZIL
02347288 AURO-CEFPROZIL

TAR **FGNQSW**
ARO **FGNQSW**

CEFTRIAZONE

1.0G/VIAL INTRAMUSCULAR INJECTION

02287633 CEFTRIAZONE FOR SODIUM
02292270 CEFTRIAZONE
02325616 CEFTRIAZONE SODIUM

TEV **NQ**
SDZ **NQ**
STE **NQ**

CEFUROXIME AXETIL

250MG TABLET

02244393 APO-CEFUROXIME
02344823 AURO-CEFUROXIME
02547198 JAMP-CEFUROXIME

APX **CFGNQSW**
ARO **CFGNQSW**
JPC **CFGNQSW**

500MG TABLET

02244394 APO-CEFUROXIME
02344831 AURO-CEFUROXIME
02547201 JAMP-CEFUROXIME

APX **CFGNQSW**
ARO **CFGNQSW**
JPC **CFGNQSW**

25MG/ML ORAL SUSPENSION

02212307 CEFTIN

SDZ **CFNQSW**

CEPHALEXIN MONOHYDRATE

250MG CAPSULE

00342084	TEVA-CEPHALEXIN	TEV	CFGNQSW

500MG CAPSULE

00342114	TEVA-CEPHALEXIN	TEV	CFGNQSW

250MG TABLET

00583413	TEVA-CEPHALEXIN	TEV	CFGNQSW
00768723	APO-CEPHALEX	APX	CFGNQSW
02470578	AURO-CEPHALEXIN	ARO	CFGNQSW
02494698	JAMP-CEPHALEXIN	JPC	CFGNQSW
02521253	CEPHALEXIN	SNS	CFGNQSW

500MG TABLET

00583421	TEVA-CEPHALEXIN	TEV	CFGNQSW
00768715	APO-CEPHALEX	APX	CFGNQSW
02470586	AURO-CEPHALEXIN	ARO	CFGNQSW
02494701	JAMP-CEPHALEXIN	JPC	CFGNQSW
02495651	CEPHALEXIN	SIV	CFGNQSW
02521261	CEPHALEXIN	SNS	CFGNQSW

25MG/ML ORAL SUSPENSION

00342106	TEVA-CEPHALEXIN	TEV	CFGNQSW
02469170	LUPIN-CEPHALEXIN	LUP	CFGNQSW
02497743	AURO-CEPHALEXIN	ARO	CFGNQSW
02528436	JAMP-CEPHALEXIN	JPC	CFGNQSW

50MG/ML ORAL SUSPENSION

00342092	TEVA-CEPHALEXIN	TEV	CFGNQSW
02469189	LUPIN-CEPHALEXIN	LUP	CFGNQSW
02497751	AURO-CEPHALEXIN	ARO	CFGNQSW
02528444	JAMP-CEPHALEXIN	JPC	CFGNQSW

08:12.07 MONOBACTAMS

AZTREONAM

[SEE APPENDIX A](#) FOR SA CRITERIA

75MG/ML INHALATION VIAL

02329840	CAYSTON (SA)	GIL	NMQW

08:12.12 ANTIBIOTICS ERYTHROMYCINS

AZITHROMYCIN

[SEE APPENDIX A](#) FOR SA CRITERIA (HIV, CYSTIC FIBROSIS, SEXUALLY TRANSMITTED INFECTIONS AND TUBERCULOSIS DO NOT REQUIRE A SA REQUEST)
250MG TABLET

02212021	ZITHROMAX (SA)	PFI	ACFNQSWVX
02261634	PMS-AZITHROMYCIN (SA)	PMS	ACFGNQSWVX
02265826	SANDOZ AZITHROMYCIN (SA)	SDZ	ACFGNQSWVX
02267845	TEVA-AZITHROMYCIN (SA)	TEV	ACFGNQSWVX
02275309	RIVA-AZITHROMYCIN (SA)	RIV	ACFGNQSWVX
02330881	AZITHROMYCIN (SA)	SNS	ACFGNQSWVX
02415542	APO-AZITHROMYCIN Z (SA)	APX	ACFGNQSWVX
02442434	AZITHROMYCIN (SA)	SIV	ACFGNQSWVX
02452308	JAMP-AZITHROMYCIN (SA)	JPC	ACFGNQSWVX
02452324	MAR-AZITHROMYCIN (SA)	MAR	ACFGNQSWVX
02479680	NRA-AZITHROMYCIN (SA)	NRA	ACFGNQSWVX
02480700	AG-AZITHROMYCIN (SA)	AGP	ACFGNQSWVX
02502038	M-AZITHROMYCIN (SA)	MRA	ACFGNQSWVX

600MG TABLET

02261642	PMS-AZITHROMYCIN (SA)	PMS	ACFGNQSWX

20MG/ML ORAL SUSPENSION

02223716	ZITHROMAX (SA)	PFI	ACFNQSWX
02332388	SANDOZ-AZITHROMYCIN (SA)	SDZ	ACFGNQSWX
02482363	AURO-AZITHROMYCIN (SA)	ARO	ACFGNQSWX

40MG/ML ORAL SUSPENSION

02223724	ZITHROMAX (SA)	PFI	ACFNQSWX
02332396	SANDOZ-AZITHROMYCIN (SA)	SDZ	ACFGNQSWX
02482371	AURO-AZITHROMYCIN (SA)	ARO	ACFGNQSWX

CLARITHROMYCIN

250MG TABLET

01984853	BIAXIN	BGP	AFCNQSWX
02247573	PMS-CLARITHROMYCIN	PMS	ACFGNQSWX
02266539	SANDOZ CLARITHROMYCIN	SDZ	ACFGNQSWX
02274744	APO-CLARITHROMYCIN	APX	ACFGNQSWX
02361426	RAN-CLARITHROMYCIN	RAN	ACFGNQSWX
02442469	CLARITHROMYCIN	SIV	ACFGNQSWX
02466120	CLARITHROMYCIN	SNS	ACFGNQSWX
02471388	M-CLARITHROMYCIN	MRA	ACFGNQSWX

500MG TABLET

02126710	BIAXIN	BGP	ACFNQSWX

02247574	PMS-CLARITHROMYCIN	PMS	ACFGNQSWX
02266547	SANDOZ-CLARITHROMYCIN	SDZ	ACFGNQSWX
02274752	APO-CLARITHROMYCIN	APX	ACFGNQSWX
02361434	RAN-CLARITHROMYCIN	RAN	ACFGNQSWX
02442485	CLARITHROMYCIN	SIV	ACFGNQSWX
02466139	CLARITHROMYCIN	SNS	ACFGNQSWX
02471396	M-CLARITHROMYCIN	MRA	ACFGNQSWX
500MG EXTENDED-RELEASE TABLET			
02403196	ACT-CLARITHROMYCIN XL	TEV	CFGNQSW
02413345	APO-CLARITHROMYCIN XL	APX	CFGNQSW
25MG/ML ORAL SUSPENSION			
02146908	BIAXIN	BGP	CFNQSWX
02390442	TARO-CLARITHROMYCIN	TAR	CFGNQSWX
50MG/ML ORAL SUSPENSION			
02244641	BIAXIN	BGP	CFNQSWX
02390450	TARO-CLARITHROMYCIN	TAR	CFGNQSWX
ERYTHROMYCIN BASE			
250MG TABLET			
00682020	ERYTHRO-BASE	AAA	CFGNQSVW
FIDAXOMICIN			
SEE APPENDIX A FOR SA CRITERIA			
200MG TABLET			
02387174	DIFICID (SA)	MSD	FNQSW

08:12.16 ANTIBIOTICS PENICILLINS

AMOXICILLIN

250MG CAPSULE

00406724	NOVAMOXIN	TEV	CFGNQSW
00628115	APO-AMOXI	APX	CFGNQSW
02388073	AURO-AMOXICILLIN	ARO	CFGNQSW
02433060	JAMP-AMOXICILLIN	JPC	CFGNQSW
02525348	AMOXICILLIN	SNS	CFGNQSW
02532042	PRZ-AMOXICILLIN	PRZ	CFGNQSW

500MG CAPSULE

00406716	NOVAMOXIN	TEV	CFGNQSVW
00628123	APO-AMOXI	APX	CFGNQSVW
02388081	AURO-AMOXICILLIN	ARO	CFGNQSVW

02401509	AMOXICILLIN	SIV	CFGNQSVW
02433079	JAMP-AMOXICILLIN	JPC	CFGNQSVW
02477726	AG-AMOXICILLIN	ANG	CFGNQSVW
02525356	AMOXICILLIN	SNS	CFGNQSVW
02532050	PRZ-AMOXICILLIN	PRZ	CFGNQSW

25MG/ML ORAL SUSPENSION

00628131	APO-AMOXI	APX	CFGNQSW
02458586	AURO-AMOXICILLIN	ARO	CFGNQSW
02535793	JAMP-AMOXICILLIN	JPC	CFGNQSW

50MG/ML ORAL SUSPENSION

00452130	NOVAMOXIN	TEV	CFGNQSW
00628158	APO-AMOXI	APX	CFGNQSW
01934163	NOVAMOXIN	TEV	CFGNQSW
02352788	AMOXICILLIN SUGAR REDUCED	SNS	CFGNQSW
02352753	AMOXICILLIN	SNS	CFGNQSW
02401541	AMOXICILLIN	SIV	CFGNQSW
02458594	AURO-AMOXICILLIN	ARO	CFGNQSW
02495864	SANDOZ-AMOXICILLIN	SDZ	CFGNQSW
02535815	JAMP-AMOXICILLIN	JPC	CFGNQSW

AMOXICILLIN & CLAVULANIC ACID

250MG & 125MG TABLET

02243350	APO-AMOXI CLAV	APX	CFGNQSW
02471671	AURO-AMOXICLAV	ARO	CFGNQSW
02508249	JAMP-AMOXI CLAV	JPC	CFGNQSW

500MG & 125MG TABLET

02243351	APO-AMOXI CLAV	APX	CFGNQSW
02471698	AURO-AMOXICLAV	ARO	CFGNQSW
02482576	SANDOZ-AMOXI CLAV	SDZ	CFGNQSW
02508257	JAMP-AMOXI CLAV	JPC	CFGNQSW
02536021	AMOXICILLIN-CLAV	SNS	CFGNQSW

875MG & 125MG TABLET

02245623	APO-AMOXI CLAV	APX	CFGNQSW
02471701	AURO-AMOXICLAV	ARO	CFGNQSW
02482584	SANDOZ-AMOXI CLAV	SDZ	CFGNQSW
02508265	JAMP-AMOXI CLAV	JPC	CFGNQSW
02536048	AMOXICILLIN-CLAV	SNS	CFGNQSW

25MG & 6.25MG/ML ORAL SUSPENSION

01916882	CLAVULIN	GSK	CFNQSW

50MG & 12.5MG/ML ORAL SUSPENSION

01916874	CLAVULIN	GSK	CFNQSW
02542226	M-AMOXI CLAV	MRA	CFGNQSW
02539438	JAMP-AMOXI CLAV	JPC	CFGNQSW

80MG & 11.4MG/ML ORAL SUSPENSION

02238830	CLAVULIN	GSK	CFNQSW
02530694	M-AMOXI CLAV	MRA	CFGNQSW
02539446	JAMP-AMOXI CLAV	JPC	CFGNQSW

AMPICILLIN

250MG CAPSULE

00020877	TEVA-AMPICILLIN	TEV	CFGNQSW

500MG CAPSULE

00020885	TEVA-AMPICILLIN	TEV	CFGNQSW

500MG INJECTION POWDER

00872652	AMPICILLIN SODIUM	TEV	NQ

CLOXACILLIN

250MG CAPSULE

00337765	TEVA-CLOXACILLIN	TEV	CFGNQSW
02510731	JAMP-CLOXACILLIN	JPC	CFGNQSW

500MG CAPSULE

00337773	TEVA-CLOXACILLIN	TEV	CFGNQSW
02510758	JAMP-CLOXACILLIN	JPC	CFGNQSW

25MG/ML ORAL LIQUID

00337757	TEVA-CLOXACILLIN	TEV	CFGNQSW

PENICILLIN V (POTASSIUM)

300MG TABLET

00642215	PEN-VK	AAA	CFGNQSW

8:12.18 QUINOLONES

CIPROFLOXACIN

[SEE APPENDIX A](#) FOR SA CRITERIA (CYSTIC FIBROSIS, NURSING HOME, AND TUBERCULOSIS PROGRAMS DO NOT REQUIRE AN SA REQUEST)

250MG TABLET

02247339	ACT-CIPROFLOXACIN (SA)	TEV	CFGNQSWX
02248437	PMS-CIPROFLOXACIN (SA)	PMS	CFGNQSWX

02248756	SANDOZ CIPROFLOXACIN (SA)	SDZ	CFGNQSWX
02303728	RAN-CIPROFLOXACIN (SA)	RAN	CFGNQSWX
02353318	CIPROFLOXACIN (SA)	SNS	CFGNQSWX
02379686	MAR-CIPROFLOXACIN (SA)	MAR	CFGNQSWX
02380358	JAMP-CIPROFLOXACIN (SA)	JPC	CFGNQSWX
02381907	AURO-CIPROFLOXACIN (SA)	ARO	CFGNQSWX
02386119	CIPROFLOXACIN (SA)	SIV	CFGNQSWX

500MG TABLET

02247340	ACT-CIPROFLOXACIN (SA)	TEV	CFGNQSWX
02248438	PMS-CIPROFLOXACIN (SA)	PMS	CFGNQSWX
02248757	SANDOZ CIPROFLOXACIN (SA)	SDZ	CFGNQSWX
02303736	RAN-CIPROFLOXACIN (SA)	RAN	CFGNQSWX
02353326	CIPROFLOXACIN (SA)	SNS	CFGNQSWX
02379694	MAR-CIPROFLOXACIN (SA)	MAR	CFGNQSWX
02380366	JAMP-CIPROFLOXACIN (SA)	JPC	CFGNQSWX
02381923	AURO-CIPROFLOXACIN (SA)	ARO	CFGNQSWX
02386127	CIPROFLOXACIN (SA)	SIV	CFGNQSWX
02423561	MINT-CIPROFLOX (SA)	MNT	CFGNQSWX
02492008	NRA-CIPROFLOXACIN (SA)	NRA	CFGNQSWX

750MG TABLET

02247341	ACT-CIPROFLOXACIN (SA)	TEV	CFGNQSW
02248439	PMS-CIPROFLOXACIN (SA)	PMS	CFGNQSW
02248758	SANDOZ-CIPROFLOXACIN (SA)	SDZ	CFGNQSW
02303744	RAN-CIPROFLOXACIN (SA)	RAN	CFGNQSW
02379708	MAR-CIPROFLOXACIN (SA)	MAR	CFGNQSW
02380374	JAMP-CIPROFLOXACIN (SA)	JPC	CFGNQSW

100MG/ML ORAL SUSPENSION

02237514	CIPRO (SA)	BAY	CFNQSW

LEVOFLOXACIN

[SEE APPENDIX A](#) FOR SA CRITERIA (CYSTIC FIBROSIS AND NURSING HOME PROGRAMS DO NOT REQUIRE AN SA REQUEST)

250MG TABLET

02284707	APO-LEVOFLOX (SA)	APX	CFGNQSW
02298635	SANDOZ-LEVOFLOXACIN (SA)	SDZ	CFGNQSW
02315424	ACT-LEVOFLOXACIN (SA)	TEV	CFGNQSW
02505797	MINT-LEVOFLOXACIN (SA)	MNT	CFGNQSW
02508443	JAMP-LEVOFLOXACIN (SA)	JPC	CFGNQSW

500MG TABLET

02284715	APO-LEVOFLOX (SA)	APX	CFGNQSW
02298643	SANDOZ-LEVOFLOXACIN (SA)	SDZ	CFGNQSW
02315432	ACT-LEVOFLOXACIN (SA)	TEV	CFGNQSW

02505819	MINT-LEVOFLOXACIN (SA)	MNT	CFGNQSW
02508451	JAMP-LEVOFLOXACIN (SA)	JPC	CFGNQSW
750MG TABLET			
02315440	ACT-LEVOFLOXACIN (SA)	TEV	CFGNQSW
02325942	APO-LEVOFLOXACIN (SA)	APX	CFGNQSW
02508478	JAMP-LEVOFLOXACIN (SA)	JPC	CFGNQSW

MOXIFLOXACIN HCL

[SEE APPENDIX A](#) FOR SA CRITERIA (CYSTIC FIBROSIS PROGRAM DOES NOT REQUIRE AN SA REQUEST)

400MG TABLET

02375702	TEVA-MOXIFLOXACIN (SA)	TEV	CFGNQSW
02383381	SANDOZ-MOXIFLOXACIN (SA)	SDZ	CFGNQSW
02404923	APO-MOXIFLOXACIN (SA)	APX	CFGNQSW
02432242	AURO-MOXIFLOXACIN (SA)	ARO	CFGNQSW
02443929	JAMP-MOXIFLOXACIN (SA)	JPC	CFGNQSW
02447053	MAR-MOXIFLOXACIN (SA)	MAR	CFGNQSW
02447061	JAMP-MOXIFLOXACIN (SA)	JPC	CFGNQSW
02472791	M-MOXIFLOXACIN (SA)	MRA	CFGNQSW
02478137	AG-MOXIFLOXACIN (SA)	ANG	CFGNQSW
02520710	MOXIFLOXACIN (SA)	SNS	CFGNQSW

NORFLOXACIN

[SEE APPENDIX A](#) FOR SA CRITERIA (NURSING HOME PROGRAM DOES NOT REQUIRE AN SA REQUEST)

400MG TABLET

02229524	NORFLOXACIN (SA)	AAA	FGNQSW

08:12.20 SULFONAMIDES

SULFAMETHOXAZOLE & TRIMETHOPRIM

100MG & 20MG TABLET

00445266	SULFATRIM PEDIATRIC	AAA	ACFGNQSWX

400MG & 80MG TABLET

00445274	SULFATRIM	AAA	ACFGNQSWX

800MG & 160MG TABLET

00445282	SULFATRIM DS	AAA	ACFGNQSWX

40MG & 8MG/ML ORAL SUSPENSION

00726540	TEVA-TRIMEL	TEV	ACFGNQSWX

08:12.24 ANTIBIOTICS TETRACYCLINES

DOXYCYCLINE

100MG CAPSULE

00725250	TEVA-DOXYCYCLINE	TEV	CFGNQSVWX
00740713	APO-DOXY	APX	CFGNQSVWX
02351234	DOXYCYCLINE	SNS	CFGNQSVWX
02528940	JAMP-DOXYCYCLINE	JPC	CFGNQSVWX

100MG TABLET

00860751	DOXYCIN	RIV	CFGNQSVWX
00874256	APO-DOXY	APX	CFGNQSVWX
02158574	TEVA-DOXYCYCLINE	TEV	CFGNQSVWX
02351242	DOXYCYCLINE	SNS	CFGNQSVWX
02536250	PRZ-DOXYCYCLINE	PRZ	CFGNQSVWX
02543478	M-DOXYCYCLINE	MRA	CFGNQSVWX

MINOCYCLINE HCL

50MG CAPSULE

02084090	MINOCYCLINE	AAA	FGNQSW

100 MG CAPSULE

02084104	MINOCYCLINE	AAA	FGNQSW

TETRACYCLINE

250MG CAPSULE

00580929	TETRACYCLINE	AAA	CFGNQSW

8:12.28 ANTIBIOTICS OTHER ANTIBIOTICS

CLINDAMYCIN HCL

150MG CAPSULE

02241709	TEVA-CLINDAMYCIN	TEV	CFGNQSW
02245232	APO-CLINDAMYCIN	APX	CFGNQSW
02400529	CLINDAMYCIN	SNS	CFGNQSW
02436906	AURO-CLINDAMYCIN	ARO	CFGNQSW
02462656	MED-CLINDAMYCIN	GMP	CFGNQSW
02468476	RIVA-CLINDAMYCIN	RIV	CFGNQSW
02479923	M-CLINDAMYCIN	MRA	CFGNQSW
02483734	JAMP-CLINDAMYCIN	JPC	CFGNQSW
02493748	NRA-CLINDAMYCIN	NRA	CFGNQSW

300MG CAPSULE

02241710	TEVA-CLINDAMYCIN	TEV	CFGNQSW
02245233	APO-CLINDAMYCIN	APX	CFGNQSW
02400537	CLINDAMYCIN	SNS	CFGNQSW
02436914	AURO-CLINDAMYCIN	ARO	CFGNQSW
02462664	MED-CLINDAMYCIN	GMP	CFGNQSW
02468484	RIVA-CLINDAMYCIN	RIV	CFGNQSW
02479931	M-CLINDAMYCIN	MRA	CFGNQSW
02483742	JAMP-CLINDAMYCIN	JPC	CFGNQSW
02493756	NRA-CLINDAMYCIN	NRA	CFGNQSW

CLINDAMYCIN PALMITATE HCL**15MG/ML ORAL SOLUTION**

00225851	DALACIN C	PFI	FNQSW

LINEZOLID[SEE APPENDIX A](#) FOR SA CRITERIA**600MG TABLET**

02422689	SANDOZ-LINEZOLID (SA)	SDZ	FGNQSW
02426552	APO-LINEZOLID (SA)	APX	FGNQSW
02520354	JAMP-LINEZOLID (SA)	JPC	FGNQSW

RIFAXIMIN[SEE APPENDIX A](#) FOR SA CRITERIA**550MG TABLET**

02410702	ZAXINE (SA)	LUP	FNQSW

VANCOMYCIN HCL**125MG CAPSULE**

00800430	VANCOCIN	MRS	FNQSW
02407744	JAMP-VANCOMYCIN	JPC	FGNQSW

08:14.00 ANTIFUNGALS**NYSTATIN****100,000U/ML ORAL SUSPENSION**

00792667	PMS-NYSTATIN	PMS	AFGNQSW
02194201	RATIO-NYSTATIN	TEV	AFGNQSW
02433443	JAMP-NYSTATIN	JPC	AFGNQSW

TERBINAFINE**250MG TABLET**

02239893	APO-TERBINAFINE	APX	AFGNQSW
02254727	ACT-TERBINAFINE	TEV	AFGNQSW
02294273	PMS-TERBINAFINE	PMS	AFGNQSW
02320134	AURO-TERBINAFINE	ARO	AFGNQSW
02353121	TERBINAFINE	SNS	AFGNQSW
02385279	TERBINAFINE	SIV	AFGNQSW

VORICONAZOLE

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG TABLET

02256460	VFEND (SA)	PFI	FNQSW
02396866	TEVA-VORICONAZOLE (SA)	TEV	FGNQSW
02399245	SANDOZ-VORICONAZOLE (SA)	SDZ	FGNQSW
02525771	JAMP-VORICONAZOLE (SA)	JPC	FGNQSW

200MG TABLET

02256479	VFEND (SA)	PFI	FNQSW
02396874	TEVA-VORICONAZOLE (SA)	TEV	FGNQSW
02399253	SANDOZ-VORICONAZOLE (SA)	SDZ	FGNQSW
02525798	JAMP-VORICONAZOLE (SA)	JPC	FGNQSW

08:16.00 ANTITUBERCULOSIS AGENTS

ETHAMBUTOL

100MG TABLET

00247960	ETIBI	BSL	AX

400MG TABLET

00247979	ETIBI	BSL	AX

ISONIAZID

300MG TABLET

00577804	PDP-ISONIAZID	PEN	AX

PYRAZINAMIDE

500MG TABLET

00618810	PDP-PYRAZINAMIDE	PEN	X

RIFABUTIN

150MG CAPSULE

02063786	MYCOBUTIN	PFI	AX

RIFAMPIN

150MG CAPSULE

00393444 ROFACT

BSL **AQX**

300MG CAPSULE

00343617 ROFACT

BSL **AQX****8:16.92 MISCELLANEOUS ANTIMYCOBACTERIALS****DAPSONE**

100MG TABLET

02481227 MAR-DAPSONE

MAR **AFGNQSW****8:18.00 ANTIVIRALS****ACYCLOVIR**

200MG TABLET

02207621 APO-ACYCLOVIR
02242784 MYLAN-ACYCLOVIR
02285959 TEVA-ACYCLOVIR
02524708 MINT-ACYCLOVIR

APX **AFGNQSW**
MYL **AFGNQSW**
TEV **AFGNQSW**
MNT **AFGNQSW**

400MG TABLET

02207648 APO-ACYCLOVIR
02242463 MYLAN-ACYCLOVIR
02285967 TEVA-ACYCLOVIR
02524716 MINT-ACYCLOVIR

APX **AFGNQSW**
MYL **AFGNQSW**
TEV **AFGNQSW**
MNT **AFGNQSW**

800MG TABLET

02207656 APO-ACYCLOVIR
02242464 MYLAN-ACYCLOVIR
02285975 TEVA-ACYCLOVIR
02524724 MINT-ACYCLOVIR

APX **AFGNQSW**
MYL **AFGNQSW**
TEV **AFGNQSW**
MNT **AFGNQSW**

FAMCICLOVIR

125MG TABLET

02229110 FAMVIR
02292025 APO-FAMCICLOVIR

ATN **AFNQSW**
APX **AFGNQSW**

250MG TABLET

02229129 FAMVIR

ATN **AFNQSW**

02292041	APO-FAMCICLOVIR	APX	AFGNQSW
500MG TABLET			
02177102	FAMVIR	ATN	AFNQSW
02292068	APO-FAMCICLOVIR	APX	AFGNQSW

VALACYCLOVIR

500MG TABLET			
02219492	VALTREX	GSK	AFNQSW
02295822	APO-VALACYCLOVIR	APX	AFGNQSW
02298457	PMS-VALACYCLOVIR	PMS	AFGNQSW
02316447	RIVA-VALACYCLOVIR	RIV	AFGNQSW
02347091	SANDOZ-VALACYCLOVIR	SDZ	AFGNQSW
02351579	MYLAN-VALACYCLOVIR	MYL	AFGNQSW
02357534	TEVA-VALACYCLOVIR	TEV	AFGNQSW
02405040	AURO-VALACYCLOVIR	ARO	AFGNQSW
02440598	JAMP-VALACYCLOVIR	JPC	AFGNQSW
02441454	JAMP-VALACYCLOVIR	JPC	AFGNQSW
02442000	VALACYCLOVIR	SIV	AFGNQSW
02454645	VALACYCLOVIR	SNS	AFGNQSW

1000MG TABLET			
02351560	MYLAN-VALACYCLOVIR	MYL	AFGNQSW
02354705	APO-VALACYCLOVIR	APX	AFGNQSW
02381230	PMS-VALACYCLOVIR	PMS	AFGNQSW
02405059	AURO-VALACYCLOVIR	ARO	AFGNQSW
02519585	VALACYCLOVIR	SNS	AFGNQSW

VALGANCICLOVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

450MG TABLET			
02245777	VALCYTE (SA)	XPI	AT
02413825	TEVA-VALGANCICLOVIR (SA)	TEV	AT
02435179	AURO-VALGANCICLOVIR (SA)	ARO	AT
02495457	MINT-VALGANCICLOVIR (SA)	MNT	AT

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG/ML ORAL SOLUTION			
02306085	VALCYTE (SA)	XPI	AT

8:18.04 ADAMANTANES

AMANTADINE HCL

10MG/ML SYRUP

02022826	PDP-AMANTADINE	PEN	FGNQSW
02538601	ODAN-AMANTADINE	ODN	FGNQSW
100MG CAPSULE			
01990403	PDP-AMANTADINE	PEN	FGNQSW

08:18.08.04 ANTIRETROVIRAL AGENTS (HIV ENTRY AND FUSION INHIBITORS)

ENFUVIRTIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

90MG/ML INJECTION KIT

02247725	FUZEON (SA)	HLR	A

MARAVIROX

150MG TABLET

02299844	CELSENTRI	VII	A

300MG TABLET

02299852	CELSENTRI	VII	A

08:18.08.08 ANTIRETROVIRAL AGENTS (PROTEASE INHIBITORS)

ATAZANAVIR

150MG CAPSULE

02248610	REYATAZ	BMS	A
02443791	TEVA-ATAZANAVIR	TEV	A
02456877	MYLAN-ATAZANAVIR	MYL	A
02513102	JAMP-ATAZANAVIR	JPC	A

200MG CAPSULE

02248611	REYATAZ	BMS	A
02443813	TEVA-ATAZANAVIR	TEV	A
02456885	MYLAN-ATAZANAVIR	MYL	A
02513110	JAMP-ATAZANAVIR	JPC	A

300MG CAPSULE

02294176	REYATAZ	BMS	A
02443821	TEVA-ATAZANAVIR	TEV	A
02456893	MYLAN-ATAZANAVIR	MYL	A
02513129	JAMP-ATAZANAVIR	JPC	A

DARUNAVIR

75MG TABLET

02338432 PREZISTA JAN **A**

150MG TABLET

02369753 PREZISTA JAN **A**

600MG TABLET

02324024 PREZISTA JAN **A**02486121 AURO-DARUNAVIR ARO **A**02487241 APO-DARUNAVIR APX **A**02521342 DARUNAVIR JPC **A**

800MG TABLET

02393050 PREZISTA JAN **A**02486148 AURO-DARUNAVIR ARO **A**02487268 APO-DARUNAVIR APX **A**02521350 DARUNAVIR JPC **A****DARUNAVIR/COBICISTAT**

800MG/150MG TABLET

02426501 PREZCOBIX JAN **A****ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR
DISOPROXIL FUMARATE**

150MG/150MG/200MG/300MG TABLET

02397137 STRIBILD GIL **A****FOSAMPRENAVIR**

700MG TABLET

02261545 TELZIR VII **A****LOPINAVIR & RITONAVIR**

200MG & 50MG TABLET

02285533 KALETRA ABV **A****NELFINAVIR MESYLATE**

250MG TABLET

02238617 VIRACEPT PFI **A****RITONAVIR**

100MG FILM COATED TABLET

02357593 NORVIR ABV **A****TIPRANAVIR**[SEE APPENDIX A](#) FOR SA CRITERIA

250MG CAPSULE		
02273322	APTIVUS (SA)	BOE A

8:18.08.12 ANTIRETROVIRAL AGENTS (INTEGRASE INHIBITORS)

ABACAVIR & DOLUTEGRAVIR & LAMIVUDINE

600MG & 50MG & 300MG TABLET		
02430932	TRIUMEQ	VII A

BICTEGRAVIR & EMTRICITABINE & TENOFOVIR ALAFENAMIDE

50MG & 200MG & 25MG TABLET		
02478579	BIKTARVY	GIL A

CABOTEGRAVIR

[SEE APPENDIX A](#) FOR SA CRITERA

30MG TABLET		
02497204	VOCABRIA (SA)	VII A

CABOTEGRAVIR & RILPIVIRINE

[SEE APPENDIX A](#) FOR SA CRITERIA

400MG/600MG VIAL		
02497220	CABENUVA (SA)	VII A

600MG/900MG VIAL

02497247	CABENUVA (SA)	VII A

DOLUTEGRAVIR SODIUM

50MG TABLET		
02414945	TIVICAY	VII A

DOLUTEGRAVIR SODIUM & LAMIVUDINE

50MG & 300MG TABLET		
02491753	DOVATO	VII A

DOLUTEGRAVIR/ & RILPIVIRINE

50MG & 25MG TABLET		
02475774	JULUCA	VII A

ELVITEGRAVIR & COBICISTAT & EMTRICITABINE & TENOFOVIR ALAFENAMIDE

150MG & 150MG & 200MG & 10MG TABLET		
02449498	GENVOYA	GIL A

RALTEGRAVIR

400MG TABLET

02301881

ISENTRESS

MSD A

8:18.08.16 ANTIRETROVIRAL AGENTS (NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS)**DORAVIRINE**

100MG TABLET

02481545

PIFELTRO

MER A

DORAVIRINE & LAMIVUDINE & TENOFIVIR

100MG & 300MG & 300MG TABLET

02482592

DELSTRIGO

MER A

EFAVIRENZ

600MG TABLET

02381524

MYLAN-EFAVIRENZ

MYL A

02389762

TEVA-EFAVIRENZ

TEV A

02418428

AURO-EFAVIRENZ

ARO A

02458233

JAMP-EFAVIRENZ

JPC A

EMTRICITABINE& RILPIVIRINE & TENOFOVIR

200MG & 25MG & 300MG TABLET

02374129

COMPLERA

GIL A

EMTRICITABINE & RILPIVIRINE & TENOFOVIR ALAFENAMIDE

200MG & 25MG & 25MG TABLET

02461463

ODEFSEY

GIL A

ETRAVIRINE

100MG TABLET

02306778

INTELENCE

JAN A

NEVIRAPINE

200MG TABLET

02318601

AURO-NEVIRAPINE

ARO A

02387727

MYLAN-NEVIRAPINE

MYL A

02405776

JAMP-NEVIRAPINE

JPC A

NEVIRAPINE

400MG EXTENDED RELEASE TABLET

02427931

APO-NEVIRAPINE XR

APX A

RILPIVIRINE

25MG TABLET

02370603

EDURANT

JAN A

08:18.08.20 ANTIRETROVIRAL AGENTS (NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS)**ABACAVIR SULFATE**

300MG TABLET

02240357	ZIAGEN	VII	A
02396769	APO-ABACAVIR	APX	A
02480956	MINT-ABACAVIR	MNT	A

ABACAVIR & LAMIVUDINE

600MG & 300MG TABLET

02269341	KIVEXA	VII	A
02399539	APO-ABACAVIR/LAMUVIDINE	APX	A
02416662	TEVA-ABACAVIR/LAMUVIDINE	TEV	A
02450682	MYLAN-ABACAVIR/LAMUVIDINE	MYL	A
02454513	AURO-ABACAVIR/LAMUVIDINE	ARO	A
02458381	PMS-ABACAVIR/LAMIVUDINE	PMS	A
02497654	JAMP-ABACAVIR/LAMIVUDINE	JPC	A

EFAVIRENZ & EMBRICITABINE & TENOFOVIR

600MG & 200MG & 300MG TABLET

02393549	TEVA-EFAVIRENZ-EMTRICITABINE-TENOFOVIR	TEV	A
02461412	MYLAN-EFAVIRENZ-EMTRICITABINE-TENOFOVIR	MYL	A
02468247	APO-EFAVIRENZ-EMTRICITABINE-TENOFOVIR	APX	A
02478404	AURO-EFAVIRENZ-EMTRICITABINE-TENOFOVIR	ARO	A
02484676	SANDOZ-EFAVIRENZ-EMTRICITABINE-TENOFOV	MYL	A
02487284	PMS-EFAVIRENZ-EMTRICITABINE-TENOFOVIR	PMS	A
02519461	JAMP-EFAVIRENZ/EMTRICITABINE/TENOFOVIR	JPC	A

EMTRICITABINE & TENOFOVIR

200MG & 300MG TABLET

02274906	TRUVADA	GIL	A
02399059	TEVA-EMTRICITABINE-TENOFOVIR	TEV	A
02443902	MYLAN-EMTRICITABINE-TENOFOVIR	MYL	A
02452006	APO-EMTRICITABINE-TENOFOVIR	APX	A
02461110	PMS-EMTRICITABINE-TENOFOVIR	PMS	A
02487012	JAMP-EMTRICITABINE-TENOFOVIR	JPC	A
02490684	AURO-EMTRICITABINE-TENOFOVIR	ARO	A
02496356	AG-EMTRICITABINE-TENOFOVIR	ANG	A

02521547	MINT-EMTRICITABINE-TENOFOVIR	MNT	A
LAMIVUDINE			
100MG TABLET			
02239193	HEPTOVIR	GSK	H
02393239	APO-LAMIVUDINE HBV	APX	H
02512467	JAMP-LAMIVUDINE HBV	JPC	H
150MG TABLET			
02192683	3TC	VII	AH
02369052	APO-LAMIVUDINE	APX	AH
02507110	JAMP-LAMIVUDINE	JPC	AH
300MG TABLET			
02247825	3TC	VII	AH
02369060	APO-LAMIVUDINE	APX	AH
02507129	JAMP-LAMIVUDINE	JPC	AH
LAMIVUDINE & ZIDOVUDINE			
150MG & 300MG TABLET			
02239213	COMBIVIR	VII	A
02375540	APO-LAMIVUDINE/ZIDOVUDINE	APX	A
02414414	AURO-LAMIVUDINE/ZIDOVUDINE	ARO	A
02502801	JAMP-LAMIVUDINE/ZIDOVUDINE	JPC	A
TENOFOVIR			
300MG TABLET			
02247128	VIREAD	GIL	AH
02403889	TEVA-TENOFOVIR	TEV	AH
02451980	APO-TENOFOVIR	APX	AH
02452634	MYLAN-TENOFOVIR	MYL	AH
02453940	PMS-TENOFOVIR	PMS	AH
02460173	AURO-TENOFOVIR	ARO	AH
02472511	NAT-TENOFOVIR	NAT	AH
02479087	JAMP-TENOFOVIR	JPC	AH
02512327	TENOFOVIR DISOPROXIL FUMARATE	SNS	AH
02512939	MINT-TENOFOVIR	MNT	AH
02523922	TENOFOVIR	SIV	AH
ZIDOVUDINE (AZT)			
100MG CAPSULE			
01946323	APO-ZIDOVUDINE	APX	A

08:18.32 NUCLEOSIDES AND NUCLEOTIDES

ENTECAVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

0.5MG TABLET

02282224	BARACLUDE (SA)	BMS	H
02396955	APO-ENTECAVIR (SA)	APX	H
02430576	PMS-ENTECAVIR (SA)	PMS	H
02448777	AURO-ENTECAVIR (SA)	ARO	H
02453797	ENTECAVIR (SA)	STR	H
02467232	JAMP-ENTECAVIR (SA)	JPC	H
02485907	MINT-ENTECAVIR (SA)	MNT	H
02527154	ENTECAVIR (SA)	SNS	H

SOFOSBUVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

400MG TABLET

02418355	SOVALDI (SA)	GIL	H

SOFOSBUVIR & LEDIPASVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

400MG & 90MG TABLET

02432226	HARVONI (SA)	GIL	H

SOFOSBUVIR & VELPATASVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

400MG & 100MG TABLET

02456370	EPCLUSA (SA)	GIL	H

SOFOSBUVIR & VELPATASVIR & VOXILAPREVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

400MG & 100MG & 100MG TABLET

02467542	VOSEVI (SA)	GIL	H

08:18.40 HCV PROTEASE INHIBITORS

GLECAPREVIR & PIBRENTASVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG & 20MG GRANULES

02522470	MAVIRET (SA)	ABV	H

100MG & 40MG TABLET

02467550	MAVIRET (SA)	ABV	H

08:18.92 MISCELLANEOUS ANTIVIRALS

LETERMOVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

240MG TABLET

02469375 PREVYMIS (SA)

MER **NMQW**

480MG TABLET

02469383 PREVYMIS (SA)

MER **NMQW**

NIRMATRELVIR & RITONAVIR

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG (2) & 100MG TABLET

02524031 PAXLOVID (SA)

PFI **FNQSW**

150MG & 100MG TABLET

02527804 PAXLOVID (SA)

PFI **FNQSW**

08:30.08 ANTIMALARIALS

HYDROXYCHLOROQUINE SULFATE

200MG TABLET

02017709 PLAQUENIL

AVN **FNQSW**

02246691 APO-HYDROXYQUINE

APX **FGNQSW**

02424991 MINT-HYDROXYCHLOROQUINE

MNT **FGNQSW**

02491427 JAMP-HYDROXYCHLOROQUINE SULFATE

JPC **FGNQSW**

02511886 NRA-HYDROXYCHLOROQUINE

NRA **FGNQSW**

02519348 HYDROXYCHLOROQUINE

SNS **FGNQSW**

08:30.92 MISCELLANEOUS ANTIPROTOZOALS

METRONIDAZOLE

250MG TABLET

00545066 APO-METRONIDAZOLE

APX **CFGNQSW**

02535807 MINT-METRONIDAZOLE

MNT **CFGNQSW**

08:36.00 URINARY ANTI INFECTIVES

FOSFOMYCIN

[SEE APPENDIX A](#) FOR SA CRITERIA

3G SACHET

02240335	MONUROL (*)	PAL	FNQSW
02473801	JAMP-FOSFOMYCIN (*)	JPC	FGNQSW

*quantity limit of 3 doses per 12 month period (one sachet per dispense). The prescriber can submit a request for consideration should beneficiaries require more than 3 doses per 12 month period.

NITROFURANTOIN

50MG CAPSULE (MACROCRYSTALS)

02231015	TEVA-NITROFURANTOIN	TEV	FGNQSW
02495503	JAMP-NITROFURANTOIN	JPC	FGNQSW

100MG CAPSULE (MACROCRYSTALS)

02231016	TEVA-NITROFURANTOIN	TEV	FGNQSW
02495511	JAMP-NITROFURANTOIN	JPC	FGNQSW

50MG TABLET

00319511	NITROFURANTOIN	AAA	FGNQSW

100MG TABLET

00312738	NITROFURANTOIN	AAA	FGNQSW

NITROFURANTOIN MONOHYDRATE/MACROCRYSTALS

100MG CAPSULE

02455676	PMS-NITROFURANTOIN BID	PMS	FGNQSW
02466392	AURO-NITROFURANTOIN BID	ARO	FGNQSW

TRIMETHOPRIM

100MG TABLET

02243116	TRIMETHOPRIM	AAA	FGNQSW

200MG TABLET

02243117	TRIMETHOPRIM	AAA	FGNQSW

10:00.00 ANTINEOPLASTIC AGENTS

ABEMACICLIB[SEE APPENDIX A](#) FOR SA CRITERIA**50MG TABLET**

02487098	VERZENIO (SA)	LIL	NMQW

100MG TABLET

02487101	VERZENIO (SA)	LIL	NMQW

150MG TABLET

02487128	VERZENIO (SA)	LIL	NMQW

ABIRATERONE ACETATE[SEE APPENDIX A](#) FOR SA CRITERIA**250MG TABLET**

02371065	ZYTIGA (SA)	JAN	NMQW

02477114	REDDY-ABIRATERONE (SA)	RCH	NMQW

02486393	SANDOZ-ABIRATERONE (SA)	SDZ	NMQW

02491397	APO-ABIRATERONE (SA)	APX	NMQW

02492601	PMS-ABIRATERONE (SA)	PMS	NMQW

02494132	NAT-ABIRATERONE (SA)	NAT	NMQW

02502305	JAMP-ABIRATERONE (SA)	JPC	NMQW

02503980	MAR-ABIRATERONE (SA)	MAR	NMQW

500MG TABLET

02457113	ZYTIGA (SA)	JAN	NMQW

02491400	APO-ABIRATERONE (SA)	APX	NMQW

02501503	PMS-ABIRATERONE (SA)	PMS	NMQW

02503999	MAR-ABIRATERONE (SA)	MAR	NMQW

02521644	SANDOZ-ABIRATERONE (SA)	SDZ	NMQW

02525380	ABIRATERONE (SA)	JPC	NMQW

02529629	JAMP ABIRATERONE (SA)	JPC	NMQW

02533251	REDDY-ABIRATERONE (SA)	RCH	NMQW

ACALABRUTINIB[SEE APPENDIX A](#) FOR SA CRITERIA**100MG CAPSULE**

02491788	CALQUENCE (SA)	AZE	NMQW

100MG TABLET

02535696	CALQUENCE (SA)	AZE	NMQW

AFATINIB[SEE APPENDIX A](#) FOR SA CRITERIA**20MG TABLET**

02415666	GIOTRIF (SA)	BOE	NMQW

02512777	SANDOZ-AFATINIB (SA)	SDZ	NMQW

02517019	MAR-AFATINIB (SA)	MAR	NMQW

30MG TABLET

02415674	GIOTRIF (SA)	BOE	NMQW
02512785	SANDOZ-AFATINIB (SA)	SDZ	NMQW
02517027	MAR-AFATINIB (SA)	MAR	NMQW

40MG TABLET

02415682	GIOTRIF (SA)	BOE	NMQW
02512793	SANDOZ-AFATINIB (SA)	SDZ	NMQW
02517035	MAR-AFATINIB (SA)	MAR	NMQW

ALECTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG CAPSULE

02458136	ALECENSARO (SA)	HLR	NMQW
00904400	ALECENSARO (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

ANASTROZOLE

1MG TABLET

02224135	ARIMIDEX	AZE	FNQSW
02320738	PMS-ANASTROZOLE	PMS	FGNQSW
02338467	SANDOZ-ANASTROZOLE	SDZ	FGNQSW
02339080	JAMP-ANASTROZOLE	JPC	FGNQSW
02351218	ACH-ANASTROZOLE	ACH	FGNQSW
02365650	TARO-ANASTROZOLE	TAR	FGNQSW
02374420	APO-ANASTROZOLE	APX	FGNQSW
02379562	MAR-ANASTROZOLE	MAR	FGNQSW
02392259	RIVA-ANASTROZOLE	RIV	FGNQSW
02393573	MINT-ANASTROZOLE	MNT	FGNQSW
02394898	TEVA-ANASTROZOLE	TEV	FGNQSW
02417855	NAT-ANASTROZOLE	NAT	FGNQSW
02442736	ANASTROZOLE	SNS	FGNQSW
02529904	ANASTROZOLE	SIV	FGNQSW

APALUTAMIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

60MG TABLET

02478374	ERLEADA (SA)	JAN	NMQW

240MG TABLET

02540185	ERLEADA (SA)	JAN	NMQW

ASCIMINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG TABLET			
02528320	SCEMBLIX (SA)	NVR	NMQW

40MG TABLET			
02528339	SCEMBLIX (SA)	NVR	NMQW

AXITINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

1MG TABLET			
02389630	INLYTA (SA)	PFI	NMQW

5MG TABLET			
02389649	INLYTA (SA)	PFI	NMQW

AZACITIDINE

[SEE APPENDIX A](#) FOR SA CRITERIA

200MG TABLET			
02510197	ONUREG (SA)	CEL	NMQW

300MG TABLET			
02510200	ONUREG (SA)	CEL	NMQW

BICALUTAMIDE

50MG TABLET			
02184478	CASODEX	AZE	FNQSW
02270226	TEVA-BICALUTAMIDE	TEV	FGNQSW
02275589	PMS-BICALUTAMIDE	PMS	FGNQSW
02296063	APO-BICALUTAMIDE	APX	FGNQSW
02325985	BICALUTAMIDE	ACH	FGNQSW
02357216	JAMP-BICALUTAMIDE	JPC	FGNQSW
02519178	BICALUTAMIDE	SNS	FGNQSW

BINIMETINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

15MG TABLET			
02513080	MEKTOVI (SA)	PFI	NMQW

BOSUTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG TABLET			
02419149	BOSULIF (SA)	PFI	NMQW

500MG TABLET			
02419157	BOSULIF (SA)	PFI	NMQW

BRIGATINIB[SEE APPENDIX A](#) FOR SA CRITERIA**30MG TABLET**

02479206 ALUNBRIG (SA)

00904758 ALUNBRIG (SA)*

*use when drug cost in excess of CPHA maximum

TAK **NMQW**
NMQW**90MG TABLET**

02479214 ALUNBRIG (SA)

00904759 ALUNBRIG (SA)*

*use when drug cost in excess of CPHA maximum

TAK **NMQW**
NMQW**180MG TABLET**

02479222 ALUNBRIG (SA)

00904760 ALUNBRIG (SA)*

*use when drug cost in excess of CPHA maximum

TAK **NMQW**
NMQW**90MG (7) & 180MG (21) INITIATION PACK**

02479230 ALUNBRIG (SA)

00904761 ALUNBRIG (SA)*

*use when drug cost in excess of CPHA maximum

TAK **NMQW**
NMQW**BUSERELIN ACETATE****6.3MG IMPLANT**

02228955 SUPREFACT DEPOT

XPI **FNQSW****9.45MG IMPLANT**

02240749 SUPREFACT DEPOT

XPI **FNQSW****BUSULFAN****2MG TABLET**

00004618 MYLERAN

ASN **FNQSW****CABOZANTINIB**[SEE APPENDIX A](#) FOR SA CRITERIA**20MG TABLET**

02480824 CABOMETYX (SA)

IPS **NMQW****40MG TABLET**

02480832 CABOMETYX (SA)

IPS **NMQW****60MG TABLET**

02480840 CABOMETYX (SA)

IPX **NMQW****CAPECITABINE****150MG TABLET**

02421917	SANDOZ-CAPECITABINE	SDZ	FGNQSW
02426757	ACH-CAPECITABINE	ACH	FGNQSW
02457490	TARO-CAPECITABINE	TAR	FGNQSW
02514982	CAPECITABINE	SNS	FGNQSW
02519879	CAPECITABINE	JPC	FGNQSW

500MG TABLET

02421925	SANDOZ-CAPECITABINE	SDZ	FGNQSW
02426765	ACH-CAPECITABINE	ACH	FGNQSW
02457504	TARO-CAPECITABINE	TAR	FGNQSW
02508028	MINT-CAPECITABINE	MNT	FGNQSW
02514990	CAPECITABINE	SNS	FGNQSW
02519887	CAPECITABINE	JPC	FGNQSW

CERITINIIB

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG CAPSULE

02436779	ZYKADIA (SA)	NVR	NMQW

CHLORAMBUCIL

2MG TABLET

00004626	LEUKERAN	ASN	FNQSW

COBIMETINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG TABLET

02452340	COTELLIC (SA)	HLR	NMQW

CRIZOTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

200MG CAPSULE

02384256	XALKORI (SA)	PFI	NMQW

250MG CAPSULE

02384264	XALKORI (SA)	PFI	NMQW

CYCLOPHOSPHAMIDE

25MG TABLET

02241795	PROCYTOX	BAX	FNQSW

50MG TABLET

02241796	PROCYTOX	BAX	FNQSW

CYPROTERONE ACETATE

50MG TABLET

00704431	ANDROCUR	AMD	FNQSW

02245898	APO-CYPROTERONE	AAA	FGNQSW
02390760	MED-CYPROTERONE	GMP	FGNQSW

DABRAFENIB

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG TABLET

02409607	TAFINLAR (SA)	NVR	NMQW

75MG TABLET

02409615	TAFINLAR (SA)	NVR	NMQW

DAROLUTAMIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

300MG TABLET

02496348	NUBEQA (SA)	BAY	NMQW

DASATINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG TABLET

02293129	SPRYCEL (SA)	BMS	NMQW
02470705	APO-DASATINIB (SA)	APX	NMQW
02478307	TEVA-DASATINIB (SA)	TEV	NMQW
02499282	TARO-DASATINIB (SA)	TAR	NMQW
02514737	REDDY-DASATINIB (SA)	RCH	NMQW

50MG TABLET

02293137	SPRYCEL (SA)	BMS	NMQW
02470713	APO-DASATINIB (SA)	APX	NMQW
02478315	TEVA-DASATINIB (SA)	TEV	NMQW
02499304	TARO-DASATINIB (SA)	TAR	NMQW
02514745	REDDY-DASATINIB (SA)	RCH	NMQW

70MG TABLET

02293145	SPRYCEL (SA)	BMS	NMQW
02478323	TEVA-DASATINIB (SA)	TEV	NMQW
02481499	APO-DASATINIB (SA)	APX	NMQW
02499312	TARO-DASATINIB (SA)	TAR	NMQW
02514753	REDDY-DASATINIB (SA)	RCH	NMQW

80MG TABLET

02360810	SPRYCEL (SA)	BMS	NMQW
02478331	TEVA-DASATINIB (SA)	TEV	NMQW
02481502	APO-DASATINIB (SA)	APX	NMQW
02499320	TARO-DASATINIB (SA)	TAR	NMQW
02514761	REDDY-DASATINIB (SA)	RCH	NMQW

100MG TABLET			
02320193	SPRYCEL (SA)	BMS	NMQW
02470721	APO-DASATINIB (SA)	APX	NMQW
02478358	TEVA-DASATINIB (SA)	TEV	NMQW
02499339	TARO-DASATINIB (SA)	TAR	NMQW
02514788	REDDY-DASATINIB (SA)	RCH	NMQW

140MG TABLET			
02360829	SPRYCEL (SA)	BMS	NMQW
02499347	TARO-DASATINIB (SA)	TAR	NMQW
02514796	REDDY-DASATINIB (SA)	RCH	NMQW

DECITABINE & CEDAZURIDINE

[SEE APPENDIX A](#) FOR SA CRITERIA

35MG & 100MG TABLET			
02501600	INQOVI (SA)	TAI	NMQW

DEGARELIX

80MG/VIAL POWDER FOR INJECTION			
02337029	FIRMAGON	FEI	FNQSW

120MG/VIAL POWDER FOR INJECTION			
02337037	FIRMAGON	FEI	FNQSW

ENCORAFENIB

[SEE APPENDIX A](#) FOR SA CRITERIA

75MG CAPSULE			
02513099	BRAFTOVI (SA)	PFI	NMQW

ENTRECTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG CAPSULE			
02495007	ROZLYTREK (SA)	HLR	NMQW

200MG CAPSULE			
02495015	ROZLYTREK (SA)	HLR	NMQW

ENZALUTAMIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

40MG CAPSULE			
02407329	XTANDI (SA)	AST	NMQW

ERLOTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG TABLET			
02377691	TEVA-ERLOTINIB (SA)	TEV	FGMNQSW

02461862	APO-ERLOTINIB (SA)	APX	FGMNQSW
02483912	NAT-ERLOTINIB (SA)	NAT	FGMNQSW

100MG TABLET

02377705	TEVA-ERLOTINIB (SA)	TEV	FGMNQSW
02454386	PMS-ERLOTINIB (SA)	PMS	FGMNQSW
02461870	APO-ERLOTINIB (SA)	APX	FGMNQSW
02483920	NAT-ERLOTIBIN (SA)	NAT	FGMNQSW

150MG TABLET

02377713	TEVA-ERLOTINIB (SA)	TEV	FGMNQSW
02454394	PMS-ERLOTINIB (SA)	PMS	FGMNQSW
02461889	APO-ERLOTINIB (SA)	APX	FGMNQSW
02483939	NAT-ERLOTINIB (SA)	NAT	FGMNQSW

ETOPOSIDE

50MG CAPSULE

00616192	VEPESID	XPI	MNQW

EVEROLIMUS

[SEE APPENDIX A](#) FOR SA CRITERIA

2.5MG TABLET

02463229	TEVA-EVEROLIMUS (SA)	TEV	NMQW
02492911	SANDOZ EVEROLIMUS (SA)	SDZ	NMQW
02504677	PMS-EVEROLIMUS (SA)	PMS	NMQW
02530090	NAT-EVEROLIMUS (SA)	NAT	NMQW
02532409	REDDY-EVEROLIMUS (SA)	RCH	NMQW

5MG TABLET

02463237	TEVA-EVEROLIMUS (SA)	TEV	NMQW
02492938	SANDOZ EVEROLIMUS (SA)	SDZ	NMQW
02504685	PMS-EVEROLIMUS (SA)	PMS	NMQW
02530104	NAT-EVEROLIMUS (SA)	NAT	NMQW
02532417	REDDY-EVEROLIMUS (SA)	RCH	NMQW

10MG TABLET

02463253	TEVA-EVEROLIMUS (SA)	TEV	NMQW
02492946	SANDOZ EVEROLIMUS (SA)	SDZ	NMQW
02504693	PMS-EVEROLIMUS (SA)	PMS	NMQW
02530120	NAT-EVEROLIMUS (SA)	NAT	NMQW
02532433	REDDY-EVEROLIMUS (SA)	RCH	NMQW

EXEMESTANE

25MG TABLET

02242705	AROMASIN	PFI	FNQSW
02390183	ACT-EXEMESTANE	TEV	FGNQSW

02407841	MED-EXEMESTANE	GMP	FGNQSW

FEDRATINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG CAPSULE

02502445	INREBIC (SA)	CEL	NMQW

FLUDARABINE PHOSPHATE

[SEE APPENDIX A](#) FOR SA CRITERIA

10 MG TABLET

02246226	FLUDARA (SA)	AVN	NMQW

FLUOROURACIL /SALICYLIC ACID

0.5%-10% TOPICAL SOLUTION

02428946	ACTIKERALL	CIP	FNQSW

FLUTAMIDE

250MG TABLET

02238560	FLUTAMIDE	AAA	FGNQSW

FULVESTRANT

[SEE APPENDIX A](#) FOR SA CRITERIA

250MG/5ML SYRINGE

02460130	TEVA-FULVESTRANT (SA)	TEV	FGNQSW
02483610	FULVESTRANT (SA)	SDZ	FGNQSW
02530635	FULVESTRANT (SA)	JPC	FGNQSW
02536293	FULVESTRANT (SA)	FRP	FGNQSW

GILTERITINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

40MG TABLET

02495058	XOSPATA (SA)	AST	NMQW
00904658	XOSPATA (SA)*		
00904659	XOSPATA (SA)*		

*use when drug cost in excess of CPHA maximum

HYDROXYUREA

500MG CAPSULE

00465283	HYDREA	XPI	FNQSW
02242920	MYLAN-HYDROXYUREA	MYL	FGNQSW
02247937	APO-HYDROXYUREA	APX	FGNQSW

IBRUTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

140MG CAPSULE

02434407	IMBRUVICA (SA)	JAN	NMQW

00904337	IMBRUVICA (SA)*		NMQW
*use when drug cost in excess of CPHA maximum			

IDELALISIB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG TABLET

02438798	ZYDELIG (SA)	GIL	NMQW

150MG TABLET

02438801	ZYDELIG (SA)	GIL	NMQW

IMATINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG TABLET

02253275	GLEEVEC (SA)	NVR	FMNQSW
02355337	APO-IMATINIB (SA)	APX	FGMNQSW
02397285	NAT-IMATINIB (SA)	NAT	FGMNQSW
02399806	TEVA-IMATINIB (SA)	TEV	FGMNQSW
02431114	PMS-IMATINIB (SA)	PMS	FGMNQSW
02490986	ACH-IMATINIB (SA)	ACH	FGMNQSW
02492334	MINT-IMATINIB (SA)	MNT	FGMNQSW
02495066	JAMP-IMATINIB (SA)	JPC	FGMNQSW
02504596	IMATINIB (SA)	SNS	FGMNQSW
02521202	IMATINIB (SA)	SIV	FGMNQSW

400MG TABLET

02253283	GLEEVEC (SA)	NVR	FMNQSW
02355345	APO-IMATINIB (SA)	APX	FGMNQSW
02397293	NAT-IMATINIB (SA)	NAT	FGMNQSW
02399814	TEVA-IMATINIB (SA)	TEV	FGMNQSW
02431122	PMS-IMATINIB (SA)	PMS	FGMNQSW
02490994	ACH-IMATINIB (SA)	ACH	FGMNQSW
02492342	MINT-IMATINIB (SA)	MNT	FGMNQSW
02495074	JAMP-IMATINIB (SA)	JPC	FGMNQSW
02504618	IMATINIB (SA)	SNS	FGMNQSW
02521210	IMATINIB (SA)	SIV	FGMNQSW

LAROTRECTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG CAPSULE

02490315	VITRAKVI (SA)	BAY	NMQW
00900012	VITRAKVI (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

100MG CAPSULE

02490323	VITRAKVI (SA)	BAY	NMQW

00900013	VITRAKVI (SA)*		NMQW
*use when drug cost in excess of CPHA maximum			

20MG/ML ORAL LIQUID

02490331	VITRAKVI (SA)	BAY	NMQW
00900014	VITRAKVI (SA)*		NMQW
*use when drug cost in excess of CPHA maximum			

LENALIDOMIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

2.5MG CAPSULE

02484714	REDDY-LENALIDOMIDE (SA)	RCH	NMQW
02493837	NAT-LENALIDOMIDE (SA)	NAT	NMQW
02506130	JAMP LENALIDOMIDE (SA)	JPC	NMQW
02507862	TARO-LENALIDOMIDE (SA)	TAR	NMQW
02507927	APO-LENALIDOMIDE (SA)	APZ	NMQW
02518562	SANDOZ-LENALIDOMIDE (SA)	SDZ	NMQW

5MG CAPSULE

02304899	REVLIMID (SA)	CEL	NMQW
02483017	REDDY-LENALIDOMIDE (SA)	RCH	NMQW
02493845	NAT-LENALIDOMIDE (SA)	NAT	NMQW
02506149	JAMP-LENALIDOMIDE (SA)	JPC	NMQW
02507870	TARO-LENALIDOMIDE (SA)	TAR	NMQW
02507935	APO-LENALIDOMIDE (SA)	APX	NMQW
02518570	SANDOZ-LENALIDOMIDE (SA)	SDZ	NMQW

10MG CAPSULE

02304902	REVLIMID (SA)	CEL	NMQW
02483025	REDDY-LENALIDOMIDE (SA)	RCH	NMQW
02493861	NAT-LENALIDOMIDE (SA)	NAT	NMQW
02506157	JAMP-LENALIDOMIDE (SA)	JPC	NMQW
02507889	TARO-LENALIDOMIDE (SA)	TAR	NMQW
02507943	APO-LENALIDOMIDE (SA)	APX	NMQW
02518589	SANDOZ-LENALIDOMIDE (SA)	SDZ	NMQW

15MG CAPSULE

02317699	REVLIMID (SA)	CEL	NMQW
02483033	REDDY-LENALIDOMIDE (SA)	RCH	NMQW
02493888	NAT-LENALIDOMIDE (SA)	NAT	NMQW
02506165	JAMP-LENALIDOMIDE (SA)	JPC	NMQW
02507897	TARO-LENALIDOMIDE (SA)	TAR	NMQW
02507951	APO-LENALIDOMIDE (SA)	APX	NMQW
02518597	SANDOZ-LENALIDOMIDE (SA)	SDZ	NMQW

20MG CAPSULE

02483041	REDDY-LENALIDOMIDE (SA)	RCH	NMQW
02493896	NAT-LENALIDOMIDE (SA)	NAT	NMQW
02506173	JAMP LENALIDOMIDE (SA)	JPC	NMQW
02507900	TARO-LENALIDOMIDE (SA)	TAR	NMQW
02507978	APO-LENALIDOMIDE (SA)	APX	NMQW
02518600	SANDOZ-LENALIDOMIDE (SA)	SDZ	NMQW

25MG CAPSULE

02317710	REVLIMID (SA)	CEL	NMQW
02483068	REDDY-LENALIDOMIDE (SA)	RCH	NMQW
02493918	NAT-LENALIDOMIDE (SA)	NAT	NMQW
02506181	JAMP-LENALIDOMIDE (SA)	JPC	NMQW
02507919	TARO-LENALIDOMIDE (SA)	TAR	NMQW
02507986	APO-LENALIDOMIDE (SA)	APX	NMQW
02518619	SANDOZ-LENALIDOMIDE (SA)	SDZ	NMQW

LENVATINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

4MG CAPSULE

02484056	LENVIMA (SA)	EIS	NMQW

8MG (2X4MG) CAPSULE

02468220	LENVIMA (SA)	EIS	NMQW

10MG CAPSULE

02450321	LENVIMA (SA)	EIS	NMQW

12MG (3X4MG) CAPSULE

02484129	LENVIMA (SA)	EIS	NMQW

14MG (1X10MG AND 1X4MG) CAPSULE

02450313	LENVIMA (SA)	EIS	NMQW

20MG (2X10MG) CAPSULE

02450305	LENVIMA (SA)	EIS	NMQW

24MG (2X10MG AND 1X4MG) CAPSULE

02450291	LENVIMA (SA)	EIS	NMQW

LETROZOLE

2.5MG TABLET

02231384	FEMARA	NVR	FNQSW
02309114	PMS-LETROZOLE	PMS	FGNQSW
02322315	MED-LETROZOLE	GMP	FGNQSW
02338459	ACH-LETROZOLE USP	ACH	FGNQSW
02343657	TEVA-LETROZOLE	TEV	FGNQSW

02344815	SANDOZ-LETROZOLE	SDZ	FGNQSW
02358514	APO-LETROZOLE	APX	FGNQSW
02372282	RAN-LETROZOLE	RAN	FGNQSW
02373009	JAMP-LETROZOLE	JPC	FGNQSW
02373424	MAR-LETROZOLE	MAR	FGNQSW
02398656	RIVA-LETROZOLE	RIV	FGNQSW
02421585	NAT-LETROZOLE	NAT	FGNQSW
02504472	LETROZOLE	SNS	FGNQSW
02508109	MINT-LETROZOLE	MNT	FGNQSW
02524244	LETROZOLE	SIV	FGNQSW
02541912	JAMP-LETROZOLE	JPC	FGNQSW

LEUPROLIDE ACETATE

3.75MG DEPOT SYRINGE

00884502	LUPRON DEPOT	ABV	FQWY

3.75 MG DEPOT VIAL

02429977	ZEULIDE DEPOT	VER	FNQSW

7.5MG/ML DEPOT SYRINGE

00836273	LUPRON DEPOT	ABV	FNQSWY

02248239 ELIGARD

TOL	FNQSWY

11.25MG DEPOT SYRINGE

02239834	LUPRON DEPOT	ABV	FNQSW

22.5MG DEPOT SYRINGE

02230248	LUPRON DEPOT	ABV	FNQSW

02248240 ELIGARD

TOL	FNQSW

22.5MG DEPOT VIAL

02462699	ZEULIDE DEPOT	VER	FNQSW

30MG DEPOT SYRINGE

02239833	LUPRON DEPOT	ABV	FNQSW

45MG DEPOT VIAL

02268892	ELIGARD	TOL	FNQSW

LORLATINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG TABLET

02485966	LORBRENA (SA)	PFI	NMQW

100MG TABLET
 02485974 LORBRENA (SA)
 00900025 LORBRENA (SA)*
 *use when drug cost in excess of CPHA maximum

PFI **NMQW**
NMQW

MEDROXYPROGESTERONE ACETATE

100MG TABLET
 02267640 APO-MEDROXY

APX **FGNQSW**

MEGESTROL ACETATE

40MG TABLET
 02195917 MEGESTROL

AAA **AFGNQSW**

160MG TABLET
 02195925 MEGESTROL

AAA **AFGNQSW**

MELPHALAN

2MG TABLET
 00004715 ALKERAN

ASN **FNQSW**

MERCAPTOPURINE

50MG TABLET
 00004723 PURINETHOL
 02415275 MERCAPTOPURINE

TEV **FGNQSW**
 STE **FGNQSW**

METHOTREXATE

2.5MG TABLET
 02170698 PMS-METHOTREXATE
 02182963 APO-METHOTREXATE
 02509067 ACH-METHOTREXATE
 02524023 AURO-METHOTREXATE
 02534916 M-METHOTREXATE

PMS **FGNQSW**
 APX **FGNQSW**
 ACH **FGNQSW**
 ARO **FGNQSW**
 MRA **FGNQSW**

10MG TABLET
 02182750 METHOTREXATE

PFI **FGNQSW**

7.5MG & 0.3ML PREFILLED SYRINGE
 02422166 METHOTREXATE

PMS **FGNQSW**

10MG & 0.2ML PREFILLED SYRINGE
 02454831 METOJECT
 02539608 PMS-METHOTREXATE

MED **FNQSW**
 PMS **FGNQSW**

10MG & 0.4ML PREFILLED SYRINGE
 02422174 METHOTREXATE

PMS **FGNQSW**

12.5MG & 0.25ML PREFILLED SYRINGE			
02454750	METOJECT	MED	FNQSW
02539616	PMS-METHOTREXATE	PMS	FGNQSW
15MG & 0.3ML PREFILLED SYRINGE			
02454858	METOJECT	MED	FNQSW
02491311	METHOTREXATE	ACH	FGNQSW
02539624	PMS-METHOTREXATE	PMS	FGNQSW
15MG & 0.6ML PREFILLED SYRINGE			
02422182	METHOTREXATE	PMS	FGNQSW
17.5MG & 0.35ML PREFILLED SYRINGE			
02454769	METOJECT	MED	FNQSW
02491338	METHOTREXATE	ACH	FGNQSW
02539632	PMS-METHOTREXATE	PMS	FGNQSW
20MG & 0.4ML PREFILLED SYRINGE			
02454866	METOJECT	MED	FNQSW
02491346	METHOTREXATE	ACH	FGNQSW
02539640	PMS-METHOTREXATE	PMS	FGNQSW
20MG & 0.7ML PREFILLED SYRINGE			
02422190	METHOTREXATE	PMS	FGNQSW
22.5MG & 0.45ML PREFILLED SYRINGE			
02454777	METOJECT	MED	FNQSW
02491354	METHOTREXATE	ACH	FGNQSW
02539659	PMS-METHOTREXATE	PMS	FGNQSW
25MG & 0.5ML PREFILLED SYRINGE			
02454874	METOJECT	MED	FNQSW
02491362	METHOTREXATE	ACH	FGNQSW
02539667	PMS-METHOTREXATE	PMS	FGNQSW
25MG/ML PREFILLED SYRINGE			
02422204	METHOTREXATE	PMS	FGNQSW
25MG/ML INJECTION SOLUTION (WITH PRESERVATIVE)			
02182777	METHOTREXATE	PFI	FNQSW
02464365	METHOTREXATE	ACH	FGNQSW
25MG/ML INJECTION SOLUTION			
02099705	METHOTREXATE SODIUM	TEV	FGNQSW
02182955	METHOTREXATE/PF	PFI	FNQSW

MIDOSTAURIN[SEE APPENDIX A](#) FOR SA CRITERIA**25MG CAPSULE**

02466236 RYDAPT (SA)

00904390 RYDAPT (SA)

NVR **NMQW****NMQW**

*use when drug cost in excess of CPHA maximum

NILOTINIB[SEE APPENDIX A](#) FOR SA CRITERIA**150MG CAPSULE**

02368250 TASIGNA (SA)

02550881 APO-NILOTINIB (SA)

02556634 REDDY-NILOTINIB (SA)

NVR **NMQW**APX **NMQW**RCH **NMQW****200MG CAPSULE**

02315874 TASIGNA (SA)

02550903 APO-NILOTINIB (SA)

02556642 REDDY-NILOTINIB (SA)

NVR **NMQW**APX **NMQW**RCH **NMQW****NIRAPARIB**[SEE APPENDIX A](#) FOR SA CRITERIA**100MG CAPSULE**

02489783 ZEJULA (SA)

00904719 ZEJULA (SA)*

GSK **NMQW****NMQW****100MG TABLET**

02530031 ZEJULA (SA)

00904985 ZEJULA (SA)*

GSK **NMQW****NMQW**

*use when drug cost in excess of CPHA maximum

OLAPARIB[SEE APPENDIX A](#) FOR SA CRITERIA**100MG TABLET**

02475200 LYNPARZA (SA)

AZE **NMQW****150MG TABLET**

02475219 LYNPARZA (SA)

AZE **NMQW****OSIMERTINIB**[SEE APPENDIX A](#) FOR SA CRITERIA**40MG TABLET**

02456214 TAGRISSO (SA)

AZE **NMQW****80MG TABLET**

02456222 TAGRISSO (SA)

AZE **NMQW**

PALBOCICLIB[SEE APPENDIX A](#) FOR SA CRITERIA**75MG TABLET**

02493535	IBRANCE (SA)	PFI	NMQW
02547635	TARO-PALBOCICLIB (SA)	TAR	NMQW
02552124	PMS-PALBOCICLIB (SA)	PMS	NMQW

100MG TABLET

02493543	IBRANCE (SA)	PFI	NMQW
02547643	TARO-PALBOCICLIB (SA)	TAR	NMQW
02552132	PMS-PALBOCICLIB (SA)	PMS	NMQW

125MG TABLET

02493551	IBRANCE (SA)	PFI	NMQW
02547651	TARO-PALBOCICLIB (SA)	TAR	NMQW
02552140	PMS-PALBOCICLIB (SA)	PMS	NMQW

PAZOPANIB[SEE APPENDIX A](#) FOR SA CRITERIA**200MG TABLET**

02352303	VOTRIENT (SA)	NVR	NMQW
02525666	PMS-PAZOPANIB (SA)	PMS	NMQW

POMALIDOMIDE[SEE APPENDIX A](#) FOR SA CRITERIA**1MG CAPSULE**

02419580	POMALYST (SA)	CEL	NMQW
02504073	REDDY-POMALIDOMIDE (SA)	RCH	NMQW
02506394	NAT-POMALIDOMIDE (SA)	NAT	NMQW
02520427	APO-POMALIDOMIDE (SA)	APX	NMQW
02523973	SANDOZ-POMALIDOMIDE (SA)	SDZ	NMQW
02538059	JAMP-POMALIDOMIDE (SA)	JPC	NMQW

2MG CAPSULE

02419599	POMALYST (SA)	CEL	NMQW
02504081	REDDY-POMALIDOMIDE (SA)	RCH	NMQW
02506408	NAT-POMALIDOMIDE (SA)	NAT	NMQW
02520435	APO-POMALIDOMIDE (SA)	APX	NMQW
02523981	SANDOZ-POMALIDOMIDE (SA)	SDZ	NMQW
02538075	JAMP-POMALIDOMIDE (SA)	JPC	NMQW

3MG CAPSULE

02419602	POMALYST (SA)	CEL	NMQW
02504103	REDDY-POMALIDOMIDE (SA)	RCH	NMQW
02506416	NAT-POMALIDOMIDE (SA)	NAT	NMQW
02520443	APO-POMALIDOMIDE (SA)	APX	NMQW

02524007	SANDOZ-POMALIDOMIDE (SA)	SDZ	NMQW
02538083	JAMP-POMALIDOMIDE (SA)	JPC	NMQW

4MG CAPSULE

02419610	POMALYST (SA)	CEL	NMQW
02504111	REDDY-POMALIDOMIDE (SA)	RCH	NMQW
02506424	NAT-POMALIDOMIDE (SA)	NAT	NMQW
02520451	APO-POMALIDOMIDE (SA)	APX	NMQW
02524015	SANDOZ-POMALIDOMIDE (SA)	SDZ	NMQW
02538091	JAMP-POMALIDOMIDE (SA)	JPC	NMQW

PONATINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

15MG TABLET

02437333	ICLUSIG (SA)	ARI	NMQW

REGORAFENIB

[SEE APPENDIX A](#) FOR SA CRITERIA

40MG TABLET

02403390	STIVARGA (SA)	BAY	NMQW

RIBOCICLIB

[SEE APPENDIX A](#) FOR SA CRITERIA

200MG TABLET

02473569	KISQALI (SA)	NVR	NMQW

RIPRETINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG TABLET

02500833	QINLOCK (SA)	MDP	NMQW
00900026	QINLOCK (SA)*		NMQW
00900027	QINLOCK (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

RITUXIMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG/ML VIAL

02478382	TRUXIMA (SA)	TEV	NMQW
00904561	TRUXIMA (SA)*	TEV	NMQW
02478390	TRUXIMA (SA)	TEV	NMQW
00904560	TRUXIMA (SA)*	TEV	NMQW
02495724	RUXIENCE (SA)	PFI	NMQW
00904559	RUXIENCE (SA)*	PFI	NMQW
02498316	RIXIMYO (SA)	SDZ	NMQW
00904590	RIXIMYO (SA)*	SDZ	NMQW

*use when drug cost in excess of CPHA maximum

RUXOLITINIB[SEE APPENDIX A](#) FOR SA CRITERIA

5MG TABLET

02388006 JAKAVI (SA) NVR **NMQW**

10MG TABLET

02434814 JAKAVI (SA) NVR **NMQW**

15MG TABLET

02388014 JAKAVI (SA) NVR **NMQW**

20MG TABLET

02388022 JAKAVI (SA) NVR **NMQW****SELINEXOR**[SEE APPENDIX A](#) FOR SA CRITERIA

20MG TABLET

02527677 XPOVIO (SA) FTI **NMQW**00900031 XPOVIO (SA)* **NMQW**

*use when drug cost in excess of CPHA maximum

SELPERCATINIB[SEE APPENDIX A](#) FOR SA CRITERIA

40MG CAPSULE

02516918 RETEVMO (SA) LIL **NMQW**

80MG CAPSULE

02516926 RETEVMO (SA) LIL **NMQW**00904987 RETEVMO (SA)* **NMQW**

*use when drug cost in excess of CPHA maximum

SELUMETINIB[SEE APPENDIX A](#) FOR SA CRITERIA

10MG CAPSULE

02530139 KOSELUGO (SA) ALX **NMQW**

25MG CAPSULE

02530147 KOSELUGO (SA) ALX **NMQW****SUNITINIB MALATE**[SEE APPENDIX A](#) FOR SA CRITERIA

12.5MG CAPSULE

02280795 SUTENT (SA) PFI **NMQW**02524058 TARO-SUNITINIB (SA) TAR **NMQW**02526204 TEVA-SUNITINIB (SA) TEV **NMQW**02532840 SANDOZ-SUNITINIB (SA) SDZ **NMQW**

25MG CAPSULE

02280809	SUTENT (SA)	PFI	NMQW
02524066	TARO-SUNITINIB (SA)	TAR	NMQW
02526212	TEVA-SUNITINIB (SA)	TEV	NMQW
02532867	SANDOZ-SUNITINIB (SA)	SDZ	NMQW

50MG CAPSULE

02280817	SUTENT (SA)	PFI	NMQW
02524082	TARO-SUNITINIB (SA)	TAR	NMQW
02526220	TEVA-SUNITINIB (SA)	TEV	NMQW
02532883	SANDOZ-SUNITINIB (SA)	SDZ	NMQW

TAMOXIFEN CITRATE**10MG TABLET**

00812404	APO-TAMOX	APX	FGNQSW
00851965	TEVA-TAMOXIFEN	TEV	FGNQSW

20MG TABLET

00812390	APO-TAMOX	APX	FGNQSW
00851973	TEVA-TAMOXIFEN	TEV	FGNQSW
02048485	NOLVADEX D	AZE	FNQSW

TEMOZOLOMIDE

[SEE APPENDIX A](#) FOR HIGH COST DRUG PROGRAM CRITERIA

5MG CAPSULE

02241093	TEMODAL	MSD	FMNQSW
02441160	TEVA-TEMOZOLOMIDE	TEV	FGMNQSW
02443473	TARO-TEMOZOLOMIDE	TAR	FGMNQSW
02516799	JAMP-TEMOZOLOMIDE	JPC	FGMNQSW

20MG CAPSULE

02241094	TEMODAL	MSD	FMNQSW
02395274	TEVA-TEMOZOLOMIDE	TEV	FGMNQSW
02443481	TARO-TEMOZOLOMIDE	TAR	FGMNQSW
02516802	JAMP-TEMOZOLOMIDE	JPC	FGMNQSW

100MG CAPSULE

02241095	TEMODAL	MSD	FMNQSW
02395282	TEVA-TEMOZOLOMIDE	TEV	FGMNQSW
02443511	TARO-TEMOZOLOMIDE	TAR	FGMNQSW
02516810	JAMP-TEMOZOLOMIDE	JPC	FGMNQSW

140MG CAPSULE

02312794	TEMODAL	MSD	FMNQSW
02395290	TEVA-TEMOZOLOMIDE	TEV	FGMNQSW

02443538	TARO-TEMOZOLOMIDE	TAR	FGMNQSW
02516829	JAMP-TEMOZOLOMIDE	JPC	FGMNQSW

250MG CAPSULE

02241096	TEMODAL	MSD	FMNQSW
02395312	TEVA-TEMOZOLOMIDE	TEV	FGMNQSW
02443554	TARO-TEMOZOLOMIDE	TAR	FGMNQSW
02516845	JAMP-TEMOZOLOMIDE	JPC	FGMNQSW

THIOGUANINE

40MG TABLET

00282081	LANVIS	ASN	FNQSW

TRAMETINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

0.5MG TABLET

02409623	MEKINIST (SA)	NVR	NMQW
00904170	MEKINIST (SA)*		NMQW

2MG TABLET

02409658	MEKINIST (SA)	NVR	NMQW
00904171	MEKINIST (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

TRETINOIN

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG CAPSULE

02145839	VESANOID (SA)	XPI	NMQW
02520036	JAMP-TRETINOIN (SA)	JPC	NMQW

TRIFLURIDINE & TIPIRACIL HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

15MG & 6.14MG TABLET

02472104	LONSURF (SA)	TAI	NMQW

20MG & 8.19MG TABLET

02472112	LONSURF (SA)	TAI	NMQW

TRIPTORELIN

3.75MG INTRAMUSCULAR INJECTION

02240000	TRELSTAR	KNI	FNQSW

11.25MG INTRAMUSCULAR INJECTION

02243856	TRELSTAR LA	KNI	FNQSW

TUCATINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG TABLET

02499827 TUKYSA (SA)

PFI **NMQW**

150MG TABLET

02499835 TUKYSA (SA)

PFI **NMQW**

00904820 TUKYSA (SA)*

PFI **NMQW**

*use when drug cost in excess of CPHA maximum

VANDETANIB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG TABLET

02378582 CAPRELSA (SA)

GZY **NMQW**

300MG TABLET

02378590 CAPRELSA (SA)

GZY **NMQW**

VEMURAFENIB

[SEE APPENDIX A](#) FOR SA CRITERIA

240MG TABLET

02380242 ZELBORAF (SA)

HLR **NMQW**

VENETOCLAX

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG (14), 50MG (7), 100MG (7), 100MG (14) STARTER PACK

02458063 VENCLEXTA (SA)

ABV **NMQW**

10MG TABLET

02458039 VENCLEXTA (SA)

ABV **NMQW**

50MG TABLET

02458047 VENCLEXTA (SA)

ABV **NMQW**

100MG TABLET

02458055 VENCLEXTA (SA)

ABV **NMQW**

VISMODEGIB

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG CAPSULE

02409267 ERIVEDGE (SA)

HLR **NMQW**

ZANUBRUTINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

80MG CAPSULE

02512963 BRUKINSA (SA)

BGN **NMQW**

12:04.00 PARASYMPATHOMIMETIC (CHOLINERGIC) AGENTS

BETHANECHOL CHLORIDE

10MG TABLET

01947958	DUVOID	PAL	FNQSW

25MG TABLET

01947931	DUVOID	PAL	FNQSW

50MG TABLET

01947923	DUVOID	PAL	FNQSW

DONEPEZIL

5MG TABLET

02232043	ARICEPT	PFI	FNQSW
02322331	PMS-DONEPEZIL	PMS	FGNQSW
02328666	SANDOZ-DONEPEZIL	SDZ	FGNQSW
02340607	TEVA-DONEPEZIL	TEV	FGNQSW
02362260	APO-DONEPEZIL	APX	FGNQSW
02381508	RAN-DONEPEZIL	RAN	FGNQSW
02400561	AURO-DONEPEZIL	ARO	FGNQSW
02402092	MAR-DONEPEZIL	MAR	FGNQSW
02402645	DONEPEZIL	SIV	FGNQSW
02408600	MINT-DONEPEZIL	MNT	FGNQSW
02416948	JAMP-DONEPEZIL	JPC	FGNQSW
02420597	DONEPEZIL	SIV	FGNQSW
02426846	DONEPEZIL	SNS	FGNQSW
02432684	AG-DONEPEZIL	ANG	FGNQSW
02439557	NAT-DONEPEZIL	NAT	FGNQSW
02467453	M-DONEPEZIL	MRA	FGNQSW
02475278	DONEPEZIL	RIV	FGNQSW

10MG TABLET

02232044	ARICEPT	PFI	FNQSW
02322358	PMS-DONEPEZIL	PMS	FGNQSW
02328682	SANDOZ-DONEPEZIL	SDZ	FGNQSW
02340615	TEVA-DONEPEZIL	TEV	FGNQSW
02362279	APO-DONEPEZIL	APX	FGNQSW
02381516	RAN-DONEPEZIL	RAN	FGNQSW
02400588	AURO-DONEPEZIL	ARO	FGNQSW
02402106	MAR-DONEPEZIL	MAR	FGNQSW
02402653	DONEPEZIL	SIV	FGNQSW
02408619	MINT-DONEPEZIL	MNT	FGNQSW
02416956	JAMP-DONEPEZIL	JPC	FGNQSW

02420600	DONEPEZIL	SIV	FGNQSW
02426854	DONEPEZIL	SNS	FGNQSW
02432692	AG-DONEPEZIL	ANG	FGNQSW
02439565	NAT-DONEPEZIL	NAT	FGNQSW
02467461	M-DONEPEZIL	MRA	FGNQSW
02475286	DONEPEZIL	RIV	FGNQSW

GALANTAMINE

SEE CHOLINESTERASE INHIBITORS IN APPENDIX A FOR SA CRITERIA

[SEE APPENDIX A](#) FOR SA CRITERIA

8MG EXTENDED RELEASE CAPSULE

02316943	PAT-GALANTAMINE ER (SA)	PAT	FGNQSW
02339439	MYLAN-GALANTAMINE (SA)	MYL	FGNQSW
02425157	AURO-GALANTAMINE ER (SA)	ARO	FGNQSW
02443015	GALANTAMINE ER (SA)	SNS	FGNQSW

16MG EXTENDED RELEASE CAPSULE

02316951	PAT-GALANTAMINE ER (SA)	PAT	FGNQSW
02339447	MYLAN-GALANTAMINE (SA)	MYL	FGNQSW
02425165	AURO-GALANTAMINE ER (SA)	ARO	FGNQSW
02443023	GALANTAMINE ER (SA)	SNS	FGNQSW

24MG EXTENDED RELEASE CAPSULE

02316978	PAT-GALANTAMINE ER (SA)	PAT	FGNQSW
02339455	MYLAN-GALANTAMINE (SA)	MYL	FGNQSW
02425173	AURO-GALANTAMINE ER (SA)	ARO	FGNQSW
02443031	GALANTAMINE ER (SA)	SNS	FGNQSW

PILOCARPINE

[SEE APPENDIX A](#) FOR SA CRITERIA

5MG TABLET

02216345	SALAGEN (SA)	AMD	FNQSW
02496119	M-PILOCARPINE (SA)	MRA	FGNQSW
02509571	JAMP-PILOCARPINE (SA)	JPC	FGNQSW

PYRIDOSTIGMINE BROMIDE

60MG TABLET

00869961	MESTINON	BSL	FNQSW
02495643	RIVA-PYRIDOSTIGMINE	RIV	FGNQSW
02508362	JAMP PYRIDOSTIGMINE BROMIDE	JPC	FGNQSW

180MG LONG ACTING TABLET

00869953	MESTINON	BSL	FNQSW

RIVASTIGMINE

SEE CHOLINESTERASE INHIBITORS FOR SA CRITERIA

[SEE APPENDIX A](#) FOR SA CRITERIA

1.5MG CAPSULE

02242115	EXELON (SA)	KNI	FNQSW
02336715	APO-RIVASTIGMINE (SA)	APX	FGNQSW
02401614	MED-RIVASTIGMINE (SA)	GMP	FGNQSW
02485362	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW
02552256	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW

3MG CAPSULE

02242116	EXELON (SA)	KNI	FNQSW
02336723	APO-RIVASTIGMINE (SA)	APX	FGNQSW
02401622	MED-RIVASTIGMINE (SA)	GMP	FGNQSW
02485370	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW
02552264	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW

4.5MG CAPSULE

02242117	EXELON (SA)	KNI	FNQSW
02336731	APO-RIVASTIGMINE (SA)	APX	FGNQSW
02401630	MED-RIVASTIGMINE (SA)	GMP	FGNQSW
02485389	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW
02552272	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW

6MG CAPSULE

02242118	EXELON (SA)	KNI	FNQSW
02336758	APO-RIVASTIGMINE (SA)	APX	FGNQSW
02401649	MED-RIVASTIGMINE (SA)	GMP	FGNQSW
02485397	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW
02552280	JAMP-RIVASTIGMINE (SA)	JPC	FGNQSW

12:08.08 ANTIMUSCARINICS/ANTISPASMODICS

ACLIDINIUM BROMIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

400MCG/ACTUATION AEROSOL POWDER

02409720	TUDORZA GENUAIR (SA)	AZE	FNQSW

ACLIDINIUM BROMIDE & FORMOTEROL FUMARATE DIHYDRATE

[SEE APPENDIX A](#) FOR SA CRITERIA

400MCG & 12MCG/ACTUATION AEROSOL POWDER

02439530	DUAKLIR GENUAIR (SA)	AZE	FNQSW

ATROPINE SULFATE

0.6MG/ML INJECTION SOLUTION (1ML)

00392693	ATROPINE SULFATE	SDZ	N
BUDESONIDE & GLYCOPYRRONIUM & FORMOTEROL			
SEE APPENDIX A FOR SA CRITERIA			
160MCG & 7.2MCG & 5MCG METERED DOSE INHALER			
02518058	BREZTRI AEROSPHERE (SA)	AZE	FNQSW
FLUTICASONE & UMECLIDINIUM & VILANTEROL			
SEE APPENDIX A FOR SA CRITERIA			
100MCG & 62.5MCG & 25MCG DRY POWDER FOR INHALATION			
02474522	TRELEGY ELLIPTA (SA)	GSK	FNQSW
GLYCOPYRRONIUM BROMIDE			
SEE APPENDIX A FOR SA CRITERIA			
50MCG INHALATION CAPSULE			
02394936	SEEBRI BREEZHALER (SA)	NVR	FNQSW
HYOSCINE BUTYLBROMIDE			
10MG TABLET			
00363812	BUSCOPAN	SNC	FNQSW
02512335	ACCEL-HYOSCINE	ACC	FGNQSW
20MG/ML VIAL			
02229868	HYOSCINE BUTYLBROMIDE	SDZ	N
INDACATEROL & GLYCOPYRRONIUM			
SEE APPENDIX A FOR SA CRITERIA			
110MCG & 50MCG INHALATION CAPSULE			
02418282	ULTIBRO BREEZHALER (SA)	NVR	FNQSW
INDACATEROL & GLYCOPYRRONIUM & MOMETASONE			
SEE APPENDIX A FOR SA CRITERIA			
150MCG & 50MCG & 160MCG INHALATION CAPSULE			
02501244	ENERZAIR BREEZHALER (SA)	NVR	FNQSW
INDACATEROL & MOMETASONE			
SEE APPENDIX A FOR SA CRITERIA			
150MCG & 80MCG INHALATION CAPSULE			
02498685	ATECTURA BREEZHALER (SA)	NVR	FNQSW
150MCG & 160MCG INHALATION CAPSULE			
02498707	ATECTURA BREEZHALER (SA)	NVR	FNQSW
150MCG & 320MCG INHALATION CAPSULE			
02498693	ATECTURA BREEZHALER (SA)	NVR	FNQSW

IPRATROPIUM BROMIDE

200UG/DOSE INHALER AEROSOL (200 DOSE)

02247686	ATROVENT HFA
02542587	JAMP-IPRATROPIUM HFA

BOE	CFNQSW
JPC	CFGNQSW

0.25MG/ML INHALATION SOLUTION (20ML)

02126222	AA-IPRAVENT
02231136	PMS-IPRATROPIUM

AAA	CFGNQSW
PMS	CFGNQSW

0.0125% INHALATION SOLUTION NEBULE (2ML)

02231135	PMS-IPRATROPIUM

PMS	FGNQSW

0.025% INHALATION SOLUTION NEBULE (2ML)

02216221	TEVA-IPRATROPIUM
02231245	PMS-IPRATROPIUM

TEV	FGNQSW
PMS	FGNQSW

0.03% NASAL SPRAY - 345 DOSES

02239627	PMS-IPRATROPIUM

PMS	CFGNQSW

IPRATROPIUM & SALBUTAMOL

1.0MG & 0.2MG PER ML INHALATION SOLUTION NEBULE (2.5ML)

02272695	TEVA-COMBO STERINEBS
02483394	IPRATROPIUM-SALBUTAMOL

TEV	FGNQSW
MDN	FGNQSW

IPRATROPIUM BROMIDE & SALBUTAMOL SULPHATE

20MCG-100MCG/ACTUATION MIST INHALER

02419106	COMBIVENT RESPIMAT

BOE	FNQSW

PINAVERIUM BROMIDE

50MG TABLET

01950592	DICETEL
02469677	PINAVERIUM

BGP	FNQSW
AAA	FGNQSW

100MG TABLET

02230684	DICETEL
02469685	PINAVERIUM

BGP	FNQSW
AAA	FGNQSW

SCOPOLAMINE HYDROBROMIDE

0.4MG/ML VIAL INJECTION

02242810	SCOPOLAMINE HYDROBROMIDE

OMG	NQ

TIOTROPIUM BROMIDE[SEE APPENDIX A](#) FOR SA CRITERIA

18UG CAPSULE WITH INHALATION DEVICE

02246793	SPIRIVA (SA)
02537850	LUPIN-TIOTROPIUM (SA)

BOE	FNQSW
LUP	FGNQSW

02550865 APO-TIOTROPIUM (SA) APX **FGNQSW**

2.5UG/ACTUATION MIST INHALER
02435381 SPIRIVA RESPIMAT (SA) BOE **FNQSW**

TIOTROPIUM & OLODATEROL

[SEE APPENDIX A](#) FOR SA CRITERIA

2.5MCG & 2.5MCG/ACTUATION MIST INHALER
02441888 INSPIOLTO RESPIMAT (SA) BOE **FNQSW**

UNMECLIDINIUM BROMIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

62.5MCG/ACTUATION BLISTER WITH INHALATION DEVICE
02423596 INCRUSE ELLIPTA (SA) GKS **FNQSW**

UMECLIDINIUM BROMIDE & VILANTEROL TRIFENATATE

[SEE APPENDIX A](#) FOR SA CRITERIA

62.5MCG & 25MCG/ACTUATION BLISTER WITH INHALATION DEVICE
02418401 ANORO ELLIPTA (SA) GSK **FNQSW**

12:12.00 SYMPATHOMIMETIC (ADRENERGIC) AGENTS

EPINEPHRINE HCL

1MG/ML INJECTION SOLUTION (1ML)
00721891 EPINEPHRINE INJECTION USP HOS **NQ**
00155357 ADRENALINE CHLORIDE ERF **NQ**
02435810 EPINEPHRINE TLG **NQ**

[SEE APPENDIX A](#) FOR SA CRITERIA

0.15MG PER DOSE AUTO-INJECTOR
00578657 EPIPEN JR. (*) MYL **FQW**

0.3MG PER DOSE AUTO-INJECTOR
00509558 EPIPEN (*) MYL **FQW**

*quantity limit of two (2) injections per 12 month period (one unit per dispense). The prescriber can submit a request for consideration should beneficiaries require more than two (2) injections per 12 month period.

EPINEPHRINE BITARTRATE

[SEE APPENDIX A](#) FOR SA CRITERIA

0.15MG PER DOSE PRE-FILLED PEN
02458438 EMERADE (*) BAU **FQW**

0.3MG PER DOSE PRE-FILLED PEN
02458446 EMERADE (*)

BAU FQW

0.5MG PER DOSE PRE-FILLED PEN
02458454 EMERADE (*)

BAU FQW

*quantity limit of two (2) injections per 12 month period (one unit per dispense). The prescriber can submit a request for consideration should beneficiaries require more than two (2) injections per 12 month period.

FLUTICASONE FUROATE/VILANTEROL

[SEE APPENDIX A](#) FOR SA CRITERIA

100MCG-25MCG/DOSE

02408872 BREO ELLIPTA (SA)

GSK FNQSW

200MCG-25MCG/DOSE

02444186 BREO ELLIPTA (SA)

GSK FNQSW

FORMOTEROL FUMARATE

[SEE APPENDIX A](#) FOR SA CRITERIA

6UG/DOSE INHALER POWDER

02237225 OXEZE TURBUHALER (SA)

AZE FNQSW

12UG/DOSE INHALER POWDER

02237224 OXEZE TURBUHALER (SA)

AZE FNQSW

FORMOTEROL & BUDESONIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

6UG & 100UG PER DOSE INHALER POWDER

02245385 SYMBICORT TURBUHALER (SA)

AZE FNQSW

6UG & 200UG PER DOSE INHALER POWDER

02245386 SYMBICORT TURBUHALER (SA)

AZE FNQSW

⑤MIDODRINE HCL

2.5MG TABLET

02278677 APO-MIDODRINE

APX FGNQSW

02473984 MAR-MIDODRINE

MAR FGNQSW

02517701 JAMP-MIDODRINE

JPC FGNQSW

02533200 MIDODRINE

SNS FGNQSW

5MG TABLET

02278685 APO-MIDODRINE

APX FGNQSW

02473992 MAR-MIDODRINE

MAR FGNQSW

02517728 JAMP-MIDODRINE

JPC FGNQSW

02533219	MIDODRINE	SNS	FGNQSW

MOMETASONE FUROATE/FORMOTEROL FUMARATE DIHYDRATE

[SEE APPENDIX A](#) FOR SA CRITERIA

100MCG/5MCG INHALER

02361752	ZENHALE (SA)	MSD	FNQSW

200MCG/5MCG INHALER

02361760	ZENHALE (SA)	MSD	FNQSW

SALBUTAMOL

100UG/DOSE INHALER AEROSOL HYDROFLUOROALKANE (HFA) (200 DOSE)

02232570	AIROMIR HFA	VAL	CFNQSW
02241497	VENTOLIN HFA	GSK	CFNQSW
02245669	APO-SALVENT CFC FREE	APX	CFGNQSW
02326450	NOVO-SALBUTAMOL HFA	TEV	CFGNQSW
02419858	SALBUTAMOL HFA	SNS	CFGNQSW

200UG/DOSE INHALER POWDER

02243115	VENTOLIN DISKUS	GSK	CFNQSW

5MG/ML INHALATION SOLUTION (10ML)

02213486	VENTOLIN	GSK	CFNQSW

0.5MG/ML INHALATION SOLUTION PRESERVATIVE FREE NEBULE (2.5ML)

02208245	PMS-SALBUTAMOL	PMS	CFGNQSW

1MG/ML INHALATION SOLUTION PRESERVATIVE FREE NEBULE (2.5ML)

01926934	TEVA-SALBUTAMOL STERINEB	TEV	CFGNQSW
02208229	PMS-SALBUTAMOL	PMS	CFGNQSW
02213419	VENTOLIN NEBULES P.F.	GSK	CFNQSW

2MG/ML INHALATION SOLUTION PRESERVATIVE FREE NEBULE (2.5ML)

02213427	VENTOLIN NEBULES P.F.	GSK	CFNQSW
02173360	TEVA-SALBUTAMOL STERINEB	TEV	CFGNQSW
02208237	PMS-SALBUTAMOL	PMS	CFGNQSW

SALMETEROL XINAFOATE

[SEE APPENDIX A](#) FOR SA CRITERIA

50MCG/DOSE INHALED POWDER DISK (60)

02231129	SEREVENT DISKUS (SA)	GSK	FNQSW

SALMETEROL & FLUTICASONE

[SEE APPENDIX A](#) FOR SA CRITERIA

25MCG & 125MCG/DOSE INHALER AEROSOL

02245126	ADVAIR (SA)	GSK	FNQSW

25MCG & 250MCG/DOSE INHALER AEROSOL
02245127 ADVAIR (SA)

GSK FNQSW

50MCG & 100MCG/DOSE INHALER POWDER DISK
02240835 ADVAIR DISKUS (SA)
02494507 PMS-FLUTICASONE/SALMETEROL (SA)
02495597 WIXELA INHUB (SA)

GSK FNQSW
PMS FGNQSW
MYL FGNQSW

50MCG & 250MCG/DOSE INHALER POWDER DISK
02240836 ADVAIR DISKUS (SA)
02494515 PMS-FLUTICASONE/SALMETEROL (SA)
02495600 WIXELA INHUB (SA)

GSK FNQSW
PMS FGNQSW
MYL FGNQSW

50MCG & 500MCG/DOSE INHALER POWDER DISK
02240837 ADVAIR DISKUS (SA)
02494523 PMS-FLUTICASONE/SALMETEROL (SA)
02495619 WIXELA INHUB (SA)

GSK FNQSW
PMS FGNQSW
MYL FGNQSW

TERBUTALINE SULFATE

0.5MG/DOSE INHALER POWDER
00786616 BRICANYL TURBUHALER

AZE CFNQSW

12:16.00 SYMPATHOLYTIC AGENTS (ANTIMIGRAINE DRUGS)

DIHYDROERGOTAMINE MESYLATE

4MG/ML NASAL SPRAY
02228947 MIGRANAL

STE FNQSW

Note: Coverage is limited to 6 bottles per 30 day period.

12:16.04 SELECTIVE ALPHA-1-ADRENERGIC BLOCKING AGENTS

ALFUZOSIN

10MG EXTENDED RELEASE TABLET
02304678 SANDOZ-ALFUZOSIN
02315866 APO-ALFUZOSIN
02443201 AURO-ALFUZOSIN
02447576 ALFUZOSIN
02519844 ALFUZOSIN

SDZ FGNQSW
APX FGNQSW
ARO FGNQSW
SIV FGNQSW
SNS FGNQSW

TAMSULOSIN

0.4MG CONTROL RELEASE TABLET

02270102	FLOMAX CR	BOE	FNQSW
02340208	SANDOZ-TAMSULOSIN	SDZ	FGNQSW
02362406	APO-TAMULOSIN	APX	FGNQSW
02368242	TEVA-TAMSULOSIN CR	TEV	FGNQSW
02427117	TAMSULOSIN CR	SNS	FGNQSW
02429667	TAMSULOSIN CR	SIV	FGNQSW
02545179	AURO-TAMSULOSIN CR	ARO	FGNQSW

12:20.00 SKELETAL MUSCLE RELAXANTS**BACLOFEN**

10MG TABLET

02063735	PMS-BACLOFEN	PMS	FGNQSW
02088398	MYLAN BACLOFEN	MYL	FGNQSW
02139332	APO-BACLOFEN	APX	FGNQSW
02287021	BACLOFEN	SNS	FGNQSW
02544660	BACLOFEN	SIV	FGNQSW

20MG TABLET

02063743	PMS-BACLOFEN	PMS	FGNQSW
02088401	MYLAN BACLOFEN	MYL	FGNQSW
02139391	APO-BACLOFEN	APX	FGNQSW
02287048	BACLOFEN	SNS	FGNQSW
02544679	BACLOFEN	SIV	FGNQSW

CYCLOBENZAPRINE HCL[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET

02080052	TEVA- CYCLOBENZAPRINE (SA)	TEV	FGNQSW
02177145	APO-CYCLOBENZAPRINE (SA)	APX	FGNQSW
02212048	PMS-CYCLOBENZAPRINE (SA)	PMS	FGNQSW
02287064	CYCLOBENZAPRINE (SA)	SNS	FGNQSW
02348853	AURO-CYCLOBENZAPRINE (SA)	ARO	FGNQSW
02357127	JAMP-CYCLOBENZAPRINE (SA)	JPC	FGNQSW
02424584	CYCLOBENZAPRINE (SA)	SIV	FGNQSW
02485419	AG-CYCLOBENZAPRINE (SA)	ANG	FGNQSW
02495422	FLEXERIL (SA)	ORI	FGNQSW

DANTROLENE SODIUM

25MG CAPSULE

01997602	DANTRIUM	PAL	FNQSW

METHOCARBAMOL & ACETAMINOPHEN

400MG & 325MG CAPLET

02026805 ROBAXACET

PFI W

METHOCARBAMOL & ACETYLSALICYLIC ACID

400MG & 325MG CAPLET

00868868 METHOXISAL

ROG W

METHOCARBAMOL & ACETYLSALICYLIC ACID & CODEINE

400MG & 325MG & 16.2MG CAPLET

01934783 ROBAXISAL C-1/4

PFI FQW

400MG & 325MG & 32.4MG CAPLET

01934791 ROBAXISAL C-1/2

PFI FQW

TIZANIDINE HCL[SEE APPENDIX A](#) FOR SA CRITERIA

4MG TABLET

02259893 APO-TIZANIDINE (SA)

APX FGNQSW

02536765 MINT-TIZANIDINE (SA)

MNT FGNQSW

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS**BUPROPION**

150 MG SUSTAINED RELEASE TABLET

02238441 ZYBAN

BSL Z

NICOTINE

7MG/24HOUR TRANSDERMAL PATCH

00999973 NICOTINE PATCH (DIN for billing purposes only)

Z

14MG/24HOUR TRANSDERMAL PATCH

00999974 NICOTINE PATCH (DIN for billing purposes only)

Z

21MG/24HOUR TRANSDERMAL PATCH

00999975 NICOTINE PATCH (DIN for billing purposes only)

Z

10MG INHALATION CARTRIDGE

02241742 NICORETTE INHALER

Z

NICOTINE BITARTRATE

1MG LOZENGE

80007461 THRIVE LOZENGE

Z

2MG LOZENGE		
80007464	THRIVE LOZENGE	Z

NICOTINE POLACRILEX

2MG GUM		
00999976	NICOTINE GUM (DIN for billing purposes only)	Z

4MG GUM		
00999980	NICOTINE GUM (DIN for billing purposes only)	Z

2MG LOZENGE		
02247347	NICORETTE LOZENGE	Z

4MG LOZENGE		
02247348	NICORETTE LOZENGE	Z

VARENICLINE TARTRATE

0.5MG TABLET		
02419882	APO-VARENICLINE	APX Z
02426226	TEVA-VARENICLINE	TEV Z
02542951	NRA-VARENICLINE	NRA Z
02546949	MINT-VARENICLINE	MNT Z

1MG TABLET		
02419890	APO-VARENICLINE	APX Z
02426234	TEVA-VARENICLINE	TEV Z
02542978	NRA-VARENICLINE	NRA Z
02546957	MINT-VARENICLINE	MNT Z

0.5MG-1MG TABLET DOSE PACK		
02426781	TEVA-VARENICLINE	TEV Z
02435675	APO-VARENICLINE	APX Z
02542986	NRA-VARENICLINE STARTER PACK	NRA Z
02546965	MINT-VARENICLINE STARTER PACK	MNT Z

20:04.04 IRON PREPARATIONS

FERROUS GLUCONATE

300MG (35MG IRON) TABLET		
80000435	NOVO-FERROGLUC	TEV CNW
00031097	JAMP-FERROUS GLUCONATE	JPC CNW

FERROUS SULFATE

30MG (6MG IRON)/ML ORAL LIQUID

80008295 JAMP-FERROUS SULFATE

JPC CNW

75MG (15MG IRON)/ML ORAL DROPS

02237385 FERODAN INFANT

ODN W

80008309 JAMP-FERROUS SULFATE

JPC W

300MG (60MG IRON) TABLET

00031100 JAMP-FERROUS SULFATE

JPC CNW

20:12.04 ANTI COAGULANTS

⑤APIXABAN

2.5MG TABLET

02377233 ELIQUIS
02484994 TEVA-APIXABAN
02486806 AURO-APIXABAN
02487381 APO-APIXABAN
02487713 ACH-APIXABAN
02489228 SANDOZ-APIXABAN
02492369 MAR-APIXABAN
02492814 NAT-APIXABAN
02495430 MINT-APIXABAN
02510464 TARO-APIXABAN
02528924 JAMP-APIXABAN
02529009 M-APIXABAN
02530708 APIXABAN
02548879 APIXABAN

BMS FNQSW
TEV FGNQSW
ARO FGNQSW
APX FGNQSW
ACH FGNQSW
SDZ FGNQSW
MAR FGNQSW
NAT FGNQSW
MNT FGNQSW
TAR FGNQSW
JPC FGNQSW
MRA FGNQSW
SIV FGNQSW
SNS FGNQSW

5MG TABLET

02397714 ELIQUIS
02485001 TEVA-APIXABAN
02486814 AURO-APIXABAN
02487403 APO-APIXABAN
02487721 ACH-APIXABAN
02489236 SANDOZ-APIXABAN
02492377 MAR-APIXABAN
02492822 NAT-APIXABAN
02495449 MINT-APIXABAN
02510472 TARO-APIXABAN
02528932 JAMP-APIXABAN
02529017 M-APIXABAN
02530716 APIXABAN

BMS FNQSW
TEV FGNQSW
ARO FGNQSW
APX FGNQSW
ACH FGNQSW
SDZ FGNQSW
MAR FGNQSW
NAT FGNQSW
MNT FGNQSW
TAR FGNQSW
JPC FGNQSW
MRA FGNQSW
SIV FGNQSW

02548887	APIXABAN	SNS	FGNQSW

⑤DABIGATRAN

[SEE APPENDIX A](#) FOR SA CRITERIA

110MG CAPSULE

02312441	PRADAXA (SA)	BOE	FNQSW
02468905	APO-DABIGATRAN (SA)	APX	FGNQSW

150MG CAPSULE

02358808	PRADAXA (SA)	BOE	FNQSW
02468913	APO-DABIGATRAN (SA)	APX	FGNQSW

⑤DALTEPARIN

[SEE APPENDIX A](#) FOR SA CRITERIA (NURSING HOME PROGRAM DOES NOT REQUIRE AN SA REQUEST)

PRE-FILLED SYRINGE 2,500 IU/0.2ML

02132621	FRAGMIN (SA)	PFI	FNQSW

PRE-FILLED SYRINGE 5,000 IU/0.2ML

02132648	FRAGMIN (SA)	PFI	FNQSW

PRE-FILLED SYRINGE 7500 IU/0.3ML

02352648	FRAGMIN (SA)	PFI	FNQSW

PRE-FILLED SYRINGE 10,000 IU/0.4ML

02352656	FRAGMIN (SA)	PFI	FNQSW

PRE-FILLED SYRINGE 12,500 IU/0.5ML

02352664	FRAGMIN (SA)	PFI	FNQSW

PRE-FILLED SYRINGE 15,000 IU/0.6ML

02352672	FRAGMIN (SA)	PFI	FNQSW

PRE-FILLED SYRINGE 18,000 UNITS/0.72ML

02352680	FRAGMIN (SA)	PFI	FNQSW

MULTIDOSE VIAL 25,000 IU/ML (3.8ML)

02231171	FRAGMIN (SA)	PFI	FNQSW

⑤EDOXABAN

15MG TABLET

02458640	LIXIANA	SER	FNQSW
02553414	SANDOZ-EDOXABAN	SDZ	FGNQSW
02554208	TEVA-EDOXABAN	TEV	FGNQSW

30MG TABLET

02458659	LIXIANA	SER	FNQSW
02553422	SANDOZ-EDOXABAN	SDZ	FGNQSW
02554216	TEVA-EDOXABAN	TEV	FGNQSW
02557282	JAMP-EDOXABAN	JPC	FGNQSW

60MG TABLET

02458667	LIXIANA	SER	FNQSW
02553430	SANDOZ-EDOXABAN	SDZ	FGNQSW
02554224	TEVA-EDOXABAN	TEV	FGNQSW
02557290	JAMP-EDOXABAN	JPC	FGNQSW

⑤ ENOXAPARIN

PRE-FILLED SYRINGE 20MG/.02ML

02506440	NOROMBY	JUN	FNQSW

PRE-FILLED SYRINGE 30MG/0.3ML

02506459	NOROMBY	JUN	FNQSW
02507501	INCLUNOX	SDZ	FNQSW
02509075	REDESCA	VAL	FNQSW
02532247	ELONOX	FKB	FNQSW

PRE-FILLED SYRINGE 40MG/0.4ML

02506467	NOROMBY	JUN	FNQSW
02507528	INCLUNOX	SDZ	FNQSW
02509083	REDESCA	VAL	FNQSW
02532255	ELONOX	FKB	FNQSW

PRE-FILLED SYRINGE 60MG/0.6ML

02506475	NOROMBY	JUN	FNQSW
02507536	INCLUNOX	SDZ	FNQSW
02509091	REDESCA	VAL	FNQSW
02532263	ELONOX	FKB	FNQSW

PRE-FILLED SYRINGE 80MG/0.8ML

02506483	NOROMBY	JUN	FNQSW
02507544	INCLUNOX	SDZ	FNQSW
02509105	REDESCA	VAL	FNQSW
02532271	ELONOX	FKB	FNQSW

PRE-FILLED SYRINGE 100MG/1.0ML

02506491	NOROMBY	JUN	FNQSW
02507552	INCLUNOX	SDZ	FNQSW
02509113	REDESCA	VAL	FNQSW
02532298	ELONOX	FKB	FNQSW

PRE-FILLED SYRINGE 120MG/0.8ML

02506505	NOROMBY	JUN	FNQSW
02507560	INCLUNOX	SDZ	FNQSW
02509148	REDESCA	VAL	FNQSW
02532301	ELONOX	FKB	FNQSW

PRE-FILLED SYRINGE 150MG/1.0ML

02506513	NOROMBY	JUN	FNQSW
02507579	INCLUNOX	SDZ	FNQSW
02509156	REDESCA	VAL	FNQSW
02532328	ELONOX	FKB	FNQSW

MULTIDOSE VIAL (300MG/3ML)

02509121	REDESCA	VAL	FNQSW

HEPARIN

100 IU/ML LOCK FLUSH SOLUTION

00727520	HEPARIN	LEO	NQ

1000 IU/ML VIAL

00453811	HEPARIN	LEO	NQ

⑤TINZAPARIN

[SEE APPENDIX A](#) FOR SA CRITERIA (NURSING HOME PROGRAM DOES NOT REQUIRE AN SA REQUEST)

2500 IU/0.25ML SYRINGE

02229755	INNOHEP (SA)	LEO	FNQSW

3500 IU/0.35ML SYRINGE

02358158	INNOHEP (SA)	LEO	FNQSW

4500 IU/0.45ML SYRINGE

02358166	INNOHEP (SA)	LEO	FNQSW

8000 IU/0.4ML SYRINGE

02429462	INNOHEP (SA)	LEO	FNQSW
10000 IU/0.5ML SYRINGE			
02231478	INNOHEP (SA)	LEO	FNQSW
12000 IU/0.6ML SYRINGE			
02429470	INNOHEP (SA)	LEO	FNQSW
14000 IU/0.7ML SYRINGE			
02358174	INNOHEP (SA)	LEO	FNQSW
16000 IU/0.8ML SYRINGE			
02429489	INNOHEP (SA)	LEO	FNQSW
18000 IU/0.9ML SYRINGE			
02358182	INNOHEP (SA)	LEO	FNQSW
10000 IU/ML MULTIDOSE VIAL			
02167840	INNOHEP (SA)	LEO	FNQSW
20000 IU/ML MULTIDOSE VIAL			
02229515	INNOHEP (SA)	LEO	FNQSW
⑤WARFARIN			
1MG TABLET			
02242680	TARO-WARFARIN	TAR	FGNQSW
02242924	APO-WARFARIN	APX	FGNQSW
2MG TABLET			
02242681	TARO-WARFARIN	TAR	FGNQSW
02242925	APO-WARFARIN	APX	FGNQSW
2.5MG TABLET			
02242682	TARO-WARFARIN	TAR	FGNQSW
02242926	APO-WARFARIN	APX	FGNQSW
3MG TABLET			
02242683	TARO-WARFARIN	TAR	FGNQSW
02245618	APO-WARFARIN	APX	FGNQSW
4MG TABLET			
02242684	TARO-WARFARIN	TAR	FGNQSW
02242927	APO-WARFARIN	APX	FGNQSW
5MG TABLET			
02242685	TARO-WARFARIN	TAR	FGNQSW

02242928	APO-WARFARIN	APX	FGNQSW
10MG TABLET			
02242687	TARO-WARFARIN	TAR	FGNQSW
02242929	APO-WARFARIN	APX	FGNQSW

⑤RIVAROXABAN

2.5MG TABLET			
02480808	XARELTO	BAY	FNQSW
02524503	REDDY-RIVAROXABAN	RCH	FGNQSW
02526786	TARO-RIVAROXABAN	TAR	FGNQSW
02527537	PMS-RIVAROXABAN	PMS	FGNQSW
02537877	SANDOZ-RIVOROXABAN	SDZ	FGNQSW
02541467	RIVAROXABAN	SIV	FGNQSW
02541734	APO-RIVAROXABAN	APX	FGNQSW
02547899	RIVAROXABAN	SNS	FGNQSW
02551608	M-RIVAROXABAN	MRA	FGNQSW
02547295	TEVA-RIVAROXABAN	TEV	FGNQSW
02553368	JAMP-RIVAROXABAN	JPC	FGNQSW

10MG TABLET			
02316986	XARELTO	BAY	FNQSW
02470497	APO-RIVAROXABAN	APX	FGNQSW
02472414	REDDY-RIVAROXABAN	RCH	FGNQSW
02482223	SANDOZ-RIVAROXABAN	SDZ	FGNQSW
02483807	TARO-RIVAROXABAN	TAR	FGNQSW
02507196	TEVA-RIVAROXABAN	TEV	FGNQSW
02512041	PMS-RIVAROXABAN	PMS	FGNQSW
02516292	JAMP-RIVAROXABAN	JPC	FGNQSW
02541475	RIVAROXABAN	SIV	FGNQSW
02547902	RIVAROXABAN	SNS	FGNQSW
02551616	M-RIVAROXABAN	MRA	FGNQSW

15MG TABLET			
02378604	XARELTO	BAY	FNQSW
02470500	APO-RIVAROXABAN	APX	FGNQSW
02472430	REDDY-RIVAROXABAN	RCH	FGNQSW
02482231	SANDOZ-RIVAROXABAN	SDZ	FGNQSW
02483815	TARO-RIVAROXABAN	TAR	FGNQSW
02507218	TEVA-RIVAROXABAN	TEV	FGNQSW
02512068	PMS-RIVAROXABAN	PMS	FGNQSW
02516306	JAMP-RIVAROXABAN	JPC	FGNQSW
02541483	RIVAROXABAN	SIV	FGNQSW
02547910	RIVAROXABAN	SNS	FGNQSW
02551624	M-RIVAROXABAN	MRA	FGNQSW

20MG TABLET

02378612	XARELTO	BAY	FNQSW
02470519	APO-RIVAROXABAN	APX	FGNQSW
02472422	REDDY-RIVAROXABAN	RCH	FGNQSW
02482258	SANDOZ-RIVAROXABAN	SDZ	FGNQSW
02483823	TARO-RIVAROXABAN	TAR	FGNQSW
02507226	TEVA-RIVAROXABAN	TEV	FGNQSW
02512076	PMS-RIVAROXABAN	PMS	FGNQSW
02516314	JAMP-RIVAROXABAN	JPC	FGNQSW
02541491	RIVAROXABAN	SIV	FGNQSW
02547929	RIVAROXABAN	SNS	FGNQSW
02551632	M-RIVAROXABAN	MRA	FGNQSW

20:12.14 PLATELET REDUCING AGENTS**ANAGRELIDE HCL**[SEE APPENDIX A](#) FOR SA CRITERIA**0.5MG CAPSULE**

02236859	AGRYLIN (SA)	SHR	FNQSW
02274949	PMS-ANAGRELIDE (SA)	PMS	FGNQSW

20:12.18 PLATELET AGGREGATION INHIBITORS**⑤CLOPIDOGREL BISULFATE****75MG TABLET**

02238682	PLAVIX	AVN	FNQSW
02293161	TEVA-CLOPIDOGREL	TEV	FGNQSW
02252767	APO-CLOPIDOGREL	APX	FGNQSW
02303027	ACT-CLOPIDOGREL	TEV	FGNQSW
02348004	PMS-CLOPIDOGREL	PMS	FGNQSW
02379813	RAN-CLOPIDOGREL	RAN	FGNQSW
02385813	CLOPIDOGREL	SIV	FGNQSW
02400553	CLOPIDOGREL	SNS	FGNQSW
02408910	MINT-CLOPIDOGREL	MNT	FGNQSW
02415550	JAMP-CLOPIDOGREL	JPC	FGNQSW
02416387	AURO-CLOPIDOGREL	ARO	FGNQSW
02422255	MAR-CLOPIDOGREL	MAR	FGNQSW
02482037	NRA-CLOPIDOGREL	NRA	FGNQSW
02502283	M-CLOPIDOGREL	MRA	FGNQSW

⑤TICAGRELOR

[SEE APPENDIX A](#) FOR SA CRITERIA

90MG TABLET

02368544	BRILINTA (SA)	AZE	FNQSW
02482630	APO-TICAGRELOR (SA)	APX	FGNQSW
02492598	TARO-TICAGRELOR (SA)	TAR	FGNQSW
02529769	M-TICAGRELOR (SA)	MRA	FGNQSW
02531801	JAMP-TICAGRELOR (SA)	JPC	FGNQSW

TICLOPIDINE HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

250MG TABLET

02237701	TICLOPIDINE (SA)	AAA	FGNQSW

20:16.00 HEMATOPOIETIC AGENTS

DARBEPOETIN ALFA

[SEE APPENDIX A](#) FOR SA CRITERIA

10MCG/ML PRE-FILLED SYRINGE

02392313	ARANESP (SA)	AMG	E

20MCG/ML PRE-FILLED SYRINGE

02392321	ARANESP (SA)	AMG	E

30MCG/ML PRE-FILLED SYRINGE

02392348	ARANESP (SA)	AMG	E

40MCG/ML PRE-FILLED SYRINGE

02391740	ARANESP (SA)	AMG	E

50MCG/ML PRE-FILLED SYRINGE

02391759	ARANESP (SA)	AMG	E

60MCG/ML PRE-FILLED SYRINGE

02392356	ARANESP (SA)	AMG	E

80MCG/ML PRE-FILLED SYRINGE

02391767	ARANESP (SA)	AMG	E

100MCG/ML PRE-FILLED SYRINGE

02391775	ARANESP (SA)	AMG	E

150MCG/ML PRE-FILLED SYRINGE

02391791	ARANESP (SA)	AMG	E

200MCG/ML PRE-FILLED SYRINGE		
02391805	ARANESP (SA)	AMG E

500MCG/ML PRE-FILLED SYRINGE		
02392364	ARANESP (SA)	AMG E

EPOETIN ALFA

[SEE APPENDIX A](#) FOR SA CRITERIA

4000IU/0.4ML PRE-FILLED SYRINGE		
02231586	EPREX (SA)	JAN E

6000IU/0.6ML PRE-FILLED SYRINGE		
02243401	EPREX (SA)	JAN E

8000IU/0.8ML PRE-FILLED SYRINGE		
02243403	EPREX (SA)	JAN E

10,000IU/1.0ML PRE-FILLED SYRINGE		
02231587	EPREX (SA)	JAN E

FILGRASTIM

[SEE APPENDIX A](#) FOR SA CRITERIA

300 MCG/0.5ML PREFILLED SYRINGE		
02441489	GRASTOFIL (SA)	APX NMQW

02485575	NIVESTYM (SA)	PFI NMQW

02520990	NYPOZI (SA)	TAV NMQW

300 MCG/ML VIAL		
02485591	NIVESTYM (SA)	PFI NMQW

480 MCG/0.8ML PREFILLED SYRINGE		
02454548	GRASTOFIL (SA)	APX NMQW

02485583	NIVESTYM (SA)	PFI NMQW

02521008	NYPOZI (SA)	TAV NMQW

480 MCG/1.6ML VIAL		
02485656	NIVESTYM (SA)	PFI NMQW

LUSPATERCEPT

[SEE APPENDIX A](#) FOR SA CRITERIA

25 MG VIAL		
02505541	REBLOZYL (SA)	CEL NMQW
00904728	REBLOZYL (SA)*	NMQW

75 MG VIAL
 02505568 REBLOZYL (SA)
 00904729 REBLOZYL (SA)*
 *use when drug cost in excess of CPHA maximum

CEL **NMQW**
NMQW

PEGFILGRASTIM

[SEE APPENDIX A](#) FOR SA CRITERIA

6 MG/0.6ML PREFILLED SYRINGE

02474565 LAPELGA (SA)

APX **NMQW**

02484153 FULPHILA (SA)

BGP **NMQW**

02497395 ZIEXTENZO (SA)

SDZ **NMQW**

02506238 NYVEPRIA (SA)

PFI **NMQW**

6 MG/0.6ML AUTOINJECTOR

02529343 LAPELGA (SA)

APX **NMQW**

20:24.00 HEMORRHEOLOGIC AGENTS

⑤PENTOXIFYLLINE

400 MG SUSTAINED RELEASE TABLET

02230090 APO-PENTOXIFYLLINE SR

APX **FGNQSW**

02543087 JAMP-PENTOXIFYLLINE SR

JPC **FGNQSW**

20:28.00 HEMOSTATIC AGENTS

TRANEXAMIC ACID

500 MG TABLET

02401231 TRANEXAMIC ACID

STE **FGNQSW**

02496232 MAR-TRANEXAMIC ACID

MAR **FGNQSW**

02519194 TRAMEXAMIC ACID

JPC **FGNQSW**

24:00.00 CARDIAC DRUGS

⑤ACEBUTOLOL HCL

100 MG TABLET

02147602 APO-ACEBUTOLOL

APX **FGNQSW**

02204517	TEVA-ACEBUTOLOL	TEV	FGNQSW
200 MG TABLET			
02147610	APO-ACEBUTOLOL	APX	FGNQSW
02204525	TEVA-ACEBUTOLOL	TEV	FGNQSW
400 MG TABLET			
02147629	APO-ACEBUTOLOL	APX	FGNQSW
02204533	TEVA-ACEBUTOLOL	TEV	FGNQSW
⑤ AMIODARONE			
100 MG TABLET			
02292173	PMS-AMIODARONE	PMS	FGNQSW
200 MG TABLET			
02239835	TEVA-AMIODARONE	TEV	FGNQSW
02242472	PMS-AMIODARONE	PMS	FGNQSW
02243836	SANDOZ-AMIODARONE	SDZ	FGNQSW
02246194	APO-AMIODARONE	APX	FGNQSW
02364336	SANIS-AMIODARONE	SNS	FGNQSW
02385465	AMIODARONE	SIV	FGNQSW
02531844	JAMP-AMIODARONE	JPC	FGNQSW
⑤ AMLODIPINE BESYLATE			
2.5 MG TABLET			
02297477	ACT-AMLODIPINE	TEV	FGNQSW
02295148	PMS-AMLODIPINE	PMS	FGNQSW
02330474	SANDOZ-AMLODIPINE	SDZ	FGNQSW
02357186	JAMP-AMLODIPINE	JPC	FGNQSW
02371707	MAR-AMLODIPINE	MAR	FGNQSW
02385783	AMLODIPINE	SIV	FGNQSW
02419556	AMLODIPINE BESYLATE	ACH	FGNQSW
02468018	M-AMLODIPINE	MRA	FGNQSW
02469022	PHARMA-AMLODIPINE	PMS	FGNQSW
02476452	NRA-AMLODIPINE	NRA	FGNQSW
02478587	AMLODIPINE	SNS	FGNQSW
02492199	AMLODIPINE	JPC	FGNQSW
02522500	PRZ-AMLODIPINE	PRZ	FGNQSW
5 MG TABLET			
00878928	NORVASC	UJC	FNQSW
02272113	MYLAN-AMLODIPINE	MYL	FGNQSW
02273373	APO-AMLODIPINE	APX	FGNQSW
02284065	PMS-AMLODIPINE	PMS	FGNQSW
02284383	SANDOZ-AMLODIPINE	SDZ	FGNQSW
02297485	ACT-AMLODIPINE	TEV	FGNQSW

02321858	RAN-AMLODIPINE	RAN	FGNQSW
02331284	SANIS-AMLODIPINE	SNS	FGNQSW
02357194	JAMP-AMLODIPINE	JPC	FGNQSW
02385791	AMLODIPINE	SIV	FGNQSW
02362651	MINT-AMLODIPINE	MNT	FGNQSW
02371715	MAR-AMLODIPINE	MAR	FGNQSW
02397072	AURO- AMLODIPINE	ARO	FGNQSW
02419564	AMLODIPINE BESYLATE	ACH	FGNQSW
02429217	AMLODIPINE	JPC	FGNQSW
02468026	M-AMLODIPINE	MRA	FGNQSW
02476460	NRA-AMLODIPINE	NRA	FGNQSW
02522519	PRZ-AMLODIPINE	PRZ	FGNQSW

10 MG TABLET

00878936	NORVASC	UJC	FNQSW
02272121	MYLAN-AMLODIPINE	MYL	FGNQSW
02273381	APO-AMLODIPINE	APX	FGNQSW
02284073	PMS-AMLODIPINE	PMS	FGNQSW
02284391	SANDOZ-AMLODIPINE	SDZ	FGNQSW
02297493	ACT-AMLODIPINE	TEV	FGNQSW
02321866	RAN-AMLODIPINE	RAN	FGNQSW
02331292	SANIS-AMLODIPINE	SNS	FGNQSW
02357208	JAMP-AMLODIPINE	JPC	FGNQSW
02362678	MINT-AMLODIPINE	MNT	FGNQSW
02371723	MAR-AMLODIPINE	MAR	FGNQSW
02385805	AMLODIPINE	SIV	FGNQSW
02397080	AURO-AMLODIPINE	ARO	FGNQSW
02419572	AMLODIPINE BESYLATE	ACH	FGNQSW
02429225	AMLODIPINE	JPC	FGNQSW
02468034	M-AMLODIPINE	MRA	FGNQSW
02476479	NRA-AMLODIPINE	NRA	FGNQSW
02522527	PRZ-AMLODIPINE	PRZ	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

1 MG/ML ORAL SOLUTION

02484706	PDP-AMLODIPINE	PEN	FGNQSW

⑤ **ATENOLOL**

25 MG TABLET

02246581	PMS-ATENOLOL	PMS	FGNQSW
02266660	TEVA-ATENOL	TEV	FGNQSW
02367556	JAMP-ATENOLOL	JPC	FGNQSW
02371979	MAR-ATENOLOL	MAR	FGNQSW
02373963	RAN-ATENOLOL	RAN	FGNQSW
02541564	ATENOLOL	SIV	FGNQSW

50 MG TABLET

00773689	APO-ATENOL	APX	FGNQSW
02039532	TENORMIN	AZE	FNQSW
02171791	TEVA-ATENOLOL	TEV	FGNQSW
02237600	PMS-ATENOLOL	PMS	FGNQSW
02238316	ATENOLOL	SIV	FGNQSW
02267985	RAN-ATENOLOL	RAN	FGNQSW
02367564	JAMP-ATENOLOL	JPC	FGNQSW
02368021	MINT-ATENOL	MNT	FGNQSW
02369184	AG-ATENOLOL	ANG	FGNQSW
02371987	MAR-ATENOLOL	MAR	FGNQSW
02466465	ATENOLOL	SNS	FGNQSW

100 MG TABLET

00773697	APO-ATENOL	APX	FGNQSW
02039540	TENORMIN	AZE	FNQSW
02171805	TEVA-ATENOLOL	TEV	FGNQSW
02237601	PMS-ATENOLOL	PMS	FGNQSW
02238318	ATENOLOL	SIV	FGNQSW
02267993	RAN-ATENOLOL	RAN	FGNQSW
02367572	JAMP-ATENOLOL	JPC	FGNQSW
02368048	MINT-ATENOL	MNT	FGNQSW
02369192	AG-ATENOLOL	ANG	FGNQSW
02371995	MAR-ATENOL	MAR	FGNQSW
02466473	ATENOLOL	SNS	FGNQSW

⑤ ATENOLOL & CHLORTHALIDONE**50 MG & 25MG TABLET**

02248763	AA-ATENIDONE	AAA	FGNQSW

100MG & 25MG TABLET

02248764	AA-ATENIDONE	AAA	FGNQSW

⑤ BISOPROLOL**1.25MG TABLET**

02544245	SANDOZ-BISOPROLOL	SDZ	FGNQSW

2.5MG TABLET

02544253	SANDOZ-BISOPROLOL	SDZ	FGNQSW

5MG TABLET

02256134	APO-BISOPROLOL	APX	FGNQSW
02267470	TEVA-BISOPROLOL	TEV	FGNQSW
02391589	BISOPROLOL	SNS	FGNQSW
02465612	MINT-BISOPROLOL	MNT	FGNQSW
02494035	SANDOZ-BISOPROLOLS	SDZ	FGNQSW

02495562	BISOPROLOL	SIV	FGNQSW
02518805	JAMP-BISOPROLOL	JPC	FGNQSW

10MG TABLET

02256177	APO-BISOPROLOL	APX	FGNQSW
02267489	TEVA-BISOPROLOL	TEV	FGNQSW
02391597	BISOPROLOL	SNS	FGNQSW
02465620	MINT-BISOPROLOL	MNT	FGNQSW
02494043	SANDOZ-BISOPROLOL	SDZ	FGNQSW
02495570	BISOPROLOL	SIV	FGNQSW
02518791	JAMP-BISOPROLOL	JPC	FGNQSW

⑤CARVEDILOL

3.125MG TABLET

02245914	PMS-CARVEDILOL	PMS	FGNQSW
02247933	APO-CARVEDILOL	APX	FGNQSW
02248752	CARVEDILOL	SIV	FGNQSW
02252309	TEVA-CARVEDILOL	TEV	FGNQSW
02364913	CARVEDILOL	SNS	FGNQSW
02368897	JAMP-CARVEDILOL	JPC	FGNQSW
02418495	AURO-CARVEDILOL	ARO	FGNQSW

6.25MG TABLET

02245915	PMS-CARVEDILOL	PMS	FGNQSW
02247934	APO-CARVEDILOL	APX	FGNQSW
02248753	CARVEDILOL	SIV	FGNQSW
02252317	TEVA-CARVEDILOL	TEV	FGNQSW
02364921	CARVEDILOL	SNS	FGNQSW
02368900	JAMP-CARVEDILOL	JPC	FGNQSW
02418509	AURO-CARVEDILOL	ARO	FGNQSW

12.5MG TABLET

02245916	PMS-CARVEDILOL	PMS	FGNQSW
02247935	APO-CARVEDILOL	APX	FGNQSW
02248754	CARVEDILOL	SIV	FGNQSW
02252325	TEVA-CARVEDILOL	TEV	FGNQSW
02364948	CARVEDILOL	SNS	FGNQSW
02368919	JAMP-CARVEDILOL	JPC	FGNQSW
02418517	AURO-CARVEDILOL	ARO	FGNQSW

25MG TABLET

02245917	PMS-CARVEDILOL	PMS	FGNQSW
02247936	APO-CARVEDILOL	APX	FGNQSW
02248755	CARVEDILOL	SIV	FGNQSW
02252333	TEVA-CARVEDILOL	TEV	FGNQSW
02364956	CARVEDILOL	SNS	FGNQSW

02368927	JAMP-CARVEDILOL	JPC	FGNQSW
02418525	AURO-CARVEDILOL	ARO	FGNQSW

⑤DIGOXIN

0.05MG/ML ELIXIR

02242320	PMS-DIGOXIN	PMS	FGNQSW

0.0625MG TABLET

02335700	PMS-DIGOXIN	PMS	FGNQSW
02498502	JAMP-DIGOXIN	JPC	FGNQSW

0.125MG TABLET

02335719	PMS-DIGOXIN	PMS	FGNQSW
02498510	JAMP-DIGOXIN	JPC	FGNQSW

0.25 MG/ML INJECTION SOLUTION

02048264	DIGOXIN	SDZ	NQ

⑤DILTIAZEM

120MG EXTENDED RELEASE CAPSULE

02231150	TIAZAC	BSL	FNQSW
02245918	SANDOZ-DILTIAZEM T	SDZ	FGNQSW
02271605	TEVA-DILTIAZEM ER	TEV	FGNQSW
02370441	TEVA-DILTIAZEM	TEV	FGNQSW
02465353	MAR-DILTIAZEM T	MAR	FGNQSW
02495376	JAMP-DILTIAZEM T	JPC	FGNQSW
02516101	DILTIAZEM T	SNS	FGNQSW
02546434	M-DILTIAZEM T	MRA	FGNQSW

180MG EXTENDED RELEASE CAPSULE

02231151	TIAZAC	BSL	FNQSW
02245919	SANDOZ-DILTIAZEM T	SDZ	FGNQSW
02271613	TEVA-DILTIAZEM ER	TEV	FGNQSW
02370492	TEVA-DILTIAZEM	TEV	FGNQSW
02465361	MAR-DILTIAZEM T	MAR	FGNQSW
02495384	JAMP-DILTIAZEM T	JPC	FGNQSW
02516128	DILTIAZEM T	SNS	FGNQSW
02546442	M-DILTIAZEM T	MRA	FGNQSW

240MG EXTENDED RELEASE CAPSULE

02231152	TIAZAC	BSL	FNQSW
02271621	TEVA-DILTIAZEM ER	TEV	FGNQSW
02370506	TEVA-DILTIAZEM	TEV	FGNQSW
02465388	MAR-DILTIAZEM T	MAR	FGNQSW
02495392	JAMP-DILTIAZEM T	JPC	FGNQSW
02516136	DILTIAZEM T	SNS	FGNQSW

02546450	M-DILTIAZEM T	MRA	FGNQSW
300MG EXTENDED RELEASE CAPSULE			
02231154	TIAZAC	BSL	FNQSW
02271648	TEVA-DILTIAZEM ER	TEV	FGNQSW
02370514	TEVA-DILTIAZEM	TEV	FGNQSW
02465396	MAR-DILTIAZEM T	MAR	FGNQSW
02495406	JAMP-DILTIAZEM T	JPC	FGNQSW
02516144	DILTIAZEM T	SNS	FGNQSW
02546469	M-DILTIAZEM T	MRA	FGNQSW
360MG EXTENDED RELEASE CAPSULE			
02231155	TIAZAC	BSL	FNQSW
02271656	TEVA-DILTIAZEM ER	TEV	FGNQSW
02370522	TEVA-DILTIAZEM	TEV	FGNQSW
02465418	MAR-DILTIAZEM T	MAR	FGNQSW
02495414	JAMP-DILTIAZEM T	JPC	FGNQSW
02516152	DILTIAZEM T	SNS	FGNQSW
02546477	M-DILTIAZEM T	MRA	FGNQSW
120MG EXTENDED RELEASE TABLET			
02256738	TIAZAC XC	BSL	FNQSW
180MG EXTENDED RELEASE TABLET			
02256746	TIAZAC XC	BSL	FNQSW
02429322	TEVA-DILTIAZEM XC	TEV	FGNQSW
240MG EXTENDED RELEASE TABLET			
02256754	TIAZAC XC	BSL	FNQSW
02429330	TEVA-DILTIAZEM XC	TEV	FGNQSW
300MG EXTENDED RELEASE TABLET			
02256762	TIAZAC XC	BSL	FNQSW
02429349	TEVA-DILTIAZEM XC	TEV	FGNQSW
360MG EXTENDED RELEASE TABLET			
02256770	TIAZAC XC	BSL	FNQSW
02429357	TEVA-DILTIAZEM XC	TEV	FGNQSW
120MG CONTROLLED DELIVERY CAPSULE			
02230997	APO-DILTIAZ CD	APX	FGNQSW
02242538	TEVA-DILTIAZEM CD	TEV	FGNQSW
02243338	SANDOZ-DILTIAZEM CD	SDZ	FGNQSW
02370611	ACT-DILTIAZEM	TEV	FGNQSW
02400421	DILTIAZEM CD	SNS	FGNQSW
02445999	DILTIAZEM CD	SIV	FGNQSW

02484064	MAR-DILTIAZEM CD	MAR	FGNQSW
02528037	JAMP-DILTIAZEM CD	JPC	FGNQSW
02546086	M-DILTIAZEM CD	MRA	FGNQSW

180MG CONTROLLED DELIVERY CAPSULE

02230998	APO-DILTIAZ CD	APX	FGNQSW
02242539	TEVA-DILTAZEM CD	TEV	FGNQSW
02243339	SANDOZ-DILTIAZEM CD	SDZ	FGNQSW
02370638	ACT-DILTIAZEM	TEV	FGNQSW
02400448	DILTIAZEM CD	SNS	FGNQSW
02446006	DILTIAZEM CD	SIV	FGNQSW
02484072	MAR-DILTIAZEM CD	MAR	FGNQSW
02528045	JAMP-DILTIAZEM CD	JPC	FGNQSW
02546094	M-DILTIAZEM CD	MRA	FGNQSW

240MG CONTROLLED DELIVERY CAPSULE

02230999	APO-DILTIAZ CD	APX	FGNQSW
02242540	TEVA-DILTAZEM CD	TEV	FGNQSW
02243340	SANDOZ-DILTIAZEM CD	SDZ	FGNQSW
02400456	DILTIAZEM CD	SNS	FGNQSW
02446014	DILTIAZEM CD	SIV	FGNQSW
02484080	MAR-DILTIAZEM CD	MAR	FGNQSW
02528053	JAMP-DILTIAZEM CD	JPC	FGNQSW
02546108	M-DILTIAZEM CD	MRA	FGNQSW

300MG CONTROLLED DELIVERY CAPSULE

02229526	APO-DILTIAZ CD	APX	FGNQSW
02242541	TEVA-DILTAZEM CD	TEV	FGNQSW
02243341	SANDOZ-DILTIAZEM CD	SDZ	FGNQSW
02370654	ACT-DILTIAZEM	TEV	FGNQSW
02400464	DILTIAZEM CD	SNS	FGNQSW
02446022	DILTIAZEM CD	SIV	FGNQSW
02484099	MAR-DILTIAZEM CD	MAR	FGNQSW
02528061	JAMP-DILTIAZEM CD	JPC	FGNQSW
02546116	M-DILTIAZEM CD	MRA	FGNQSW

30MG TABLET

00771376	AA-DILTIAZ	AAA	FGNQSW

60MG TABLET

00771384	AA-DILTIAZ	AAA	FGNQSW

⑤DISOPYRAMIDE

100MG CAPSULE

02224801	RYTHMODAN	XPI	FNQSW

⑤FLECAINIDE ACETATE

50MG TABLET

02275538	FLECAINIDE	APX	FGNQSW
02459957	AURO-FLECAINIDE	ARO	FGNQSW
02476177	MAR-FLECAINIDE	MAR	FGNQSW
02493705	JAMP-FLECAINIDE	JPC	FGNQSW
02534800	FLECAINIDE	SNS	FGNQSW

100MG TABLET

02275546	FLECAINIDE	APX	FGNQSW
02459965	AURO-FLECAINIDE	ARO	FGNQSW
02476185	MAR-FLECAINIDE	MAR	FGNQSW
02493713	JAMP-FLECAINIDE	JPC	FGNQSW
02534819	FLECAINIDE	SNS	FGNQSW

⑤IVABRADINE

[SEE APPENDIX A](#) FOR SA CRITERIA

5MG TABLET

02459973	LANCORA (SA)	SER	FNQSW

7.5MG TABLET

02459981	LANCORA (SA)	SER	FNQSW

⑤LABETALOL HCL

100MG TABLET

02106272	TRANDATE	PAL	FNQSW
02243538	APO-LABETALOL	APX	FGNQSW
02489406	RIVA-LABETALOL	RIV	FGNQSW

200MG TABLET

02106280	TRANDATE	PAL	FNQSW
02243539	APO-LABETALOL	APX	FGNQSW
02489414	RIVA-LABETALOL	RIV	FGNQSW

MAVACAMTEN

[SEE APPENDIX A](#) FOR SA CRITERIA

2.5MG CAPSULE

02532549	CAMZYOS (SA)	BMS	NMQW

5MG CAPSULE

02532557	CAMZYOS (SA)	BMS	NMQW

10MG CAPSULE

02532565	CAMZYOS (SA)	BMS	NMQW

15MG CAPSULE

02532573	CAMZYOS (SA)	BMS	NMQW
⑤METOPROLOL TARTRATE			
100MG SUSTAINED RELEASE TABLET			
02285169	AA-METOPROLOL SR	AAA	FGNQSW
200MG SUSTAINED RELEASE TABLET			
02285177	AA-METOPROLOL SR	AAA	FGNQSW
25MG TABLET			
02246010	APO-METOPROLOL	APX	FGNQSW
02248855	PMS-METOPROLOL-L	PMS	FGNQSW
02356813	JAMP-METOPROLOL-L	JPC	FGNQSW
50MG TABLET			
00618632	APO-METOPROLOL	APX	FGNQSW
00648035	TEVA-METOPROL	TEV	FGNQSW
00749354	APO-METOPROLOL (TYPE L)	APX	FGNQSW
00842648	TEVA-METOPROL (UNCOATED)	TEV	FGNQSW
02230803	PMS-METOPROLOL-L	PMS	FGNQSW
02350394	METOPROLOL	SNS	FGNQSW
02356821	JAMP-METOPROLOL-L	JPC	FGNQSW
02442124	METOPROLOL-L	SIV	FGNQSW
02481316	AG-METOPROLOL-L	ANG	FGNQSW
100MG TABLET			
00618640	APO-METOPROLOL	APX	FGNQSW
00648043	TEVA-METOPROL	TEV	FGNQSW
00751170	APO-METOPROLOL (TYPE L)	APX	FGNQSW
00842656	TEVA-METOPROL (UNCOATED)	TEV	FGNQSW
02230804	PMS-METOPROLOL-L	PMS	FGNQSW
02350408	METOPROLOL	SNS	FGNQSW
02356848	JAMP-METOPROLOL-L	JPC	FGNQSW
02442132	METOPROLOL-L	SIV	FGNQSW
02481324	AG-METOPROLOL-L	ANG	FGNQSW
⑤MEXILETINE HCL			
100MG CAPSULE			
02230359	TEVA-MEXILETINE	TEV	FGNQSW
02536846	MINT-MEXILETINE	MNT	FGNQSW
200MG CAPSULE			
02230360	TEVA-MEXILETINE	TEV	FGNQSW
02536854	MINT-MEXILETINE	MNT	FGNQSW

⑤NADOLOL

40MG TABLET			
00782505	APO-NADOLOL	APX	FGNQSW
02496380	MINT-NADOLOL	MNT	FGNQSW
80MG TABLET			
00782467	APO-NADOLOL	APX	FGNQSW
02496399	MINT-NADOLOL	MNT	FGNQSW
160MG TABLET			
00782475	APO-NADOLOL	APX	FGNQSW
⑤NIFEDIPINE			
5MG CAPSULE			
00725110	NIFEDIPINE	AAA	FGNQSW
10MG CAPSULE			
00755907	NIFEDIPINE	AAA	FGNQSW
30MG EXTENDED RELEASE TABLET			
02155907	ADALAT XL	BAY	FNQSW
02349167	MYLAN-NIFEDIPINE ER	MYL	FGNQSW
60MG EXTENDED RELEASE TABLET			
02321149	MYLAN-NIFEDIPINE ER	MYL	FGNQSW
⑤PINDOLOL			
5MG TABLET			
00417270	VISKEN	XPI	FNQSW
00869007	TEVA-PINDOL	TEV	FGNQSW
10MG TABLET			
00443174	VISKEN	XPI	FNQSW
00869015	TEVA-PINDOL	TEV	FGNQSW
15MG TABLET			
00869023	TEVA-PINDOL	TEV	FGNQSW
⑤PROPAFENONE HCL			
150MG TABLET			
00603708	RYTHMOL	BGP	FNQSW
02243324	APO-PROPAFENONE	APX	FGNQSW
02457172	MYLAN-PROPAFENONE	MYL	FGNQSW
300MG TABLET			
00603716	RYTHMOL	BGP	FNQSW
02243325	APO-PROPAFENONE	APX	FGNQSW

02343061	PROPAFENONE	SNS	FGNQSW
02457164	MYLAN-PROPAFENONE	MYL	FGNQSW

⑤**PROPRANOLOL**

10MG TABLET			
00496480	TEVA-PROPRANOLOL	TEV	FGNQSW

20MG TABLET			
00740675	TEVA-PROPRANOLOL	TEV	FGNQSW

40MG TABLET			
00496499	TEVA-PROPRANOLOL	TEV	FGNQSW

80MG TABLET			
00496502	TEVA-PROPRANOLOL	TEV	FGNQSW

PROPRANOLOL ORAL SOLUTION

[SEE APPENDIX A](#) FOR SA CRITERIA

3.75MG/ML ORAL SOLUTION			
02457857	HEMANGIOL (SA)	PFB	FQW

⑤**SOTALOL HCL**

80MG TABLET			
02210428	APO-SOTALOL	APX	FGNQSW
02368617	JAMP-SOTALOL	JPC	FGNQSW
02238326	PMS-SOTALOL	PMS	FGNQSW

160MG TABLET			
02167794	APO-SOTALOL	APX	FGNQSW
02238327	PMS-SOTALOL	PMS	FGNQSW
02368625	JAMP-SOTALOL	JPC	FGNQSW

TAFAMIDIS

[SEE APPENDIX A](#) FOR SA CRITERIA

61MG TABLET			
02517841	VYNDAMAX (SA)	PFI	MNQW
00904778	VYNDAMAX (SA)*		MNQW

*use when drug cost in excess of CPHA maximum

TAFAMIDIS MEGLUMINE

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG CAPSULE			
02495732	VYNDAQEL (SA)	PFI	MNQW
00904637	VYNDAQEL (SA)*		MNQW

*use when drug cost in excess of CPHA maximum

⑤TIMOLOL MALEATE

5MG TABLET

00755842	TIMOLOL	AAA	FGNQSW

10MG TABLET

00755850	TIMOLOL	AAA	FGNQSW

20MG TABLET

00755869	TIMOLOL	AAA	FGNQSW

⑤VERAPAMIL HCL

80MG TABLET

00782483	APO-VERAP	APX	FGNQSW

02237921	MYLAN-VERAPAMIL	MYL	FGNQSW

120MG TABLET

00782491	APO-VERAP	APX	FGNQSW

02237922	MYLAN-VERAPAMIL	MYL	FGNQSW

120MG SUSTAINED RELEASE TABLET

01907123	ISOPTIN SR	BGP	FNQSW

02210347	MYLAN-VERAPAMIL SR	MYL	FGNQSW

02246893	APO-VERAP SR	APX	FGNQSW

180MG SUSTAINED RELEASE TABLET

01934317	ISOPTIN SR	BGP	FNQSW

02450488	MYLAN-VERAPAMIL SR	MYL	FGNQSW

240MG SUSTAINED RELEASE TABLET

00742554	ISOPTIN SR	BGP	FNQSW

02450496	MYLAN-VERAPAMIL SR	MYL	FGNQSW

24:06.00 ANTILIPEMIC DRUGS

⑤ALIROCUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

75MG/ML PREFILLED PEN

02453819	PRALUENT (SA)	SAV	FNQSW

150MG/ML PREFILLED PEN

02453835	PRALUENT (SA)	SAV	FNQSW

300MG/2ML PREFILLED PEN

02547732 PRALUENT (SA)

SAV FNQSW

⑤ATORVASTATIN CALCIUM

10MG TABLET

02230711	LIPITOR	UJC	FNQSW
02295261	APO-ATORVASTATIN	APX	FGNQSW
02310899	TEVA-ATORVASTATIN	TEV	FGNQSW
02313707	TARO-ATORVASTATIN	SUN	FGNQSW
02324946	SANDOZ-ATORVASTATIN	SDZ	FGNQSW
02348705	ATORVASTATIN	SNS	FGNQSW
02391058	JAMP-ATORVASTATIN	JPC	FGNQSW
02392933	MYLAN-ATORVASTATIN	MYL	FGNQSW
02407256	AURO-ATORVASTATIN	ARO	FGNQSW
02411350	ATORVASTATIN	SIV	FGNQSW
02417936	REDDY-ATORVASTATIN	RCH	FGNQSW
02454017	MAR-ATORVASTATIN	MAR	FGNQSW
02457741	ACH-ATORVASTATIN	ACH	FGNQSW
02471167	M-ATORVASTATIN	MRA	FGNQSW
02475022	ATORVASTATIN	RIV	FGNQSW
02476517	NRA-ATORVASTATIN	NRA	FGNQSW
02477149	PMS-ATORVASTATIN	PMS	FGNQSW
02478145	AG-ATORVASTATIN	ANG	FGNQSW
02479508	MINT-ATORVASTATIN	MNT	FGNQSW
02504197	JAMP-ATORVASTATIN	JPC	FGNQSW
02507234	PMSC-ATORVASTATIN	PMS	FGNQSW
02521555	PRZ-ATORVASTATIN	PRZ	FGNQSW

20MG TABLET

02230713	LIPITOR	UJC	FNQSW
02295288	APO-ATORVASTATIN	APX	FGNQSW
02310902	TEVA-ATORVASTATIN	TEV	FGNQSW
02313715	TARO-ATORVASTATIN	SUN	FGNQSW
02324954	SANDOZ-ATORVASTATIN	SDZ	FGNQSW
02348713	ATORVASTATIN	SNS	FGNQSW
02391066	JAMP-ATORVASTATIN	JPC	FGNQSW
02392941	MYLAN-ATORVASTATIN	MYL	FGNQSW
02407264	AURO-ATORVASTATIN	ARO	FGNQSW
02411369	ATORVASTATIN	SIV	FGNQSW
02417944	REDDY-ATORVASTATIN	RCH	FGNQSW
02454025	MAR-ATORVASTATIN	MAR	FGNQSW
02457768	ACH-ATORVASTATIN	ACH	FGNQSW
02471175	M-ATORVASTATIN	MRA	FGNQSW
02475030	ATORVASTATIN	RIV	FGNQSW
02476525	NRA-ATORVASTATIN	NRA	FGNQSW
02477157	PMS-ATORVASTATIN	PMS	FGNQSW
02478153	AG-ATORVASTATIN	ANG	FGNQSW

02479516	MINT-ATORVASTATIN	MNT	FGNQSW
02504200	JAMP-ATORVASTATIN	JPC	FGNQSW
02507242	PMSC-ATORVASTATIN	PMS	FGNQSW
02521563	PRZ-ATORVASTATIN	PRZ	FGNQSW

40MG TABLET

02230714	LIPITOR	UJC	FNQSW
02295296	APO-ATORVASTATIN	APX	FGNQSW
02310910	TEVA-ATORVASTATIN	TEV	FGNQSW
02313723	TARO-ATORVASTATIN	SUN	FGNQSW
02324962	SANDOZ-ATORVASTATIN	SDZ	FGNQSW
02348721	ATORVASTATIN	SNS	FGNQSW
02391074	JAMP-ATORVASTATIN	JPC	FGNQSW
02392968	MYLAN-ATORVASTATIN	MYL	FGNQSW
02407272	AURO-ATORVASTATIN	ARO	FGNQSW
02411377	ATORVASTATIN	SIV	FGNQSW
02417952	REDDY-ATORVASTATIN	RCH	FGNQSW
02454033	MAR-ATORVASTATIN	MAR	FGNQSW
02457776	ACH-ATORVASTATIN	ACH	FGNQSW
02471183	M-ATORVASTATIN	MRA	FGNQSW
02475049	ATORVASTATIN	RIV	FGNQSW
02476533	NRA-ATORVASTATIN	NRA	FGNQSW
02477165	PMS-ATORVASTATIN	PMS	FGNQSW
02478161	AG-ATORVASTATIN	ANG	FGNQSW
02479524	MINT-ATORVASTATIN	MNT	FGNQSW
02504219	JAMP-ATORVASTATIN	JPC	FGNQSW
02507250	PMSC-ATORVASTATIN	PMS	FGNQSW
02521571	PRZ-ATORVASTATIN	PRZ	FGNQSW

80MG TABLET

02243097	LIPITOR	UJC	FNQSW
02295318	APO-ATORVASTATIN	APX	FGNQSW
02310929	TEVA-ATORVASTATIN	TEV	FGNQSW
02313758	TARO-ATORVASTATIN	SUN	FGNQSW
02324970	SANDOZ-ATORVASTATIN	SDZ	FGNQSW
02348748	ATORVASTATIN	SNS	FGNQSW
02391082	JAMP-ATORVASTATIN	JPC	FGNQSW
02392976	MYLAN-ATORVASTATIN	MYL	FGNQSW
02407280	AURO-ATORVASTATIN	ARO	FGNQSW
02411385	ATORVASTATIN	SIV	FGNQSW
02417960	REDDY-ATORVASTATIN	RCH	FGNQSW
02454041	MAR-ATORVASTATIN	MAR	FGNQSW
02457784	ACH-ATORVASTATIN	ACH	FGNQSW
02471191	M-ATORVASTATIN	MRA	FGNQSW
02475057	ATORVASTATIN	RIV	FGNQSW
02476541	NRA-ATORVASTATIN	NRA	FGNQSW

02479532	MINT-ATORVASTATIN	MNT	FGNQSW
02478188	AG-ATORVASTATIN	ANG	FGNQSW
02504235	JAMP-ATORVASTATIN	JPC	FGNQSW
02507269	PMSC-ATORVASTATIN	PMS	FGNQSW
02521598	PRZ-ATORVASTATIN	PRZ	FGNQSW

⑤**CHOLESTYRAMINE**

REGULAR - 4G/POUCH X 30 POUCHES - 120G/PK ORAL POWDER (POUCHES)

02210320	OLESTYR	PMS	FGNQSW

*price per gram for cholestyramine powder pouches

LIGHT - 4G/POUCH X 30 POUCHES- 120G/PK

02455609	CHOLESTYRAMINE-ODAN	ODN	FGNQSW
02478595	JAMP-CHOLESTYRAMINE	JPC	FGNQSW

⑤**COLESEVELAM**

625MG TABLET

02373955	LODALIS	BSL	FNQSW
02494051	APO-COLESEVELAM	APX	FGNQSW

3.75G PACKET

02432463	LODALIS	BSL	FNQSW

⑤**EVOLOCUMAB**

[SEE APPENDIX A](#) FOR SA CRITERIA

140MG/ML PEN INJECTOR

02446057	REPATHA (SA)	AMG	FNQSW

⑤**EZETIMIBE**

10MG TABLET

02247521	EZETROL	MSD	FNQSW
02354101	TEVA-EZETIMIBE	TEV	FGNQSW
02416409	PMS-EZETIMIBE	PMS	FGNQSW
02416778	SANDOZ-EZETIMIBE	SDZ	FGNQSW
02419548	RAN-EZETIMIBE	RAN	FGNQSW
02422662	MAR-EZETIMIBE	MAR	FGNQSW
02423235	JAMP-EZETIMIBE	JPC	FGNQSW
02423243	MINT-EZETIMIBE	MNT	FGNQSW
02425610	ACH-EZETIMIBE	ACH	FGNQSW
02427826	APO-EZETIMIBE	APX	FGNQSW
02429659	EZETIMIBE	SIV	FGNQSW
02431300	EZETIMIBE	SNS	FGNQSW
02460750	GLN-EZETIMIBE	GLM	FGNQSW
02467437	M-EZETIMIBE	MRA	FGNQSW
02469286	AURO-EZETIMIBE	ARO	FGNQSW
02475898	AG-EZETIMIBE	AGP	FGNQSW

02481669	NRA-EZETIMIBE	NRA	FGNQSW
⑤FENOFIBRATE			
67MG CAPSULE			
02243180	AA-FENO-MICRO	AAA	FGNQSW
100MG TABLET			
02246859	AA-FENO-SUPER	AAA	FGNQSW
160MG TABLET			
02241602	LIPIDIL SUPRA	BGP	FNQSW
02246860	AA-FENO-SUPER	AAA	FGNQSW
200MG CAPSULE			
02239864	AA-FENO-MICRO	AAA	FGNQSW
⑤FLUVASTATIN SODIUM			
20MG CAPSULE			
02299224	TEVA-FLUVASTATIN	TEV	FGNQSW
40MG CAPSULE			
02299232	TEVA-FLUVASTATIN	TEV	FGNQSW
⑤GEMFIBROZIL			
600MG TABLET			
02142074	TEVA-GEMFIBROZIL	TEV	FGNQSW
ICOSAPENT ETHYL			
SEE APPENDIX A FOR SA CRITERIA			
1G CAPSULE			
02495244	VASCEPA (SA)	HLS	FNQSW
⑤LOVASTATIN			
20MG TABLET			
02220172	LOVASTATIN	AAA	FGNQSW
40MG TABLET			
02220180	LOVASTATIN	AAA	FGNQSW
⑤PRAVASTATIN			
10MG TABLET			
02243506	APO-PRAVASTATIN	APX	FGNQSW
02247008	TEVA-PRAVASTATIN	TEV	FGNQSW
02247655	PMS-PRAVASTATIN	PMS	FGNQSW
02284421	RAN-PRAVASTATIN	RAN	FGNQSW
02317451	MINT-PRAVASTATIN	MNT	FGNQSW

02330954	JAMP PRAVASTATIN	JPC	FGNQSW
02356546	PRAVASTATIN	SNS	FGNQSW
02389703	PRAVASTATIN	SVI	FGNQSW
02432048	MAR-PRAVASTATIN	MAR	FGNQSW
02440644	ACH-PRAVASTATIN	ACH	FGNQSW
02458977	AURO-PRAVASTATIN	ARO	FGNQSW
02468700	SANDOZ-PRAVASTATIN	SDZ	FGNQSW
02476142	AG-PRAVASTATIN	ANG	FGNQSW
02476274	M-PRAVASTATIN	MRA	FGNQSW

20MG TABLET

02243507	APO-PRAVASTATIN	APX	FGNQSW
02247009	TEVA-PRAVASTATIN	TEV	FGNQSW
02247656	PMS-PRAVASTATIN	PMS	FGNQSW
02284448	RAN-PRAVASTATIN	RAN	FGNQSW
02317478	MINT-PRAVASTATIN	MNT	FGNQSW
02330962	JAMP PRAVASTATIN	JPC	FGNQSW
02356554	PRAVASTATIN	SNS	FGNQSW
02389738	PRAVASTATIN	SIV	FGNQSW
02432056	MAR-PRAVASTATIN	MAR	FGNQSW
02440652	ACH-PRAVASTATIN	ACH	FGNQSW
02458985	AURO-PRAVASTATIN	ARO	FGNQSW
02468719	SANDOZ-PRAVASTATIN	SDZ	FGNQSW
02476150	AG-PRAVASTATIN	ANG	FGNQSW
02476282	M-PRAVASTATIN	MRA	FGNQSW

40MG TABLET

02243508	APO-PRAVASTATIN	APX	FGNQSW
02247010	TEVA-PRAVASTATIN	TEV	FGNQSW
02247657	PMS-PRAVASTATIN	PMS	FGNQSW
02284456	RAN-PRAVASTATIN	RAN	FGNQSW
02317486	MINT-PRAVASTATIN	MNT	FGNQSW
02330970	JAMP PRAVASTATIN	JPC	FGNQSW
02356562	PRAVASTATIN	SNS	FGNQSW
02389746	PRAVASTATIN	SIV	FGNQSW
02432064	MAR-PRAVASTATIN	MAR	FGNQSW
02458993	AURO-PRAVASTATIN	ARO	FGNQSW
02468727	SANDOZ-PRAVASTATIN	SDZ	FGNQSW
02476169	AG-PRAVASTATIN	ANG	FGNQSW
02476290	M-PRAVASTATIN	MRA	FGNQSW

⑤ROSUVASTATIN

5MG TABLET

02265540	CRESTOR	AZE	FNQSW
02337975	APO-ROSUVASTATIN	APX	FGNQSW
02338726	SANDOZ-ROSUVASTATIN	SDZ	FGNQSW

02354608	TEVA-ROSUVASTATIN	TEV	FGNQSW
02378523	PMS-ROSUVASTATIN	PMS	FGNQSW
02382644	TARO-ROSUVASTATIN	SUN	FGNQSW
02391252	JAMP-ROSUVASTATIN	JPC	FGNQSW
02405628	ROSUVASTATIN	SNS	FGNQSW
02397781	MINT-ROSUVASTATIN	MNT	FGNQSW
02399164	MED-ROSUVASTATIN	GMP	FGNQSW
02411628	ROSUVASTATIN-5	SIV	FGNQSW
02413051	MAR-ROSUVASTATIN	MAR	FGNQSW
02438917	ACH-ROSUVASTATIN	ACH	FGNQSW
02442574	AURO-ROSUVASTATIN	ARO	FGNQSW
02477483	NRA-ROSUVASTATIN	NRA	FGNQSW
02496534	M-ROSUVASTATIN	MRA	FGNQSW
02498332	JAMP-ROSUVASTATIN CALCIUM	JPC	FGNQSW
02505576	PRZ-ROSUVASTATIN	PRZ	FGNQSW

10MG TABLET

02247162	CRESTOR	AZE	FNQSW
02337983	APO-ROSUVASTATIN	APX	FGNQSW
02338734	SANDOZ-ROSUVASTATIN	SDZ	FGNQSW
02354616	TEVA-ROSUVASTATIN	TEV	FGNQSW
02378531	PMS-ROSUVASTATIN	PMS	FGNQSW
02382652	TARO-ROSUVASTATIN	SUN	FGNQSW
02391260	JAMP-ROSUVASTATIN	JPC	FGNQSW
02405636	ROSUVASTATIN	SNS	FGNQSW
02397803	MINT-ROSUVASTATIN	MNT	FGNQSW
02399172	MED-ROSUVASTATIN	GMP	FGNQSW
02411636	ROSUVASTATIN-10	SIV	FGNQSW
02413078	MAR-ROSUVASTATIN	MAR	FGNQSW
02438925	ACH-ROSUVASTATIN	ACH	FGNQSW
02442582	AURO-ROSUVASTATIN	ARO	FGNQSW
02477491	NRA-ROSUVASTATIN	NRA	FGNQSW
02496542	M-ROSUVASTATIN	MRA	FGNQSW
02498340	JAMP-ROSUVASTATIN CALCIUM	JPC	FGNQSW
02505584	PRZ-ROSUVASTATIN	PRZ	FGNQSW

20MG TABLET

02247163	CRESTOR	AZE	FNQSW
02337991	APO-ROSUVASTATIN	APX	FGNQSW
02338742	SANDOZ-ROSUVASTATIN	SDZ	FGNQSW
02354624	TEVA-ROSUVASTATIN	TEV	FGNQSW
02378558	PMS-ROSUVASTATIN	PMS	FGNQSW
02382660	TARO-ROSUVASTATIN	SUN	FGNQSW
02391279	JAMP-ROSUVASTATIN	JPC	FGNQSW
02405644	ROSUVASTATIN	SNS	FGNQSW
02399180	MED-ROSUVASTATIN	GMP	FGNQSW

02411644	ROSUVASTATIN-20	SIV	FGNQSW
02413086	MAR-ROSUVASTATIN	MAR	FGNQSW
02438933	ACH-ROSUVASTATIN	ACH	FGNQSW
02442590	AURO-ROSUVASTATIN	ARO	FGNQSW
02477505	NRA-ROSUVASTATIN	NRA	FGNQSW
02496550	M-ROSUVASTATIN	MRA	FGNQSW
02498359	JAMP-ROSUVASTATIN	JPC	FGNQSW
02505592	PRZ-ROSUVASTATIN	PRZ	FGNQSW

40MG TABLET

02247164	CRESTOR	AZE	FNQSW
02338009	APO-ROSUVASTATIN	APX	FGNQSW
02338750	SANDOZ-ROSUVASTATIN	SDZ	FGNQSW
02354632	TEVA-ROSUVASTATIN	TEV	FGNQSW
02378566	PMS-ROSUVASTATIN	PMS	FGNQSW
02382679	TARO-ROSUVASTATIN	SUN	FGNQSW
02391287	JAMP-ROSUVASTATIN	JPC	FGNQSW
02405652	ROSUVASTATIN	SNS	FGNQSW
02399199	MED-ROSUVASTATIN	GMP	FGNQSW
02411652	ROSUVASTATIN-40	SIV	FGNQSW
02413108	MAR-ROSUVASTATIN	MAR	FGNQSW
02438941	ACH-ROSUVASTATIN	ACH	FGNQSW
02442604	AURO-ROSUVASTATIN	ARO	FGNQSW
02477513	NRA-ROSUVASTATIN	NRA	FGNQSW
02496569	M-ROSUVASTATIN	MRA	FGNQSW
02498367	JAMP-ROSUVASTATIN	JPC	FGNQSW
02505606	PRZ-ROSUVASTATIN	PRZ	FGNQSW

⑤SIMVASTATIN

5MG TABLET

02247011	APO-SIMVASTATIN	APX	FGNQSW
02250144	TEVA-SIMVASTATIN	TEV	FGNQSW
02284723	SIMVASTATIN	SNS	FGNQSW
02329131	RAN-SIMVASTATIN	RAN	FGNQSW
02372932	MINT-SIMVASTATIN	MNT	FGNQSW
02375036	MAR-SIMVASTATIN	MAR	FGNQSW
02375591	JAMP-SIMVASTATIN	JPC	FGNQSW
02386291	SIMVASTATIN	SIV	FGNQSW
02405148	AURO-SIMVASTATIN	ARO	FGNQSW
02469979	PHARMA-SIMVASTATIN	PMS	FGNQSW
02480050	AG-SIMVASTATIN	ANG	FGNQSW
02549638	PMSC-SIMVASTATIN	PMS	FGNQSW

10MG TABLET

00884332	ZOCOR	MSD	FNQSW
02247012	APO-SIMVASTATIN	APX	FGNQSW

02250152	TEVA-SIMVASTATIN	TEV	FGNQSW
02284731	SIMVASTATIN	SNS	FGNQSW
02329158	RAN-SIMVASTATIN	RAN	FGNQSW
02372940	MINT-SIMVASTATIN	MNT	FGNQSW
02375044	MAR-SIMVISTATIN	MAR	FGNQSW
02375605	JAMP-SIMVASTATIN	JPC	FGNQSW
02386305	SIMVASTATIN	SIV	FGNQSW
02405156	AURO-SIMVASTATIN	ARO	FGNQSW
02469987	PHARMA-SIMVASTATIN	PMS	FGNQSW
02480069	AG-SIMVASTATIN	ANG	FGNQSW
02549646	PMSC-SIMVASTATIN	PMS	FGNQSW

20MG TABLET

00884340	ZOCOR	MSD	FNQSW
02247013	APO-SIMVASTATIN	APX	FGNQSW
02250160	TEVA-SIMVASTATIN	TEV	FGNQSW
02284758	SIMVASTATIN	SNS	FGNQSW
02329166	RAN-SIMVASTATIN	RAN	FGNQSW
02372959	MINT-SIMVASTATIN	MNT	FGNQSW
02375052	MAR-SIMVISTATIN	MAR	FGNQSW
02375613	JAMP-SIMVASTATIN	JPC	FGNQSW
02386313	SIMVASTATIN	SIV	FGNQSW
02405164	AURO-SIMVASTATIN	ARO	FGNQSW
02469995	PHARMA-SIMVASTATIN	PMS	FGNQSW
02480077	AG-SIMVASTATIN	ANG	FGNQSW
02549654	PMSC-SIMVASTATIN	PMS	FGNQSW

40MG TABLET

00884359	ZOCOR	MSD	FNQSW
02247014	APO-SIMVASTATIN	APX	FGNQSW
02250179	TEVA-SIMVASTATIN	TEV	FGNQSW
02284766	SIMVASTATIN	SNS	FGNQSW
02329174	RAN-SIMVASTATIN	RAN	FGNQSW
02372967	MINT-SIMVASTATIN	MNT	FGNQSW
02375060	MAR-SIMVISTATIN	MAR	FGNQSW
02375621	JAMP-SIMVASTATIN	JPC	FGNQSW
02386321	SIMVASTATIN	SIV	FGNQSW
02405172	AURO-SIMVASTATIN	ARO	FGNQSW
02470004	PHARMA-SIMVASTATIN	PMS	FGNQSW
02480085	AG-SIMVASTATIN	ANG	FGNQSW
02549662	PMSC-SIMVASTATIN	PMS	FGNQSW

80MG TABLET

02247015	APO-SIMVASTATIN	APX	FGNQSW
02250187	TEVA-SIMVASTATIN	TEV	FGNQSW
02284774	SIMVASTATIN	SNS	FGNQSW

02329182	RAN-SIMVASTATIN	RAN	FGNQSW
02372975	MINT-SIMVASTATIN	MNT	FGNQSW
02375079	MAR-SIMVISTATIN	MAR	FGNQSW
02375648	JAMP-SIMVASTATIN	JPC	FGNQSW
02386348	SIMVASTATIN	SIV	FGNQSW
02405180	AURO-SIMVASTATIN	ARO	FGNQSW
02470012	PHARMA-SIMVASTATIN	PMS	FGNQSW
02480093	AG-SIMVASTATIN	ANG	FGNQSW
02549670	PMSC-SIMVASTATIN	PMS	FGNQSW

24:08.00 HYPOTENSIVE DRUGS

⑤EPLERENONE

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG TABLET

02471442	MINT-EPLERENONE (SA)	MNT	FGNQSW
02543389	JAMP-EPLERENONE (SA)	JPC	FGNQSW

50MG TABLET

02471450	MINT-EPLERENONE (SA)	MNT	FGNQSW
02543397	JAMP-EPLERENONE (SA)	JPC	FGNQSW

⑤HYDRALAZINE HCL

10MG TABLET

00441619	APO-HYDRALAZINE	APX	FGNQSW
02457865	JAMP-HYDRALAZINE	JPC	FGNQSW
02468778	MINT-HYDRALAZINE	MNT	FGNQSW
02539802	HYDRALAZINE	SNS	FGNQSW

25MG TABLET

00441627	APO-HYDRALAZINE	APX	FGNQSW
02457873	JAMP-HYDRALAZINE	JPC	FGNQSW
02468786	MINT-HYDRALAZINE	MNT	FGNQSW
02539810	HYDRALAZINE	SNS	FGNQSW

50MG TABLET

00441635	APO-HYDRALAZINE	APX	FGNQSW
02457881	JAMP-HYDRALAZINE	JPC	FGNQSW
02468794	MINT-HYDRALAZINE	MNT	FGNQSW
02539829	HYDRALAZINE	SNS	FGNQSW

⑤PERINDOPRIL

2MG TABLET

02123274	COVERSYL	SEV	FNQSW
02289261	APO-PERINDOPRIL	APX	FGNQSW
02459817	AURO-PERINDOPRIL	ARO	FGNQSW
02464985	TEVA-PERINDOPRIL	TEV	FGNQSW
02470225	SANDOZ-PERINDOPRIL ERBUMINE	SDZ	FGNQSW
02470675	PMS-PERINDOPRIL	PMS	FGNQSW
02474824	MAR-PERINDOPRIL	MAR	FGNQSW
02476762	MINT-PERINDOPRIL	MNT	FGNQSW
02477009	JAMP-PERINDOPRIL	JPC	FGNQSW
02479877	PERINDOPRIL ERBUMINE	SIV	FGNQSW
02481634	PERINDOPRIL ERBUMINE	SNS	FGNQSW
02481677	AG-PERINDOPRIL	ANG	FGNQSW
02482924	M-PERINDOPRIL ERBUMINE	MRA	FGNQSW
02489015	NRA-PERINDOPRIL	NRA	FGNQSW
02527200	JAMP-PERINDOPRIL	JPC	FGNQSW

4MG TABLET

02123282	COVERSYL	SEV	FNQSW
02289288	APO-PERINDOPRIL	APX	FGNQSW
02459825	AURO-PERINDOPRIL	ARO	FGNQSW
02464993	TEVA-PERINDOPRIL	TEV	FGNQSW
02470233	SANDOZ-PERINDOPRIL ERBUMINE	SDZ	FGNQSW
02470683	PMS-PERINDOPRIL	PMS	FGNQSW
02474832	MAR-PERINDOPRIL	MAR	FGNQSW
02477017	JAMP-PERINDOPRIL	JPC	FGNQSW
02476770	MINT-PERINDOPRIL	MNT	FGNQSW
02479885	PERINDOPRIL ERBUMINE	SIV	FGNQSW
02481642	PERINDOPRIL ERBUMINE	SNS	FGNQSW
02481685	AG-PERINDOPRIL	ANG	FGNQSW
02482932	M-PERINDOPRIL ERBUMINE	MRA	FGNQSW
02489023	NRA-PERINDOPRIL	NRA	FGNQSW
02527219	JAMP-PERINDOPRIL	JPC	FGNQSW

8MG TABLET

02246624	COVERSYL	SEV	FNQSW
02289296	APO-PERINDOPRIL	APX	FGNQSW
02459833	AURO-PERINDOPRIL	ARO	FGNQSW
02465000	TEVA-PERINDOPRIL	TEV	FGNQSW
02470241	SANDOZ-PERINDOPRIL ERBUMINE	SDZ	FGNQSW
02470691	PMS-PERINDOPRIL	PMS	FGNQSW
02474840	MAR-PERINDOPRIL	MAR	FGNQSW
02477025	JAMP-PERINDOPRIL	JPC	FGNQSW
02476789	MINT-PERINDOPRIL	MNT	FGNQSW
02479893	PERINDOPRIL ERBUMINE	SIV	FGNQSW
02481650	PERINDOPRIL ERBUMINE	SNS	FGNQSW
02481693	AG-PERINDOPRIL	ANG	FGNQSW

02482940	M-PERINDOPRIL ERBUMINE	MRA	FGNQSW
02489031	NRA-PERINDOPRIL	NRA	FGNQSW
02527227	JAMP-PERINDOPRIL	JPC	FGNQSW

⑤PERINDOPRIL & INDAPAMIDE

4MG & 1.25MGMG TABLET

02246569	COVERSYL PLUS	SEV	FNQSW
02297574	APO-PERINDOPRIL/INDAPAMIDE	APX	FGNQSW
02464020	TEVA-PERINDOPRIL/INDAPAMIDE	TEV	FGNQSW
02470438	PERINDOPRIL ERBUMIN-INDAPAMIDE	SDZ	FGNQSW
02479834	PERINDOPRIL ERBUMIN-INDAPAMIDE	SIV	FGNQSW
02519720	PERINDOPRIL-INDAPAMIDE	SNS	FGNQSW
02538008	PMS-PERINDOPRIL INDAPAMIDE	PMS	FGNQSW

⑤PERINDOPRIL ERBUMIN/INDAPAMIDE

8MG & 2.5MG TABLET

02321653	COVERSYL PLUS HD	SEV	FNQSW
02453061	APO-PERINDOPRIL/INDAPAMIDE	APX	FGNQSW
02464039	TEVA-PERINDOPRIL/INDAPAMIDE	TEV	FGNQSW
02470446	PERINDOPRIL ERBUMIN-INDAPAMIDE HD	SDZ	FGNQSW
02479842	PERINDOPRIL ERBUMIN-INDAPAMIDE HD	SIV	FGNQSW
02519739	PERINDOPRIL-INDAPAMIDE	SNS	FGNQSW
02537982	PMS-PERINDOPRIL INDAPAMIDE	PMS	FGNQSW

PINDOLOL & HYDROCHLOROTHIAZIDE

10MG & 50MG TABLET

00568635	VISKAZIDE	XPI	FNQSW

24:08.16 CENTRAL ALPHA AGONISTS

⑤CLONIDINE HCL

0.025MG TABLET

02304163	TEVA-CLONIDINE	TEV	FGNQSW
02516217	SANDOZ-CLONIDINE	SDZ	FGNQSW
02524198	MAR-CLONIDINE	MAR	FGNQSW
02528207	JAMP-CLONIDINE	JPC	FGNQSW
02534738	MINT-CLONIDINE	MNT	FGNQSW
02540061	CLONIDINE	SIV	FGNQSW

0.1MG TABLET

02046121	TEVA-CLONIDINE	TEV	FGNQSW
02462192	MINT-CLONIDINE	MNT	FGNQSW
02515784	SANDOZ-CLONIDINE	SDZ	FGNQSW

02538490	CLONIDINE	SIV	FGNQSW
0.2MG TABLET			
02046148	TEVA-CLONIDINE	TEV	FGNQSW
02462206	MINT-CLONIDINE	MNT	FGNQSW
02515792	SANDOZ-CLONIDINE	SDZ	FGNQSW
02538504	CLONIDINE	SIV	FGNQSW

⑤ METHYLDOPA

125MG TABLET			
00360252	METHYLDOPA	AAA	FGNQSW
250MG TABLET			
00360260	METHYLDOPA	AAA	FGNQSW
500MG TABLET			
00426830	METHYLDOPA	AAA	FGNQSW

24:12.00 MISCELLANEOUS VASODILATING AGENTS

AMBRISANTAN

[SEE APPENDIX A](#) FOR SA CRITERIA

5MG TABLET			
02307065	VOLIBRIS (SA)	GSK	NMQW
02475375	APO-AMBRISANTAN (SA)	APX	NMQW
02521938	JAMP-AMBRISANTAN (SA)	JPC	NMQW
02526875	SANDOZ-AMBRISANTAN (SA)	SDZ	NMQW
10MG TABLET			
02307073	VOLIBRIS (SA)	GSK	NMQW
02475383	APO-AMBRISANTAN (SA)	APX	NMQW
02521946	JAMP-AMBRISANTAN (SA)	JPC	NMQW
02526883	SANDOZ-AMBRISANTAN (SA)	SDZ	NMQW

BETAHISTINE HCL

[SEE APPENDIX A](#) FOR SA CRITERIA (EXCEPT NURSING HOME PROGRAM)

16MG TABLET			
02243878	SERC (SA)	BGP	FNQSW
02280191	TEVA-BETAHISTINE (SA)	TEV	FGNQSW
02330210	PMS-BETAHISTINE (SA)	PMS	FGNQSW
02449153	AURO-BETAHISTINE (SA)	ARO	FGNQSW
02466449	BETAHISTINE (SA)	SNS	FGNQSW
02519690	M-BETAHISTINE (SA)	MRA	FGNQSW

02538148	MINT-BETAHISTINE (SA)	MNT	FGNQSW
24MG TABLET			
02247998	SERC (SA)	BGP	FNQSW
02280205	TEVA-BETAHISTINE (SA)	TEV	FGNQSW
02330237	PMS-BETAHISTINE (SA)	PMS	FGNQSW
02449161	AURO-BETAHISTINE (SA)	ARO	FGNQSW
02466457	BETAHISTINE (SA)	SNS	FGNQSW
02519704	M-BETAHISTINE (SA)	MRA	FGNQSW
02538156	MINT-BETAHISTINE (SA)	MNT	FGNQSW

DIPYRIDAMOLE

25MG TABLET			
00895644	APO-DIPYRIDAMOLE-FC	APX	FGNQSW
50MG TABLET			
00895652	APO-DIPYRIDAMOLE-FC	APX	FGNQSW
75MG TABLET			
00895660	APO-DIPYRIDAMOLE-FC	APX	FGNQSW

EPOPROSTENOL SODIUM (GLYCINE)

[SEE APPENDIX A](#) FOR SA CRITERIA

0.5 MG INJECTION			
02230845	FLOLAN (SA)	GSK	NMQW
1.5 MG INJECTION			
02230848	FLOLAN (SA)	GSK	NMQW

EPOPROSTENOL SODIUM (ARGININE)

[SEE APPENDIX A](#) FOR SA CRITERIA

0.5MG INJECTION			
02397447	CARIPUL (SA)	JAN	NMQW
1.5MG INJECTION			
02397455	CARIPUL (SA)	JAN	NMQW

⑤ISOSORBIDE DINITRATE

10MG TABLET			
00441686	ISDN	AAA	FGNQSW
30MG TABLET			
00441694	ISDN	AAA	FGNQSW

⑤ISOSORBIDE MONONITRATE

60MG TABLET

02126559	IMDUR	AST	FNQSW
02272830	APO-ISMM	APX	FGNQSW
02301288	PMS-ISMN	PMS	FGNQSW

MACITENTAN

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET

02415690	OPSUMIT (SA)	JAN	NMQW

NIMODIPINE

30MG TABLET

02325926	NIMOTOP	BAY	FNQSW

NITROGLYCERIN

NOTES:

1. To prevent development of tolerance, patches should be removed after 12-14 hours to provide daily NITRATE-FREE periods of 10-12 hours. The NITRATE-FREE period should be timed to coincide with the period in which angina is least likely to occur (USUALLY AT NIGHT).

⑤ NITROGLYCERIN TRANSDERMAL

Eligible for a 90 day supply

0.2MG/HR TRANSDERMAL PATCH

01911910	NITRO-DUR 0.2	RCH	FNQSW
02407442	MYLAN-NITRO PATCH	MYL	FGNQSW

0.2MG/HR TRANSDERMAL PATCH

02230732	TRINIPATCH 0.2	PAL	FQSW

0.4 MG/HR TRANSDERMAL PATCH

01911902	NITRO-DUR 0.4	RCH	FNQSW
02407450	MYLAN-NITRO PATCH	MYL	FGNQSW

0.4 MG/HR TRANSDERMAL PATCH

02230733	TRINIPATCH 0.4	PAL	FQSW

0.6 MG/HR TRANSDERMAL PATCH

01911929	NITRO-DUR 0.6	RCH	FNQSW
02407469	MYLAN-NITRO PATCH	MYL	FGNQSW

0.6 MG/HR TRANSDERMAL PATCH

02046156	TRANSDERM - NITRO 0.6	NVR	FQSW
02230734	TRINIPATCH 0.6	PAL	FQSW

0.8MG/HR TRANSDERMAL PATCH

02011271	NITRO-DUR 0.8	RCH	FNQSW

02407477	MYLAN-NITRO PATCH	MYL	FGNQSW

NITROGLYCERIN

0.3MG SUBLINGUAL TABLET			
00037613	NITROSTAT	UJC	NQW

0.6MG SUBLINGUAL TABLET			
00037621	NITROSTAT	UJC	NQW

0.4MG/DOSE METERED DOSE LINGUAL SPRAY			
02231441	NITROLINGUAL PUMPSPRAY	AVN	NQW
02238998	RHO-NITRO PUMPSPRAY	SDZ	NQW

RIOCIGUAT

[SEE APPENDIX A](#) FOR SA CRITERIA

0.5MG TABLET			
02412764	ADEMPAS (SA)	BAY	NMQW
02533545	SANDOZ-RIOCIGUAT (SA)	SDZ	NMQW

1MG TABLET			
02412772	ADEMPAS (SA)	BAY	NMQW
02533561	SANDOZ-RIOCIGUAT (SA)	SDZ	NMQW

1.5MG TABLET			
02412799	ADEMPAS (SA)	BAY	NMQW
02533588	SANDOZ-RIOCIGUAT (SA)	SDZ	NMQW

2MG TABLET			
02412802	ADEMPAS (SA)	BAY	NMQW
02533596	SANDOZ-RIOCIGUAT (SA)	SDZ	NMQW

2.5MG TABLET			
02412810	ADEMPAS (SA)	BAY	NMQW
02533618	SANDOZ-RIOCIGUAT (SA)	SDZ	NMQW

SELEXIPAG

[SEE APPENDIX A](#) FOR SA CRITERIA

200MCG TABLET			
02451158	UPTRAVI (SA)	JAN	NMQW

400MCG TABLET			
02451166	UPTRAVI (SA)	JAN	NMQW

600MCG TABLET			
02451174	UPTRAVI (SA)	JAN	NMQW

800MCG TABLET			
02451182	UPTRAVI (SA)	JAN	NMQW
1000MCG TABLET			
02451190	UPTRAVI (SA)	JAN	NMQW
1200MCG TABLET			
02451204	UPTRAVI (SA)	JAN	NMQW
1400MCG TABLET			
02451212	UPTRAVI (SA)	JAN	NMQW
1600MCG TABLET			
02451220	UPTRAVI (SA)	JAN	NMQW

SILDENAFIL CITRATE

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG TABLET			
02279401	REVATIO (SA)	UJC	MNSQW
02319500	TEVA-SILDENAFIL R (SA)	TEV	GMNSQW
02412179	PMS-SILDENAFIL-R (SA)	PMS	GMNSQW
02469669	JAMP-SILDENAFIL R (SA)	JPC	GMNSQW

24:20.00 ALPHA ADRENERGIC BLOCKING AGENTS

⑤DOXAZOSIN

1MG TABLET			
02240588	APO-DOXAZOSIN	APX	FGNQSW
02242728	TEVA-DOXAZOSIN	TEV	FGNQSW
02489937	JAMP-DOXAZOSIN	JPC	FGNQSW

2MG TABLET			
02240589	APO-DOXAZOSIN	APX	FGNQSW
02242729	TEVA-DOXAZOSIN	TEV	FGNQSW
02489945	JAMP-DOXAZOSIN	JPC	FGNQSW

4MG TABLET			
02240590	APO-DOXAZOSIN	APX	FGNQSW
02242730	TEVA-DOXAZOSIN	TEV	FGNQSW
02489953	JAMP-DOXAZOSIN	JPC	FGNQSW

⑤PRAZOSIN HCL

1MG TABLET

01934198	TEVA-PRAZOSIN	TEV	FGNQSW
2MG TABLET			
01934201	TEVA-PRAZOSIN	TEV	FGNQSW
5MG TABLET			
01934228	TEVA-PRAZOSIN	TEV	FGNQSW
⑤TERAZOSIN HCL			
1MG TABLET			
02234502	APO-TERAZOSIN	APX	FGNQSW
02243518	PMS-TERAZOSIN	PMS	FGNQSW
2MG TABLET			
02234503	APO-TERAZOSIN	APX	FGNQSW
02243519	PMS-TERAZOSIN	PMS	FGNQSW
5MG TABLET			
02234504	APO-TERAZOSIN	APX	FGNQSW
02243520	PMS-TERAZOSIN	PMS	FGNQSW
10MG TABLET			
02234505	APO-TERAZOSIN	APX	FGNQSW
02243521	PMS-TERAZOSIN	PMS	FGNQSW

24:28.08 DIHYDROPYRIDINES (CALCIUM CHANNEL BLOCKERS)

⑤FELODIPINE

2.5MG SUSTAINED RELEASE TABLET			
02057778	PLENDIL	AZE	FNQSW
02452367	APO-FELODIPINE	APX	FGNQSW
5MG SUSTAINED RELEASE TABLET			
00851779	PLENDIL	AZE	FNQSW
02280264	SANDOZ FELODIPINE	SDZ	FGNQSW
02452375	APO-FELODIPINE	APX	FGNQSW
10MG SUSTAINED RELEASE TABLET			
00851787	PLENDIL	AZE	FNQSW
02280272	SANDOZ FELODIPINE	SDZ	FGNQSW
02452383	APO-FELODIPINE	APX	FGNQSW

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

⑤BENAZEPRIL HCL

5MG TABLET

02290332 BENAZEPRIL AAA **FGNQSW**

10MG TABLET

02290340 BENAZEPRIL AAA **FGNQSW**

20MG TABLET

02273918 BENAZEPRIL AAA **FGNQSW**

⑤CAPTOPRIL

12.5MG TABLET

01942964 TEVA-CAPTOPRIL TEV **FGNQSW**

25MG TABLET

01942972 TEVA-CAPTOPRIL TEV **FGNQSW**

50MG TABLET

01942980 TEVA-CAPTOPRIL TEV **FGNQSW**

100MG TABLET

01942999 TEVA-CAPTORIL TEV **FGNQSW**

⑤CILAZAPRIL

1MG TABLET

02283778 MYLAN-CILAZAPRIL MYL **FGNQSW**

2.5MG TABLET

02283786 MYLAN-CILAZAPRIL MYL **FGNQSW**

02291142 APO-CILAZAPRIL APX **FGNQSW**

5MG TABLET

01911481 INHIBACE XPI **FNQSW**

02283794 MYLAN-CILAZAPRIL MYL **FGNQSW**

02291150 APO-CILAZAPRIL APX **FGNQSW**

⑤CILAZAPRIL & HYDROCHLOROTHIAZIDE

5MG & 12.5MG TABLET

02181479 INHIBACE PLUS XPI **FNQSW**

02284987 APO-CILAZAPRIL/HCTZ APX **FGNQSW**

02313731 TEVA-CILAZAPRIL/HCTZ TEV **FGNQSW**

⑤ ENALAPRIL MALEATE

2.5MG TABLET

02020025	APO-ENALAPRIL	APX	FGNQSW
02291878	ACT-ENALAPRIL	TEV	FGNQSW
02352230	RAN-ENALAPRIL	RAN	FGNQSW
02400650	ENALAPRIL	SNS	FGNQSW
02442957	ENALAPRIL	SIV	FGNQSW
02459450	MAR-ENALAPRIL	MAR	FGNQSW
02474786	JAMP-ENALAPRIL	JPC	FGNQSW

5MG TABLET

00708879	VASOTEC	MSD	FNQSW
02019884	APO-ENALAPRIL	APX	FGNQSW
02291886	ACT-ENALAPRIL	TEV	FGNQSW
02352249	RAN-ENALAPRIL	RAN	FGNQSW
02400669	ENALAPRIL	SNS	FGNQSW
02442965	ENALAPRIL	SIV	FGNQSW
02459469	MAR-ENALAPRIL	MAR	FGNQSW
02474794	JAMP-ENALAPRIL	JPC	FGNQSW

10MG TABLET

00670901	VASOTEC	MSD	FNQSW
02019892	APO-ENALAPRIL	APX	FGNQSW
02291894	ACT-ENALAPRIL	TEV	FGNQSW
02352257	RAN-ENALAPRIL	RAN	FGNQSW
02400677	ENALAPRIL	SNS	FGNQSW
02442973	ENALAPRIL	SIV	FGNQSW
02444771	MAR-ENALAPRIL	MAR	FGNQSW
02474808	JAMP-ENALAPRIL	JPC	FGNQSW

20MG TABLET

00670928	VASOTEC	MSD	FNQSW
02019906	APO-ENALAPRIL	APX	FGNQSW
02291908	ACT-ENALAPRIL	TEV	FGNQSW
02352265	RAN-ENALAPRIL	RAN	FGNQSW
02400685	ENALAPRIL	SNS	FGNQSW
02442981	ENALAPRIL	SIV	FGNQSW
02444798	MAR-ENALAPRIL	MAR	FGNQSW
02474816	JAMP-ENALAPRIL	JPC	FGNQSW

⑤ ENALAPRIL & HYDROCHLOROTHIAZIDE

5MG & 12.5MG TABLET

02352923	ENALAPRIL MALEATE/HCTZ	AAA	FGNQSW

10MG & 25MG TABLET

00657298	VASERETIC	MSD	FNQSW

02352931	ENALAPRIL MALEATE/HCTZ	AAA	FGNQSW

FINERENONE

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET

02531917	KERENDIA (SA)	BAY	FNQSW

20MG TABLET

02531925	KERENDIA (SA)	BAY	FNQSW

⑤FOSINOPRIL

10MG TABLET

02247802	TEVA-FOSINOPRIL	TEV	FGNQSW
02266008	APO-FOSINOPRIL	APX	FGNQSW
02331004	JAMP-FOSINOPRIL	JPC	FGNQSW
02294524	RAN-FOSINOPRIL	RAN	FGNQSW
02459388	FOSINOPRIL	SNS	FGNQSW

20MG TABLET

02247803	TEVA-FOSINOPRIL	TEV	FGNQSW
02266016	APO-FOSINOPRIL	APX	FGNQSW
02331012	JAMP-FOSINOPRIL	JPC	FGNQSW
02294532	RAN-FOSINOPRIL	RAN	FGNQSW
02459396	FOSINOPRIL	SNS	FGNQSW

⑤LISINOPRIL

5MG TABLET

02049333	ZESTRIL	AZE	FNQSW
02217481	APO-LISINOPRIL	APX	FGNQSW
02285118	TEVA-LISINOPRIL (TYPE Z)	TEV	FGNQSW
02361531	JAMP-LISINOPRIL	JPC	FGNQSW
02386232	LISINOPRIL	SIV	FGNQSW
02394472	AURO-LISINOPRIL	ARO	FGNQSW
02525186	LISINOPRIL	SNS	FGNQSW

10MG TABLET

02049376	ZESTRIL	AZE	FNQSW
02217503	APO-LISINOPRIL	APX	FGNQSW
02285126	TEVA-LISINOPRIL (TYPE Z)	TEV	FGNQSW
02294249	RAN-LISINOPRIL	RAN	FGNQSW
02361558	JAMP-LISINOPRIL	JPC	FGNQSW
02386240	LISINOPRIL	SIV	FGNQSW
02394480	AURO-LISINOPRIL	ARO	FGNQSW
02525194	LISINOPRIL	SNS	FGNQSW

20MG TABLET

02049384	ZESTRIL	AZE	FNQSW
02217511	APO-LISINOPRIL	APX	FGNQSW
02285134	TEVA-LISINOPRIL (TYPE Z)	TEV	FGNQSW
02294257	RAN-LISINOPRIL	RAN	FGNQSW
02361566	JAMP-LISINOPRIL	JPC	FGNQSW
02386259	LISINOPRIL	SIV	FGNQSW
02394499	AURO-LISINOPRIL	ARO	FGNQSW
02525208	LISINOPRIL	SNS	FGNQSW

⑤LISINOPRIL & HYDROCHLOROTHIAZIDE

10MG & 12.5MG TABLET

02103729	ZESTORESTIC	AZE	FNQSW
02301768	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV	FGNQSW
02302136	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	FGNQSW
02302365	SANDOZ LISINOPRIL/HCT	SDZ	FGNQSW
02362945	LISINOPRIL	SNS	FGNQSW

20MG & 12.5MG TABLET

02045737	ZESTORESTIC	AZE	FNQSW
02301776	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV	FGNQSW
02302144	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	FGNQSW
02302373	SANDOZ LISINOPRIL/HCT	SDZ	FGNQSW
02362953	LISINOPRIL	SNS	FGNQSW

20MG & 25MG TABLET

02045729	ZESTORESTIC	AZE	FNQSW
02301784	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV	FGNQSW
02302152	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	FGNQSW
02302381	SANDOZ-LISINOPRIL/HCT	SDZ	FGNQSW
02362961	LISINOPRIL	SNS	FGNQSW

⑤QUINAPRIL HCL

5MG TABLET

02248499	APO-QUINAPRIL	APX	FGNQSW
02340550	PMS-QUINAPRIL	PMS	FGNQSW

10MG TABLET

02248500	APO-QUINAPRIL	APX	FGNQSW
02340569	PMS-QUINAPRIL	PMS	FGNQSW
02517450	JAMP-QUINAPRIL	JPC	FGNQSW

20MG TABLET

02340577	PMS-QUINAPRIL	PMS	FGNQSW
02517469	JAMP-QUINAPRIL	JPC	FGNQSW

40MG TABLET

02340585	PMS-QUINAPRIL	PMS	FGNQSW
02517477	JAMP-QUINAPRIL	JPC	FGNQSW

⑤QUINAPRIL HCL & HYDROCHLOROTHIAZIDE

10MG & 12.5MG TABLET

02408767	APO-QUINAPRIL HCTZ	APX	FGNQSW
02473291	AURO-QUINAPRIL HCTZ	ARO	FGNQSW
02547430	JAMP-QUINAPRIL HCTZ	JPC	FGNQSW

20MG & 12.5MG TABLET

02408775	APO-QUINAPRIL HCTZ	APX	FGNQSW
02473305	AURO-QUINAPRIL HCTZ	ARO	FGNQSW

20MG & 25MG TABLET

02408783	APO-QUINAPRIL HCTZ	APX	FGNQSW
02473321	AURO-QUINAPRIL HCTZ	ARO	FGNQSW
02547449	JAMP-QUINAPRIL HCTZ	JPC	FGNQSW

⑤RAMIPRIL

1.25MG CAPSULE

02221829	ALTACE	BSL	FNQSW
02251515	APO-RAMIPRIL	APX	FGNQSW
02308363	RAMIPRIL	SIV	FGNQSW
02310503	RAN-RAMIPRIL	RAN	FGNQSW
02331101	JAMP RAMIPRIL	JPC	FGNQSW
02387387	AURO-RAMIPRIL	ARO	FGNQSW
02420457	MAR-RAMIPRIL	MAR	FGNQSW
02469057	PHARMA-RAMIPRIL	PMS	FGNQSW

2.5MG CAPSULE

02221837	ALTACE	BSL	FNQSW
02247945	TEVA-RAMIPRIL	TEV	FGNQSW
02251531	APO-RAMIPRIL	APX	FGNQSW
02287927	RAMIPRIL	SIV	FGNQSW
02310511	RAN-RAMIPRIL	RAN	FGNQSW
02331128	JAMP-RAMIPRIL	JPC	FGNQSW
02374846	RAMIPRIL	SNS	FGNQSW
02387395	AURO-RAMIPRIL	ARO	FGNQSW
02420465	MAR-RAMIPRIL	MAR	FGNQSW
02421305	MINT-RAMIPRIL	MNT	FGNQSW
02469065	PHARMA-RAMIPRIL	PMS	FGNQSW
02477572	AG-RAMIPRIL	ANG	FGNQSW
02486172	NRA-RAMIPRIL	NRA	FGNQSW

5MG CAPSULE

02221845	ALTACE	BSL	FNQSW

02247946	TEVA-RAMIPRIL	TEV	FGNQSW
02251574	APO-RAMIPRIL	APX	FGNQSW
02287935	RAMIPRIL	SIV	FGNQSW
02310538	RAN-RAMIPRIL	RAN	FGNQSW
02331136	JAMP-RAMIPRIL	JPC	FGNQSW
02374854	RAMIPRIL	SNS	FGNQSW
02387409	AURO-RAMIPRIL	ARO	FGNQSW
02420473	MAR-RAMIPRIL	MAR	FGNQSW
02421313	MINT-RAMIPRIL	MNT	FGNQSW
02469073	PHARMA-RAMIPRIL	PMS	FGNQSW
02477580	AG-RAMIPRIL	ANG	FGNQSW
02486180	NRA-RAMIPRIL	NRA	FGNQSW

10MG CAPSULE

02221853	ALTACE	BSL	FNQSW
02247947	TEVA-RAMIPRIL	TEV	FGNQSW
02251582	APO-RAMIPRIL	APX	FGNQSW
02287943	RAMIPRIL	SIV	FGNQSW
02310546	RAN-RAMIPRIL	RAN	FGNQSW
02331144	JAMP-RAMIPRIL	JPC	FGNQSW
02374862	RAMIPRIL	SNS	FGNQSW
02387417	AURO-RAMIPRIL	ARO	FGNQSW
02420481	MAR-RAMIPRIL	MAR	FGNQSW
02421321	MINT-RAMIPRIL	MNT	FGNQSW
02469081	PHARMA-RAMIPRIL	PMS	FGNQSW
02477599	AG-RAMIPRIL	ANG	FGNQSW
02486199	NRA-RAMIPRIL	NRA	FGNQSW

⑤RAMIPRIL & HYDROCHLOROTHIAZIDE

2.5MG & 12.5MG TABLET

02283131	ALTACE HCT	BSL	FNQSW
02449439	RAN-RAMIPRIL HCTZ	RAN	FGNQSW

5MG & 12.5MG TABLET

02283158	ALTACE HCT	BSL	FNQSW
02449447	RAN-RAMIPRIL HCTZ	RAN	FGNQSW

10MG & 12.5MG TABLET

02283166	ALTACE HCT	BSL	FNQSW
02342154	PMS-RAMIPRIL HCTZ	PMS	FGNQSW
02449455	RAN-RAMIPRIL HCTZ	RAN	FGNQSW

5MG & 25MG TABLET

02283174	ALTACE HCT	BSL	FNQSW
02449463	RAN-RAMIPRIL HCTZ	RAN	FGNQSW

10MG & 25MG TABLET

02283182	ALTACE HCT	BSL	FNQSW
02342170	PMS-RAMIPRIL-HCTZ	PMS	FGNQSW
02449471	RAN-RAMIPRIL HCTZ	RAN	FGNQSW

⑤TRANDOLAPRIL**0.5MG CAPSULE**

02231457	MAVIK	BGP	FNQSW
02325721	SANDOZ-TRANDOLAPRIL	SDZ	FGNQSW
02357755	PMS-TRANDOLAPRIL	PMS	FGNQSW
02471868	AURO-TRANDOLAPRIL	ARO	FGNQSW

1MG CAPSULE

02231459	MAVIK	BGP	FNQSW
02325748	SANDOZ-TRANDOLAPRIL	SDZ	FGNQSW
02357763	PMS-TRANDOLAPRIL	PMS	FGNQSW
02471876	AURO-TRANDOLAPRIL	ARO	FGNQSW
02525046	TRANDOLAPRIL	SNS	FGNQSW
02526565	TRANDOLAPRIL	SIV	FGNQSW

2MG CAPSULE

02231460	MAVIK	BGP	FNQSW
02325756	SANDOZ-TRANDOLAPRIL	SDZ	FGNQSW
02357771	PMS-TRANDOLAPRIL	PMS	FGNQSW
02471884	AURO-TRANDOLAPRIL	ARO	FGNQSW
02525054	TRANDOLAPRIL	SNS	FGNQSW
02526573	TRANDOLAPRIL	SIV	FGNQSW

4MG CAPSULE

02239267	MAVIK	BGP	FNQSW
02325764	SANDOZ-TRANDOLAPRIL	SDZ	FGNQSW
02357798	PMS-TRANDOLAPRIL	PMS	FGNQSW
02471892	AURO-TRANDOLAPRIL	ARO	FGNQSW
02525070	TRANDOLAPRIL	SNS	FGNQSW
02526581	TRANDOLAPRIL	SIV	FGNQSW

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS**⑤CANDESARTAN CILEXETIL****4MG TABLET**

02239090	ATACAND	XPI	FNQSW
02326957	SANDOZ-CANDESARTAN	SDZ	FGNQSW
02365340	APO-CANDESARTAN	APX	FGNQSW
02379260	CANDESARTAN CILEXETIL	ACH	FGNQSW

02380684	RAN-CANDESARTAN	RAN	FGNQSW
02388901	CANDESARTAN	SNS	FGNQSW
02391171	PMS-CANDESARTAN	PMS	FGNQSW
02445786	AURO-CANDESARTAN	ARO	FGNQSW
02476908	MINT-CANDESARTAN	MNT	FGNQSW
02528258	CANDESARTAN	SIV	FGNQSW
02541289	APO-CANDESARTAN	APX	FGNQSW

8MG TABLET

02239091	ATACAND	XPI	FNQSW
02326965	SANDOZ-CANDESARTAN	SDZ	FGNQSW
02365359	APO-CANDESARTAN	APX	FGNQSW
02366312	TEVA-CANDESARTAN	TEV	FGNQSW
02379279	CANDESARTAN CILEXETIL	ACH	FGNQSW
02380692	RAN-CANDESARTAN	RAN	FGNQSW
02386518	JAMP-CANDESARTAN	JPC	FGNQSW
02388707	CANDESARTAN	SIV	FGNQSW
02388928	CANDESARTAN	SNS	FGNQSW
02391198	PMS-CANDESARTAN	PMS	FGNQSW
02445794	AURO-CANDESARTAN	ARO	FGNQSW
02476916	MINT-CANDESARTAN	MNT	FGNQSW
02527014	NRA-CANDESARTAN	NRA	FGNQSW
02541297	APO-CANDESARTAN	APX	FGNQSW

16MG TABLET

02239092	ATACAND	XPI	FNQSW
02326973	SANDOZ-CANDESARTAN	SDZ	FGNQSW
02365367	APO-CANDESARTAN	APX	FGNQSW
02366320	TEVA-CANDESARTAN	TEV	FGNQSW
02379287	CANDESARTAN CILEXETIL	ACH	FGNQSW
02380706	RAN-CANDESARTAN	RAN	FGNQSW
02386526	JAMP-CANDESARTAN	JPC	FGNQSW
02388715	CANDESARTAN	SIV	FGNQSW
02388936	CANDESARTAN	SNS	FGNQSW
02391201	PMS-CANDESARTAN	PMS	FGNQSW
02445808	AURO-CANDESARTAN	ARO	FGNQSW
02476924	MINT-CANDESARTAN	MNT	FGNQSW
02527022	NRA-CANDESARTAN	NRA	FGNQSW
02541300	APO-CANDESARTAN	APX	FGNQSW

32MG TABLET

02311658	ATACAND	XPI	FNQSW
02366339	TEVA-CANDESARTAN	TEV	FGNQSW
02379295	CANDESARTAN CILEXETIL	ACH	FGNQSW
02380714	RAN-CANDESARTAN	RAN	FGNQSW
02386534	JAMP-CANDESARTAN	JPC	FGNQSW

02391228	PMS-CANDESARTAN	PMS	FGNQSW
02399105	APO-CANDESARTAN	APX	FGNQSW
02417340	SANDOZ-CANDESARTAN	SDZ	FGNQSW
02435845	CANDESARTAN	SNS	FGNQSW
02445816	AURO-CANDESARTAN	ARO	FGNQSW
02476932	MINT-CANDESARTAN	MNT	FGNQSW
02528266	CANDESARTAN	SIV	FGNQSW
02527030	NRA-CANDESARTAN	NRA	FGNQSW
02541319	APO-CANDESARTAN	APX	FGNQSW

⑤ **CANDESARTAN CILEXETIL & HYDROCHLOROTHIAZIDE**

16MG & 12.5MG TABLET

02244021	ATACAND PLUS	XPI	FNQSW
02327902	SANDOZ-CANDESARTAN PLUS	SDZ	FGNQSW
02391295	PMS-CANDESARTAN HCTZ	PMS	FGNQSW
02394804	CANDESARTAN/HCTZ	SNS	FGNQSW
02394812	CANDESARTAN/HCTZ	SIV	FGNQSW
02395541	TEVA-CANDESARTAN HCTZ	TEV	FGNQSW
02421038	AURO-CANDESARTAN HCT	ARO	FGNQSW
02473240	JAMP-CANDESARTAN HCT	JPC	FGNQSW
02531240	NRA-CANDESARTAN HCTZ	NRA	FGNQSW

32MG & 12.5MG TABLET

02332922	ATACAND PLUS	XPI	FNQSW
02395568	TEVA-CANDESARTAN HCTZ	TEV	FGNQSW
02420732	SANDOZ-CANDESARTAN HCTZ	SDZ	FGNQSW
02421046	AURO-CANDESARTAN HCT	ARO	FGNQSW
02473259	JAMP-CANDESARTAN HCT	JPC	FGNQSW
02536064	CANDESARTAN HCTZ	SNS	FGNQSW
02531259	NRA-CANDESARTAN HCTZ	NRA	FGNQSW

32MG & 25MG TABLET

02332957	ATACAND PLUS	XPI	FNQSW
02420740	SANDOZ-CANDESARTAN HCTZ	SDZ	FGNQSW
02421054	AURO-CANDESARTAN HCT	ARO	FGNQSW
02473267	JAMP-CANDESARTAN HCT	JPC	FGNQSW
02531267	NRA-CANDESARTAN HCTZ	NRA	FGNQSW

⑤ **EPROSARTAN MESYLATE**

400MG TABLET

02240432	TEVETEN	BGP	FNQSW

600MG TABLET

02243942	TEVETEN	BGP	FNQSW

⑤EPROSARTAN & HYDROCHLOROTHIAZIDE

600MG & 12.5MG TABLET

02253631 TEVETEN PLUS

BGP FNQSW

⑤IRBESARTAN

75MG TABLET

02316390 TEVA-IRBESARTAN

TEV FGNQSW

02317060 PMS-IRBESARTAN

PMS FGNQSW

02328461 SANDOZ-IRBESARTAN

SDZ FGNQSW

02372347 IRBESARTAN

SNS FGNQSW

02385287 IRBESARTAN

SIV FGNQSW

02406098 AURO-IRBESARTAN

ARO FGNQSW

02406810 RAN-IRBESARTAN

RAN FGNQSW

02422980 MINT-IRBESARTAN

MNT FGNQSW

02524813 M-IRBESARTAN

MRA FGNQSW

02545225 JAMP-IRBESARTAN

JPC FGNQSW

150MG TABLET

02237924 AVAPRO

AVN FNQSW

02316404 TEVA-IRBESARTAN

TEV FGNQSW

02317079 PMS-IRBESARTAN

PMS FGNQSW

02328488 SANDOZ-IRBESARTAN

SDZ FGNQSW

02372371 IRBESARTAN

SNS FGNQSW

02385295 IRBESARTAN

SIV FGNQSW

02406101 AURO-IRBESARTAN

ARO FGNQSW

02406829 RAN-IRBESARTAN

RAN FGNQSW

02422999 MINT-IRBESARTAN

MNT FGNQSW

02524821 M-IRBESARTAN

MRA FGNQSW

02545233 JAMP-IRBESARTAN

JPC FGNQSW

300MG TABLET

02237925 AVAPRO

AVN FNQSW

02316412 TEVA-IRBESARTAN

TEV FGNQSW

02317087 PMS-IRBESARTAN

PMS FGNQSW

02328496 SANDOZ-IRBESARTAN

SDZ FGNQSW

02372398 IRBESARTAN

SNS FGNQSW

02385309 IRBESARTAN

SIV FGNQSW

02406128 AURO-IRBESARTAN

ARO FGNQSW

02406837 RAN-IRBESARTAN

RAN FGNQSW

02423006 MINT-IRBESARTAN

MNT FGNQSW

02524848 M-IRBESARTAN

MRA FGNQSW

02545241 JAMP-IRBESARTAN

JPC FGNQSW

⑤IRBESARTAN & HYDROCHLOROTHIAZIDE

150MG & 12.5MG TABLET

02241818 AVALIDE

AVN FNQSW

02328518	PMS-IRBESARTAN HCTZ	PMS	FGNQSW
02330512	TEVA-IRBESARTAN HCTZ	TEV	FGNQSW
02337428	SANDOZ-IRBESARTAN HCT	SDZ	FGNQSW
02372886	IRBESARTAN HCTZ	SNS	FGNQSW
02385317	IRBESARTAN HCT	SIV	FGNQSW
02447878	AURO-IRBESARTAN HCT	ARO	FGNQSW

300MG & 12.5MG TABLET

02241819	AVALIDE	AVN	FNQSW
02328526	PMS-IRBESARTAN HCTZ	PMS	FGNQSW
02330520	TEVA-IRBESARTAN HCTZ	TEV	FGNQSW
02337436	SANDOZ-IRBESARTAN HCT	SDZ	FGNQSW
02372894	IRBESARTAN HCTZ	SNS	FGNQSW
02385325	IRBESARTAN HCT	SIV	FGNQSW
02447886	AURO-IRBESARTAN HCT	ARO	FGNQSW

300MG & 25MG TABLET

02328534	PMS-IRBESARTAN HCTZ	PMS	FGNQSW
02330539	TEVA-IRBESARTAN HCTZ	TEV	FGNQSW
02337444	SANDOZ-IRBESARTAN HCT	SDZ	FGNQSW
02372908	IRBESARTAN HCTZ	SNS	FGNQSW
02385333	IRBESARTAN HCT	SIV	FGNQSW
02447894	AURO-IRBESARTAN HCT	ARO	FGNQSW

⑤LOSARTAN POTASSIUM

25MG TABLET

02182815	COZAAR	MSD	FNQSW
02313332	SANDOZ-LOSARTAN	SDZ	FGNQSW
02309750	PMS-LOSARTAN	PMS	FGNQSW
02380838	TEVA-LOSARTAN	TEV	FGNQSW
02388790	LOSARTAN	SIV	FGNQSW
02388863	LOSARTAN	SNS	FGNQSW
02398834	JAMP-LOSARTAN	JPC	FGNQSW
02403323	AURO-LOSARTAN	ARO	FGNQSW
02405733	MINT-LOSARTAN	MNT	FGNQSW

50MG TABLET

02182874	COZAAR	MSD	FNQSW
02309769	PMS-LOSARTAN	PMS	FGNQSW
02313340	SANDOZ-LOSARTAN	SDZ	FGNQSW
02357968	TEVA-LOSARTAN	TEV	FGNQSW
02388804	LOSARTAN	SIV	FGNQSW
02388871	LOSARTAN	SNS	FGNQSW
02398842	JAMP-LOSARTAN	JPC	FGNQSW
02403331	AURO-LOSARTAN	ARO	FGNQSW
02405741	MINT-LOSARTAN	MNT	FGNQSW

100MG TABLET

02182882	COZAAR	MSD	FNQSW
02309777	PMS-LOSARTAN	PMS	FGNQSW
02313359	SANDOZ-LOSARTAN	SDZ	FGNQSW
02357976	TEVA-LOSARTAN	TEV	FGNQSW
02388812	LOSARTAN	SIV	FGNQSW
02388898	LOSARTAN	SNS	FGNQSW
02398850	JAMP-LOSARTAN	JPC	FGNQSW
02403358	AURO-LOSARTAN	ARO	FGNQSW
02405768	MINT-LOSARTAN	MNT	FGNQSW

⑤LOSARTAN POTASSIUM & HYDROCHLOROTHIAZIDE**50MG & 12.5MG TABLET**

02230047	HYZAAR	MSD	FNQSW
02313375	SANDOZ-LOSARTAN HCT	SDZ	FGNQSW
02358263	TEVA-LOSARTAN HCTZ	TEV	FGNQSW
02388960	LOSARTAN HCTZ	SIV	FGNQSW
02389657	MINT-LOSARTAN HCTZ	MNT	FGNQSW
02392224	PMS-LOSARTAN HCTZ	PMS	FGNQSW
02423642	AURO-LOSARTAN HCT	ARO	FGNQSW
02427648	LOSARTAN-HCTZ	SNS	FGNQSW

100MG & 12.5MG TABLET

02297841	HYZAAR	MSD	FNQSW
02362449	SANDOZ-LOSARTAN HCT	SDZ	FGNQSW
02377144	TEVA-LOSARTAN HCTZ	TEV	FGNQSW
02388979	LOSARTAN HCTZ	SIV	FGNQSW
02389665	MINT-LOSARTAN HCTZ	MNT	FGNQSW
02392232	PMS-LOSARTAN HCTZ	PMS	FGNQSW
02423650	AURO-LOSARTAN HCT	ARO	FGNQSW
02427656	LOSARTAN-HCTZ	SNS	FGNQSW

100MG & 25MG TABLET

02241007	HYZAAR DS	MSD	FNQSW
02313383	SANDOZ-LOSARTAN HCT	SDZ	FGNQSW
02377152	TEVA-LOSARTAN HCTZ	TEV	FGNQSW
02388987	LOSARTAN HCTZ	SIV	FGNQSW
02389673	MINT-LOSARTAN HCTZ	MNT	FGNQSW
02392240	PMS-LOSARTAN HCTZ	PMS	FGNQSW
02423669	AURO-LOSARTAN HCT	ARO	FGNQSW
02427664	LOSARTAN-HCTZ	SNS	FGNQSW

⑤OLMESARTAN**20MG TABLET**

02318660	OLMETEC	MSD	FNQSW

02442191	TEVA-OLMESARTAN	TEV	FGNQSW
02443414	SANDOZ-OLMESARTAN	SDZ	FGNQSW
02443864	AURO-OLMESARTAN	ARO	FGNQSW
02453452	APO-OLMESARTAN	APX	FGNQSW
02456311	ACH-OLMESARTAN	ACH	FGNQSW
02461307	PMS-OLMESARTAN	PMS	FGNQSW
02461641	JAMP-OLMESARTAN	JPC	FGNQSW
02469812	GLN-OLMESARTAN	GLM	FGNQSW
02481057	OLMESARTAN	SNS	FGNQSW
02499258	NRA-OLMESARTAN	NRA	FGNQSW

40MG TABLET

02318679	OLMETEC	MSD	FNQSW
02442205	TEVA-OLMESARTAN	TEV	FGNQSW
02443422	SANDOZ-OLMESARTAN	SDZ	FGNQSW
02443872	AURO-OLMESARTAN	ARO	FGNQSW
02453460	APO-OLMESARTAN	APX	FGNQSW
02456338	ACH-OLMESARTAN	ACH	FGNQSW
02461315	PMS-OLMESARTAN	PMS	FGNQSW
02461668	JAMP-OLMESARTAN	JPC	FGNQSW
02469820	GLN-OLMESARTAN	GLM	FGNQSW
02481065	OLMESARTAN	SNS	FGNQSW
02499266	NRA-OLMESARTAN	NRA	FGNQSW

⑤OLMESARTAN & HYDROCHLOROTHIAZIDE

20MG & 12.5MG TABLET

02319616	OLMETEC PLUS	MSD	FNQSW
02443112	ACT-OLMESARTAN/HCTZ	TEV	FGNQSW
02453606	APO-OLMESARTAN/HCTZ	APX	FGNQSW
02468948	ACH-OLMESARTAN/HCTZ	ACH	FGNQSW
02475707	GLN-OLMESARTAN/HCTZ	GLM	FGNQSW
02476487	AURO-OLMESARTAN HCTZ	ARO	FGNQSW
02508273	NRA-OLMESARTAN/HCTZ	NRA	FGNQSW
02509601	OLMESARTAN-HCTZ	SNS	FGNQSW
02526468	PRZ-OLMESARTAN-HCTZ	PRZ	FGNQSW

40MG & 12.5MG TABLET

02319624	OLMETEC PLUS	MSD	FNQSW
02443120	ACT-OLMESARTAN/HCTZ	TEV	FGNQSW
02453614	APO-OLMESARTAN/HCTZ	APX	FGNQSW
02468956	ACH-OLMESARTAN/HCTZ	ACH	FGNQSW
02475715	GLN-OLMESARTAN/HCTZ	GLM	FGNQSW
02476495	AURO-OLMESARTAN HCTZ	ARO	FGNQSW
02508281	NRA-OLMESARTAN/HCTZ	NRA	FGNQSW
02509636	OLMESARTAN-HCTZ	SNS	FGNQSW
02526476	PRZ-OLMESARTAN-HCTZ	PRZ	FGNQSW

40MG & 25MG TABLET

02319632	OLMETEC PLUS	MSD	FNQSW
02443139	ACT-OLMESARTAN/HCTZ	TEV	FGNQSW
02453622	APO-OLMESARTAN/HCTZ	APX	FGNQSW
02468964	ACH-OLMESARTAN/HCTZ	ACH	FGNQSW
02475723	GLN-OLMESARTAN/HCTZ	GLM	FGNQSW
02476509	AURO-OLMESARTAN HCTZ	ARO	FGNQSW
02508303	NRA-OLMESARTAN/HCTZ	NRA	FGNQSW
02509628	OLMESARTAN-HCTZ	SNS	FGNQSW
02526484	PRZ-OLMESARTAN-HCTZ	PRZ	FGNQSW

⑤SACUBITRIL & VALSARTAN[SEE APPENDIX A](#) FOR SA CRITERIA**24MG & 26MG TABLET**

02446928	ENTRESTO (SA)	NVR	FNQSW

49MG & 51MG TABLET

02446936	ENTRESTO (SA)	NVR	FNQSW

97MG & 103MG TABLET

02446944	ENTRESTO (SA)	NVR	FNQSW

⑤TELMISARTAN**40MG TABLET**

02240769	MICARDIS	BOE	FNQSW
02320177	TEVA-TELMISARTAN	TEV	FGNQSW
02375958	SANDOZ-TELMISARTAN	SDZ	FGNQSW
02386755	JAMP-TELMISARTAN	JPC	FGNQSW
02388944	TELMISARTAN	SNS	FGNQSW
02390345	TELMISARTAN	SIV	FGNQSW
02407485	TELMISARTAN	ACH	FGNQSW
02453568	AURO-TELMISARTAN	ARO	FGNQSW
02486369	MINT-TELMISARTAN	MNT	FGNQSW
02499622	PMS-TELMISARTAN	PMS	FGNQSW
02503794	NRA-TELMISARTAN	NRA	FGNQSW

80MG TABLET

02240770	MICARDIS	BOE	FNQSW
02320185	TEVA-TELMISARTAN	TEV	FGNQSW
02375966	SANDOZ-TELMISARTAN	SDZ	FGNQSW
02386763	JAMP-TELMISARTAN	JPC	FGNQSW
02388952	TELMISARTAN	SNS	FGNQSW
02390353	TELMISARTAN	SIV	FGNQSW
02407493	TELMISARTAN	ACH	FGNQSW
02453576	AURO-TELMISARTAN	ARO	FGNQSW

02486377	MINT-TELMISARTAN	MNT	FGNQSW
02499630	PMS-TELMISARTAN	PMS	FGNQSW
02503808	NRA-TELMISARTAN	NRA	FGNQSW

⑤ **TELMISARTAN & AMLODIPINE**

40/5MG TABLET

02371022	TWYNSTA	BOE	FNQSW

40/10MG TABLET

02371030	TWYNSTA	BOE	FNQSW

80/5MG TABLET

02371049	TWYNSTA	BOE	FNQSW

80/10MG TABLET

02371057	TWYNSTA	BOE	FNQSW

⑤ **TELMISARTAN & HYDROCHLOROTHIAZIDE**

80MG & 12.5MG TABLET

02244344	MICARDIS PLUS	BOE	FNQSW
02330288	TEVA-TELMISARTAN HCTZ	TEV	FGNQSW
02389940	JAMP-TELMISARTAN HCT	JPC	FGNQSW
02390302	TELMISARTAN-HCTZ	SIV	FGNQSW
02393557	SANDOZ-TELMISARTAN HCT	SDZ	FGNQSW
02395355	TELMISARTAN HCTZ	SNS	FGNQSW
02419114	ACH-TELMISARTAN HCTZ	ACH	FGNQSW
02456389	AURO-TELMISARTAN HCTZ	ARO	FGNQSW
02504146	NRA-TELMISARTAN HCTZ	NRA	FGNQSW

80MG & 25 MG TABLET

02318709	MICARDIS PLUS	BOE	FNQSW
02379252	TEVA-TELMISARTAN HCTZ	TEV	FGNQSW
02389959	JAMP-TELMISARTAN HCT	JPC	FGNQSW
02390310	TELMISARTAN-HCTZ	SIV	FGNQSW
02393565	SANDOZ-TELMISARTAN HCT	SDZ	FGNQSW
02395363	TELMISARTAN HCTZ	SNS	FGNQSW
02419122	ACH-TELMISARTAN HCTZ	ACH	FGNQSW
02456397	AURO-TELMISARTAN HCTZ	ARO	FGNQSW
02504138	NRA-TELMISARTAN HCTZ	NRA	FGNQSW

⑤ **VALSARTAN**

40MG TABLET

02270528	DIOVAN	NVR	FNQSW
02356740	SANDOZ-VALSARTAN	SDZ	FGNQSW
02356643	TEVA-VALSARTAN	TEV	FGNQSW
02363062	TARO-VALSARTAN	SUN	FGNQSW

02366940	VALSARTAN	SNS	FGNQSW
02384523	VALSARTAN	SIV	FGNQSW
02414201	AURO-VALSARTAN	ARO	FGNQSW
02524511	M-VALSARTAN	MRA	FGNQSW

80MG TABLET

02244781	DIOVAN	NVR	FNQSW
02356759	SANDOZ-VALSARTAN	SDZ	FGNQSW
02356651	TEVA-VALSARTAN	TEV	FGNQSW
02363100	TARO-VALSARTAN	SUN	FGNQSW
02366959	VALSARTAN	SNS	FGNQSW
02384531	VALSARTAN	SIV	FGNQSW
02414228	AURO-VALSARTAN	ARO	FGNQSW
02524538	M-VALSARTAN	MRA	FGNQSW

160MG TABLET

02244782	DIOVAN	NVR	FNQSW
02356767	SANDOZ-VALSARTAN	SDZ	FGNQSW
02356678	TEVA-VALSARTAN	TEV	FGNQSW
02363119	TARO-VALSARTAN	SUN	FGNQSW
02366967	VALSARTAN	SNS	FGNQSW
02384558	VALSARTAN	SIV	FGNQSW
02414236	AURO-VALSARTAN	ARO	FGNQSW
02524546	M-VALSARTAN	MRA	FGNQSW

320MG TABLET

02289504	DIOVAN	NVR	FNQSW
02356775	SANDOZ-VALSARTAN	SDZ	FGNQSW
02356686	TEVA-VALSARTAN	TEV	FGNQSW
02366975	VALSARTAN	SNS	FGNQSW
02384566	VALSARTAN	SIV	FGNQSW
02414244	AURO-VALSARTAN	ARO	FGNQSW

⑤ VALSARTAN & HYDROCHLORTHIAZIDE

80MG & 12.5MG TABLET

02241900	DIOVAN-HCT	NVR	FNQSW
02356694	SANDOZ-VALSARTAN HCT	SDZ	FGNQSW
02356996	TEVA-VALSARTAN HCTZ	TEV	FGNQSW
02367009	VALSARTAN HCTZ	SNS	FGNQSW
02384736	VALSARTAN HCT	SIV	FGNQSW
02408112	AURO-VALSARTAN HCT	ARO	FGNQSW

160MG & 12.5MG TABLET

02241901	DIOVAN-HCT	NVR	FNQSW
02356708	SANDOZ-VALSARTAN HCT	SDZ	FGNQSW
02357003	TEVA-VALSARTAN HCTZ	TEV	FGNQSW

02367017	VALSARTAN HCTZ	SNS	FGNQSW
02384744	VALSARTAN HCT	SIV	FGNQSW
02408120	AURO-VALSARTAN HCT	ARO	FGNQSW

160MG & 25MG TABLET

02246955	DIOVAN-HCT	NVR	FNQSW
02356716	SANDOZ-VALSARTAN HCT	SDZ	FGNQSW
02357011	TEVA-VALSARTAN HCTZ	TEV	FGNQSW
02367025	VALSARTAN HCTZ	SNS	FGNQSW
02384752	VALSARTAN HCT	SIV	FGNQSW
02408139	AURO-VALSARTAN HCT	ARO	FGNQSW

320MG & 12.5MG TABLET

02308908	DIOVAN-HCT	NVR	FNQSW
02356724	SANDOZ-VALSARTAN HCT	SDZ	FGNQSW
02357038	TEVA-VALSARTAN HCTZ	TEV	FGNQSW
02367033	VALSARTAN HCTZ	SNS	FGNQSW
02384760	VALSARTAN HCT	SIV	FGNQSW
02408147	AURO-VALSARTAN HCT	ARO	FGNQSW

320MG & 25MG TABLET

02308916	DIOVAN-HCT	NVR	FNQSW
02356732	SANDOZ-VALSARTAN HCT	SDZ	FGNQSW
02357046	TEVA-VALSARTAN HCTZ	TEV	FGNQSW
02367041	VALSARTAN HCTZ	SNS	FGNQSW
02408155	AURO-VALSARTAN HCT	ARO	FGNQSW

28:08.04 NONSTEROIDAL ANTI INFLAMMATORY AGENTS

ACETYLSALICYLIC ACID

325MG TABLET

00999963	ASA (DIN for billing purposes only)	NW

81MG ENTERIC COATED TABLET

00999971	ASA (DIN for billing purposes only)	NW

CELECOXIB

100MG CAPSULE

02239941	CELEBREX	UJC	FNQSW
02355442	PMS-CELECOXIB	PMS	FGNQSW
02412373	RAN-CELECOXIB	RAN	FGNQSW
02412497	MINT-CELECOXIB	MNT	FGNQSW
02418932	APO-CELECOXIB	APX	FGNQSW

02420058	MAR-CELECOXIB	MAR	FGNQSW
02420155	ACT-CELECOXIB	TEV	FGNQSW
02424533	JAMP-CELECOXIB	JPC	FGNQSW
02429675	CELECOXIB	SIV	FGNQSW
02436299	CELECOXIB	SNS	FGNQSW
02437570	AG-CELECOXIB	ANG	FGNQSW
02445670	AURO-CELECOXIB	ARO	FGNQSW
02479737	NRA-CELECOXIB	NRA	FGNQSW
02495465	M-CELECOXIB	MRA	FGNQSW
02517116	PMSC-CELECOXIB	PMS	FGNQSW

200MG CAPSULE

02239942	CELEBREX	UJC	FNQSW
02355450	PMS-CELECOXIB	PMS	FGNQSW
02412381	RAN-CELECOXIB	RAN	FGNQSW
02412500	MINT-CELECOXIB	MNT	FGNQSW
02418940	APO-CELECOXIB	APO	FGNQSW
02420066	MAR-CELECOXIB	MAR	FGNQSW
02420163	ACT-CELECOXIB	TEV	FGNQSW
02424541	JAMP-CELECOXIB	JPC	FGNQSW
02429683	CELECOXIB	SIV	FGNQSW
02436302	CELECOXIB	SNS	FGNQSW
02437589	AG-CELECOXIB	ANG	FGNQSW
02445689	AURO-CELECOXIB	ARO	FGNQSW
02479745	NRA-CELECOXIB	NRA	FGNQSW
02495473	M-CELECOXIB	MRA	FGNQSW
02517124	PMSC-CELECOXIB	PMS	FGNQSW

DICLOFENAC SODIUM

25MG ENTERIC COATED TABLET

00808539	TEVA-DICLOFENAC EC	TEV	FGNQSW
00839175	APO-DICLO	APX	FGNQSW
02302616	PMS-DICLOFENAC	PMS	FGNQSW

50MG ENTERIC COATED TABLET

00808547	TEVA DIFENAC	TEV	FGNQSW
00839183	APO-DICLO	APX	FGNQSW
02302624	PMS-DICLOFENAC	PMS	FGNQSW

75MG SUSTAINED RELEASE TABLET

02162814	APO-DICLO SR	APX	FGNQSW

100MG SUSTAINED RELEASE TABLET

02091194	APO-DICLO SR	APX	FGNQSW

50MG SUPPOSITORY

00632724	VOLTAREN	NVR	FNQSW
02261928	SANDOZ-DICLOFENAC	SDZ	FGNQSW

DICLOFENAC & MISOPROSTOL

50MG/200MG TABLET

01917056	ARTHROTEC	PFI	FNQSW
02341689	GD-DICLOFENAC/MISOPROSTOL	GMD	FGNQSW
02413469	PMS-DICLOFENAC/MISOPROSTOL	PMS	FGNQSW

75MG/200MG TABLET

02229837	ARTHROTEC	PFI	FNQSW
02341697	GD-DICLOFENAC/MISOPROSTOL	GMD	FGNQSW
02413477	PMS-DICLOFENAC/MISOPROSTOL	PMS	FGNQSW

FLURBIPROFEN

50MG TABLET

01912046	FLURBIPROFEN	AAA	FGNQSW

100MG TABLET

01912038	FLURBIPROFEN	AAA	FGNQSW

IBUPROFEN

300MG TABLET

00999986	IBUPROFEN (DIN for billing purposes only)		NW

400MG TABLET

00999987	IBUPROFEN (DIN for billing purposes only)		NW

600MG TABLET

00585114	APO-IBUPROFEN	APX	FNQSW
00629359	TEVA-PROFEN	TEV	FNQSW

INDOMETHACIN

25MG CAPSULE

00337420	TEVA-METHACIN	TEV	FGNQSW
02461811	MINT-INDOMETHACIN	MNT	FGNQSW

50MG CAPSULE

00337439	TEVA-METHACIN	TEV	FGNQSW
02461536	MINT-INDOMETHACIN	MNT	FGNQSW

KETOPROFEN

50MG CAPSULE

00790427	KETOPROFEN	AAA	FGNQSW

50MG ENTERIC COATED TABLET

00790435	KETOPROFEN-E	AAA	FGNQSW
100MG ENTERIC COATED TABLET			
00842664	KETOPROFEN-E	AAA	FGNQSW
MEFENAMIC ACID			
250MG CAPSULE			
00155225	PONSTAN	AAA	FQW
MELOXICAM			
7.5MG TABLET			
02248267	PMS-MELOXICAM	PMS	FGNQSW
02248973	APO-MELOXICAM	APX	FGNQSW
02258315	TEVA-MELOXICAM	TEV	FGNQSW
02353148	MELOXICAM	SNS	FGNQSW
02390884	AURO-MELOXICAM	ARO	FGNQSW
15MG TABLET			
02248268	PMS-MELOXICAM	PMS	FGNQSW
02248974	APO-MELOXICAM	APX	FGNQSW
02258323	TEVA-MELOXICAM	TEV	FGNQSW
02353156	MELOXICAM	SNS	FGNQSW
02390892	AURO-MELOXICAM	ARO	FGNQSW
NABUMETONE			
500MG TABLET			
02238639	NABUMETONE	AAA	FGNQSW
NAPROXEN			
125MG TABLET			
00522678	APO-NAPROXEN	APX	FGNQSW
250MG TABLET			
00522651	APO-NAPROXEN	APX	FGNQSW
00565350	TEVA-NAPROX	TEV	FGNQSW
375MG TABLET			
00600806	APO-NAPROXEN	APX	FGNQSW
00627097	TEVA NAPROX	TEV	FGNQSW
500MG TABLET			
00589861	TEVA-NAPROX	TEV	FGNQSW
00592277	APO-NAPROXEN	APX	FGNQSW
250MG ENTERIC COATED TABLET			
02243312	TEVA-NAPROXEN EC	TEV	FGNQSW

375MG ENTERIC COATED TABLET			
02243313	TEVA-NAPROXEN EC	TEV	FGNQSW
02246700	APO-NAPROXEN EC	APX	FGNQSW

500MG ENTERIC COATED TABLET			
02162423	NAPROSYN-E	MTP	FNQSW
02243314	TEVA-NAPROXEN EC	TEV	FGNQSW
02246701	APO-NAPROXEN EC	APX	FGNQSW

750MG SUSTAINED RELEASE TABLET			
02162466	NAPROSYN SR	MTP	FNQSW

PIROXICAM

10MG CAPSULE			
00695718	TEVA-PIROXICAM	TEV	FGNQSW

20MG CAPSULE			
00695696	TEVA-PIROXICAM	TEV	FGNQSW

SULINDAC

150MG TABLET			
00745588	TEVA-SULINDAC	TEV	FGNQSW

200MG TABLET			
00745596	TEVA-SULINDAC	TEV	FGNQSW

TIAPROFENIC ACID

200MG TABLET			
02179679	TEVA-TIAPROFENIC ACID	TEV	FGNQSW

300MG TABLET			
02179687	TEVA-TIAPROFENIC ACID	TEV	FGNQSW

28:08.08 OPIATE AGONISTS (NARCOTIC ANALGESICS)

ACETAMINOPHEN & CODEINE

300MG & 60MG TABLET			
00621463	TEVA-LENOLTEC NO.4	TEV	FNQSW

ACETAMINOPHEN COMPOUND WITH CODEINE

15MG CODEINE TABLET			
00653241	TEVA-LENOLTEC NO.2	TEV	FNQSW

30MG CODEINE TABLET			
00653276	TEVA-LENOLTEC NO.3	TEV	FNQSW

CODEINE

15MG TABLET			
00593435	TEVA-CODEINE	TEV	FNQSW

30MG TABLET			
00593451	TEVA-CODEINE	TEV	FNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG CONTROLLED RELEASE TABLET			
02230302	CODEINE CONTIN (SA)	PFR	FNQSW

100MG CONTROLLED RELEASE TABLET			
02163748	CODEINE CONTIN (SA)	PFR	FNQSW

150MG CONTROLLED RELEASE TABLET			
02163780	CODEINE CONTIN (SA)	PFR	FNQSW

200MG CONTROLLED RELEASE TABLET			
02163799	CODEINE CONTIN (SA)	PFR	FNQSW

FENTANYL

[SEE APPENDIX A](#) FOR SA CRITERIA

12MCG/HR TRANSDERMAL PATCH			
02311925	TEVA-FENTANYL (SA)	TEV	FNQSW
02327112	SANDOZ-FENTANYL (SA)	SDZ	FNQSW

25MCG/HR TRANSDERMAL PATCH			
02282941	TEVA-FENTANYL (SA)	TEV	FNQSW
02327120	SANDOZ-FENTANYL (SA)	SDZ	FNQSW

37MCG/HR TRANSDERMAL PATCH			
02327139	SANDOZ-FENTANYL (SA)	SDZ	FNQSW

50MCG/HR TRANSDERMAL PATCH			
02282968	TEVA-FENTANYL (SA)	TEV	FNQSW
02327147	SANDOZ-FENTANYL (SA)	SDZ	FNQSW

75MCG/HR TRANSDERMAL PATCH			
02282976	TEVA-FENTANYL (SA)	TEV	FNQSW
02327155	SANDOZ-FENTANYL (SA)	SDZ	FNQSW

100MCG/HR TRANSDERMAL PATCH			

02282984	TEVA-FENTANYL (SA)	TEV	FNQSW
02327163	SANDOZ-FENTANYL (SA)	SDZ	FNQSW

HYDROMORPHONE HCL

1MG TABLET

00705438	DILAUDID	PFR	FNQSW
00885444	PMS-HYDROMORPHONE	PMS	FNQSW
02364115	APO-HYDROMORPHONE	APX	FNQSW

2MG TABLET

00125083	DILAUDID	PFR	FNQSW
00885436	PMS-HYDROMORPHONE	PMS	FNQSW
02364123	APO-HYDROMORPHONE	APX	FNQSW

4MG TABLET

00125121	DILAUDID	PFR	FNQSW
00885401	PMS-HYDROMORPHONE	PMS	FNQSW
02364131	APO-HYDROMORPHONE	APX	FNQSW

8MG TABLET

00786543	DILAUDID	PFR	FNQSW
00885428	PMS-HYDROMORPHONE	PMS	FNQSW
02364158	APO-HYDROMORPHONE	APX	FNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

3MG CONTROLLED-RELEASE CAPSULE

02125323	HYDROMORPH CONTIN (SA)	PFR	FNQSW

4.5MG CONTROLLED-RELEASE CAPSULE

02359502	HYDROMORPH CONTIN (SA)	PFR	FNQSW

6MG CONTROLLED-RELEASE CAPSULE

02125331	HYDROMORPH CONTIN (SA)	PFR	FNQSW

9MG CONTROLLED-RELEASE CAPSULE

02359510	HYDROMORPH CONTIN (SA)	PFR	FNQSW

12MG CONTROLLED-RELEASE CAPSULE

02125366	HYDROMORPH CONTIN (SA)	PFR	FNQSW

18MG CONTROLLED-RELEASE CAPSULE

02243562	HYDROMORPH CONTIN (SA)	PFR	FNQSW

24MG CONTROLLED-RELEASE CAPSULE

02125382	HYDROMORPH CONTIN (SA)	PFR	FNQSW

30MG CONTROLLED-RELEASE CAPSULE		
02125390	HYDROMORPH CONTIN (SA)	PFR FNQSW

1MG/ML ORAL LIQUID		
01916386	PMS-HYDROMORPHONE	PMS FNQSW

2MG/ML INJECTION SOLUTION (1ML)		
02145901	HYDROMORPHONE	SDZ NQ

[SEE APPENDIX A](#) FOR SA CRITERIA. **NOTE:** SA NOT REQUIRED FOR NURSING HOME PROGRAM.

10MG/ML INJECTION SOLUTION (1ML, 5ML, AND 50ML)		
02145928	HYDROMORPHONE (SA)	SDZ FNQSW

20MG/ML INJECTION		
02145936	HYDROMORPHONE (SA)	SDZ FNQSW

50MG/ML INJECTION SOLUTION (50ML)		
02146126	HYDROMORPHONE HP (SA)	SDZ FNQSW

METHADONE

[SEE APPENDIX A](#) FOR SA CRITERIA

1MG TABLET		
02247698	METADOL (SA)	PAL FNQSW
02533642	APO-METHADONE (SA)	APX FNQSW

5MG TABLET		
02247699	METADOL (SA)	PAL FNQSW
02533650	APO-METHADONE (SA)	APX FNQSW

10MG TABLET		
02247700	METADOL (SA)	PAL FNQSW
02533669	APO-METHADONE (SA)	APX FNQSW

25MG TABLET		
02247701	METADOL (SA)	PAL FNQSW
02533677	APO-METHADONE (SA)	APX FNQSW

Tablets Only - For the management of severe chronic or malignant pain as an alternative to other opiates

⑤METHADONE SOLUTION

10MG/ML		
02244290	METADOL-D	PAL FLNQSW
02495872	ODAN-METHADONE (CHERRY FLAVORED)	ODN FLNQSW
02495880	ODAN-METHADONE (UNFLAVORED)	ODN FLNQSW

02552728	PMS-METHADONE HCL (UNFLAVORED)	PMS	FLNQSW
02552736	PMS-METHADONE HCL (CHERRY FLAVORED)	PMS	FLNQSW

MORPHINE

1MG/ML ORAL SYRUP

00614491	DOLORAL 1	ATL	FNQSW

5MG TABLET

00594652	STATEX	PAL	FNQSW

02549794	PMS-MORPHINE SULFATE	PMS	FNQSW

02014203	MSIR	PFR	FNQSW

10MG TABLET

00594644	STATEX	PAL	FNQSW

02549808	PMS-MORPHINE SULFATE	PMS	FNQSW

02014211	MSIR	PFR	FNQSW

20MG TABLET

02014238	MSIR	PFR	FNQSW

25MG TABLET

00594636	STATEX	PAL	FNQSW

30MG TABLET

02014254	MSIR	PFR	FNQSW

50MG TABLET

00675962	STATEX	PAL	FNQSW

10MG EXTENDED RELEASE CAPSULE

02019930	M-ESLON	ETH	FNQSW

15MG EXTENDED RELEASE CAPSULE

02177749	M-ESLON	ETH	FNQSW

30MG EXTENDED RELEASE CAPSULE

02019949	M-ESLON	ETH	FNQSW

60MG EXTENDED RELEASE CAPSULE

02019957	M-ESLON	ETH	FNQSW

100MG EXTENDED RELEASE CAPSULE

02019965	M-ESLON	ETH	FNQSW

200MG EXTENDED RELEASE CAPSULE

02177757	M-ESLON	ETH	FNQSW
15MG SUSTAINED RELEASE TABLET			
02015439	MS CONTIN	PFR	FNQSW
02244790	SANDOZ-MORPHINE SR	SDZ	FNQSW
02302764	TEVA-MORPHINE SR	TEV	FNQSW
30MG SUSTAINED RELEASE TABLET			
02014297	MS CONTIN	PFR	FNQSW
02244791	SANDOZ-MORPHINE SR	SDZ	FNQSW
02302772	TEVA-MORPHINE SR	TEV	FNQSW
60MG SUSTAINED RELEASE TABLET			
02014300	MS CONTIN	PFR	FNQSW
02244792	SANDOZ-MORPHINE SR	SDZ	FNQSW
02302780	TEVA-MORPHINE SR	TEV	FNQSW
100MG SUSTAINED RELEASE TABLET			
02014319	MS CONTIN	PFR	FNQSW
02302799	TEVA-MORPHINE SR	TEV	FNQSW
02478889	SANDOZ-MORPHINE SR	SDZ	FNQSW
200MG SUSTAINED RELEASE TABLET			
02014327	MS CONTIN	PFR	FNQSW
02302802	TEVA-MORPHINE SR	TEV	FNQSW
02478897	SANDOZ-MORPHINE SR	SDZ	FNQSW
10MG/ML INJECTION SOLUTION (1ML)			
00392588	MORPHINE SULFATE	SDZ	NQ
15MG/ML INJECTION SOLUTION (1ML)			
00392561	MORPHINE SULFATE	SDZ	NQ
SEE APPENDIX A FOR SA CRITERIA			
50MG/ML INJECTION SOLUTION(5ML AND 10ML)			
00617288	MORPHINE SULFATE (SA)	SDZ	NQ
OXYCODONE			
5MG TABLET			
00789739	SUPEUDOL	SDZ	FNQSW
02231934	OXY-IR	PFR	FNQSW
02319977	PMS-OXYCODONE	PMS	FNQSW
10MG TABLET			
00443948	SUPEUDOL	SDZ	FNQSW
02240131	OXY-IR	PFR	FNQSW

02319985	PMS-OXYCODONE	PMS	FNQSW

20MG TABLET

02240132	OXY-IR	PFR	FNQSW
02262983	SUPEUDOL	SDZ	FNQSW
02319993	PMS-OXYCODONE	PMS	FNQSW

OXYCODONE HCL & ACETAMINOPHEN

5MG & 325MG TABLET

00608165	TEVA-OXYCOCET	TEV	FNQSW
02307898	SANDOZ-OXYCODONE ACET	SDZ	FNQSW
02324628	APO-OXYCODONE/ACET	APX	FNQSW

OXYCODONE HCL & ACETYLSALICYLIC ACID

5MG & 325MG TAB

00608157	TEVA-OXYCODAN	TEV	FQSW

28:08.12 OPIATE PARTIAL AGONISTS

⑤BUPRENORPHINE

100MG/0.5ML SYRINGE

02483084	SUBLOCADE	ICL	FLNQSW

300MG/1.5ML SYRINGE

02483092	SUBLOCADE	ICL	FLNQSW

⑤BUPRENORPHINE & NALOXONE

2MG/0.5MG TABLET

02295695	SUBOXONE	ICL	FLNQSW
02424851	PMS-BUPRENORPHINE/NALOXONE	PMS	FLNQSW
02453908	TEVA-BUPRENORPHINE/NALOXONE	TEV	FLNQSW

8MG/2MG TABLET

02295709	SUBOXONE	ICL	FLNQSW
02424878	PMS-BUPRENORPHINE/NALOXONE	PMS	FLNQSW
02453916	TEVA-BUPRENORPHINE/NALOXONE	TEV	FLNQSW

2MG/0.5MG FILM

02502313	SUBOXONE	ICL	FLNQSW

4MG/1MG FILM

02502321	SUBOXONE	ICL	FLNQSW

8MG/2MG FILM			
02502348	SUBOXONE	ICL	FLNQSW
12MG/3MG FILM			
02502356	SUBOXONE	ICL	FLNQSW

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

32MG/ML ELIXIR			
00999929	ACETAMINOPHEN		NW
Note: The Drug Identification Number listed is for billing purposes only.			

80MG/ML DROPS			
00999719	ACETAMINOPHEN		W
Note: The Drug Identification Number listed is for billing purposes only.			

325MG TABLET			
00999939	ACETAMINOPHEN		NW
Note: The Drug Identification Number listed is for billing purposes only.			

500MG TABLET			
00999949	ACETAMINOPHEN		NW
Note: The Drug Identification Number listed is for billing purposes only.			

120MG RECTAL SUPPOSITORY			
02230434	ACET-120	PEN	W

325MG RECTAL SUPPOSITORY			
02230436	ACET-325	PEN	NW

650MG RECTAL SUPPOSITORY			
02230437	ACET-650	PEN	NW

28:10:00 OPIATE ANTAGONISTS

NALOXONE HCL

0.4MG/ML INJECTION SOLUTION			
02148706	NALOXONE	SDZ	NQ

⑤ NALTREXONE HCL

[SEE APPENDIX A](#) FOR SA CRITERIA (FOR SUBSTANCE USE HARM REDUCTION DRUG PROGRAM, NO SA IS REQUIRED)

50MG TABLET

02213826	REVIA (SA)	TEV	FLNQSW
02444275	APO-NALTREXONE (SA)	APX	FGLNQSW
02451883	NALTREXONE (SA)	JPC	FGLNQSW

28:12.04 ANTICONVULSANTS (BARBITURATES)

⑤ PHENOBARBITAL

Eligible for a 90 day supply

15MG TABLET

00178799	PHENOBARB	PEN	FNQSW

30MG TABLET

00178802	PHENOBARB	PEN	FNQSW

60MG TABLET

00178810	PHENOBARB	PEN	FNQSW

100MG TABLET

00178829	PHENOBARB	PEN	FNQSW

5MG/ML ELIXIR

00645575	PHENOBARB	PEN	FNQSW

PRIMIDONE

125MG TABLET

00399310	PRIMIDONE	AAA	FGQW

250MG TABLET

00396761	PRIMIDONE	AAA	FGNQSW

28:12.08 ANTICONVULSANTS (BENZODIAZEPINES)

CLONAZEPAM

Eligible for a 90 day supply

0.5MG TABLET

00382825	RIVOTRIL	XPI	FNQSW

02048701	PMS-CLONAZEPAM	PMS	FNQSW
02177889	APO-CLONAZEPAM	APX	FNQSW
02207818	PMS-CLONAZEPAM-R	PMS	FNQSW

1MG TABLET			
02048728	PMS-CLONAZEPAM	PMS	FNQSW

2MG TABLET			
00382841	RIVOTRIL	XPI	FNQSW
02048736	PMS-CLONAZEPAM	PMS	FNQSW
02177897	APO-CLONAZEPAM	APX	FNQSW

LORAZEPAM

4MG/ML INJECTION SOLUTION			
02243278	LORAZEPAM	SDZ	NQ

28:12.12 ANTICONVULSANTS (HYDANTOINS)

PHENYTOIN

50MG TABLET			
00023698	DILANTIN	UJC	FNQSW

30MG CAPSULE			
00022772	DILANTIN	UJC	FNQSW

100MG CAPSULE			
00022780	DILANTIN	UJC	FNQSW
02460912	PHENYTOIN SODIUM	AAA	FGNQSW

25MG/ML ORAL SUSPENSION			
00023450	DILANTIN	UJC	FNQSW
02250896	TARO-PHENYTOIN	TAR	FGNQSW

50MG/ML INJECTION SOLUTION			
00780626	PHENYTOIN SODIUM	SDZ	NQ

28:12.20 ANTICONVULSANTS (SUCCINIMIDES)

ETHOSUXIMIDE

50MG/ML SYRUP			
00023485	ZARONTIN	ERF	FNQSW

250MG CAPSULE		
00022799	ZARONTIN	ERF FNQSW
02545772	MAR-ETHOSUXIMIDE	MAR FGNQSW
02547171	ODAN-ETHOSUXIMIDE	ODN FGNQSW

28:12.92 ANTICONVULSANTS (MISCELLANEOUS)

BRIVARACETAM

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET		
02452936	BRIVLERA (SA)	UCB FNQSW
02538679	APO-BRIVARACETAM (SA)	APX FGNQSW
25MG TABLET		
02452944	BRIVLERA (SA)	UCB FNQSW
02538687	APO-BRIVARACETAM (SA)	APX FGNQSW
50MG TABLET		
02452952	BRIVLERA (SA)	UCB FNQSW
02538695	APO-BRIVARACETAM (SA)	APX FGNQSW
02539292	AURO-BRIVARACETAM (SA)	ARO FGNQSW
75MG TABLET		
02452960	BRIVLERA (SA)	UCB FNQSW
02538709	APO-BRIVARACETAM (SA)	APX FGNQSW
100MG TABLET		
02452979	BRIVLERA (SA)	UCB FNQSW
02538717	APO-BRIVARACETAM (SA)	APX FGNQSW
02539306	AURO-BRIVARACETAM (SA)	ARO FGNQSW

⑤CARBAMAZEPINE

100MG CHEWABLE TABLET		
02244403	TARO-CARBAMAZEPINE	TAR FGQW
200MG CHEWABLE TABLET		
02244404	TARO-CARBAMAZEPINE	TAR FGQW
200MG TABLET		
00010405	TEGRETOL	NVR FNQSW
00782718	TEVA-CARBAMAZEPINE	TEV FGNQSW
02541238	MINT-CARBAMAZEPINE	MNT FGNQSW

200MG CONTROLLED RELEASE TABLET
 00773611 TEGRETOL CR
 02261839 SANDOZ-CARBAMAZEPINE CR

NVR **FNQSW**
 SDZ **FGNQSW**

400MG CONTROLLED RELEASE TABLET
 00755583 TEGRETOL CR
 02261847 SANDOZ-CARBAMAZEPINE CR

NVR **FNQSW**
 SDZ **FGNQSW**

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG/5ML SUSPENSION

02194333 TEGRETOL (SA)
 02367394 TARO-CARBAMAZEPINE (SA)

NVR **FNQSW**
 TAR **FGNQSW**

CLOBAZAM

Eligible for a 90 day supply

10MG TABLET

02238334 TEVA-CLOBAZAM
 02244638 APO-CLOBAZAM

TEV **FGNQSW**
 APX **FGNQSW**

⑤DIVALPROEX SODIUM

125MG ENTERIC COATED TABLET

00596418 EPIVAL
 02239698 APO-DIVALPROEX
 02458926 MYLAN-DIVALPROEX

BGP **FNQSW**
 APX **FGNQSW**
 MYL **FGNQSW**

250MG ENTERIC COATED TABLET

00596426 EPIVAL
 02239699 APO-DIVALPROEX
 02458934 MYLAN-DIVALPROEX

BGP **FNQSW**
 APX **FGNQSW**
 MYL **FGNQSW**

500MG ENTERIC COATED TABLET

00596434 EPIVAL
 02239700 APO-DIVALPROEX
 02459019 MYLAN-DIVALPROEX

BGP **FNQSW**
 APX **FGNQSW**
 MYL **FGNQSW**

ESLICARBAZEPINE ACETATE

[SEE APPENDIX A](#) FOR SA CRITERIA

200MG TABLET

02426862 APTIOM (SA)
 02527421 AURO-ESLICARBAZEPINE (SA)
 02537931 APO-ESLICARBAZEPINE (SA)

SNV **FNQSW**
 ARO **FGNQSW**
 APX **FGNQSW**

400MG TABLET

02426870 APTIOM (SA)

SNV **FNQSW**

02527448	AURO-ESLICARBAZEPINE (SA)	ARO	FGNQSW
02537958	APO-ESLICARBAZEPINE (SA)	APX	FGNQSW

600MG TABLET

02426889	APTiom (SA)	SNV	FNQSW
02527456	AURO-ESLICARBAZEPINE (SA)	ARO	FGNQSW
02537966	APO-ESLICARBAZEPINE (SA)	APX	FGNQSW

800MG TABLET

02426897	APTiom (SA)	SNV	FNQSW
02527464	AURO-ESLICARBAZEPINE (SA)	ARO	FGNQSW
02537974	APO-ESLICARBAZEPINE (SA)	APX	FGNQSW

GABAPENTIN

100MG CAPSULE

02084260	NEURONTIN	UJC	FNQSW
02243446	PMS-GABAPENTIN	PMS	FGNQSW
02244304	APO-GABAPENTIN	APX	FGNQSW
02244513	TEVA-GABAPENTIN	TEV	FGNQSW
02246314	GABAPENTIN	SIV	FGNQSW
02321203	AURO-GABAPENTIN	ARO	FGNQSW
02353245	GABAPENTIN	SNS	FGNQSW
02361469	JAMP-GABAPENTIN	JPC	FGNQSW
02391473	MAR-GABAPENTIN	MAR	FGNQSW
02408880	MINT-GABAPENTIN	MNT	FGNQSW
02416840	GABAPENTIN	ACH	FGNQSW
02535246	JAMP-GABAPENTIN	JPC	FGNQSW

300MG CAPSULE

02084279	NEURONTIN	UJC	FNQSW
02243447	PMS-GABAPENTIN	PMS	FGNQSW
02244305	APO-GABAPENTIN	APX	FGNQSW
02244514	TEVA-GABAPENTIN	TEV	FGNQSW
02246315	GABAPENTIN	SIV	FGNQSW
02321211	AURO-GABAPENTIN	ARO	FGNQSW
02319063	RAN-GABAPENTIN	RAN	FGNQSW
02353253	GABAPENTIN	SNS	FGNQSW
02361485	JAMP-GABAPENTIN	JPC	FGNQSW
02391481	MAR-GABAPENTIN	MAR	FGNQSW
02408899	MINT-GABAPENTIN	MNT	FGNQSW
02416859	GABAPENTIN	ACH	FGNQSW
02535254	JAMP-GABAPENTIN	JPC	FGNQSW

400MG CAPSULE

02084287	NEURONTIN	UJC	FNQSW
02243448	PMS-GABAPENTIN	PMS	FGNQSW

02244306	APO-GABAPENTIN	APX	FGNQSW
02244515	TEVA-GABAPENTIN	TEV	FGNQSW
02246316	GABAPENTIN	SIV	FGNQSW
02321238	AURO-GABAPENTIN	ARO	FGNQSW
02353261	GABAPENTIN	SNS	FGNQSW
02361493	JAMP-GABAPENTIN	JPC	FGNQSW
02391503	MAR-GABAPENTIN	MAR	FGNQSW
02408902	MINT-GABAPENTIN	MNT	FGNQSW
02416867	GABAPENTIN	ACH	FGNQSW
02535262	JAMP-GABAPENTIN	JPC	FGNQSW

600MG TABLET

02239717	NEURONTIN	UJC	FNQSW
02248457	TEVA-GABAPENTIN	TEV	FGNQSW
02293358	APO-GABAPENTIN	APX	FGNQSW
02388200	GABAPENTIN	SIV	FGNQSW
02392526	GABAPENTIN	ACH	FGNQSW
02402289	JAMP-GABAPENTIN	JPC	FGNQSW
02410990	GLN-GABAPENTIN	GLM	FGNQSW
02428334	AURO-GABAPENTIN	ARO	FGNQSW
02431289	GABAPENTIN	SNS	FGNQSW
02432072	GABAPENTIN	JPC	FGNQSW

800MG TABLET

02239718	NEURONTIN	UJC	FNQSW
02247346	TEVA-GABAPENTIN	TEV	FGNQSW
02293366	APO-GABAPENTIN	APX	FGNQSW
02388219	GABAPENTIN	SIV	FGNQSW
02392534	GABAPENTIN	ACH	FGNQSW
02402297	JAMP-GABAPENTIN	JPC	FGNQSW
02411008	GLN-GABAPENTIN	GLM	FGNQSW
02428342	AURO-GABAPENTIN	ARO	FGNQSW
02431297	GABAPENTIN	SNS	FGNQSW
02432080	GABAPENTIN	JPC	FGNQSW

LACOSAMIDE

50MG TABLET

02357615	VIMPAT	UCB	FNQSW
02472902	TEVA-LACOSAMIDE	TEV	FGNQSW
02474670	SANDOZ-LACOSAMIDE	SDZ	FGNQSW
02475332	AURO-LACOSAMIDE	ARO	FGNQSW
02478196	PHARMA-LACOSAMIDE	PMS	FGNQSW
02487802	MAR-LACOSAMIDE	MAR	FGNQSW
02488388	JAMP-LACOSAMIDE	JPC	FGNQSW
02489287	ACH-LACOSAMIDE	ACH	FGNQSW
02490544	MINT-LACOSAMIDE	MNT	FGNQSW

02499568	NRA-LACOSAMIDE	NRA	FGNQSW
02512874	LACOSAMIDE	SNS	FGNQSW

100MG TABLET

02357623	VIMPAT	UCB	FNQSW
02472910	TEVA-LACOSAMIDE	TEV	FGNQSW
02474689	SANDOZ-LACOSAMIDE	SDZ	FGNQSW
02475340	AURO-LACOSAMIDE	ARO	FGNQSW
02478218	PHARMA-LACOSAMIDE	PMS	FGNQSW
02487810	MAR-LACOSAMIDE	MAR	FGNQSW
02488396	JAMP-LACOSAMIDE	JPC	FGNQSW
02489295	ACH-LACOSAMIDE	ACH	FGNQSW
02490552	MINT-LACOSAMIDE	MNT	FGNQSW
02499576	NRA-LACOSAMIDE	NRA	FGNQSW
02512882	LACOSAMIDE	SNS	FGNQSW

150MG TABLET

02357631	VIMPAT	UCB	FNQSW
02472929	TEVA-LACOSAMIDE	TEV	FGNQSW
02474697	SANDOZ-LACOSAMIDE	SDZ	FGNQSW
02475359	AURO-LACOSAMIDE	ARO	FGNQSW
02478226	PHARMA-LACOSAMIDE	PMS	FGNQSW
02487829	MAR-LACOSAMIDE	MAR	FGNQSW
02488418	JAMP-LACOSAMIDE	JPC	FGNQSW
02489309	ACH-LACOSAMIDE	ACH	FGNQSW
02490560	MINT-LACOSAMIDE	MNT	FGNQSW
02499584	NRA-LACOSAMIDE	NRA	FGNQSW
02512890	LACOSAMIDE	SNS	FGNQSW

200MG TABLET

02357658	VIMPAT	UCB	FNQSW
02472937	TEVA-LACOSAMIDE	TEV	FGNQSW
02474700	SANDOZ-LACOSAMIDE	SDZ	FGNQSW
02475367	AURO-LACOSAMIDE	ARO	FGNQSW
02478234	PHARMA-LACOSAMIDE	PMS	FGNQSW
02487837	MAR-LACOSAMIDE	MAR	FGNQSW
02488426	JAMP-LACOSAMIDE	JPC	FGNQSW
02489317	ACH-LACOSAMIDE	ACH	FGNQSW
02490579	MINT-LACOSAMIDE	MNT	FGNQSW
02499592	NRA-LACOSAMIDE	NRA	FGNQSW
02512904	LACOSAMIDE	SNS	FGNQSW

LAMOTRIGINE

25MG TABLET

02142082	LAMICTAL	GSK	FNQSW
02245208	APO-LAMOTRIGINE	APX	FGNQSW

02246897	PMS-LAMOTRIGINE	PMS	FGNQSW
02265494	MYLAN-LAMOTRIGINE	MYL	FGNQSW
02343010	LAMOTRIGINE	SNS	FGNQSW
02381354	AURO-LAMOTRIGINE	ARO	FGNQSW
02428202	LAMOTRIGINE	SIV	FGNQSW
02542730	JAMP-LAMOTRIGINE	JPC	FGNQSW

100MG TABLET

02142104	LAMICTAL	GSK	FNQSW
02245209	APO-LAMOTRIGINE	APX	FGNQSW
02246898	PMS-LAMOTRIGINE	PMS	FGNQSW
02248233	TEVA-LAMOTRIGINE	TEV	FGNQSW
02265508	MYLAN-LAMOTRIGINE	MYL	FGNQSW
02343029	LAMOTRIGINE	SNS	FGNQSW
02381362	AURO-LAMOTRIGINE	ARO	FGNQSW
02428210	LAMOTRIGINE	SIV	FGNQSW
02542749	JAMP-LAMOTRIGINE	JPC	FGNQSW

150MG TABLET

02142112	LAMICTAL	GSK	FNQSW
02245210	APO-LAMOTRIGINE	APX	FGNQSW
02246899	PMS-LAMOTRIGINE	PMS	FGNQSW
02248234	TEVA-LAMOTRIGINE	TEV	FGNQSW
02265516	MYLAN-LAMOTRIGINE	MYL	FGNQSW
02343037	LAMOTRIGINE	SNS	FGNQSW
02381370	AURO-LAMOTRIGINE	ARO	FGNQSW
02428229	LAMOTRIGINE	SIV	FGNQSW
02542757	JAMP-LAMOTRIGINE	JPC	FGNQSW

LEVETIRACETAM

250MG TABLET

02247027	KEPPRA	UCB	FNQSW
02274183	TEVA-LEVETIRACETAM	TEV	FGNQSW
02285924	APO-LEVETIRACETAM	APX	FGNQSW
02296101	PMS-LEVETIRACETAM	PMS	FGNQSW
02353342	LEVETIRACETAM	SNS	FGNQSW
02375249	AURO-LEVETIRACETAM	ARO	FGNQSW
02399776	LEVETIRACETAM	ACH	FGNQSW
02403005	JAMP-LEVETIRACETAM	JPC	FGNQSW
02440202	NAT-LEVETIRACETAM	NAT	FGNQSW
02442388	MINT-LEVETIRACETAM	MNT	FGNQSW
02442531	LEVETIRACETAM	SIV	FGNQSW
02461986	SANDOZ-LEVETIRACETAM	SDZ	FGNQSW
02482274	RIVA-LEVETIRACETAM	RIV	FGNQSW
02499193	NRA-LEVETIRACETAM	NRA	FGNQSW
02504553	JAMP-LEVETIRACETAM	JPC	FGNQSW

02524562	M-LEVETIRACETAM	MRA	FGNQSW
500MG TABLET			
02247028	KEPPRA	UCB	FNQSW
02274191	TEVA-LEVETIRACETAM	TEV	FGNQSW
02285932	APO-LEVETIRACETAM	APX	FGNQSW
02296128	PMS-LEVETIRACETAM	PMS	FGNQSW
02353350	LEVETIRACETAM	SNS	FGNQSW
02375257	AURO-LEVETIRACETAM	ARO	FGNQSW
02399784	LEVETIRACETAM	ACH	FGNQSW
02403021	JAMP-LEVETIRACETAM	JPC	FGNQSW
02440210	NAT-LEVETIRACETAM	NAT	FGNQSW
02442396	MINT-LEVETIRACETAM	MNT	FGNQSW
02442558	LEVETIRACETAM	SIV	FGNQSW
02461994	SANDOZ-LEVETIRACETAM	SDZ	FGNQSW
02482282	RIVA-LEVETIRACETAM	RIV	FGNQSW
02499207	NRA-LEVETIRACETAM	NRA	FGNQSW
02504561	JAMP-LEVETIRACETAM	JPC	FGNQSW
02524570	M-LEVETIRACETAM	MRA	FGNQSW
750MG TABLET			
02247029	KEPPRA	UCB	FNQSW
02274205	TEVA-LEVETIRACETAM	TEV	FGNQSW
02285940	APO-LEVETIRACETAM	APX	FGNQSW
02296136	PMS-LEVETIRACETAM	PMS	FGNQSW
02353369	LEVETIRACETAM	SNS	FGNQSW
02375265	AURO-LEVETIRACETAM	ARO	FGNQSW
02399792	LEVETIRACETAM	ACH	FGNQSW
02403048	JAMP-LEVETIRACETAM	JPC	FGNQSW
02440229	NAT-LEVETIRACETAM	NAT	FGNQSW
02442418	MINT-LEVETIRACETAM	MNT	FGNQSW
02442566	LEVETIRACETAM	SIV	FGNQSW
02462001	SANDOZ-LEVETIRACETAM	SDZ	FGNQSW
02482290	RIVA-LEVETIRACETAM	RIV	FGNQSW
02499215	NRA-LEVETIRACETAM	NRA	FGNQSW
02504588	JAMP-LEVETIRACETAM	JPC	FGNQSW
02524589	M-LEVETIRACETAM	MRA	FGNQSW
1000MG TABLET			
02462028	SANDOZ-LEVETIRACETAM	SDZ	FGNQSW
SEE APPENDIX A FOR SA CRITERIA			
100MG/ML ORAL SOLUTION			
02490447	PDP-LEVETIRACETAM (SA)	PEN	FGNQSW

OXCARBAZEPINE

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG TABLET

02284294	APO-OXCARBAZEPINE (SA)	APX	FGNQSW

300MG TABLET

02242068	TRILEPTAL (SA)	NVR	FNQSW
02284308	APO-OXCARBAZEPINE (SA)	APX	FGNQSW

600MG TABLET

02242069	TRILEPTAL (SA)	NVR	FNQSW
02284316	APO-OXCARBAZEPINE (SA)	APX	FGNQSW

PERAMPANEL

[SEE APPENDIX A](#) FOR SA CRITERIA

2MG TABLET

02404516	FYCOMPA (SA)	EIS	FNQSW
02522632	TARO-PERAMPANEL (SA)	TAR	FGNQSW

4MG TABLET

02404524	FYCOMPA (SA)	EIS	FNQSW
02522640	TARO-PERAMPANEL (SA)	TAR	FGNQSW

6MG TABLET

02404532	FYCOMPA (SA)	EIS	FNQSW
02522659	TARO-PERAMPANEL (SA)	TAR	FGNQSW

8MG TABLET

02404540	FYCOMPA (SA)	EIS	FNQSW
02522667	TARO-PERAMPANEL (SA)	TAR	FGNQSW

10MG TABLET

02404559	FYCOMPA (SA)	EIS	FNQSW
02522675	TARO-PERAMPANEL (SA)	TAR	FGNQSW

12MG TABLET

02404567	FYCOMPA (SA)	EIS	FNQSW
02522683	TARO-PERAMPANEL (SA)	TAR	FGNQSW

PREGABALIN

25MG CAPSULE

02268418	LYRICA	UJC	FNQSW
02359596	PMS-PREGABALIN	PMS	FGNQSW
02361159	TEVA-PREGABALIN	TEV	FGNQSW
02390817	SANDOZ-PREGABALIN	SDZ	FGNQSW
02392801	RAN-PREGABALIN	RAN	FGNQSW
02394235	APO-PREGABALIN	APX	FGNQSW

02403692	PREGABALIN	SIV	FGNQSW
02405539	PREGABALIN	SNS	FGNQSW
02417529	MAR-PREGABALIN	MAR	FGNQSW
02423804	MINT-PREGABALIN	MNT	FGNQSW
02433869	AURO-PREGABALIN	ARO	FGNQSW
02435977	JAMP-PREGABALIN	JPC	FGNQSW
02449838	ACH-PREGABALIN	ACH	FGNQSW
02467291	M-PREGABALIN	MRA	FGNQSW
02479117	NRA-PREGABALIN	NRA	FGNQSW
02480727	AG-PREGABALIN	ANG	FGNQSW
02494841	NAT-PREGABALIN	NAT	FGNQSW

50MG CAPSULE

02268426	LYRICA	UJC	FNQSW
02359618	PMS-PREGABALIN	PMS	FGNQSW
02361175	TEVA-PREGABALIN	TEV	FGNQSW
02390825	SANDOZ-PREGABALIN	SDZ	FGNQSW
02392828	RAN-PREGABALIN	RAN	FGNQSW
02394243	APO-PREGABALIN	APX	FGNQSW
02403706	PREGABALIN	SIV	FGNQSW
02405547	PREGABALIN	SNS	FGNQSW
02417537	MAR-PREGABALIN	MAR	FGNQSW
02423812	MINT-PREGABALIN	MNT	FGNQSW
02433877	AURO-PREGABALIN	ARO	FGNQSW
02435985	JAMP-PREGABALIN	JPC	FGNQSW
02449846	ACH-PREGABALIN	ACH	FGNQSW
02467305	M-PREGABALIN	MRA	FGNQSW
02479125	NRA-PREGABALIN	NRA	FGNQSW
02480735	AG-PREGABALIN	ANG	FGNQSW
02494868	NAT-PREGABALIN	NAT	FGNQSW

75MG CAPSULE

02268434	LYRICA	UJC	FNQSW
02359626	PMS-PREGABALIN	PMS	FGNQSW
02361183	TEVA-PREGABALIN	TEV	FGNQSW
02390833	SANDOZ-PREGABALIN	SDZ	FGNQSW
02392836	RAN-PREGABALIN	RAN	FGNQSW
02394251	APO-PREGABALIN	APX	FGNQSW
02403714	PREGABALIN	SIV	FGNQSW
02405555	PREGABALIN	SNS	FGNQSW
02417545	MAR-PREGABALIN	MAR	FGNQSW
02424185	MINT-PREGABALIN	MNT	FGNQSW
02433885	AURO-PREGABALIN	ARO	FGNQSW
02435993	JAMP-PREGABALIN	JPC	FGNQSW
02449854	ACH-PREGABALIN	ACH	FGNQSW
02467313	M-PREGABALIN	MRA	FGNQSW

02479133	NRA-PREGABALIN	NRA	FGNQSW
02480743	AG-PREGABALIN	ANG	FGNQSW
02494876	NAT-PREGABALIN	NAT	FGNQSW

150MG CAPSULE

02268450	LYRICA	UJC	FNQSW
02359634	PMS-PREGABALIN	PMS	FGNQSW
02361205	TEVA-PREGABALIN	TEV	FGNQSW
02390841	SANDOZ-PREGABALIN	SDZ	FGNQSW
02392844	RAN-PREGABALIN	RAN	FGNQSW
02394278	APO-PREGABALIN	APX	FGNQSW
02403722	PREGABALIN	SIV	FGNQSW
02405563	PREGABALIN	SNS	FGNQSW
02417561	MAR-PREGABALIN	MAR	FGNQSW
02424207	MINT-PREGABALIN	MNT	FGNQSW
02433907	AURO-PREGABALIN	ARO	FGNQSW
02436000	JAMP-PREGABALIN	JPC	FGNQSW
02449870	ACH-PREGABALIN	ACH	FGNQSW
02467321	M-PREGABALIN	MRA	FGNQSW
02479168	NRA-PREGABALIN	NRA	FGNQSW
02480751	AG-PREGABALIN	ANG	FGNQSW
02494884	NAT-PREGABALIN	NAT	FGNQSW

225MG CAPSULE

02268477	LYRICA	UJC	FNQSW
02361221	TEVA-PREGABALIN	TEV	FGNQSW
02392852	RAN-PREGABALIN	RAN	FGNQSW
02394286	APO-PREGABALIN	APX	FGNQSW
02398079	PMS-PREGABALIN	PMS	FGNQSW
02449897	ACH-PREGABALIN	ACH	FGNQSW
02494892	NAT-PREGABALIN	NAT	FGNQSW

300MG CAPSULE

02268485	LYRICA	UJC	FNQSW
02359642	PMS-PREGABALIN	PMS	FGNQSW
02361248	TEVA-PREGABALIN	TEV	FGNQSW
02390868	SANDOZ-PREGABALIN	SDZ	FGNQSW
02392860	RAN-PREGABALIN	RAN	FGNQSW
02394294	APO-PREGABALIN	APX	FGNQSW
02403730	PREGABALIN	SIV	FGNQSW
02405598	PREGABALIN	SNS	FGNQSW
02436019	JAMP-PREGABALIN	JPC	FGNQSW
02449900	ACH-PREGABALIN	ACH	FGNQSW
02480778	AG-PREGABALIN	ANG	FGNQSW
02494906	NAT-PREGABALIN	NAT	FGNQSW
02541963	M-PREGABALIN	MRA	FGNQSW

RUFINAMIDE[SEE APPENDIX A](#) FOR SA CRITERIA

100MG TABLET

02369613 BANZEL (SA)

EIS **FNQSW**

200MG TABLET

02369621 BANZEL (SA)

EIS **FNQSW**

02545985 AURO-RUFINAMIDE (SA)

ARO **FGNQSW**

400MG TABLET

02369648 BANZEL (SA)

EIS **FNQSW**

02545993 AURO-RUFINAMIDE (SA)

ARO **FGNQSW****STIRIPENTOL**[SEE APPENDIX A](#) FOR SA CRITERIA

250MG CAPSULE

02398958 DIACOMIT (SA)

BOX **NMQW**

250MG POWDER FOR SUSPENSION

02398974 DIACOMIT (SA)

BOX **NMQW**

500MG CAPSULE

02398966 DIACOMIT (SA)

BOX **NMQW****TOPIRAMATE**

25MG TABLET

02230893 TOPAMAX

JAN **FNQSW**

02248860 TEVA-TOPIRAMATE

TEV **FGNQSW**

02262991 PMS-TOPIRAMATE

PMS **FGNQSW**

02263351 MYLAN-TOPIRAMATE

MYL **FGNQSW**

02279614 APO-TOPIRAMATE

APX **FGNQSW**

02287765 GLN-TOPIRAMATE

GLM **FGNQSW**

02315645 MINT-TOPIRAMATE

MNT **FGNQSW**

02345250 JAMP-TOPIRAMATE

JPC **FGNQSW**

02345803 AURO-TOPIRAMATE

ARO **FGNQSW**

02356856 TOPIRAMATE

SNS **FGNQSW**

02389460 TOPIRAMATE

SIV **FGNQSW**

02395738 TOPIRAMATE

ACH **FGNQSW**

02431807 SANDOZ-TOPIRAMATE

SDZ **FGNQSW**

02432099 MAR-TOPIRAMATE

MAR **FGNQSW**

02435608 JAMP-TOPIRAMATE

JPC **FGNQSW**

02475936 AG-TOPIRAMATE

ANG **FGNQSW**

50MG TABLET

02312085 PMS-TOPIRAMATE

PMS **FGNQSW**

02544377	JAMP-TOPIRAMATE	JPC	FGNQSW
100MG TABLET			
02230894	TOPAMAX	JAN	FNQSW
02248861	TEVA-TOPIRAMATE	TEV	FGNQSW
02263009	PMS-TOPIRAMATE	PMS	FGNQSW
02263378	MYLAN-TOPIRAMATE	MYL	FGNQSW
02279630	APO-TOPIRAMATE	APX	FGNQSW
02287773	GLN-TOPIRAMATE	GLM	FGNQSW
02315653	MINT-TOPIRAMATE	MNT	FGNQSW
02345269	JAMP-TOPIRAMATE	JPC	FGNQSW
02345838	AURO-TOPIRAMATE	ARO	FGNQSW
02356864	TOPIRAMATE	SNS	FGNQSW
02389487	TOPIRAMATE	SIV	FGNQSW
02395746	TOPIRAMATE	ACH	FGNQSW
02431815	SANDOZ-TOPIRAMATE	SDZ	FGNQSW
02432102	MAR-TOPIRAMATE	MAR	FGNQSW
02435616	JAMP-TOPIRAMATE	JPC	FGNQSW
02475944	AG-TOPIRAMATE	ANG	FGNQSW

200MG TABLET

02230896	TOPAMAX	JAN	FNQSW
02248862	TEVA-TOPIRAMATE	TEV	FGNQSW
02263017	PMS-TOPIRAMATE	PMS	FGNQSW
02263386	MYLAN-TOPIRAMATE	MYL	FGNQSW
02279649	APO-TOPIRAMATE	APX	FGNQSW
02287781	GLN-TOPIRAMATE	GLM	FGNQSW
02315661	MINT-TOPIRAMATE	MNT	FGNQSW
02345277	JAMP-TOPIRAMATE	JPC	FGNQSW
02345846	AURO-TOPIRAMATE	ARO	FGNQSW
02356872	TOPIRAMATE	SNS	FGNQSW
02395754	TOPIRAMATE	ACH	FGNQSW
02431823	SANDOZ-TOPIRAMATE	SDZ	FGNQSW
02432110	MAR-TOPIRAMATE	MAR	FGNQSW
02435624	JAMP-TOPIRAMATE	JPC	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

15MG SPRINKLE CAPSULE

02239907	TOPAMAX (SA)	JAN	FQW

25MG SPRINKLE CAPSULE

02239908	TOPAMAX (SA)	JAN	FQW

⑤ VALPROATE SODIUM

50MG/ML SYRUP

00443832	DEPAKENE	BGP	FNQSW

02236807	PMS-VALPROIC	PMS	FGNQSW
02238370	APO-VALPROIC ACID	APX	FGNQSW
02532441	JAMP-VALPROIC ACID	JPC	FGNQSW
02549190	ODAN-VALPROIC ACID	ODN	FGNQSW

⑤VALPROIC ACID

250MG CAPSULE

02230768	PMS-VALPROIC	PMS	FGNQSW
02238048	APO-VALPROIC	APX	FGNQSW

500MG ENTERIC COATED CAPSULE

02229628	PMS-VALPROIC	PMS	FGNQSW

VIGABATRIN

[SEE APPENDIX A](#) FOR SA CRITERIA

500MG TABLET

02065819	SABRIL (SA)	LUD	FNQSW

28:16.04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

⑤AMITRIPTYLINE

10MG TABLET

00335053	ELAVIL	AAA	FNQSW
00654523	PMS-AMITRIPTYLINE	PMS	FGNQSW
02326043	TEVA-AMITRIPTYLINE	TEV	FGNQSW
02403137	APO-AMITRIPTYLINE	APX	FGNQSW
02429861	MAR-AMITRIPTYLINE	MAR	FGNQSW
02457679	JAMP-AMITRIPTYLINE	JPC	FGNQSW

25MG TABLET

00335061	ELAVIL	AAA	FNQSW
00654515	PMS-AMITRIPTYLINE	PMS	FGNQSW
02326051	TEVA-AMITRIPTYLINE	TEV	FGNQSW
02403145	APO-AMITRIPTYLINE	APX	FGNQSW
02429888	MAR-AMITRIPTYLINE	MAR	FGNQSW
02457695	JAMP-AMITRIPTYLINE	JPC	FGNQSW

50MG TABLET

00335088	ELAVIL	AAA	FNQSW
00654507	PMS-AMITRIPTYLINE	PMS	FGNQSW
02326078	TEVA-AMITRIPTYLINE	TEV	FGNQSW
02403153	APO-AMITRIPTYLINE	APX	FGNQSW
02429896	MAR-AMITRIPTYLINE	MAR	FGNQSW
02457687	JAMP-AMITRIPTYLINE	JPC	FGNQSW

75MG TABLET

00754129	ELAVIL	AAA	FNQSW
02403161	APO-AMITRIPTYLINE	APX	FGNQSW
02429918	MAR-AMITRIPTYLINE	MAR	FGNQSW
02457660	JAMP-AMITRIPTYLINE	JPC	FGNQSW

⑤BUPROPION HCL**100MG TABLET**

02275074	ODAN-BUPROPION SR	ODN	FGNQSW

150MG TABLET

02275082	ODAN-BUPROPION SR	ODN	FGNQSW

150MG EXTENDED RELEASE TABLET

02275090	WELLBUTRIN XL	BSL	FNQSW
02439654	TEVA-BUPROPION XL	TEV	FGNQSW
02475804	TARO-BUPROPION XL	SUN	FGNQSW

300MG EXTENDED RELEASE TABLET

02275104	WELLBUTRIN XL	BSL	FNQSW
02439662	TEVA-BUPROPION XL	TEV	FGNQSW
02475812	TARO-BUPROPION XL	SUN	FGNQSW

⑤CITALOPRAM**10MG TABLET**

02270609	PMS-CITALOPRAM	PMS	FGNQSW
02312336	TEVA-CITALOPRAM	TEV	FGNQSW
02371871	MAR-CITALOPRAM	MAR	FGNQSW
02387948	CITALOPRAM	SIV	FGNQSW
02409003	NATCO-CITALOPRAM	NAT	FGNQSW
02429691	MINT-CITALOPRAM	MNT	FGNQSW
02430517	CITALOPRAM	JPC	FGNQSW
02443880	NATCO-CITALOPRAM	NAT	FGNQSW
02445719	CITALOPRAM	SNS	FGNQSW
02532123	M-CITALOPRAM	MRA	FGNQSW

20MG TABLET

02239607	CELEXA	LUD	FNQSW
02246056	APO-CITALOPRAM	APX	FGNQSW
02248010	PMS-CITALOPRAM	PMS	FGNQSW
02275562	AURO-CITALOPRAM	ARO	FGNQSW
02293218	TEVA-CITALOPRAM	TEV	FGNQSW
02353660	CITALOPRAM	SNS	FGNQSW
02371898	MAR-CITALOPRAM	MAR	FGNQSW
02387956	CITALOPRAM	SIV	FGNQSW

02429705	MINT-CITALOPRAM	MNT	FGNQSW
02430541	CITALOPRAM	JPC	FGNQSW
02443899	NATCO-CITALOPRAM	NAT	FGNQSW
02467836	M-CITALOPRAM	MRA	FGNQSW

40MG TABLET

02239608	CELEXA	LUD	FNQSW
02246057	APO-CITALOPRAM	APX	FGNQSW
02248011	PMS-CITALOPRAM	PMS	FGNQSW
02275570	AURO-CITALOPRAM	ARO	FGNQSW
02293226	TEVA-CITALOPRAM	TEV	FGNQSW
02353679	CITALOPRAM	SNS	FGNQSW
02371901	MAR-CITALOPRAM	MAR	FGNQSW
02387964	CITALOPRAM	SIV	FGNQSW
02429713	MINT-CITALOPRAM	MNT	FGNQSW
02430568	CITALOPRAM	JPC	FGNQSW
02467844	M-CITALOPRAM	MRA	FGNQSW

⑤CLOMIPRAMINE HCL

10MG TABLET

00330566	ANAFRANIL	AAA	FNQSW

25MG TABLET & CAPSULE

00324019	ANAFRANIL	APX	FNQSW
02497506	TARO-CLOMIPRAMINE	TAR	FGNQSW

50MG TABLET & CAPSULE

00402591	ANAFRANIL	APX	FNQSW
02497514	TARO-CLOMIPRAMINE	TAR	FGNQSW

⑤DESIPRAMINE

10MG TABLET

02216248	DESIPRAMINE	AAA	FGNQSW

25MG TABLET

02216256	DESIPRAMINE	AAA	FGNQSW

50MG TABLET

02216264	DESIPRAMINE	AAA	FGNQSW

75MG TABLET

02216272	DESIPRAMINE	AAA	FGNQSW

100MG TABLET

02216280	DESIPRAMINE	AAA	FGNQSW

⑤DOXEPIN HCL

10MG CAPSULE

00024325	SINEQUAN	AAA	FNQSW

25MG CAPSULE

00024333	SINEQUAN	AAA	FNQSW

50MG CAPSULE

00024341	SINEQUAN	AAA	FNQSW

75MG CAPSULE

00400750	SINEQUAN	AAA	FNQSW

100MG CAPSULE

00326925	SINEQUAN	AAA	FNQSW

⑤DULOXETINE HYDROCHLORIDE

30MG DELAYED RELEASE CAPSULE

02301482	CYMBALTA	LIL	FNQSW
02429446	PMS-DULOXETINE	PMS	FGNQSW
02436647	AURO-DULOXETINE	ARO	FGNQSW
02438984	MINT-DULOXETINE	MNT	FGNQSW
02439948	SANDOX-DULOXETINE	SDZ	FGNQSW
02440423	APO-DULOXETINE	APX	FGNQSW
02446081	MAR-DULOXETINE	MAR	FGNQSW
02451913	JAMP-DULOXETINE	JPC	FGNQSW
02453630	DULOXETINE	SIV	FGNQSW
02456753	TEVA-DULOXETINE	TEV	FGNQSW
02473208	M-DULOXETINE	MRA	FGNQSW
02475308	AG-DULOXETINE	ANG	FGNQSW
02482126	NRA-DULOXETINE	NRA	FGNQSW
02490889	DULOXETINE	SNS	FGNQSW

60MG DELAYED RELEASE CAPSULE

02301490	CYMBALTA	LIL	FNQSW
02429454	PMS-DULOXETINE	PMS	FGNQSW
02436655	AURO-DULOXETINE	ARO	FGNQSW
02438992	MINT-DULOXETINE	MNT	FGNQSW
02439956	SANDOZ-DULOXETINE	SDZ	FGNQSW
02440431	APO-DULOXETINE	APX	FGNQSW
02446103	MAR-DULOXETINE	MAR	FGNQSW
02451921	JAMP-DULOXETINE	JPC	FGNQSW
02453649	DULOXETINE	SIV	FGNQSW
02456761	TEVA-DULOXETINE	TEV	FGNQSW
02473216	M-DULOXETINE	MRA	FGNQSW
02475316	AG-DULOXETINE	ANG	FGNQSW

02482134	NRA-DULOXETINE	NRA	FGNQSW
02490897	DULOXETINE	SNS	FGNQSW

⑤ESCITALOPRAM

10MG TABLET

02263238	CIPRALEX	LUD	FNQSW
02295016	APO-ESCITALOPRAM	APX	FGNQSW
02309467	MYLAN-ESCITALOPRAM	MYL	FGNQSW
02318180	TEVA-ESCITALOPRAM	TEV	FGNQSW
02364077	SANDOZ-ESCITALOPRAM	SDZ	FGNQSW
02385481	RAN-ESCITALOPRAM	RAN	FGNQSW
02397358	AURO-ESCITALOPRAM	ARO	FGNQSW
02407418	MINT-ESCITALOPRAM	MNT	FGNQSW
02429039	ESCITALOPRAM	SIV	FGNQSW
02429780	JAMP-ESCITALOPRAM	JPC	FGNQSW
02430118	ESCITALOPRAM	SNS	FGNQSW
02434652	ACH-ESCITALOPRAM	ACH	FGNQSW
02440296	NAT-ESCITALOPRAM	NAT	FGNQSW
02469243	PMS-ESCITALOPRAM	PMS	FGNQSW
02471418	M-ESCITALOPRAM	MRA	FGNQSW
02476851	NRA-ESCITALOPRAM	NRA	FGNQSW
02508893	JAMP-ESCITALOPRAM	JPC	FGNQSW

15MG TABLET

02512653	KYE-ESCITALOPRAM	KYE	FGNQSW

20MG TABLET

02263254	CIPRALEX	LUD	FNQSW
02295024	APO-ESCITALOPRAM	APX	FGNQSW
02309475	MYLAN-ESCITALOPRAM	MYL	FGNQSW
02318202	TEVA-ESCITALOPRAM	TEV	FGNQSW
02364085	SANDOZ-ESCITALOPRAM	SDZ	FGNQSW
02385503	RAN-ESCITALOPRAM	RAN	FGNQSW
02397374	AURO-ESCITALOPRAM	ARO	FGNQSW
02407434	MINT-ESCITALOPRAM	MNT	FGNQSW
02429047	ESCITALOPRAM	SIV	FGNQSW
02429799	JAMP-ESCITALOPRAM	JPC	FGNQSW
02430126	ESCITALOPRAM	SNS	FGNQSW
02434660	ACH-ESCITALOPRAM	ACH	FGNQSW
02440318	NAT-ESCITALOPRAM	NAT	FGNQSW
02469251	PMS-ESCITALOPRAM	PMS	FGNQSW
02471426	M-ESCITALOPRAM	MRA	FGNQSW
02476878	NRA-ESCITALOPRAM	NRA	FGNQSW
02508907	JAMP-ESCITALOPRAM	JPC	FGNQSW

⑤FLUOXETINE HCL

10MG CAPSULE

02018985	PROZAC	LIL	FNQSW
02177579	PMS-FLUOXETINE	PMS	FGNQSW
02216353	APO-FLUOXETINE	APX	FGNQSW
02216582	TEVA-FLUOXETINE	TEV	FGNQSW
02286068	FLUOXETINE	SNS	FGNQSW
02374447	FLUOXETINE	SIV	FGNQSW
02380560	MINT-FLUOXETINE	MNT	FGNQSW
02385627	AURO-FLUOXETINE	ARO	FGNQSW
02392909	MAR-FLUOXETINE	MAR	FGNQSW
02393441	FLUOXETINE	ACH	FGNQSW
02401894	JAMP-FLUOXETINE	JPC	FGNQSW
02485052	AG-FLUOXETINE	ANG	FGNQSW
02503875	NRA-FLUOXETINE	NRA	FGNQSW
02529432	M-FLUOXETINE	MRA	FGNQSW

20MG CAPSULE

00636622	PROZAC	LIL	FNQSW
02177587	PMS-FLUOXETINE	PMS	FGNQSW
02216361	APO-FLUOXETINE	APX	FGNQSW
02216590	TEVA-FLUOXETINE	TEV	FGNQSW
02286076	FLUOXETINE	SNS	FGNQSW
02374455	FLUOXETINE	SIV	FGNQSW
02380579	MINT-FLUOXETINE	MNT	FGNQSW
02383241	FLUOXETINE	ACH	FGNQSW
02385635	AURO-FLUOXETINE	ARO	FGNQSW
02386402	JAMP-FLUOXETINE	JPC	FGNQSW
02392917	MAR-FLUOXETINE	MAR	FGNQSW
02485060	AG-FLUOXETINE	ANG	FGNQSW
02503883	NRA-FLUOXETINE	NRA	FGNQSW
02529440	M-FLUOXETINE	MRA	FGNQSW

40MG CAPSULE

02464640	PMS-FLUOXETINE	PMS	FGNQSW

60MG CAPSULE

02464659	PMS-FLUOXETINE	PMS	FGNQSW

⑤FLUOXETINE

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG/5ML ORAL SOLUTION

02231328	APO-FLUOXETINE (SA)	APX	FGNQSW
02459361	ODAN-FLUOXETINE (SA)	ODN	FGNQSW
02546752	JAMP-FLUOXETINE (SA)	JPC	FGNQSW

⑤FLUVOXAMINE MALEATE

50MG TABLET

01919342	LUVOX	BGP	FNQSW
02231329	APO-FLUVOXAMINE	APX	FGNQSW
02255529	TEVA-FLUVOXAMINE	TEV	FGNQSW

100MG TABLET

01919369	LUVOX	BGP	FNQSW
02231330	APO-FLUVOXAMINE	APX	FGNQSW
02255537	TEVA-FLUVOXAMINE	TEV	FGNQSW

⑤IMIPRAMINE

10MG TABLET

00360201	APO-IMIPRAMINE	APX	FGNQSW
02546337	JAMP-IMIPRAMINE	JPC	FGNQSW

25MG TABLET

00312797	APO-IMIPRAMINE	APX	FGNQSW
02546345	JAMP-IMIPRAMINE	JPC	FGNQSW

50MG TABLET

00326852	APO-IMIPRAMINE	APX	FGNQSW
02546353	JAMP-IMIPRAMINE	JPC	FGNQSW

75MG TABLET

00644579	APO-IMIPRAMINE	APX	FGNQSW
02546361	JAMP-IMIPRAMINE	JPC	FGNQSW

TRYPTOPHAN

500MG CAPSULE

00718149	TRYPTAN	BSL	FNQSW
02248540	APO-TRYPTOPHAN	APX	FGNQSW

500MG TABLET

02029456	TRYPTAN	BSL	FNQSW
02240333	TEVA-TRYPTOPHAN	TEV	FGNQSW
02248538	APO-TRYPTOPHAN	APX	FGNQSW

1G TABLET

00654531	TRYPTAN	BSL	FNQSW
02237250	TEVA-TRYPTOPHAN	TEV	FGNQSW
02248539	APO-TRYPTOPHAN	APX	FGNQSW

⑤MIRTAZAPINE

15 MG TABLET

02250594	SANDOZ-MIRTAZAPINE	SDZ	FGNQSW

02256096	MYLAN-MIRTAZAPINE	MYL	FGNQSW
02273942	PMS-MIRTAZAPINE	PMS	FGNQSW
02286610	APO-MIRTAZAPINE	APX	FGNQSW
02411695	AURO-MIRTAZAPINE	ARO	FGNQSW
02496666	MIRTAZAPINE	SIV	FGNQSW
02532689	MIRTAZAPINE	SNS	FGNQSW
02541572	TEVA-MIRTAZAPINE	TEV	FGNQSW

30MG TABLET

02243910	REMERON	MSD	FNQSW
02248762	PMS-MIRTAZAPINE	PMS	FGNQSW
02250608	SANDOZ-MIRTAZAPINE	SDZ	FGNQSW
02256118	MYLAN-MIRTAZAPINE	MYL	FGNQSW
02259354	TEVA-MIRTAZAPINE	TEV	FGNQSW
02286629	APO-MIRTAZAPINE	APX	FGNQSW
02370689	MIRTAZIPINE	SNS	FGNQSW
02411709	AURO-MIRTAZAPINE	ARO	FGNQSW
02496674	MIRTAZAPINE	SIV	FGNQSW

45MG TABLET

02286637	APO-MIRTAZAPINE	APX	FGNQSW
02411717	MIRTAZAPINE	ARO	FGNQSW
02496682	MIRTAZAPINE	SIV	FGNQSW
02541580	TEVA-MIRTAZAPINE	TEV	FGNQSW

15MG ORALLY DISINTEGRATING TABLET

02248542	REMERON RD	MSD	FNQSW
02299801	AURO-MIRTAZAPINE	ARO	FGNQSW

30MG ORALLY DISINTEGRATING TABLET

02248543	REMERON RD	MSD	FNQSW
02299828	AURO-MIRTAZAPINE	ARO	FGNQSW

45MG ORALLY DISINTEGRATING TABLET

02248544	REMERON RD	MSD	FNQSW
02299836	AURO-MIRTAZAPINE	ARO	FGNQSW

MOCLOBEMIDE

100MG TABLET

02232148	MOCLOBEMIDE	AAA	FGNQSW

150MG TABLET

00899356	MANERIX	BSL	FNQSW
02232150	MOCLOBEMIDE	AAA	FGNQSW

300MG TABLET

02166747	MANERIX	BSL	FNQSW
02240456	MOCLOBEMIDE	AAA	FGNQSW

⑤NORTRIPTYLINE

10MG CAPSULE

00015229	AVENTYL	AAA	FNQSW

25MG CAPSULE

00015237	AVENTYL	AAA	FNQSW

⑤PAROXETINE HCL

20MG TABLET

01940481	PAXIL	GSK	FNQSW
02240908	APO-PAROXETINE	APX	FGNQSW
02247751	PMS-PAROXETINE	PMS	FGNQSW
02368870	JAMP-PAROXETINE	JPC	FGNQSW
02248557	TEVA-PAROXETINE	TEV	FGNQSW
02282852	PAROXETINE	SNS	FGNQSW
02383284	AURO-PAROXETINE	ARO	FGNQSW
02388235	PAROXETINE	SIV	FGNQSW
02411954	MAR-PAROXETINE	MAR	FGNQSW
02421380	MINT-PAROXETINE	MNT	FGNQSW
02467410	M-PAROXETINE	MRA	FGNQSW
02475545	AG-PAROXETINE	ANG	FGNQSW
02479761	NRA-PAROXETINE	NRA	FGNQSW
02507781	JAMP-PAROXETINE	JPC	FGNQSW

30MG TABLET

01940473	PAXIL	GSK	FNQSW
02240909	APO-PAROXETINE	APX	FGNQSW
02247752	PMS-PAROXETINE	PMS	FGNQSW
02248558	TEVA-PAROXETINE	TEV	FGNQSW
02368889	JAMP-PAROXETINE	JPC	FGNQSW
02282860	PAROXETINE	SNS	FGNQSW
02383292	AURO-PAROXETINE	ARO	FGNQSW
02388243	PAROXETINE	SIV	FGNQSW
02411962	MAR-PAROXETINE	MAR	FGNQSW
02421399	MINT-PAROXETINE	MNT	FGNQSW
02467429	M-PAROXETINE	MRA	FGNQSW
02475553	AG-PAROXETINE	ANG	FGNQSW
02479788	NRA-PAROXETINE	NRA	FGNQSW
02507803	JAMP-PAROXETINE	JPC	FGNQSW

PHENELZINE SULFATE

15MG TABLET

00476552	NARDIL	ERF	FNQSW

⑤SERTRALINE HCL**25MG CAPSULE**

02132702	ZOLOFT	UJC	FNQSW
02238280	APO-SERTRALINE	APX	FGNQSW
02240485	TEVA-SERTRALINE	TEV	FGNQSW
02244838	PMS-SERTRALINE	PMS	FGNQSW
02245159	SANDOZ-SERTRALINE	SDZ	FGNQSW
02353520	SERTRALINE	SNS	FGNQSW
02386070	SERTRALINE	SIV	FGNQSW
02390906	AURO-SERTRALINE	ARO	FGNQSW
02399415	MAR-SERTRALINE	MAR	FGNQSW
02402378	MINT-SERTRALINE	MNT	FGNQSW
02469626	SERTRALINE	JPC	FGNQSW
02477882	AG-SERTRALINE	ANG	FGNQSW
02488434	NRA-SERTRALINE	NRA	FGNQSW
02530937	M-SERTRALINE	MRA	FGNQSW

50MG CAPSULE

01962817	ZOLOFT	UJC	FNQSW
02238281	APO-SERTRALINE	APX	FGNQSW
02240484	TEVA-SERTRALINE	TEV	FGNQSW
02244839	PMS-SERTRALINE	PMS	FGNQSW
02245160	SANDOZ-SERTRALINE	SDZ	FGNQSW
02353539	SERTRALINE	SNS	FGNQSW
02386089	SERTRALINE	SIV	FGNQSW
02390914	AURO-SERTRALINE	ARO	FGNQSW
02399423	MAR-SERTRALINE	MAR	FGNQSW
02402394	MINT-SERTRALINE	MNT	FGNQSW
02469634	SERTRALINE	JPC	FGNQSW
02477890	AG-SERTRALINE	ANG	FGNQSW
02488442	NRA-SERTRALINE	NRA	FGNQSW
02530945	M-SERTRALINE	MRA	FGNQSW

100MG CAPSULE

01962779	ZOLOFT	UJC	FNQSW
02238282	APO-SERTRALINE	APX	FGNQSW
02240481	TEVA-SERTRALINE	TEV	FGNQSW
02244840	PMS-SERTRALINE	PMS	FGNQSW
02353547	SERTRALINE	SNS	FGNQSW
02386097	SERTRALINE	SIV	FGNQSW
02390922	AURO-SERTRALINE	ARO	FGNQSW
02399431	MAR-SERTRALINE	MAR	FGNQSW
02402408	MINT-SERTRALINE	MNT	FGNQSW
02469642	SERTRALINE	JPC	FGNQSW
02477904	AG-SERTRALINE	ANG	FGNQSW

02488450	NRA-SERTRALINE	NRA	FGNQSW
02530953	M-SERTRALINE	MRA	FGNQSW

TRANLYCYPROMINE SULFATE

10MG TABLET

01919598	PARNATE	GSK	FNQSW

⑤TRAZODONE HCL

50MG TABLET

01937227	PMS-TRAZODONE	PMS	FGNQSW
02144263	TEVA-TRAZODONE	TEV	FGNQSW
02147637	APO-TRAZODONE	APX	FGNQSW
02348772	TRAZADONE	SNS	FGNQSW
02442809	JAMP-TRAZADONE	JPC	FGNQSW

100MG TABLET

01937235	PMS-TRAZODONE	PMS	FGNQSW
02144271	TEVA-TRAZODONE	TEV	FGNQSW
02147645	APO-TRAZODONE	APX	FGNQSW
02348780	TRAZODONE	SNS	FGNQSW
02442817	JAMP-TRAZADONE	JPC	FGNQSW

150MG TABLET

02144298	TEVA-TRAZADONE	TEV	FGNQSW
02147653	APO-TRAZADONE D	APX	FGNQSW
02348799	TRAZADONE	SNS	FGNQSW
02442825	JAMP-TRAZADONE	JPC	FGNQSW

⑤TRIMIPRAMINE

12.5MG TABLET

00740799	TRIMIPRAMINE	AAA	FGNQSW

25MG TABLET

00740802	TRIMIPRAMINE	AAA	FGNQSW

50MG TABLET

00740810	TRIMIPRAMINE	AAA	FGNQSW

100MG TABLET

00740829	TRIMIPRAMINE	AAA	FGNQSW

75MG CAPSULE

02070987	TRIMIPRAMINE	AAA	FGNQSW

⑤VENLAFAXINE HCL

37.5MG EXTENDED RELEASE CAPSULE

02237279	EFFEXOR XR	UJC	FNQSW
02275023	TEVA-VENLAFAXINE XR	TEV	FGNQSW
02278545	PMS-VENLAFAXINE XR	PMS	FGNQSW
02304317	ACT-VENLAFAXINE XR	TEV	FGNQSW
02310317	SANDOZ-VENLAFAXINE XR	SDZ	FGNQSW
02331683	APO-VENLAFAXINE XR	APX	FGNQSW
02354713	VENLAFAXINE XR	SNS	FGNQSW
02380072	TARO-VENLAFAXINE XR	SUN	FGNQSW
02385929	VENLAFAXINE XR	SIV	FGNQSW
02452839	AURO-VENLAFAXINE XR	ARO	FGNQSW
02471280	M-VENLAFAXINE XR	MRA	FGNQSW
02489678	VENLAFAXINE XR	RIV	FGNQSW
02516535	VENLAFAXINE XR	JPC	FGNQSW
02521466	PMSC-VENLAFAXINE XR	PMS	FGNQSW
02522977	MINT-VENLAFAXINE XR	MNT	FGNQSW

75MG EXTENDED RELEASE CAPSULE

02237280	EFFEXOR XR	UJC	FNQSW
02275031	TEVA-VENLAFAXINE XR	TEV	FGNQSW
02278553	PMS-VENLAFAXINE XR	PMS	FGNQSW
02304325	ACT-VENLAFAXINE XR	TEV	FGNQSW
02310325	SANDOZ VENLAFAXINE XR	SDZ	FGNQSW
02331691	APO-VENLAFAXINE XR	APX	FGNQSW
02354721	VENLAFAXINE XR	SNS	FGNQSW
02380080	TARO-VENLAFAXINE XR	SUN	FGNQSW
02385937	VENLAFAXINE XR	SIV	FGNQSW
02452847	AURO-VENLAFAXINE XR	ARO	FGNQSW
02471299	M-VENLAFAXINE XR	MRA	FGNQSW
02489686	VENLAFAXINE XR	RIV	FGNQSW
02516543	VENLAFAXINE XR	JPC	FGNQSW
02521482	PMSC-VENLAFAXINE XR	PMS	FGNQSW
02522985	MINT-VENLAFAXINE XR	MNT	FGNQSW

150MG EXTENDED RELEASE CAPSULE

02237282	EFFEXOR XR	UJC	FNQSW
02275058	TEVA-VENLAFAXINE XR	TEV	FGNQSW
02278561	PMS-VENLAFAXINE XR	PMS	FGNQSW
02304333	ACT-VENLAFAXINE XR	TEV	FGNQSW
02310333	SANDOZ-VENLAFAXINE XR	SNS	FGNQSW
02331705	APO-VENLAFAXINE XR	APX	FGNQSW
02354748	VENLAFAXINE XR	SNS	FGNQSW
02380099	TARO-VENLAFAXINE XR	SUN	FGNQSW
02385945	VENLAFAXINE XR	SIV	FGNQSW
02452855	AURO-VENLAFAXINE XR	ARO	FGNQSW
02471302	M-VENLAFAXINE XR	MRA	FGNQSW
02489694	VENLAFAXINE XR	RIV	FGNQSW

02516551	VENLAFAXINE XR	JPC	FGNQSW
02521474	PMSC-VENLAFAXINE XR	PMS	FGNQSW
02522993	MINT-VENLAFAXINE XR	MNT	FGNQSW

VORTIOXETINE

5MG TABLET

02432919	TRINTELLIX	LUD	FNQSW
02552744	APO-VORTIOXETINE	APX	FGNQSW

10MG TABLET

02432927	TRINTELLIX	LUD	FNQSW
02552752	APO-VORTIOXETINE	APX	FGNQSW

20MG TABLET

02432943	TRINTELLIX	LUD	FNQSW
02552779	APO-VORTIOXETINE	APX	FGNQSW

28:16.08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTICS)

⑤ARIPIIPRAZOLE

2MG TABLET

02322374	ABILIFY	OTS	FNQSW
02460025	AURO-ARIPIIPRAZOLE	ARO	FGNQSW
02466635	PMS-ARIPIIPRAZOLE	PMS	FGNQSW
02471086	APO-ARIPIIPRAZOLE	APX	FGNQSW
02473658	SANDOZ-ARIPIIPRAZOLE	SDZ	FGNQSW
02483556	MINT-ARIPIIPRAZOLE	MNT	FGNQSW
02506688	ARIPIIPRAZOLE	SNS	FGNQSW
02534320	ARIPIIPRAZOLE	SIV	FGNQSW

5MG TABLET

02322382	ABILIFY	OTS	FNQSW
02460033	AURO-ARIPIIPRAZOLE	ARO	FGNQSW
02466643	PMS-ARIPIIPRAZOLE	PMS	FGNQSW
02471094	APO-ARIPIIPRAZOLE	APX	FGNQSW
02473666	SANDOZ-ARIPIIPRAZOLE	SDZ	FGNQSW
02483564	MINT-ARIPIIPRAZOLE	MNT	FGNQSW
02506718	ARIPIIPRAZOLE	SNS	FGNQSW
02534339	ARIPIIPRAZOLE	SIV	FGNQSW

10MG TABLET

02322390	ABILIFY	OTS	FNQSW
02460041	AURO-ARIPIIPRAZOLE	ARO	FGNQSW

02466651	PMS-ARIPIRAZOLE	PMS	FGNQSW
02471108	APO-ARIPIRAZOLE	APX	FGNQSW
02473674	SANDOZ-ARIPIRAZOLE	SDZ	FGNQSW
02483572	MINT-ARIPIRAZOLE	MNT	FGNQSW
02506726	ARIPIRAZOLE	SNS	FGNQSW
02534347	ARIPIRAZOLE	SIV	FGNQSW

15MG TABLET

02322404	ABILIFY	OTS	FNQSW
02460068	AURO-ARIPIRAZOLE	ARO	FGNQSW
02466678	PMS-ARIPIRAZOLE	PMS	FGNQSW
02471116	APO-ARIPIRAZOLE	APX	FGNQSW
02473682	SANDOZ-ARIPIRAZOLE	SDZ	FGNQSW
02483580	MINT-ARIPIRAZOLE	MNT	FGNQSW
02506734	ARIPIRAZOLE	SNS	FGNQSW
02534355	ARIPIRAZOLE	SIV	FGNQSW

20MG TABLET

02322412	ABILIFY	OTS	FNQSW
02460076	AURO-ARIPIRAZOLE	ARO	FGNQSW
02466686	PMS-ARIPIRAZOLE	PMS	FGNQSW
02471124	APO-ARIPIRAZOLE	APX	FGNQSW
02473690	SANDOZ-ARIPIRAZOLE	SDZ	FGNQSW
02483599	MINT-ARIPIRAZOLE	MNT	FGNQSW
02506750	ARIPIRAZOLE	SNS	FGNQSW
02534363	ARIPIRAZOLE	SIV	FGNQSW

30MG TABLET

02322455	ABILIFY	OTS	FNQSW
02460084	AURO-ARIPIRAZOLE	ARO	FGNQSW
02466694	PMS-ARIPIRAZOLE	PMS	FGNQSW
02471132	APO-ARIPIRAZOLE	APX	FGNQSW
02473704	SANDOZ-ARIPIRAZOLE	SDZ	FGNQSW
02483602	MINT-ARIPIRAZOLE	MNT	FGNQSW
02506785	ARIPIRAZOLE	SNS	FGNQSW
02534371	ARIPIRAZOLE	SIV	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA (COMMUNITY MENTAL HEALTH DRUG PROGRAM DOES NOT REQUIRE A SA)

300MG INJECTION

02420864	ABILIFY MAINTENA (SA)	OTS	BFNQSW

400MG INJECTION

02420872	ABILIFY MAINTENA (SA)	OTS	BFNQSW

ASENAPINE

[SEE APPENDIX A](#) FOR SA CRITERIA

5MG SUBLINGUAL TABLET

02374803 SAPHRIS (SA)

LUD **FNQSW**

10MG SUBLINGUAL TABLET

02374811 SAPHRIS (SA)

LUD **FNQSW**

BREXPIRAZOLE

0.25MG TABLET

02461749 REXULTI

OTS **FNQSW**

0.5MG TABLET

02461757 REXULTI

OTS **FNQSW**

1MG TABLET

02461765 REXULTI

OTS **FNQSW**

2MG TABLET

02461773 REXULTI

OTS **FNQSW**

3MG TABLET

02461781 REXULTI

OTS **FNQSW**

4MG TABLET

02461803 REXULTI

OTS **FNQSW**

CARIPRAZINE

[SEE APPENDIX A](#) FOR SA CRITERIA

1.5MG CAPSULE

02526794 VRAYLAR (SA)

ABV **FNQSW**

3MG CAPSULE

02526808 VRAYLAR (SA)

ABV **FNQSW**

4.5MG CAPSULE

02526816 VRAYLAR (SA)

ABV **FNQSW**

6MG CAPSULE

02526824 VRAYLAR (SA)

ABV **FNQSW**

⑤CHLORPROMAZINE

25MG TABLET

00232823 TEVA-CHLORPROMAZINE

TEV **FGNQSW**

50MG TABLET

00232807 TEVA-CHLORPROMAZINE

TEV **FGNQSW**

100MG TABLET		
00232831	TEVA-CHLORPROMAZINE	TEV FGNQSW

⑤CLOZAPINE

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG TABLET		
00894737	CLOZARIL (SA)	NVR FNQSW
02247243	GEN-CLOZAPINE (SA)	MYL FGNQSW
02248034	AA-CLOZAPINE (SA)	AAA FGNQSW

50MG TABLET		
02305003	GEN-CLOZAPINE (SA)	MYL FGNQSW
02458748	AA-CLOZAPINE (SA)	AAA FGNQSW

100MG TABLET		
00894745	CLOZARIL (SA)	NVR FNQSW
02247244	GEN-CLOZAPINE (SA)	MYL FGNQSW
02248035	AA-CLOZAPINE (SA)	AAA FGNQSW

200MG TABLET		
02305011	GEN-CLOZAPINE (SA)	MYL FGNQSW
02458756	AA-CLOZAPINE (SA)	AAA FGNQSW

Note: Clozapine is only to be dispensed to patients upon receipt of weekly or bi-weekly hematological test results by the pharmacy.

FLUPENTHIXOL DECANOATE

20MG/ML DEPOT INJECTION SOLUTION (10ML)		
02156032	FLUANXOL DEPOT	LUD B

100MG/ML DEPOT INJECTION SOLUTION (2ML)		
02156040	FLUANXOL DEPOT	LUD B

⑤FLUPENTHIXOL DIHYDROCHLORIDE

0.5MG TABLET		
02156008	FLUANXOL	LUD FNQSW

3MG TABLET		
02156016	FLUANXOL	LUD FNQSW

⑤FLUPHENAZINE HCL

1MG TABLET		
00405345	FLUPHENAZINE	AAA FGNQSW

2MG TABLET 00410632	FLUPHENAZINE	AAA	FGNQSW
5MG TABLET 00405361	FLUPHENAZINE	AAA	FGNQSW
⑤HALOPERIDOL			
0.5MG TABLET 00363685	TEVA-HALOPERIDOL	TEV	FGNQSW
1MG TABLET 00363677	TEVA-HALOPERIDOL	TEV	FGNQSW
2MG TABLET 00363669	TEVA-HALOPERIDOL	TEV	FGNQSW
5MG TABLET 00363650	TEVA-HALOPERIDOL	TEV	FGNQSW
10MG TABLET 00713449	TEVA-HALOPERIDOL	TEV	FGNQSW
5MG/ML INJECTION SOLUTION (1ML) 00808652	HALOPERIDOL	SDZ	NQ
02366010	HALOPERIDOL	OMG	NQ
HALOPERIDOL DECANOATE			
100MG/ML DEPOT INJECTION SOLUTION (5ML) 02130300	HALOPERIDOL LA	SDZ	B
⑤LOXAPINE SUCCINATE			
2.5MG TABLET 02242868	XYLAC	PEN	FNQSW
10MG TABLET 02230838	XYLAC	PEN	FNQSW
25MG TABLET 02230839	XYLAC	PEN	FNQSW
⑤LURASIDONE			
20MG TABLET 02422050	LATUDA	SNV	FNQSW
02504499	TARO-LURASIDONE	TAR	FGNQSW
02505878	PMS-LURASIDONE	PMS	FGNQSW
02513986	AURO-LURASIDONE	ARO	FGNQSW

02516438	JAMP-LURASIDONE	JPC	FGNQSW
02521075	SANDOZ-LURASIDONE	SDZ	FGNQSW
02548585	LURASIDONE	SNS	FGNQSW

40MG TABLET

02387751	LATUDA	SNV	FNQSW
02504502	TARO-LURASIDONE	TAR	FGNQSW
02505886	PMS-LURASIDONE	PMS	FGNQSW
02513994	AURO-LURASIDONE	ARO	FGNQSW
02516446	JAMP-LURASIDONE	JPC	FGNQSW
02521091	SANDOZ-LURASIDONE	SDZ	FGNQSW
02548593	LURASIDONE	SNS	FGNQSW

60MG TABLET

02413361	LATUDA	SNV	FNQSW
02504510	TARO-LURASIDONE	TAR	FGNQSW
02505894	PMS-LURASIDONE	PMS	FGNQSW
02514001	AURO-LURASIDONE	ARO	FGNQSW
02516454	JAMP-LURASIDONE	JPC	FGNQSW
02521105	SANDOZ-LURASIDONE	SDZ	FGNQSW
02548607	LURASIDONE	SNS	FGNQSW

80MG TABLET

02387778	LATUDA	SNV	FNQSW
02504529	TARO-LURASIDONE	TAR	FGNQSW
02505908	PMS-LURASIDONE	PMS	FGNQSW
02514028	AURO-LURASIDONE	ARO	FGNQSW
02516462	JAMP-LURASIDONE	JPC	FGNQSW
02521113	SANDOZ-LURASIDONE	SDZ	FGNQSW
02548615	LURASIDONE	SNS	FGNQSW

120MG TABLET

02387786	LATUDA	SNV	FNQSW
02504537	TARO-LURASIDONE	TAR	FGNQSW
02505916	PMS-LURASIDONE	PMS	FGNQSW
02514036	AURO-LURASIDONE	ARO	FGNQSW
02516470	JAMP-LURASIDONE	JPC	FGNQSW
02521121	SANDOZ-LURASIDONE	SDZ	FGNQSW

⑤METHOTRIMEPRAZINE

2MG TABLET

02238403	METHOPRAZINE	AAA	FGNQSW

5MG TABLET

02238404	METHOPRAZINE	AAA	FGNQSW

25MG TABLET			
02238405	METHOPRAZINE	AAA	FGNQSW
50MG TABLET			
02238406	METHOPRAZINE	AAA	FGNQSW
25MG/ML AMPUL			
01927698	NOZINAN	XPI	N
⑤OLANZAPINE			
2.5MG TABLET			
02229250	ZYPREXA	XPI	FNQSW
02276712	TEVA-OLANZAPINE	TEV	FGNQSW
02281791	APO-OLANZAPINE	APX	FGNQSW
02303116	PMS-OLANZAPINE	PMS	FGNQSW
02310341	SANDOZ-OLANZAPINE	SDZ	FGNQSW
02372819	OLANZAPINE	SNS	FGNQSW
02385864	OLANZAPINE	SIV	FGNQSW
02410141	MINT-OLANZAPINE	MNT	FGNQSW
02417243	JAMP-OLANZAPINE	JPC	FGNQSW
02487608	AG-OLANZAPINE	ANG	FGNQSW
5MG TABLET			
02229269	ZYPREXA	XPI	FNQSW
02276720	TEVA-OLANZAPINE	TEV	FGNQSW
02281805	APO-OLANZAPINE	APX	FGNQSW
02303159	PMS-OLANZAPINE	PMS	FGNQSW
02310368	SANDOZ-OLANZAPINE	SDZ	FGNQSW
02372827	OLANZAPINE	SNS	FGNQSW
02385872	OLANZAPINE	SIV	FGNQSW
02410168	MINT-OLANZAPINE	MNT	FGNQSW
02417251	JAMP-OLANZAPINE	JPC	FGNQSW
02487616	AG-OLANZAPINE	ANG	FGNQSW
7.5MG TABLET			
02229277	ZYPREXA	XPI	FNQSW
02276739	TEVA-OLANZAPINE	TEV	FGNQSW
02281813	APO-OLANZAPINE	APX	FGNQSW
02303167	PMS-OLANZAPINE	PMS	FGNQSW
02310376	SANDOZ-OLANZAPINE	SDZ	FGNQSW
02372835	OLANZAPINE	SNS	FGNQSW
02385880	OLANZAPINE	SIV	FGNQSW
02410176	MINT-OLANZAPINE	MNT	FGNQSW
02417278	JAMP-OLANZAPINE	JPC	FGNQSW
10MG TABLET			

02229285	ZYPREXA	XPI	FNQSW
02276747	TEVA-OLANZAPINE	TEV	FGNQSW
02281821	APO-OLANZAPINE	APX	FGNQSW
02303175	PMS-OLANZAPINE	PMS	FGNQSW
02310384	SANDOZ-OLANZAPINE	SDZ	FGNQSW
02372843	OLANZAPINE	SNS	FGNQSW
02385899	OLANZAPINE	SIV	FGNQSW
02410184	MINT-OLANZAPINE	MNT	FGNQSW
02417286	JAMP-OLANZAPINE	JPC	FGNQSW
02487632	AG-OLANZAPINE	ANG	FGNQSW

15MG TABLET

02238850	ZYPREXA	XPI	FNQSW
02276755	TEVA-OLANZAPINE	TEV	FGNQSW
02281848	APO-OLANZAPINE	APX	FGNQSW
02303183	PMS-OLANZAPINE	PMS	FGNQSW
02310392	SANDOZ-OLANZAPINE	SDZ	FGNQSW
02372851	OLANZAPINE	SNS	FGNQSW
02385902	OLANZAPINE	SIV	FGNQSW
02410192	MINT-OLANZAPINE	MNT	FGNQSW
02417294	JAMP-OLANZAPINE	JPC	FGNQSW

20MG TABLET

02238851	ZYPREXA	XPI	FNQSW
02333015	APO-OLANZAPINE	APX	FGNQSW
02359707	TEVA-OLANZAPINE	TEV	FGNQSW
02385910	OLANZAPINE	SIV	FGNQSW
02417308	JAMP-OLANZAPINE	JPC	FGNQSW

5MG ORALLY DISINTEGRATING TABLET

02243086	ZYPREXA ZYDIS	XPI	FNQSW
02303191	PMS-OLANZAPINE ODT	PMS	FGNQSW
02327775	SANDOZ-OLANZAPINE ODT	SDZ	FGNQSW
02343665	OLANZAPINE ODT	SIV	FGNQSW
02352974	OLANZAPINE ODT	SNS	FGNQSW
02360616	APO-OLANZAPINE ODT	APX	FGNQSW
02406624	JAMP-OLANZAPINE ODT	JPC	FGNQSW
02436965	MINT-OLANZAPINE ODT	MNT	FGNQSW
02448726	AURO-OLANZAPINE ODT	ARO	FGNQSW

10MG ORALLY DISINTEGRATING TABLET

02243087	ZYPREXA ZYDIS	XPI	FNQSW
02303205	PMS-OLANZAPINE ODT	PMS	FGNQSW
02327783	SANDOZ-OLANZAPINE ODT	SDZ	FGNQSW
02343673	OLANZAPINE ODT	SIV	FGNQSW
02352982	OLANZAPINE ODT	SNS	FGNQSW

02360624	APO-OLANZAPINE ODT	APX	FGNQSW
02406632	JAMP-OLANZAPINE ODT	JPC	FGNQSW
02436973	MINT-OLANZAPINE ODT	MNT	FGNQSW
02448734	AURO-OLANZAPINE ODT	ARO	FGNQSW

15MG ORALLY DISINTEGRATING TABLET

02243088	ZYPREXA ZYDIS	XPI	FNQSW
02303213	PMS-OLANZAPINE ODT	PMS	FGNQSW
02327791	SANDOZ-OLANZAPINE ODT	SDZ	FGNQSW
02343681	OLANZAPINE ODT	SIV	FGNQSW
02352990	OLANZAPINE ODT	SNS	FGNQSW
02360632	APO-OLANZAPINE ODT	APX	FGNQSW
02406640	JAMP-OLANZAPINE ODT	JPC	FGNQSW
02436981	MINT-OLANZAPINE ODT	MNT	FGNQSW
02448742	AURO-OLANZAPINE ODT	ARO	FGNQSW

20MG ORALLY DISINTEGRATING TABLET

02243089	ZYPREXA ZYDIS	XPI	FNQSW
02327805	SANDOZ-OLANZAPINE ODT	SDZ	FGNQSW
02343703	OLANZAPINE ODT	SIV	FGNQSW
02360640	APO-OLANZAPINE ODT	APX	FGNQSW
02406659	JAMP-OLANZAPINE ODT	JPC	FGNQSW
02448750	AURO-OLANZAPINE ODT	ARO	FGNQSW

⑤PALIPERIDONE

SEE APPENDIX A FOR SA CRITERIA (COMMUNITY MENTAL HEALTH DRUG PROGRAM

DOES NOT REQUIRE A SA)

50MG/0.5ML INJECTION

02354217	INVEGA SUSTENNA (SA)	JAN	BFNQSW

75MG/0.75ML INJECTION

02354225	INVEGA SUSTENNA (SA)	JAN	BFNQSW

100MG/ML INJECTION

02354233	INVEGA SUSTENNA (SA)	JAN	BFNQSW

150MG/1.5ML INJECTION

02354241	INVEGA SUSTENNA (SA)	JAN	FNQSW

SEE APPENDIX A FOR SA CRITERIA (COMMUNITY MENTAL HEALTH DRUG PROGRAM

DOES NOT REQUIRE A SA)

175MG/0.875ML PREFILLED SYRINGE

02455943	INVEGA TRINZA (SA)	JAN	BFNQSW

263MG/1.315ML PREFILLED SYRINGE

02455986	INVEGA TRINZA (SA)	JAN	BFNQSW

350MG/1.75ML PREFILLED SYRINGE 02455994	INVEGA TRINZA (SA)	JAN	BFNQSW
525MG/2.625ML PREFILLED SYRINGE 02456001	INVEGA TRINZA (SA)	JAN	BFNQSW
⑤PERICYAZINE			
5MG CAPSULE 01926780	NEULEPTIL	ERF	FNQSW
10MG CAPSULE 01926772	NEULEPTIL	ERF	FNQSW
10MG/ML ORAL DROPS 01926756	NEULEPTIL	ERF	FNQSW
⑤PERPHENAZINE			
2MG TABLET 00335134	PERPHENAZINE	AAA	FGNQSW
4MG TABLET 00335126	PERPHENAZINE	AAA	FGNQSW
8MG TABLET 00335118	PERPHENAZINE	AAA	FGNQSW
16MG TABLET 00335096	PERPHENAZINE	AAA	FGNQSW
⑤PIMOZIDE			
2MG TABLET 02245432	PIMOZIDE	AAA	FGNQSW
4MG TABLET 02245433	PIMOZIDE	AAA	FGNQSW
⑤PROCHLORPERAZINE			
5MG TABLET 00886440	PROCHLORAZINE	AAA	FGNQSW
10MG TABLET 00886432	PROCHLORAZINE	AAA	FGNQSW

⑤QUETIAPINE

25MG TABLET

02236951	SEROQUEL	AZE	FNQSW
02296551	PMS-QUETIAPINE	PMS	FGNQSW
02316080	ACT-QUETIAPINE	TEV	FGNQSW
02317893	QUETIAPINE	SIV	FGNQSW
02330415	JAMP-QUETIAPINE	JPC	FGNQSW
02353164	QUETIAPINE	SNS	FGNQSW
02387794	QUETIAPINE	ACH	FGNQSW
02390140	JAMP-QUETIAPINE	JPC	FGNQSW
02399822	MAR-QUETIAPINE	MAR	FGNQSW
02390205	AURO-QUETIAPINE	ARO	FGNQSW
02438003	MINT-QUETIAPINE	MNT	FGNQSW
02439158	NAT-QUETIAPINE	NAT	FGNQSW
02475979	AG-QUETIAPINE	ANG	FGNQSW
02486237	NRA-QUETIAPINE	NRA	FGNQSW
02501635	APO-QUETIAPINE FUMARATE	APX	FGNQSW

100MG TABLET

02236952	SEROQUEL	AZE	FNQSW
02296578	PMS-QUETIAPINE	PMS	FGNQSW
02316099	ACT-QUETIAPINE	TEV	FGNQSW
02317907	QUETIAPINE	SIV	FGNQSW
02330423	JAMP-QUETIAPINE	JPC	FGNQSW
02353172	QUETIAPINE	SNS	FGNQSW
02387808	QUETIAPINE	ACH	FGNQSW
02390159	JAMP-QUETIAPINE	JPC	FGNQSW
02399830	MAR-QUETIAPINE	MAR	FGNQSW
02390213	AURO-QUETIAPINE	ARO	FGNQSW
02438011	MINT-QUETIAPINE	MNT	FGNQSW
02439166	NAT-QUETIAPINE	NAT	FGNQSW
02501643	APO-QUETIAPINE FUMARATE	APX	FGNQSW

150MG TABLET

02439174	NAT-QUETIAPINE	NAT	FGNQSW

200MG TABLET

02236953	SEROQUEL	AZE	FNQSW
02296594	PMS-QUETIAPINE	PMS	FGNQSW
02316110	ACT-QUETIAPINE	TEV	FGNQSW
02317923	QUETIAPINE	SIV	FGNQSW
02330458	JAMP-QUETIAPINE	JPC	FGNQSW
02353199	QUETIAPINE	SNS	FGNQSW
02387824	QUETIAPINE	ACH	FGNQSW
02390167	JAMP-QUETIAPINE	JPC	FGNQSW
02399849	MAR-QUETIAPINE	MAR	FGNQSW

02390248	AURO-QUETIAPINE	ARO	FGNQSW
02438046	MINT-QUETIAPINE	MNT	FGNQSW
02439182	NAT-QUETIAPINE	NAT	FGNQSW
02501651	APO-QUETIAPINE FUMARATE	APX	FGNQSW

300MG TABLET

02244107	SEROQUEL	AZE	FNQSW
02296608	PMS-QUETIAPINE	PMS	FGNQSW
02316129	ACT-QUETIAPINE	TEV	FGNQSW
02317931	QUETIAPINE	SIV	FGNQSW
02330466	JAMP-QUETIAPINE	JPC	FGNQSW
02353202	QUETIAPINE	SNS	FGNQSW
02387832	QUETIAPINE	ACH	FGNQSW
02390175	JAMP-QUETIAPINE	JPC	FGNQSW
02399857	MAR-QUETIAPINE	MAR	FGNQSW
02390256	AURO-QUETIAPINE	ARO	FGNQSW
02438054	MINT-QUETIAPINE	MNT	FGNQSW
02439190	NAT-QUETIAPINE	NAT	FGNQSW
02501678	APO-QUETIAPINE FUMARATE	APX	FGNQSW

50MG EXTENDED RELEASE TABLET

02395444	TEVA-QUETIAPINE XR	TEV	FGNQSW
02407671	SANDOZ-QUETIAPINE XR	SDZ	FGNQSW
02417359	QUETIAPINE XR	SIV	FGNQSW

150MG EXTENDED RELEASE TABLET

02395452	TEVA-QUETIAPINE XR	TEV	FGNQSW
02407698	SANDOZ-QUETIAPINE XR	SDZ	FGNQSW
02417375	QUETIAPINE XR	SIV	FGNQSW

200MG EXTENDED RELEASE TABLET

02395460	TEVA-QUETIAPINE XR	TEV	FGNQSW
02407701	SANDOZ-QUETIAPINE XR	SDZ	FGNQSW
02417367	QUETIAPINE XR	SIV	FGNQSW

300MG EXTENDED RELEASE TABLET

02395479	TEVA-QUETIAPINE XR	TEV	FGNQSW
02407728	SANDOZ-QUETIAPINE XR	SDZ	FGNQSW
02417383	QUETIAPINE XR	SIV	FGNQSW

400MG EXTENDED RELEASE TABLET

02395487	TEVA-QUETIAPINE XR	TEV	FGNQSW
02407736	SANDOZ-QUETIAPINE XR	SDZ	FGNQSW
02417391	QUETIAPINE XR	SIV	FGNQSW

⑤RISPERIDONE

0.25MG TABLET

02252007	PMS-RISPERIDONE	PMS	FGNQSW
02282119	APO-RISPERIDONE	APX	FGNQSW
02282690	TEVA-RISPERIDONE	TEV	FGNQSW
02328305	RAN-RISPERIDONE	RAN	FGNQSW
02356880	RISPERIDONE	SNS	FGNQSW
02359529	JAMP-RISPERIDONE	JPC	FGNQSW
02359790	MINT-RISPERIDONE	MNT	FGNQSW
02371766	MAR-RISPERIDONE	MAR	FGNQSW
02533804	RISPERIDONE	SIV	FGNQSW

0.5MG TABLET

02252015	PMS-RISPERIDONE	PMS	FGNQSW
02264188	TEVA-RISPERIDONE	TEV	FGNQSW
02282127	APO-RISPERIDONE	APX	FGNQSW
02328313	RAN-RISPERIDONE	RAN	FGNQSW
02356899	RISPERIDONE	SNS	FGNQSW
02359537	JAMP-RISPERIDONE	JPC	FGNQSW
02359804	MINT-RISPERIDONE	MNT	FGNQSW
02371774	MAR-RISPERIDONE	MAR	FGNQSW
02533928	RISPERIDONE	SIV	FGNQSW

1MG TABLET

02252023	PMS-RISPERIDONE	PMS	FGNQSW
02264196	TEVA-RISPERIDONE	TEV	FGNQSW
02282135	APO-RISPERIDONE	APX	FGNQSW
02328321	RAN-RISPERIDONE	RAN	FGNQSW
02356902	RISPERIDONE	SNS	FGNQSW
02359545	JAMP-RISPERIDONE	JPC	FGNQSW
02359812	MINT-RISPERIDONE	MNT	FGNQSW
02371782	MAR-RISPERIDONE	MAR	FGNQSW
02533936	RISPERIDONE	SIV	FGNQSW

2MG TABLET

02252031	PMS-RISPERIDONE	PMS	FGNQSW
02264218	TEVA-RISPERIDONE	TEV	FGNQSW
02282143	APO-RISPERIDONE	APX	FGNQSW
02328348	RAN-RISPERIDONE	RAN	FGNQSW
02356910	RISPERIDONE	SNS	FGNQSW
02359553	JAMP-RISPERIDONE	JPC	FGNQSW
02359820	MINT-RISPERIDONE	MNT	FGNQSW
02371790	MAR-RISPERIDONE	MAR	FGNQSW
02533944	RISPERIDONE	SIV	FGNQSW

3MG TABLET

02252058	PMS-RISPERIDONE	PMS	FGNQSW
02264226	TEVA-RISPERIDONE	TEV	FGNQSW
02282151	APO-RISPERIDONE	APX	FGNQSW
02328364	RAN-RISPERIDONE	RAN	FGNQSW
02356929	RISPERIDONE	SNS	FGNQSW
02359561	JAMP-RISPERIDONE	JPC	FGNQSW
02359839	MINT-RISPERIDONE	MNT	FGNQSW
02371804	MAR-RISPERIDONE	MAR	FGNQSW
02533952	RISPERIDONE	SIV	FGNQSW

4MG TABLET

02252066	PMS-RISPERIDONE	PMS	FGNQSW
02264234	TEVA-RISPERIDONE	TEV	FGNQSW
02282178	APO-RISPERIDONE	APX	FGNQSW
02328372	RAN-RISPERIDONE	RBX	FGNQSW
02356937	RISPERIDONE	SNS	FGNQSW
02359588	JAMP-RISPERIDONE	JPC	FGNQSW
02359847	MINT-RISPERIDONE	MNT	FGNQSW
02371812	MAR-RISPERIDONE	MAR	FGNQSW
02533960	RISPERIDONE	SIV	FGNQSW

1MG/ML ORAL SOLUTION

02236950	RISPERDAL	JAN	FNQSW
02279266	PMS-RISPERIDONE	PMS	FGNQSW
02454319	JAMP-RISPERIDONE	JPC	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA (COMMUNITY MENTAL HEALTH DRUG PROGRAM DOES NOT REQUIRE A SA)

12.5MG PROLONGED RELEASE INJECTION

02298465	RISPERDAL CONSTA (SA)	JAN	BFNQSW

25MG PROLONGED RELEASE INJECTION

02255707	RISPERDAL CONSTA (SA)	JAN	BFNQSW

37.5MG PROLONGED RELEASE INJECTION

02255723	RISPERDAL CONSTA (SA)	JAN	BFNQSW

50MG PROLONGED RELEASE INJECTION

02255758	RISPERDAL CONSTA (SA)	JAN	BFNQSW

⑤ TRIFLUOPERAZINE

1MG TABLET

00345539	TRIFLUOPERAZINE	AAA	FGNQSW

2MG TABLET

00312754	TRIFLUOPERAZINE	AAA	FGNQSW

5MG TABLET			
00312746	TRIFLUOPERAZINE	AAA	FGNQSW

10MG TABLET			
00326836	TRIFLUOPERAZINE	AAA	FGNQSW

⑤ZIPRASIDONE HYDROCHLORIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG CAPSULE			
02298597	ZELDOX (SA)	UJC	FNQSW
02449544	AURO-ZIPRASIDONE (SA)	ARO	FGNQSW

40MG CAPSULE			
02298600	ZELDOX (SA)	UJC	FNQSW
02449552	AURO-ZIPRASIDONE (SA)	ARO	FGNQSW

60MG CAPSULE			
02298619	ZELDOX (SA)	UJC	FNQSW
02449560	AURO-ZIPRASIDONE (SA)	ARO	FGNQSW

80MG CAPSULE			
02298627	ZELDOX (SA)	UJC	FNQSW
02449579	AURO-ZIPRASIDONE (SA)	ARO	FGNQSW

ZUCLOPENTHIXOL DECANOATE

200MG INJECTION			
02230406	CLOPIXOL	LUD	B

⑤ZUCLOENTHIXOL HCL

10MG TABLET			
02230402	CLOPIXOL	LUD	FNQSW

25MG TABLET			
02230403	CLOPIXOL	LUD	FNQSW

28:20.00 RESPIRATORY AND CEREBRAL STIMULANTS

⑤DEXTROAMPHETAMINE/AMPHETAMINE

5MG CAPSULE			
02248808	ADDERALL XR	SHR	FQW
02439239	TEVA-AMPHETAMINE XR	TEV	FQW
02445492	APO-AMPHETAMINE XR	APX	FQW

02457288	SANDOZ-AMPHETAMINE XR	SDZ	FQW
10MG CAPSULE			
02248809	ADDERALL XR	SHR	FQW
02439247	TEVA-AMPHETAMINE XR	TEV	FQW
02445506	APO-AMPHETAMINE XR	APX	FQW
02457296	SANDOZ-AMPHETAMINE XR	SDZ	FQW
15MG CAPSULE			
02248810	ADDERALL XR	SHR	FQW
02439255	TEVA-AMPHETAMINE XR	TEV	FQW
02445514	APO-AMPHETAMINE XR	APX	FQW
02457318	SANDOZ-AMPHETAMINE XR	SDZ	FQW
20MG CAPSULE			
02248811	ADDERALL XR	SHR	FQW
02439263	TEVA-AMPHETAMINE XR	TEV	FQW
02445522	APO-AMPHETAMINE XR	APX	FQW
02457326	SANDOZ-AMPHETAMINE XR	SDZ	FQW
25MG CAPSULE			
02248812	ADDERALL XR	SHR	FQW
02439271	TEVA-AMPHETAMINE XR	TEV	FQW
02445530	APO-AMPHETAMINE XR	APX	FQW
02457334	SANDOZ-AMPHETAMINE XR	SDZ	FQW
30MG CAPSULE			
02248813	ADDERALL XR	SHR	FQW
02439298	TEVA-AMPHETAMINE XR	TEV	FQW
02445549	APO-AMPHETAMINE XR	APX	FQW
02457342	SANDOZ-AMPHETAMINE XR	SDZ	FQW

⑤ DEXTROAMPHETAMINE SULFATE

5MG TABLET			
01924516	DEXEDRINE	PAL	FQW
02443236	DEXTROAMPHETAMINE	AAA	FQW
10MG SUSTAINED RELEASE CAPSULE			
01924559	DEXEDRINE	PAL	FQW
02448319	TEVA-DEXTROAMPHETAMINE	TEV	FQW

15MG SUSTAINED RELEASE CAPSULE			
01924567	DEXEDRINE	PAL	FQW
02448327	TEVA-DEXTROAMPHETAMINE SR	TEV	FQW

⑤ LISDEXAMFETAMINE

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG CAPSULE

02439603	VYVANSE (SA)	TAK	FQW
02535122	JAMP-LISDEXAMFETAMINE (SA)	JPC	FQW
02545861	TEVA-LISDEXAMFETAMINE (SA)	TEV	FQW
02546248	SANDOZ-LISDEXAMFETAMINE (SA)	SDZ	FQW
02546647	APO-LISDEXAMFETAMINE (SA)	APX	FQW

10MG CHEWABLE TABLET

02490226	VYVANSE (SA)	TAK	FQW
02533340	TARO-LISDEXAMFETAMINE (SA)	TAR	FQW
02534444	APO-LISDEXAMFETAMINE (SA)	APX	FQW

20MG CAPSULE

02347156	VYVANSE (SA)	TAK	FQW
02535130	JAMP-LISDEXAMFETAMINE (SA)	JPC	FQW
02545888	TEVA-LISDEXAMFETAMINE (SA)	TEV	FQW
02546256	SANDOZ-LISDEXAMFETAMINE (SA)	SDZ	FQW
02546655	APO-LISDEXAMFETAMINE (SA)	APX	FQW

20MG CHEWABLE TABLET

02490234	VYVANSE (SA)	TAK	FQW
02533359	TARO-LISDEXAMFETAMINE (SA)	TAR	FQW
02534452	APO-LISDEXAMFETAMINE (SA)	APX	FQW

30MG CAPSULE

02322951	VYVANSE (SA)	TAK	FQW
02535149	JAMP-LISDEXAMFETAMINE (SA)	JPC	FQW
02545896	TEVA-LISDEXAMFETAMINE (SA)	TEV	FQW
02546264	SANDOZ-LISDEXAMFETAMINE (SA)	SDZ	FQW
02546663	APO-LISDEXAMFETAMINE (SA)	APX	FQW

30MG CHEWABLE TABLET

02490242	VYVANSE (SA)	TAK	FQW
02533367	TARO-LISDEXAMFETAMINE (SA)	TAR	FQW
02534460	APO-LISDEXAMFETAMINE (SA)	APX	FQW

40MG CAPSULE

02347164	VYVANSE (SA)	TAK	FQW
02535157	JAMP-LISDEXAMFETAMINE (SA)	JPC	FQW
02545918	TEVA-LISDEXAMFETAMINE (SA)	TEV	FQW
02546272	SANDOZ-LISDEXAMFETAMINE (SA)	SDZ	FQW
02546671	APO-LISDEXAMFETAMINE (SA)	APX	FQW

40MG CHEWABLE TABLET

02490250	VYVANSE (SA)	TAK	FQW

02533375	TARO-LISDEXAMFETAMINE (SA)	TAR	FQW
02534479	APO-LISDEXAMFETAMINE (SA)	APX	FQW

50MG CAPSULE

02322978	VYVANSE (SA)	TAK	FQW
02535165	JAMP-LISDEXAMFETAMINE (SA)	JPC	FQW
02545926	TEVA-LISDEXAMFETAMINE (SA)	TEV	FQW
02546280	SANDOZ-LISDEXAMFETAMINE (SA)	SDZ	FQW
02546698	APO-LISDEXAMFETAMINE (SA)	APX	FQW

50MG CHEWABLE TABLET

02490269	VYVANSE (SA)	TAK	FQW
02533383	TARO-LISDEXAMFETAMINE (SA)	TAR	FQW
02534487	APO-LISDEXAMFETAMINE (SA)	APX	FQW

60MG CAPSULE

02347172	VYVANSE (SA)	TAK	FQW
02535173	JAMP-LISDEXAMFETAMINE (SA)	JPC	FQW
02545934	TEVA-LISDEXAMFETAMINE (SA)	TEV	FQW
02546299	SANDOZ-LISDEXAMFETAMINE (SA)	SDZ	FQW
02546701	APO-LISDEXAMFETAMINE (SA)	APX	FQW

60MG CHEWABLE TABLET

02490277	VYVANSE (SA)	TAK	FQW
02533391	TARO-LISDEXAMFETAMINE (SA)	TAR	FQW
02534495	APO-LISDEXAMFETAMINE (SA)	APX	FQW

⑤ METHYLPHENIDATE HCL

5MG TABLET

02234749	PMS-METHYLPHENIDATE	PMS	FQW
02273950	APO-METHYLPHENIDATE	APX	FQW

10MG TABLET

00584991	PMS-METHYLPHENIDATE	PMS	FQW
02249324	APO-METHYLPHENIDATE	APX	FQW

20MG TABLET

00585009	PMS-METHYLPHENIDATE	PMS	FQW
02249332	APO-METHYLPHENIDATE	APX	FQW

20MG SUSTAINED RELEASE TABLET

02266687	APO-METHYLPHENIDATE SR	APX	FQW

18MG EXTENDED RELEASE TABLET

02247732	CONCERTA	JAN	FQW
02441934	ACT-METHYLPHENIDATE ER	TEV	FQW

02452731	APO-METHYLPHENIDATE ER	APX	FQW
27MG EXTENDED RELEASE TABLET			
02250241	CONCERTA	JAN	FQW
02441942	ACT-METHYLPHENIDATE ER	TEV	FQW
02452758	APO-METHYLPHENIDATE ER	APX	FQW
36MG EXTENDED RELEASE TABLET			
02247733	CONCERTA	JAN	FQW
02441950	ACT-METHYLPHENIDATE ER	TEV	FQW
02452766	APO-METHYLPHENIDATE ER	APX	FQW
54MG EXTENDED RELEASE TABLET			
02247734	CONCERTA	JAN	FQW
02330377	APO-METHYLPHENIDATE ER	APX	FQW
02441969	ACT-METHYLPHENIDATE ER	TEV	FQW
SEE APPENDIX A FOR SA CRITERIA			
10MG CONTROLLED RELEASE CAPSULE			
02277166	BIPHENTIN (SA)	ELV	FQW
02536943	PMS-METHYLPHENIDATE CR	PMS	FQW
15MG CONTROLLED RELEASE CAPSULE			
02277131	BIPHENTIN (SA)	ELV	FQW
02536951	PMS-METHYLPHENIDATE CR	PMS	FQW
20MG CONTROLLED RELEASE CAPSULE			
02277158	BIPHENTIN (SA)	ELV	FQW
02536978	PMS-METHYLPHENIDATE CR	PMS	FQW
30MG CONTROLLED RELEASE CAPSULE			
02277174	BIPHENTIN (SA)	ELV	FQW
02536986	PMS-METHYLPHENIDATE CR	PMS	FQW
40MG CONTROLLED RELEASE CAPSULE			
02277182	BIPHENTIN (SA)	ELV	FQW
02536994	PMS-METHYLPHENIDATE CR	PMS	FQW
50MG CONTROLLED RELEASE CAPSULE			
02277190	BIPHENTIN (SA)	ELV	FQW
02537001	PMS-METHYLPHENIDATE CR	PMS	FQW
60MG CONTROLLED RELEASE CAPSULE			
02277204	BIPHENTIN (SA)	ELV	FQW
02537028	PMS-METHYLPHENIDATE CR	PMS	FQW

80MG CONTROLLED RELEASE CAPSULE		
02277212	BIPHENTIN (SA)	ELV FQW
02537036	PMS-METHYLPHENIDATE CR	PMS FQW
25MG EXTENDED RELEASE CAPSULE		
02470292	FOQUEST	ELV FQW
35MG EXTENDED RELEASE CAPSULE		
02470306	FOQUEST	ELV FQW
45MG EXTENDED RELEASE CAPSULE		
02470314	FOQUEST	ELV FQW
55MG EXTENDED RELEASE CAPSULE		
02470322	FOQUEST	ELV FQW
70MG EXTENDED RELEASE CAPSULE		
02470330	FOQUEST	ELV FQW
85MG EXTENDED RELEASE CAPSULE		
02470349	FOQUEST	ELV FQW
100MG EXTENDED RELEASE CAPSULE		
02470357	FOQUEST	ELV FQW

⑤MODAFINIL

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG TABLET

02239665	ALERTEC (SA)	TEV FNQSW
02285398	APO-MODAFINIL (SA)	APX FGNQSW
02420260	TEVA-MODAFINIL (SA)	TEV FGNQSW
02430487	AURO-MODAFINIL (SA)	ARO FGNQSW
02432560	MAR-MODAFINIL (SA)	MAR FGNQSW
02503727	JAMP-MODAFINIL (SA)	JPC FGNQSW
02530244	MODAFINIL (SA)	SNS FGNQSW

28:24.08 ANXIOLYTICS, SEDATIVES, HYPNOTICS (BENZODIAZEPINES)

ALPRAZOLAM

0.25MG TABLET

00548359	XANAX	UJC FNQSW
00865397	APO-ALPRAZ	APX FNQSW
01913484	TEVA-ALPRAZOLAM	TEV FNQSW

0.5MG TABLET			
00548367	XANAX	UJC	FNQSW
00865400	APO-ALPRAZ	APX	FNQSW
01913492	TEVA-ALPRAZOLAM	TEV	FNQSW

BROMAZEPAM

1.5MG TABLET			
02177153	APO-BROMAZEPAM	APX	FNQSW

3MG TABLET			
02177161	APO-BROMAZEPAM	APX	FNQSW
02230584	TEVA-BROMAZEPAM	TEV	FNQSW

6MG TABLET			
02177188	APO-BROMAZEPAM	APX	FNQSW
02230585	TEVA-BROMAZEPAM	TEV	FNQSW

CHLORDIAZEPOXIDE

5MG CAPSULE			
00522724	CHLORDIAZEPOXIDE	AAA	FNQSW

10MG CAPSULE			
00522988	CHLORDIAZEPOXIDE	AAA	FNQSW

25MG CAPSULE			
00522996	CHLORDIAZEPOXIDE	AAA	FNQSW

CLORAZEPATE DIPOTASSIUM

3.75MG CAPSULE			
00860689	CLORAZEPATE	AAA	FNQSW

7.5MG CAPSULE			
00860700	CLORAZEPATE	AAA	FNQSW

15MG CAPSULE			
00860697	CLORAZEPATE	AAA	FNQSW

DIAZEPAM

2MG TABLET			
00405329	DIAZEPAM	AAA	FNQSW

5MG TABLET			
00013285	VALIUM	SLP	FNQSW
00362158	DIAZEPAM	AAA	FNQSW

10MG TABLET 00405337	DIAZEPAM	AAA	FNQSW
FLURAZEPAM			
15MG CAPSULE 00521698	FLURAZEPAM	AAA	FNQSW
30MG CAPSULE 00521701	FLURAZEPAM	AAA	FNQSW
LORAZEPAM			
0.5MG TABLET 00655740	APO-LORAZEPAM	APX	FNQSW
00711101	TEVA-LORAZEPAM	TEV	FNQSW
00728187	PMS-LORAZEPAM	PMS	FNQSW
02041413	ATIVAN	PFI	FNQSW
1MG TABLET 00637742	TEVA-LORAZEPAM	TEV	FNQSW
00655759	APO-LORAZEPAM	APX	FNQSW
00728195	PMS-LORAZEPAM	PMS	FNQSW
02041421	ATIVAN	PFI	FNQSW
2MG TABLET 00637750	TEVA-LORAZEPAM	TEV	FNQSW
00655767	APO-LORAZEPAM	APX	FNQSW
00728209	PMS-LORAZEPAM	PMS	FNQSW
02041448	ATIVAN	PFI	FNQSW
MIDAZOLAM			
5MG/ML INJECTION SOLUTION (2ML) 02240286	MIDAZOLAM	SDZ	NQ
NITRAZEPAM			
5MG TABLET 00511528	MOGADON	AAA	FNQSW
10MG TABLET 00511536	MOGADON	AAA	FNQSW
OXAZEPAM			
10MG TABLET 00402680	APO-OXAZEPAM	APX	FNQSW
15MG TABLET 00402745	APO-OXAZEPAM	APX	FNQSW

30MG TABLET			
00402737	APO-OXAZEPAM	APX	FNQSW

TEMAZEPAM

15MG CAPSULE			
00604453	RESTORIL	AAA	FNQSW

30MG CAPSULE			
00604461	RESTORIL	AAA	FNQSW

TRIAZOLAM

Note: Treatment with Triazolam should usually not exceed 7 to 10 consecutive days. Use for more than 2 to 3 consecutive weeks requires a complete re-evaluation of the patient.

0.25MG TABLET			
00808571	TRIAZOLAM	AAA	FW

28:24.92 MISCELLANEOUS ANXIOLYTICS, SEDATIVES, HYPNOTICS

⑤BUSPIRONE

10MG TABLET			
02211076	APO-BUSPIRONE	APX	FGNQSW
02230942	PMS-BUSPIRONE	PMS	FGNQSW
02231492	TEVA-BUSPIRONE	TEV	FGNQSW
02447851	BUSPIRONE	SNS	FGNQSW
02500213	AURO-BUSPIRONE	ARO	FGNQSW
02509911	JAMP-BUSPIRONE	JPC	FGNQSW
02519054	MINT-BUSPIRONE	MNT	FGNQSW
02550555	AMB-BUSPIRONE	AMB	FGNQSW

HYDROXYZINE HCL

10 MG CAPSULE			
00646059	HYDROXYZINE	AAA	FGNQSW

25 MG CAPSULE			
00646024	HYDROXYZINE	AAA	FGNQSW

50 MG CAPSULE			
00646016	HYDROXYZINE	AAA	FGNQSW

2 MG/ML SYRUP			
00024694	ATARAX	ERF	FNQSW

ZOPICLONE**3.75 MG TABLET**

02458543	PMS-ZOPICLONE	PMS	FNQW
02549271	JAMP-ZOPICLONE	JPC	FNQW

5 MG TABLET

02243426	PMS-ZOPICLONE	PMS	FNQW
02245077	APO-ZOPICLONE	APX	FNQW
02246534	TEVA-ZOPICLONE	TEV	FNQW
02267918	RAN-ZOPICLONE	RAN	FNQW
02278030	RIVA-ZOPICLONE	RIV	FNQW
02344122	ZOPICLONE	SNS	FNQW
02385821	ZOPICLONE	SIV	FNQW
02386771	MAR-ZOPICLONE	MAR	FNQW
02391716	MINT-ZOPICLONE	MNT	FNQW
02406969	JAMP-ZOPICLONE	JPC	FNQW
02467941	M-ZOPICLONE	MRA	FNQW
02475839	AG-ZOPICLONE	ANG	FNQW
02477378	NRA-ZOPICLONE	NRA	FNQW

7.5 MG TABLET

01926799	IMOVANE	AVN	FNQW
02218313	APO-ZOPICLONE	APX	FNQW
02240606	PMS-ZOPICLONE	PMS	FNQW
02242481	TEVA-ZOPICLONE	TEV	FNQW
02267926	RAN-ZOPICLONE	RAN	FNQW
02278049	RIVA-ZOPICLONE	RIV	FNQW
02282445	ZOPICLONE	SNS	FNQW
02385848	ZOPICLONE	SIV	FNQW
02386798	MAR-ZOPICLONE	MAR	FNQW
02391724	MINT-ZOPICLONE	MNT	FNQW
02406977	JAMP-ZOPICLONE	JPC	FNQW
02467968	M-ZOPICLONE	MRA	FNQW
02475847	AG-ZOPICLONE	ANG	FNQW
02477386	NRA-ZOPICLONE	NRA	FNQW

28:28.00 ANTIMANIC AGENTS**⑤LITHIUM CARBONATE****150MG CAPSULE**

00461733	CARBOLITH	BSL	FNQSW
02216132	PMS-LITHIUM CARBONATE	PMS	FGNQSW
02242837	APO-LITHIUM CARBONATE	APX	FGNQSW

150MG CAPSULE			
02013231	LITHANE	ERF	FNQSW
300MG CAPSULE			
00236683	CARBOLITH	BSL	FNQSW
02216140	PMS-LITHIUM CARBONATE	PMS	FGNQSW
02242838	APO-LITHIUM CARBONATE	APX	FGNQSW
300MG CAPSULE			
00406775	LITHANE	ERF	FNQSW
600MG CAPSULE			
02011239	CARBOLITH	BSL	FNQSW
02216159	PMS-LITHIUM CARBONATE	PMS	FGNQSW
300MG SUSTAINED RELEASE TABLET			
02266695	LITHMAX	AAA	FNQSW

28:32.00 MISCELLANEOUS ANTIMIGRAINE AGENTS

ALMOTRIPTAN

12.5MG TABLET			
02398443	MYLAN-ALMOTRIPTAN	MYL	FGNQSW
02405334	SANDOZ-ALMOTRIPTAN	SDZ	FGNQSW
02405806	APO-ALMOTRIPTAN	APX	FGNQSW
02434849	TEVA-ALMOTRIPTAN	TEV	FGNQSW
02466821	ALMOTRIPTAN	SNS	FGNQSW

Note: Coverage is limited to 6 tablets per 30 day period

ATOGEPAANT

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET			
02533979	QULIPTA (SA)	ABV	FNQSW
30MG TABLET			
02533987	QULIPTA (SA)	ABV	FNQSW
60MG TABLET			
02533995	QULIPTA (SA)	ABV	FNQSW

EPTINEZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG/1.0ML VIAL

02510839 VYEPTI (SA)

LUD **FNQSW**

300MG/3ML VIAL

02542269 VYEPTI (SA)

LUD **FNQSW**

FREMANEZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

225MG/1.5ML

02497859 AJOVY PREFILLED SYRINGE (SA)

TEV **FNQSW**

02509474 AJOVY AUTOINJECTOR (SA)

TEV **FNQSW**

GALCANEZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

120MG/ML PREFILLED PEN

02491087 EMGALITY (SA)

LIL **FNQSW**

120MG/ML PREFILLED SYRINGE

02491060 EMGALITY (SA)

LIL **FNQSW**

NARATRIPTAN HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

1MG TABLET

02314290 TEVA-NARATRIPTAN (SA)

TEV **FGNQSW**

2.5MG TABLET

02314304 TEVA-NARATRIPTAN (SA)

TEV **FGNQSW**

02322323 SANDOZ-NARATRIPTAN (SA)

SDZ **FGNQSW**

Note: Coverage is limited to 6 tablets per 30 day period.

PIZOTYLINE

1MG TABLET

00511552 SANDOMIGRAN DS

PAL **FNQSW**

RIZATRIPTAN

5MG TABLET

02393468 APO-RIZATRIPTAN

APX **FGNQSW**

02429233 JAMP-RIZATRIPTAN IR

JPC **FGNQSW**

10MG TABLET

02240521 MAXALT

MSD **FNQSW**

02379678 MAR-RIZATRIPTAN

MAR **FGNQSW**

02380463 JAMP-RIZATRIPTAN

JPC **FGNQSW**

02381702 ACT-RIZATRIPTAN

TEV **FGNQSW**

02393476 APO-RIZATRIPTAN

APX **FGNQSW**

02429241	JAMP-RIZATRIPTAN IR	JPC	FGNQSW
02441144	AURO-RIZATRIPTAN	ARO	FGNQSW
02516756	RIZATRIPTAN	SNS	FGNQSW

5MG ORALLY DISINTEGRATING TABLET

02240518	MAXALT RPD	MSD	FNQSW
02351870	SANDOZ-RIZATRIPTAN ODT	SDZ	FGNQSW
02379198	MYLAN-RIZATRIPTAN ODT	MYL	FGNQSW
02393360	PMS-RIZATRIPTAN ODT	PMS	FGNQSW
02396661	TEVA-RIZATRIPTAN ODT	TEV	FGNQSW
02436604	NAT-RIZATRIPTAN ODT	NAT	FGNQSW
02442906	RIZATRIPTAN ODT	SNS	FGNQSW
02446111	RIZATRIPTAN ODT	SIV	FGNQSW
02462788	MAR-RIZATRIPTAN ODT	MAR	FGNQSW
02465086	JAMP-RIZATRIPTAN ODT	JPC	FGNQSW

10MG ORALLY DISINTEGRATING TABLET

02240519	MAXALT RPD	MSD	FNQSW
02351889	SANDOZ-RIZATRIPTAN ODT	SDZ	FGNQSW
02379201	MYLAN-RIZATRIPTAN ODT	MYL	FGNQSW
02393379	PMS-RIZATRIPTAN ODT	PMS	FGNQSW
02396688	TEVA-RIZATRIPTAN ODT	TEV	FGNQSW
02436612	NAT-RIZATRIPTAN ODT	NAT	FGNQSW
02442914	RIZATRIPTAN ODT	SNS	FGNQSW
02446138	RIZATRIPTAN ODT	SIV	FGNQSW
02462796	MAR-RIZATRIPTAN ODT	MAR	FGNQSW
02465094	JAMP-RIZATRIPTAN ODT	JPC	FGNQSW
02492490	AG-RIZATRIPTAN ODT	ANG	FGNQSW

Note: Coverage is limited to 6 tablets per 30 day period.

SUMATRIPTAN

50MG TABLET

02212153	IMITREX DF	GSK	FNQSW
02256436	PMS-SUMATRIPTAN	PMS	FGNQSW
02268388	APO-SUMATRIPTAN	APX	FGNQSW
02268914	MYLAN-SUMATRIPTAN	MYL	FGNQSW
02286823	TEVA-SUMATRIPTAN DF	TEV	FGNQSW
02286521	SUMATRIPTAN	SNS	FGNQSW
02385570	SUMATRIPTAN DF	SIV	FGNQSW
02545306	JAMP-SUMATRIPTAN DF	JPC	FGNQSW
02545357	JAMP-SUMATRIPTAN	JPC	FGNQSW
02546035	SUMATRIPTAN	SIV	FGNQSW

100MG TABLET

02212161	IMITREX DF	GSK	FNQSW
02239367	TEVA-SUMATRIPTAN	TEV	FGNQSW

02256444	PMS-SUMATRIPTAN	PMS	FGNQSW
02268396	APO-SUMATRIPTAN	APX	FGNQSW
02268922	MYLAN-SUMATRIPTAN	MYL	FGNQSW
02286831	TEVA-SUMATRIPTAN DF	TEV	FGNQSW
02286548	SUMATRIPTAN	SNS	FGNQSW
02385589	SUMATRIPTAN DF	SIV	FGNQSW
02545314	JAMP-SUMATRIPTAN DF	JPC	FGNQSW
02545365	JAMP-SUMATRIPTAN	JPC	FGNQSW
02546043	SUMATRIPTAN	SIV	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

6MG/0.5ML INJECTION SOLUTION

02212188	IMITREX (SA)	GSK	FNQSW
02361698	TARO-SUMATRIPTAN (SA)	TAR	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

5MG NASAL SPRAY

02230418	IMITREX (SA)	GSK	FNQSW

20MG NASAL SPRAY

02230420	IMITREX (SA)	GSK	FNQSW

Note: Coverage is limited to 6 tablets or 6 sprays or 6 syringes per 30 day period.

ZOLMITRIPTAN

2.5MG TABLET

02238660	ZOMIG	XPI	FNQSW
02313960	TEVA-ZOLMITRIPTAN	TEV	FGNQSW
02362988	SANDOZ-ZOLMITRIPTAN	SDZ	FGNQSW
02380951	APO-ZOLMITRIPTAN	APX	FGNQSW
02399458	MAR-ZOLMITRIPTAN	MAR	FGNQSW
02419521	MINT-ZOLMITRIPTAN	MNT	FGNQSW
02421534	NAT-ZOLMITRIPTAN	NAT	FGNQSW
02421623	JAMP-ZOLMITRIPTAN	JPC	FGNQSW
02442655	ZOLMITRIPTAN	SNS	FGNQSW
02477106	JAMP-ZOLMITRIPTAN	JPC	FGNQSW
02481030	AURO-ZOLMITRIPTAN	ARO	FGNQSW

2.5MG ORALLY DISINTEGRATING TABLET

02243045	ZOMIG RAPIMELT	XPI	FNQSW
02342545	TEVA-ZOLMITRIPTAN ODT	TEV	FGNQSW
02362996	SANDOZ-ZOLMITRIPTAN ODT	SDZ	FGNQSW
02428237	JAMP-ZOLMITRIPTAN ODT	JPC	FGNQSW
02442671	ZOLMITRIPTAN ODT	SNS	FGNQSW

Note: Coverage is limited to 6 tablets per 30 day period.

28:36.00 ANTI PARKINSONIAN AGENTS

BROMOCRIPTINE

2.5MG TABLET

02087324	BROMOCRIPTINE	AAA	FGNQSW

5MG CAPSULE

02230454	BROMOCRIPTINE	AAA	FGNQSW

CABERGOLINE

0.5MG TABLET

02455897	APO-CABERGOLINE	APX	FGNQSW

02549611	JAMP-CABERGOLINE	JPC	FGNQSW

CARBIDOPA & LEVODOPA & ENTACAPONE

[SEE APPENDIX A](#) FOR SA CRITERIA

12.5/50/200MG TABLET

02305933	STALEVO 50 (SA)	SDZ	FNQSW

18.75/75/200MG TABLET

02337827	STALEVO 75 (SA)	SDZ	FNQSW

25/100/200MG TABLET

02305941	STALEVO 100 (SA)	SDZ	FNQSW

31.25/125/200MG TABLET

02337835	STALEVO 125 (SA)	SDZ	FNQSW

37.5/150/200MG TABLET

02305968	STALEVO 150 (SA)	SDZ	FNQSW

ENTACAPONE

200MG TABLET

02243763	COMTAN	SDZ	FNQSW

02375559	TEVA-ENTACAPONE	TEV	FGNQSW

02380005	SANDOZ-ENTACAPONE	SDZ	FGNQSW

02535939	MINT-ENTACAPONE	MNT	FGNQSW

FOSLEVODOPA & FOSCARBIDOPA

[SEE APPENDIX A](#) FOR SA CRITERIA

12MG-240MG/ML

02537702	VYALEV (SA)	ABV	NMQW

LEVODOPA & CARBIDOPA

100MG & 10MG TABLET

02195933	APO-LEVOCARB	APX	FGNQSW
02244494	TEVA-LEVOCARBIDOPA	TEV	FGNQSW
02457954	MINT-LEVOCARB	MNT	FGNQSW
02531593	AURO-LEVOCARB	ARO	FGNQSW
02546396	JAMP-LEVOCARB	JPC	FGNQSW
02549719	PMS-LEVODOPA-CARBIDOPA	PMS	FGNQSW

100MG & 25MG TABLET

02195941	APO-LEVOCARB	APX	FGNQSW
02244495	TEVA-LEVOCARBIDOPA	TEV	FGNQSW
02457962	MINT-LEVOCARB	MNT	FGNQSW
02531607	AURO-LEVOCARB	ARO	FGNQSW
02546418	JAMP-LEVOCARB	JPC	FGNQSW
02549727	PMS-LEVODOPA-CARBIDOPA	PMS	FGNQSW

250MG & 25MG TABLET

02195968	APO-LEVOCARB	APX	FGNQSW
02244496	TEVA-LEVOCARBIDOPA	TEV	FGNQSW
02457970	MINT-LEVOCARB	MNT	FGNQSW
02531615	AURO-LEVOCARB	ARO	FGNQSW
02546426	JAMP-LEVOCARB	JPC	FGNQSW
02549735	PMS-LEVODOPA-CARBIDOPA	PMS	FGNQSW

100MG & 25MG CONTROLLED RELEASE TABLET

02272873	AA-LEVOCARB CR	AAA	FGNQSW

200MG & 50MG CONTROLLED RELEASE TABLET

02245211	AA-LEVOCARB CR	AAA	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG/ML & 5MG INTESTINAL GEL CASSETTE

02292165	DUODOPA (SA)	ABV	NMQW

PRAMIPEXOLE DIHYDROCHLORIDE

0.25MG TABLET

02237145	MIRAPEX	BOE	FNQSW
02292378	APO-PRAMIPEXOLE	APX	FGNQSW
02297302	ACT-PRAMIPEXOLE	TEV	FGNQSW
02309122	PRAMIPEXOLE	SIV	FGNQSW
02315262	SANDOZ PRAMIPEXOLE	SDZ	FGNQSW
02367602	PRAMIPEXOLE	SNS	FGNQSW
02424061	AURO-PRAMIPEXOLE	ARO	FGNQSW

1MG TABLET

02292394	APO-PRAMIPEXOLE	APX	FGNQSW
02297329	ACT-PRAMIPEXOLE	TEV	FGNQSW
02309149	PRAMIPEXOLE	SIV	FGNQSW
02315289	SANDOZ-PRAMIPEXOLE	SDZ	FGNQSW
02367629	PRAMIPEXOLE	SNS	FGNQSW
02424096	AURO-PRAMIPEXOLE	ARO	FGNQSW

1.5MG TABLET

02292408	APO-PRAMIPEXOLE	APX	FGNQSW
02297337	ACT-PRAMIPEXOLE	TEV	FGNQSW
02309157	PRAMIPEXOLE	SIV	FGNQSW
02315297	SANDOZ-PRAMIPEXOLE	SDZ	FGNQSW
02367645	PRAMIPEXOLE	SNS	FGNQSW
02424118	AURO-PRAMIPEXOLE	ARO	FGNQSW

ROPINIROLE HCL

0.25MG TABLET

02314037	RAN-ROPINIROLE	RAN	FGNQSW
02316846	TEVA-ROPINIROLE	TEV	FGNQSW

1MG TABLET

02314053	RAN-ROPINIROLE	RAN	FGNQSW
02316854	TEVA-ROPINIROLE	TEV	FGNQSW

2MG TABLET

02314061	RAN-ROPINIROLE	RAN	FGNQSW
02316862	TEVA-ROPINIROLE	TEV	FGNQSW

5MG TABLET

02314088	RAN-ROPINIROLE	RAN	FGNQSW
02316870	TEVA-ROPINIROLE	TEV	FGNQSW

ROTIGOTINE

[SEE APPENDIX A](#) FOR SA CRITERIA

2MG TRANSDERMAL PATCH

02403900	NEUPRO (SA)	UCB	FNQSW

4MG TRANSDERMAL PATCH

02403927	NEUPRO (SA)	UCB	FNQSW

6MG TRANSDERMAL PATCH

02403935	NEUPRO (SA)	UCB	FNQSW

8MG TRANSDERMAL PATCH

02403943	NEUPRO (SA)	UCB	FNQSW

SELEGILINE HCL

5MG TABLET

02230641

SELEGILINE

AAA FGNQSW

28:36.08 ANTICHOLINERIC AGENTS**⑤ BENZTROPINE MESYLATE**

1MG TABLET

00706531

PDP-BENZTROPINE

PEN FGNQSW

1MG/ML INJECTION SOLUTION (2ML)

02238903

BENZTROPINE OMEGA

OMG NQ

PROCYCLIDINE HCL

5MG TABLET

00587354

PDP-PROCYCLIDINE

PEN FGNQSW

TRIHEXYPHENIDYL HCL

2MG TABLET

00545058

TRIHEXYPHENIDYL

AAA FGNQSW

5MG TABLET

00545074

TRIHEXYPHENIDYL

AAA FGNQSW

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS**⑤ ACAMPROSATE**

[SEE APPENDIX A](#) FOR SA CRITERIA (FOR SUBSTANCE USE HARM REDUCTION DRUG PROGRAM, NO SA IS REQUIRED)

333MG DELAYED RELEASE TABLET

02293269

CAMPRAL (SA)

MYL FLNQSW

⑤ ATOMOXETINE

10MG CAPSULE

02262800

STRATTERA

LIL FQW

02314541

TEVA-ATOMOXETINE

TEV FGQW

02318024

APO-ATOMOXETINE

APX FGQW

02381028

PMS-ATOMOXETINE

PMS FGQW

02386410

SANDOZ-ATOMOXETINE

SDZ FGQW

02445883

ATOMOXETINE

SIV FGQW

02467747	ATOMOXETINE	SNS	FGQW
02471485	AURO-ATOMOXETINE	ARO	FGQW
02506807	JAMP-ATOMOXETINE	JPC	FGQW
18MG CAPSULE			
02262819	STRATTERA	LIL	FQW
02314568	TEVA-ATOMOXETINE	TEV	FGQW
02318032	APO-ATOMOXETINE	APX	FGQW
02381036	PMS-ATOMOXETINE	PMS	FGQW
02386429	SANDOZ-ATOMOXETINE	SDZ	FGQW
02445905	ATOMOXETINE	SIV	FGQW
02467755	ATOMOXETINE	SNS	FGQW
02471493	AURO-ATOMOXETINE	ARO	FGQW
02506815	JAMP-ATOMOXETINE	JPC	FGQW
25MG CAPSULE			
02262827	STRATTERA	LIL	FQW
02314576	TEVA-ATOMOXETINE	TEV	FGQW
02318040	APO-ATOMOXETINE	APX	FGQW
02381044	PMS-ATOMOXETINE	PMS	FGQW
02386437	SANDOZ-ATOMOXETINE	SDZ	FGQW
02445913	ATOMOXETINE	SIV	FGQW
02467763	ATOMOXETINE	SNS	FGQW
02471507	AURO-ATOMOXETINE	ARO	FGQW
02506823	JAMP-ATOMOXETINE	JPC	FGQW
40MG CAPSULE			
02262835	STRATTERA	LIL	FQW
02314584	TEVA-ATOMOXETINE	TEV	FGQW
02318059	APO-ATOMOXETINE	APX	FGQW
02381052	PMS-ATOMOXETINE	PMS	FGQW
02386445	SANDOZ-ATOMOXETINE	SDZ	FGQW
02445948	ATOMOXETINE	SIV	FGQW
02467771	ATOMOXETINE	SNS	FGQW
02471515	AURO-ATOMOXETINE	ARO	FGQW
02506831	JAMP-ATOMOXETINE	JPC	FGQW
60MG CAPSULE			
02262843	STRATTERA	LIL	FQW
02314592	TEVA-ATOMOXETINE	TEV	FGQW
02318067	APO-ATOMOXETINE	APX	FGQW
02381060	PMS-ATOMOXETINE	PMS	FGQW
02386453	SANDOZ-ATOMOXETINE	SDZ	FGQW
02445956	ATOMOXETINE	SIV	FGQW
02467798	ATOMOXETINE	SNS	FGQW
02471523	AURO-ATOMOXETINE	ARO	FGQW

02506858	JAMP-ATOMOXETINE	JPC	FGQW
80MG CAPSULE			
02279347	STRATTERA	LIL	FQW
02318075	APO-ATOMOXETINE	APX	FGQW
02362511	TEVA-ATOMOXETINE	TEV	FGQW
02386461	SANDOZ-ATOMOXETINE	SDZ	FGQW
02467801	ATOMOXETINE	SNS	FGQW
02471531	AURO-ATOMOXETINE	ARO	FGQW
02506866	JAMP-ATOMOXETINE	JPC	FGQW

100MG CAPSULE			
02279355	STRATTERA	LIL	FQW
02318083	APO-ATOMOXETINE	APX	FGQW
02386488	SANDOZ-ATOMOXETINE	SDZ	FGQW
02467828	ATOMOXETINE	SNS	FGQW
02471558	AURO-ATOMOXETINE	ARO	FGQW
02506874	JAMP-ATOMOXETINE	JPC	FGQW

EDARAVONE

[SEE APPENDIX A](#) FOR SA CRITERIA

105MG/5ML ORAL SOLUTION

02532611	RADICAVA (SA)	BMT	NMQW
00904996	RADICAVA (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

RILUZOLE

50MG TABLET

02242763	RILUTEK	AVN	FNQSW
02352583	APO-RILUZOLE	APX	FGNQSW
02390299	MYLAN-RILUZOLE	MYL	FGNQSW

36:26.00 DIABETES MELLITUS

NOTE: THE DRUG IDENTIFICATION NUMBERS LISTED IN THIS SECTION ARE FOR BILLING PURPOSES ONLY.

BLOOD GLUCOSE TEST STRIP

97799814	ACCU-CHEK AVIVA (100)	ROC	DQ
97799962	ACCU-CHEK COMPACT (102)	ROC	DQ
97799177	ACCU-CHEK GUIDE (100)	ROC	DQ
97799497	ACCU-CHEK MOBILE (100)	ROC	DQ
97799702	ASCENSIA CONTOUR (100)	BDD	DQ
97799459	CONTOUR NEXT (100)	BDD	DQ

97799564	EZ HEALTH ORACLE (100)	THI	DQ
97799597	FREESTYLE LITE (100)	ABC	DQ
97799373	GE200 (100)	BIN	DQ
97799403	MEDISURE (100)	MSR	DQ
97799985	ONE TOUCH ULTRA (100)	LSN	DQ
97799475	ONE TOUCH VERIO (100)	LSN	DQ
97799840	PRECISION FREESTYLE/XTRA (100)	ABC	DQ
97799532	TRUE TEST (100)	TRI	DQ
97799602	TRUE TRACK (100)	TRI	DQ

URINE GLUCOSE TEST STRIP

STRIP

00977160	DIASTIX	BAY	DQW

URINE KETONE TEST STRIP

STRIP

00977322	KETOSTIX	BAY	DQW

36:60.00 THYROID FUNCTION

THYROTROPIN ALFA

[SEE APPENDIX A](#) FOR SA CRITERIA

1.1MG INJECTION

02246016	THYROGEN (SA)	GZY	FNQSW

36:84.00 TUBERCULOSIS

TUBERCULIN PURIFIED PROTEIN DERIVATIVE

5TUB/0.5ML INJECTION SOLUTION

00317268	TUBERSOL	AVN	I

40:08.00 ALKALINIZING AGENTS

SODIUM BICARBONATE

500MG TABLET

80022194	SODIUM BICARBONATE	SDZ	NW
80030520	JAMP-SODIUM BICARBONATE	JPC	NW

50MMOL INJECTION SOLUTION (50ML SYRINGE)

00261998

SODIUM BICARBONATE INJECTION

PFI **NQ****40:12.00 REPLACEMENT AGENTS****CALCIUM CARBONATE**

250MG TABLET

00999910 CALCIUM CARBONATE

NW

Note: The Drug Identification Number listed is for billing purposes only.

500MG TABLET

00999919 CALCIUM CARBONATE

NW

Note: The Drug Identification Number listed is for billing purposes only.

DEXTROSE

50% INJECTION SOLUTION (50ML SYRINGE)

00037974 DEXTROSE 50%

HOS **NQ****MAGNESIUM GLUCOHEPTONATE**

100MG/ML ORAL SOLUTION

00026697 ROUGIER-MAGNESIUM

ROG **FNQSW**

80004109 MAGNESIUM-ODAN

ODN **FNQSW**

80009357 JAMP-MAGNESIUM

JPC **FNQSW****POTASSIUM CHLORIDE**

2MMOL/ML INJECTION SOLUTION (10ML)

00037869 POTASSIUM CHLORIDE

PFI **NQ**

8MMOL EXTENDED RELEASE TABLET

80013005 JAMP-K8

JPC **NW**

80108882 PRZ-K8

PRZ **NW**

20MMOL/15ML ORAL SOLUTION

02238604 PMS-POTASSIUM CHLORIDE

PMS **NW**

80024835 JAMP-POTASSIUM CHLORIDE

JPC **NW**

80046782 ODAN POTASSIUM CHLORIDE

ODN **NW**

20MMOL EXTENDED RELEASE TABLET

80004415 ODAN-K 20

ODN **NW**

80013007 JAMP-K 20

JPC **NW**

80025624 M-K 20

MRA **NW**

80107649 PRZ-K 20

PRZ **NW****POTASSIUM CITRATE**

25MMOL EFFERVESCENT TABLET

02085992 K-LYTE
 80033602 JAMP-K EFFERVESCENT

WES **NW**
 JPC **NW**

SODIUM CHLORIDE**0.9% INJECTION SOLUTION (10ML)**

00037796 SODIUM CHLORIDE
 02304341 SODIUM CHLORIDE

PFI **NQ**
 TLG **NQ**

0.9% IRRIGATION SOLUTION (1000ML)

00786160 SODIUM CHLORIDE

BAX **CNQW**

STERILE WATER**INJECTION SOLUTION (10ML)**

02142546 STERILE WATER FOR INJECTION
 02299186 STERILE WATER FOR INJECTION

PFI **CNQ**
 TLG **CNQ**

40:18.00 ION-REMOVING RESINS**SEVELAMER CARBONATE**

[SEE APPENDIX A](#) FOR SA CRITERIA

800MG TABLET

02461501 ACCEL-SEVELAMER (SA)

ACC **FGNQSW**

SEVELAMER HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

800MG TABLET

02244310 RENAGEL (SA)

AVN **FNQSW**

SODIUM POLYSTYRENE SULFONATE**ORAL POWDER (1G BINDS WITH APPROXIMATELY 1MMOL K+ IN VIVO)**

00755338 SOLYSTAT
 02026961 KAYEXALATE
 02473941 ODAN-SODIUM POLYSTYRENE SULFONATE
 02497557 JAMP-SODIUM POLYSTYRENE SULFONATE

PEN **FGNQSW**
 AVN **FNQSW**
 ODN **FGNQSW**
 JPC **FGNQSW**

15G/60ML ORAL POWDER

00769541 SOLYSTAT
 02473968 ODAN-SODIUM POLYSTYRENE SULFONATE

PEN **FGNQSW**
 ODN **FGNQSW**

SUCROFERRIC OXYHYDROXIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

500MG CHEWABLE TABLET

02471574 VELPHORO (SA)

VFM **FNQSW**

40:20.00 CALORIC AGENTS

TRHEPTANOIN

[SEE APPENDIX A](#) FOR SA CRITERIA

8.3KCAL/ML

02512556 DOJOLVI (SA)

00900021 DOJOLVI (SA)*

*use when drug cost in excess of CPHA maximum

UGX **NMQW**
NMQW

40:28.00 DIURETICS

⑤CHLORTHALIDONE

50MG TABLET

00360279 APO-CHLORTHALIDONE

02523817 JAMP-CHLORTHALIDONE

APX **FGNQSW**
JPC **FGNQSW**

ETHACRYNIC ACID

25MG TABLET

02258528 EDECRIN

BLO **FNQSW**

⑤FUROSEMIDE

20MG TABLET

00337730 TEVA-FUROSEMIDE

00396788 APO-FUROSEMIDE

02351420 FUROSEMIDE

02466759 MINT-FUROSEMIDE

TEV **FGNQSW**
APX **FGNQSW**
SNS **FGNQSW**
MNT **FGNQSW**

40MG TABLET

00337749 TEVA-FUROSEMIDE

00362166 APO-FUROSEMIDE

02351439 FUROSEMIDE

02466767 MINT-FUROSEMIDE

TEV **FGNQSW**
APX **FGNQSW**
SNS **FGNQSW**
MNT **FGNQSW**

80MG TABLET

00707570 APO-FUROSEMIDE

00765953 TEVA-FUROSEMIDE

02351447 FUROSEMIDE

02466775 MINT-FUROSEMIDE

APX **FGNQSW**
TEV **FGNQSW**
SNS **FGNQSW**
MNT **FGNQSW**

10MG/ML ORAL SOLUTION
02224720 LASIX

AVN **FNQSW**

10MG/ML INJECTION
02382539 FUROSEMIDE (2ML AMP)
02527502 FUROSEMIDE (2ML VIAL)

SDZ **NQ**
JPC **NQ**

10MG/ML INJECTION
00527033 FUROSEMIDE (2ML VIAL)

SDZ **NQ**

⑤HYDROCHLOROTHIAZIDE

12.5MG TABLET

02327856 APO-HYDRO
02425947 MINT-HYDROCHLOROTHIAZIDE

APX **FGNQSW**
MNT **FGNQSW**

25MG TABLET

00021474 TEVA-HYDROCHLOROTHIAZIDE
00326844 APO-HYDRO 25
02247386 PMS-HYDROCHLOROTHIAZIDE
02360594 HYDROCHLOROTHIAZIDE
02426196 MINT-HYDROCHLOROTHIAZIDE

TEV **FGNQSW**
APX **FGNQSW**
PMS **FGNQSW**
SNS **FGNQSW**
MNT **FGNQSW**

50MG TABLET

00021482 TEVA-HYDROCHLOROTHIAZIDE
00312800 APO-HYDRO 50
02247387 PMS-HYDROCHLOROTHIAZIDE
02360608 HYDROCHLOROTHIAZIDE

TEV **FGNQSW**
APX **FGNQSW**
PMS **FGNQSW**
SNS **FGNQSW**

⑤INDAPAMIDE HEMIHYDRATE

1.25MG TABLET

02240067 MYLAN-INDAPAMIDE
02245246 APO-INDAPAMIDE

MYL **FGNQSW**
APX **FGNQSW**

2.5MG TABLET

02153483 MYLAN-INDAPAMIDE
02223678 APO-INDAPAMIDE

MYL **FGNQSW**
APX **FGNQSW**

⑤METOLAZONE

2.5MG TABLET

00888400 ZAROXOLYN

AVN **FNQSW**

40:28.10 DIURETICS (POTASSIUM SPARING)

⑤ AMILORIDE HCL & HYDROCHLOROTHIAZIDE

5MG & 50MG TABLET

00784400	AA-AMILZIDE	AAA	FGNQSW

⑤ SPIRONOLACTONE

25MG TABLET

00028606	ALDACTONE	PFI	FNQSW
00613215	TEVA-SPIRONOLACTONE	TEV	FGNQSW
02488140	MINT-SPIRONOLACTONE	MNT	FGNQSW
02518821	JAMP-SPIRONOLACTONE	JPC	FGNQSW

100MG TABLET

00285455	ALDACTONE	PFI	FNQSW
00613223	TEVA-SPIRONOLACTONE	TEV	FGNQSW
02488159	MINT-SPIRONOLACTONE	MNT	FGNQSW
02518848	JAMP-SPIRONOLACTONE	JPC	FGNQSW

⑤ SPIRONOLACTONE & HYDROCHLOROTHIAZIDE

25MG & 25MG TABLET

00613231	TEVA-SPIRONOLACTONE/HCTZ	TEV	FGNQSW

50MG & 50MG TABLET

00657182	TEVA-SPIRONOLACTONE/HCTZ	TEV	FGNQSW

⑤ TRIAMTERENE & HYDROCHLOROTHIAZIDE

50MG & 25MG TABLET

00441775	APO-TRIAZIDE	APX	FGNQSW
00532657	TEVA-TRIAMTERENE/HCTZ	TEV	FGNQSW

44:00.00 ENZYMES

AGALSIDASE ALFA

[SEE APPENDIX A](#) FOR SA CRITERIA

1MG/ML VIAL

02249057	REPLAGAL (SA)	TAK	NMQW

AGALSIDASE BETA

[SEE APPENDIX A](#) FOR SA CRITERIA

5MG VIAL

02248965	FABRAZYME (SA)	AVN	NMQW

35MG VIAL

02248966	FABRAZYME (SA)	AVN	NMQW

DORNASE ALFA[SEE APPENDIX A](#) FOR SA CRITERIA

1MG/ML INHALATION SOLUTION

02046733 PULMOZYME (SA)

HLR C

VELAGLUCERASE ALFA[SEE APPENDIX A](#) FOR SA CRITERIA

400 UNIT VIAL

02357119 VPRIV (SA)

00904378 VPRIV (SA)*

00904379 VPRIV (SA)*

00904380 VPRIV (SA)*

SHR NMQW
NMQW
NMQW
NMQW

*use when drug cost in excess of CPHA maximum

48:08.00 ANTITUSSIVES**CODEINE & GUAIFENESIN & PHENIRAMINE**

2MG & 20MG & 1.5MG PER ML SYRUP

01934740 ROBITUSSIN AC

PFI W

DEXTROMETHORPHAN HBR

3MG/ML SYRUP

01944738 BENYLIN DM (SUCROSE & ALCOHOL FREE)

MCL NW

HYDROCODONE

1MG/ML SYRUP

02324253 PDP-HYDROCODONE

PEN N

48:24.00 MYCOLYTIC AGENTS**ACETYLCYSTEINE**

200MG/ML VIAL

02243098 ACETYLCYSTEINE

SDZ CFGNQSW

12:12.20 INTERLEUKIN ANTAGONISTS**BENRALIZUMAB**[SEE APPENDIX A](#) FOR SA CRITERIA

30MG/ML SYRINGE		
02473232	FASENRA (SA)	AZN NMQW

30MG/ML AUTOINJECTOR		
02496135	FASENRA (SA)	AZN NMQW

MEPOLIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG/ML AUTOINJECTOR		
02492989	NUCALA (SA)	GSK NMQW

100MG/ML SYRINGE		
02492997	NUCALA (SA)	GSK NMQW

48:14.12 CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR POTENTIATORS

ELEXACAFITOR & TEZACAFITOR & IVACAFITOR & IVACAFITOR

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG & 25MG & 37.5MG TABLET & 75MG TABLET		
02526670	TRIKAFTA (SA)	VTX C

100MG & 50MG & 75MG TABLET & 150MG TABLET		
02517140	TRIKAFTA (SA)	VTX C

80MG & 40MG & 60MG & 59.5MG GRANULES		
02542285	TRIKAFTA (SA)	VTX C

100MG & 50MG & 75MG & 75MG GRANULES		
02542277	TRIKAFTA (SA)	VTX C

IVACAFITOR

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG TABLET		
02397412	KALYDECO (SA)	VTX C

48:16.00 EXPECTORANTS

GUAIFENESIN

40MG/ML ORAL LIQUID

01931032	ROBITUSSIN (SUCROSE & ALCOHOL FREE)	PFI	NW
02142783	ROBITUSSIN MUCUS AND PHLEGM	PFI	NW
02320940	BENYLIN MUCOUS & PHLEGM RELIEF	MCL	NW

48:92.00 RESPIRATORY AGENTS, MISCELLANEOUS

OMALIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG VIAL

02260565	XOLAIR (SA)	NVR	NMQW

150MG PREFILLED SYRINGE

02459795	XOLAIR (SA)	NVR	NMQW

TEZEPELUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

210MG/1.91ML PREFILLED SYRINGE

02529548	TEZSPIRE (SA)	AZE	NMQW

210MG/1.91ML PREFILLED PEN

02529556	TEZSPIRE (SA)	AZE	NMQW

52:02.00 ANTIALLERGIC AGENTS

KETOTIFEN

0.025% OPHTHALMIC DROPS

02242324	ZADITOR	LTH	FNQSW
02542722	JAMP-KETOTIFEN	JPC	FGNQSW

OLOPATADINE

0.1% OPHTHALMIC DROPS

02233143	PATANOL	NVR	FNQSW
02305054	APO-OLOPATADINE	APX	FGNQSW
02358913	SANDOZ-OLOPATADINE	SDZ	FGNQSW
02422727	MINT-OLOPATADINE	MNT	FGNQSW
02458411	JAMP-OLOPATADINE	JPC	FGNQSW

OLOPATADINE

0.2% OPHTHALMIC DROPS

02362171	PATADAY	NVR	FNQSW
02402823	APO-OLOPATADINE	APX	FGNQSW

02420171	SANDOZ-OLOPATADINE	SDZ	FGNQSW
02508605	MINT-OLOPATADINE	MNT	FGNQSW

52:04.04 ANTI INFECTIVES (ANTIBIOTICS)

CIPROFLOXACIN

[SEE APPENDIX A](#) FOR SA CRITERIA

0.3% OPHTHALMIC OINTMENT (3.5G)

02200864	CILOXAN (SA)	ALC	FNQSW

0.3% OPHTHALMIC SOLUTION

01945270	CILOXAN (SA)	ALC	FNQSW

02387131	SANDOZ-CIPROFLOXACIN (SA)	SDZ	FGNQSW

CIPROFLOXACIN & DEXAMETHASONE

[SEE APPENDIX A](#) FOR SA CRITERIA

0.3% & 0.1% OTIC SUSPENSION

02252716	CIPRODEX (SA)	ALC	FNQSW

02481901	TARO-CIPROFLOXACIN/DEXAMETHASONE (SA)	TAR	FGNQSW

02506882	SANDOZ-CIPROFLOXACIN/DEXAMETHASONE(SA)	SDZ	FGNQSW

ERYTHROMYCIN BASE

0.5% OPHTHALMIC OINTMENT (3.5G)

01912755	PDP-ERYTHROMYCIN	PEN	FGNQSW

02141574	ERYTHROMYCIN	PSL	FGNQSW

02326663	ERYTHROMYCIN	STM	FGNQSW

GATIFLOXACIN

[SEE APPENDIX A](#) FOR SA CRITERIA

0.3% OPHTHALMIC DROPS

02257270	ZYMAR (SA)	ALL	FNQSW

02327260	APO-GATIFLOXACIN (SA)	APX	FGNQSW

02533235	JAMP-GATIFLOXACIN (SA)	JPC	FGNQSW

MOXIFLOXACIN

[SEE APPENDIX A](#) FOR SA CRITERIA

0.5% OPHTHALMIC DROPS

02252260	VIGAMOX (SA)	ALC	FNQSW

02406373	APO-MOXIFLOXACIN (SA)	APX	FGNQSW

02411520	SANDOZ-MOXIFLOXACIN (SA)	SDZ	FGNQSW

02432218	PMS-MOXIFLOXACIN (SA)	PMS	FGNQSW

02472120	JAMP-MOXIFLOXACIN (SA)	JPC	FGNQSW

02484757	AG-MOXIFLOXACIN (SA)	ANG	FGNQSW

02529076 MOXIFLOXACIN (SA) SNS **FGNQSW**

OFLOXACIN

[SEE APPENDIX A](#) FOR SA CRITERIA

0.3% OPHTHALMIC SOLUTION

02143291 OCUFLOX (SA) ALL **FNQSW**

POLYMYXIN B & GRAMICIDIN

10,000U & 0.025MG/ML OPHTHALMIC/OTIC SOLUTION

02239156 POLYSPORIN JJM **NW**

TOBRAMYCIN

0.3% OPHTHALMIC OINTMENT (3.5G)

00614254 TOBREX ALC **FNQSW**

0.3% OPHTHALMIC SOLUTION

00513962 TOBREX ALC **FNQSW**
02241755 SANDOZ TOBRAMYCIN SDZ **FGNQSW**

52:04.06 ANTI INFECTIVES (ANTIVIRALS)

TRIFLURIDINE

1% OPHTHALMIC SOLUTION

00687456 VIROPTIC VAL **FNQSW**

52:04.92 MISCELLANEOUS ANTI INFECTIVES

CHLORHEXIDINE

[SEE APPENDIX A](#) FOR SA CRITERIA

0.12% ORAL RINSE

02237452 PERIDEX (SA) MDA **N**
02240433 PMS-CHLORHEXIDINE (SA) PMS **N**

52:08.00 ANTI INFLAMMATORY AGENTS

BECLOMETHASONE DIPROPIONATE

50MCG/DOSE AQUEOUS NASAL SPRAY

02172712 MYLAN-BECLO AQ. MYL **FGNQSW**

02238796	APO-BECLOMETHASONE	APX	FGNQSW

BUDESONIDE

64MCG/DOSE NASAL SPRAY

02241003	MYLAN-BUDESONIDE AQ	MYL	FGNQSW

100MCG/DOSE NASAL SPRAY

02230648	MYLAN-BUDESONIDE AQ	MYL	FGNQSW

CYCLOSPORINE

[SEE APPENDIX A](#) FOR SA CRITERIA

0.1% OPHTHALMIC EMULSION

02484137	VERKAZIA (SA)	APX	FQW

DEXAMETHASONE

0.1% OPHTHALMIC OINTMENT (3.5G)

00042579	MAXIDEX	ALC	FNQSW

0.1% OPHTHALMIC SUSPENSION

00042560	MAXIDEX	ALC	FNQSW

DICLOFENAC SODIUM

0.1% OPHTHALMIC SOLUTION

01940414	VOLTAREN OPHTHA	ALC	FNQSW

02441020	APO-DICLOFENAC	APX	FGNQSW

02454807	SANDOZ-DICLOFENAC OPHTHA	SDZ	FGNQSW

02475065	DICLOFENAC	PSL	FGNQSW

02475197	MINT-DICLOFENAC	MNT	FGNQSW

02534525	JAMP-DICLOFENAC	JPC	FGNQSW

FLUOROMETHOLONE

0.1% OPHTHALMIC SUSPENSION

00247855	FML 0.1%	ALL	FNQSW

00432814	SANDOZ-FLUOROMETHOLONE	SDZ	FGNQSW

FLUOROMETHOLONE ACETATE

0.1% OPHTHALMIC SUSPENSION

00756784	FLAREX	ALC	FNQSW

FLUTICASONE PROPIONATE

50MCG/DOSE AQUEOUS NASAL SPRAY

02294745	APO-FLUTICASONE	APX	FGNQSW

KETOROLAC TROMETHAMINE

0.45% OPHTHALMIC SOLUTION

02369362	ACUVAIL	ABV	FNQSW
0.5% OPHTHALMIC SOLUTION			
01968300	ACULAR	ALL	FNQSW
02245821	KETOROLAC	AAA	FGNQSW

MOMETASONE

50MCG/DOSE NASAL SPRAY			
02238465	NASONEX	MSD	FNQSW
02403587	APO-MOMETASONE	APX	FGNQSW
02449811	SANDOZ-MOMETASONE	SDZ	FGNQSW
02475863	TEVA-MOMETASONE	TEV	FGNQSW
02519127	MOMETASONE	SNS	FGNQSW
02551756	MOMETASONE	SIV	FGNQSW

PREDNISOLONE ACETATE

1% OPHTHALMIC SUSPENSION			
00301175	PRED FORTE	ALL	FNQSW
00700401	TEVA-PREDNISOLONE	TEV	FGNQSW
01916203	SANDOZ-PREDNISOLONE	SDZ	FGNQSW

TRIAMCINOLONE

55MCG/DOSE NASAL SPRAY			
02213834	NASACORT AQ	SNC	FNQSW
02437635	APO-TRIAMCINOLONE AQ	APX	FGNQSW

52:08.08 COMBINATION ANTI-INFECTIVE / ANTI INFLAMMATORY AGENTS

CLIOQUINOL & FLUMETHASONE PIVALATE

1% & 0.02% OTIC SOLUTION			
00074454	LOCACORTEN-VIOFORM	PAL	FNQSW

FRAMYCETIN SULFATE & GRAMICIDIN & DEXAMETHASONE

5MG & 50MCG & 0.5MG/ML OPHTHALMIC/OTIC SOLUTION			
02224623	SOFRACORT	AVN	FNQSW

TOBRAMYCIN & DEXAMETHASONE

0.3% & 0.1% OPHTHALMIC OINTMENT			
00778915	TOBRADEX	ALC	FNQSW

0.3% & 0.1% OPHTHALMIC SUSPENSION

00778907	TOBRADEX	ALC	FNQSW

52:10.00 CARBONIC ANHYDRASE INHIBITORS

ACETAZOLAMIDE

250MG TABLET

00545015 ACETAZOLAMIDE

AAA **FGNQSW**

BRINZOLAMIDE

02238873 AZOPT

ALC **FNQSW**

DORZOLAMIDE HCL

2% OPHTHALMIC SOLUTION

02216205 TRUSOPT

ELV **FNQSW**

02453347 JAMP-DORZOLAMIDE

JPC **FGNQSW**

02457210 MED-DORZOLAMIDE

GMP **FGNQSW**

02522373 DORZOLAMIDE

JPC **FGNQSW**

METHAZOLAMIDE

50MG TABLET

02245882 METHAZOLAMIDE

AAA **FGNQSW**

52:24.00 MYDRIATICS

ATROPINE SULFATE

1% OPHTHALMIC SOLUTION

00035017 ISOPTO ATROPINE

ALC **FNQSW**

02023695 ATROPINE

PSL **FGNQSW**

CYCLOPENTOLATE

1% OPHTHALMIC SOLUTION

00252506 CYCLOGYL

ALC **FNQSW**

PHENYLEPHRINE HCL

2.5% OPHTHALMIC SOLUTION

00465763 MYDFRIN

ALC **FNQSW**

52:28.00 MOUTHWASHES AND GARGLES

BENZYDAMINE HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

0.15% ORAL RINSE

02239537 PMS-BENZYDAMINE (SA)
02463105 ODAN-BENZYDAMINE (SA)

PMS FGNQSW
ODN FGNQSW

52:32.00 VASOCONSTRICTORS

XYLOMETAZOLINE

0.1% NASAL SPRAY

00653330 OTRIVIN

NVR N

52:40.00 ALPHA AND BETA ADRENERGIC AGENTS AND PROSTAGLANDIN ANALOGS

BETAXOLOL HCL

0.25% OPHTHALMIC SUSPENSION

01908448 BETOPTIC S

ALC FNQSW

BIMATOPROST

0.1 MG/ML OPHTHALMIC SOLUTION

02324997 LUMIGAN

ALL FNQSW

BRIMONIDINE TARTRATE

0.15% OPHTHALMIC SOLUTION

02248151 ALPHAGAN P
02301334 BRIMONIDINE P

ALL FNQSW
AAA FGNQSW

0.2% OPHTHALMIC SOLUTION

02236876 ALPHAGAN
02260077 APO-BRIMONIDINE
02305429 SANDOZ BRIMONIDINE
02449226 JAMP-BRIMONIDINE
02507811 MED-BRIMONIDINE
02515377 BRIMONIDINE TARTRATE

ALL FNQSW
APX FGNQSW
SDZ FGNQSW
JPC FGNQSW
GMP FGNQSW
TEL FGNQSW

BRIMONIDINE & TIMOLOL

0.2% & 0.5% OPHTHALMIC SOLUTION

02248347	COMBIGAN	ALL	FNQSW
02375311	APO-BRIMONIDINE-TIMOP	APX	FGNQSW
02531704	JAMP-BRIMONIDINE-TIMOLOL	JP	FGNQSW

BRINZOLAMIDE & BRIMONIDINE

1% & 0.2% OPHTHALMIC SUSPENSION

02435411	SIMBRINZA	ALC	FNQSW

BRINZOLAMIDE & TIMOLOL

1% & 0.5% OPHTHALMIC SUSPENSION

02331624	AZARGA	ALC	FNQSW

DORZOLAMIDE & TIMOLOL

2% & 0.5% OPHTHALMIC SOLUTION

02240113	COSOPT	ELV	FNQSW
02299615	APO-DORZO-TIMOP	APX	FGNQSW
02437686	MED-DORZOLAMIDE-TIMOLOL	GMP	FGNQSW
02344351	SANDOZ-DORZOLAMIDE/TIMOLOL	SDZ	FGNQSW
02441659	RIVA-DORZOLAMIDE/TIMOLOL	RIV	FGNQSW
02457539	JAMP-DORZOLAMIDE/TIMOLOL	JPC	FGNQSW
02489635	DORZOLAMIDE AND TIMOLOL	TEL	FGNQSW
02522020	DORZOLAMIDE-TIMOLOL	JPC	FGNQSW
02537796	M-DORZOLAMIDE-TIMOLOL	MRA	FGNQSW

LATANOPROST

50MCG/ML OPHTHALMIC SOLUTION

02231493	XALATAN	UJC	FNQSW
02254786	TEVA-LATANOPROST	TEV	FGNQSW
02296527	APO-LATANOPROST	APX	FGNQSW
02317125	PMS-LANANOPROST	PMS	FGNQSW
02367335	SANDOZ-LATANOPROST	SDZ	FGNQSW
02373041	GD-LATANOPROST	UJC	FGNQSW
02426935	MED-LATANOPROST	GMP	FGNQSW
02453355	JAMP-LATANOPROST	JPC	FGNQSW
02489570	LATANOPROST	TLG	FGNQSW
02513285	M-LATANOPROST	MRA	FGNQSW

LATANOPROST & TIMOLOL

50MCG & 5MG PER ML OPHTHALMIC SOLUTION

02246619	XALACOM	UJC	FNQSW
02373068	MYLAN-LATANOPROST/TIMOLOL	MYL	FGNQSW
02436256	TEVA-LATANOPROST/TIMOLOL	TEV	FGNQSW
02453770	JAMP-LATANOPROST/TIMOLOL	JPC	FGNQSW
02454505	MED-LATANOPROST/TIMOLOL	MED	FGNQSW
02514516	M-LATANOPROST/TIMOLOL	MRA	FGNQSW

LATANOPROSTENE BUNOD

0.024% OPHTHALMIC SOLUTION

02484218 VYZULTA

BLO **FNQSW****TIMOLOL MALEATE**

0.25% OPHTHALMIC SOLUTION

02166712 SANDOZ-TIMOLOL

SDZ **FGNQSW**

0.5% OPHTHALMIC SOLUTION

00451207 TIMOPTIC

ELV **FNQSW**

00755834 APO-TIMOP

APX **FGNQSW**

02166720 SANDOZ-TIMOLOL MALEATE

SDZ **FGNQSW**

02447800 JAMP-TIMOLOL

JPC **FGNQSW**

0.25% GEL FORMING SOLUTION

02242275 TIMOLOL MALEATE-EX

SDZ **FGNQSW**

0.5% GEL FORMING SOLUTION

02171899 TIMOPTIC-XE

PFR **FNQSW**

02242276 TIMOLOL MALEATE-EX

SDZ **FGNQSW****TRAVOPROST**

0.003% OPHTHALMIC SOLUTION

02457997 IZBA

NVR **FNQSW**

0.004% OPHTHALMIC SOLUTION

02318008 TRAVATAN Z

ALC **FNQSW**

02413167 SANDOZ-TRAVOPROST

SDZ **FGNQSW**

02548089 JAMP-TRAVOPROST Z

JPC **FGNQSW****TRAVOPROST & TIMOLOL**

0.004% & 0.5% OPHTHALMIC SOLUTION

02278251 DUOTRAV

ALC **FNQSW**

02415305 APO-TRAVOPROST-TIMOLOL

APX **FGNQSW****52:40.20 MIOTICS****PILOCARPINE HCL**

2% OPHTHALMIC SOLUTION

00000868 ISOPTO CARPINE

ALC **FNQSW**

4% OPHTHALMIC SOLUTION

00000884 ISOPTO CARPINE

ALC **FNQSW**

52:92.00 EYE, EAR, NOSE, AND THROAT DRUGS, MISCELLANEOUS

AFLIBERCEPT

[SEE APPENDIX A](#) FOR SA CRITERIA

2MG/0.05ML VIAL

02415992 EYLEA (SA)

BAY NMQW

APRACLOPIDINE HCL

0.5% OPHTHALMIC SOLUTION

02076306 IOPIDINE

EPM FNQSW

ARTIFICIAL TEARS

0.5% OPHTHALMIC SOLUTION

00000809 ALCON TEARS

ALC NW

1% OPHTHALMIC SOLUTION

00000817 ALCON TEARS

ALC NW

5% OPHTHALMIC OINTMENT

00750816 MURO-128

BLO NW

BROLUCIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

6 MG/0.05 ML PREFILLED SYRINGE

02496976 BEOVU (SA)

NVR NMQW

CYSTEAMINE

[SEE APPENDIX A](#) FOR SA CRITERIA

3.8MG/ML VIAL

02485605 CYSTADROPS (SA)

RRD NMQW

LANOLIN & MINERAL OIL & PETROLATUM

3 % & 3 % & 94 % OINTMENT

02444062 SYSTANE

ALC NW

RANIBIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

2.3MG/0.23ML VIAL

02296810 LUCENTIS (SA)

NVR NMQW

02525852 BYOOVIZ (SA)

BGH NMQW

02542250 RANOPTO (SA)

TEV NMQW

0.5MG/0.5ML PREFILLED SYRINGE
02425629 LUCENTIS (SA)

NVR **NMQW**

CROMOLYN SODIUM

2% OPHTALMIC SOLUTION
02009277 CROMOLYN

PEN **FNSW**

FARICIMAB

[SEE APPENDIX A](#) FOR SA CRITERIA
6MG & 0.05ML VIAL
02527618 VABYSMO (SA)

HLR **NMQW**

56:04.00 ANTACIDS AND ADSORBENTS

ALGINIC ACID & ALUMINIUM HYDROXIDE

50MG & 20MG/ML ORAL SUSPENSION
02159775 GAVISCON

GSK **NW**

ALGINIC ACID & MAGNESIUM CARBONATE

200MG & 40MG TABLET
02159791 GAVISCON HEARTBURN RELIEF

GSK **NW**

MAGNESIUM HYDROXIDE & ALUMINIUM HYDROXIDE

40MG & 33MG/ML ORAL SUSPENSION
01966529 DIOVOL

CDC **NW**

56:08.00 ANTIDIARRHEA AGENTS

DIPHENOXYLATE HCL/ATROPINE SULFATE

2.5MG/0.025MG TABLET
00036323 LOMOTIL

PFI **FNQSW**

LOPERAMIDE

2MG CAPLET
02132591 TEVA-LOPERAMIDE
02212005 APO-LOPERAMIDE
02228351 PMS-LOPERAMIDE

TEV **FNQSW**
APX **FNQSW**
PMS **FNQSW**

0.2MG/ML ORAL SOLUTION
02016095 PMS-LOPERAMIDE HCL

PMS **FNQSW**

56:10.00 ANTIFLATULENTS

SIMETHICONE

80MG TABLET

00292990

OVOL

CDC **NW**

56:12.00 CATHARTICS AND LAXATIVES

Note: Cathartics and laxatives should only be used after failure of simpler measures. A high fiber diet, adequate hydration, and a review of potentially constipating medications is often effective in relieving constipation.

BISACODYL

5MG ENTERIC COATED TABLET

00254142

DULCOLAX

SNC **NW**

02273411

ODAN-BISACODYL

ODN **NW**

10MG RECTAL SUPPOSITORY

00003875

DULCOLAX

SNC **NW**

02361450

JAMP-BISACODYL

JPC **NW**

02520478

AMB-BISACODYL

AMB **NW**

10MG RECTAL SUPPOSITORY

[SEE APPENDIX A](#) FOR SA CRITERIA

02241091

MAGIC BULLET (SA)

D&C **FNSW**

GLYCERIN

90%/2.6G SUPPOSITORY

02020394

GLYCERIN

ROG **N**

LACTULOSE

[SEE APPENDIX A](#) FOR SA CRITERIA

667MG/ML SYRUP

00703486

PMS-LACTULOSE (SA)

PMS **NW**

00854409

RATIO-LACTULOSE (SA)

TEV **NW**

02295881

JAMP-LACTULOSE (SA)

JPC **NW**

02412268

LACTULOSE (SA)

SNS **NW**

02469391

PMS-LACTULOSE-PHARMA (SA)

PMS **NW**

MAGNESIUM CITRATE

50MG/ML ORAL SOLUTION

00262609	CITRO-MAG	ROG	NW

MAGNESIUM HYDROXIDE & MINERAL OIL

60MG & 0.25ML PER ML ORAL EMULSION

00202045	MAGNOLAX	PEN	N

POLYETHYLENE GLYCOL 3350

ORAL POWDER

09991054	POLYETHYLENE GLYCOL 3350		NW

Note: The Drug Identification Number listed is for billing purposes only.

PSYLLIUM MUCILLOID

ORAL POWDER

02174782	METAMUCIL SUGAR FREE	PGA	NW

02174812	METAMUCIL	PGA	NW

SENNOSIDES A&B

8.6MG TABLET

00026158	SENOKOT	ANB	NW

00896411	PMS-SENNOSIDES	PMS	NW

80009595	JAMP-SENNNA	JPC	NW

1.7MG/ML ORAL LIQUID

00367729	SENOKOT	PFR	N

SODIUM PHOSPHATES

220MG/ML ENEMA (130ML)

00009911	FLEET	JJM	NW

56:14.00 CHOLELITHOLYTIC AGENTS

URSODIOL

250MG TABLET

02273497	PMS-URSODIOL C	PMS	FGNQSW

02426900	GLN-URSODIOL	GLM	FGNQSW

02472392	JAMP-URSODIOL	JPC	FGNQSW

02505363	AG-URSODIOL	ANG	FGNQSW

02515520	URSODIOL	SNS	FGNQSW

500MG TABLET

02273500	PMS-URSODIOL C	PMS	FGNQSW

02426919	GLN-URSODIOL	GLM	FGNQSW

02472406	JAMP-URSODIOL	JPC	FGNQSW

02505371	AG-URSODIOL	ANG	FGNQSW
02515539	URSODIOL	SNS	FGNQSW

56:16.00 DIGESTANTS

LIPASE & PROTEASE & AMYLASE

5,000 & 320 & 5,100 UNIT GRANULES

02445158	CREON MINIMICROSPHERES MICRO	BGP	CFNQSW

10,000 & 730 & 11,200 UNIT CAPSULE

02200104	CREON 10 MINIMICROSPHERES	BGP	CFNQSW

25,000 & 1,600 & 25,500 UNIT CAPSULE

01985205	CREON 25 MINIMICROSPHERES	BGP	CFNQSW

35,000 & 2,240 & 35,700 UNIT CAPSULE

02494639	CREON 35 MINIMICROSPHERES	BGP	CFNQSW

PANCRELIPASE EQUIVALENT TO LIPASE & PROTEASE & AMYLASE

10,000 & 35,000 & 40,000 USP U CAPSULE

00263818	COTAZYM	MSD	CFNQSW

10,800 & 45,000 & 42,000 USP U CAPSULE (ENTERIC COATED PARTICLES)

00502790	COTAZYM ECS 8	MSD	CFNQSW

25,000 & 100,000 & 100,000 USP U CAPSULE (ENTERIC COATED PARTICLES)

00821373	COTAZYM ECS 20	MSD	CFNQSW

10,440 & 57,100 & 56,400 USP U TABLET

02230019	VIOKACE	ARN	CFNQSW

20,880 & 112,500 & 113,400 USP U TABLET

02241933	VIOKACE	ARN	CFNQSW

56:22.00 ANTIEMETICS

APREPITANT

[SEE APPENDIX A](#) FOR SA CRITERIA

80MG CAPSULE

02298791	EMEND (SA)	MSD	FNQSW

125MG CAPSULE		
02298805	EMEND (SA)	MSD FNQSW

80MG & 80MG & 125MG CAPSULE (PACKAGE)		
02298813	EMEND TRI-PACK (SA)	MSD FNQSW

DIMENHYDRINATE

50MG TABLET		
00999972	DIMENHYDRINATE	NW

Note: The Drug Identification Number listed is for billing purposes only.

50MG RECTAL SUPPOSITORY		
00392553	SANDOZ-DIMENHYDRINATE	SDZ NW

100MG RECTAL SUPPOSITORY		
00013609	GRAVOL	CDC NW
00392545	SANDOZ-DIMENHYDRINATE	SDZ NW

50MG/ML INTRAMUSCULAR INJECTION SOLUTION (5ML)		
00392537	DIMENHYDRINATE PF	SDZ NW
02536536	DIMENHYDRINATE	SDZ NW

DOXYLAMINE SUCCINATE & PYRIDOXINE HCL

10MG & 10MG DELAYED RELEASE TABLET		
00609129	DICLECTIN	DUI FQW
02406187	PMS-DOXYLAMINE-PYRIDOXINE	PMS FGQW
02413248	APO-DOXYLAMINE/B6	APX FGQW
02552574	ALOG-DOXYLAMINE-PYRIDOXINE	ANA FGQW

GRANISETRON

[SEE APPENDIX A](#) FOR SA CRITERIA

1MG TABLET		
02308894	APO-GRANISETRON (SA)	APX FGNQSW
02452359	NAT-GRANISETRON (SA)	NAT FGNQSW
02472686	JAMP GRANISETRON (SA)	JPC FGNQSW

NABILONE

[SEE APPENDIX A](#) FOR SA CRITERIA

0.5MG CAPSULE		
02256193	CESAMET (SA)	BSL FNQSW
02380900	PMS-NABILONE (SA)	PMS FNQSW
02384884	TEVA-NABILONE (SA)	TEV FNQSW

1MG CAPSULE		
00548375	CESAMET (SA)	BSL FNQSW

02380919	PMS-NABILONE (SA)	PMS	FNQSW
02384892	TEVA-NABILONE (SA)	TEV	FNQSW

NETUPITANT & PALONOSETRON HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

300MG/0.5MG CAPSULE

02468735	AKYNZEO (SA)	ELV	FNQSW

ONDANSETRON

[SEE APPENDIX A](#) FOR SA CRITERIA

4MG MEDICATED FILM

02389983	ONDISSOLVE ODT (SA)	TAK	FNQSW
02541351	JAMP-ONDANSETRON ODT (SA)	JPC	FGNQSW

8MG MEDICATED FILM

02389991	ONDISSOLVE ODT (SA)	TAK	FNQSW
02541378	JAMP-ONDANSETRON ODT (SA)	JPC	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

4MG ORAL DISINTEGRATING TABLET

02481723	ONDANSETRON ODT (SA)	SDZ	FGNQSW
02487330	MINT-ONDANSETRON ODT (SA)	MNT	FGNQSW
02511282	AURO-ONDANSETRON ODT (SA)	ARO	FGNQSW
02514966	MAR-ONDANSETRON ODT (SA)	MAR	FGNQSW
02519232	ONDANSETRON ODT (SA)	JPC	FGNQSW
02519445	PMS-ONDANSETRON ODT (SA)	PMS	FGNQSW
02524279	ONDANSETRON ODT (SA)	SNS	FGNQSW

8MG ORAL DISINTEGRATING TABLET

02481731	ONDANSETRON ODT (SA)	SDZ	FGNQSW
02487349	MINT-ONDANSETRON ODT (SA)	MNT	FGNQSW
02511290	AURO-ONDANSETRON ODT (SA)	ARO	FGNQSW
02514974	MAR-ONDANSETRON ODT (SA)	MAR	FGNQSW
02519240	ONDANSETRON ODT (SA)	JPC	FGNQSW
02519453	PMS-ONDANSETRON ODT (SA)	PMS	FGNQSW
02524287	ONDANSETRON ODT (SA)	SNS	FGNQSW

ONDANSETRON HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

4MG TABLET

02213567	ZOFran (SA)	NVR	FNQSW
02258188	PMS-ONDANSETRON (SA)	PMS	FGNQSW
02274310	SANDOZ-ONDANSETRON (SA)	SDZ	FGNQSW
02288184	APO-ONDANSETRON (SA)	APX	FGNQSW
02296349	TEVA-ONDANSETRON (SA)	TEV	FGNQSW
02297868	MYLAN-ONDANSETRON (SA)	MYL	FGNQSW

02305259	MINT-ONDANSETRON (SA)	MNT	FGNQSW
02312247	RAN-ONDANSETRON (SA)	RAN	FGNQSW
02313685	JAMP-ONDANSETRON (SA)	JPC	FGNQSW
02371731	MAR-ONDANSETRON (SA)	MAR	FGNQSW
02417839	NAT-ONDANSETRON (SA)	NAT	FGNQSW
02421402	ONDANSETRON (SA)	SNS	FGNQSW
02541424	ONDANSETRON (SA)	SIV	FGNQSW

8MG TABLET

02213575	ZOFRAN (SA)	NVR	FNQSW
02258196	PMS-ONDANSETRON (SA)	PMS	FGNQSW
02274329	SANDOZ-ONDANSETRON (SA)	SDZ	FGNQSW
02288192	APO-ONDANSETRON (SA)	APX	FGNQSW
02296357	TEVA-ONDANSETRON (SA)	TEV	FGNQSW
02297876	MYLAN-ONDANSETRON (SA)	MYL	FGNQSW
02305267	MINT-ONDANSETRON (SA)	MNT	FGNQSW
02312255	RAN-ONDANSETRON (SA)	RAN	FGNQSW
02313693	JAMP-ONDANSETRON (SA)	JPC	FGNQSW
02371758	MAR-ONDANSETRON (SA)	MAR	FGNQSW
02417847	NAT-ONDANSETRON (SA)	NAT	FGNQSW
02421410	ONDANSETRON (SA)	SNS	FGNQSW
02541432	ONDANSETRON (SA)	SIV	FGNQSW

0.8MG/ML ORAL SOLUTION

02229639	ZOFRAN (SA)	NVR	FNQSW
02291967	APO-ONDANSETRON (SA)	APX	FGNQSW
02490617	JAMP-ONDANSETRON (SA)	JPC	FGNQSW
02524090	MINT-ONDANSETRON (SA)	MNT	FGNQSW

56:28.12 HISTAMINE H2 ANTAGONISTS

CIMETIDINE

200MG TABLET

00584215	CIMETIDINE	AAA	FGNQSW

300MG TABLET

00487872	CIMETIDINE	AAA	FGNQSW

FAMOTIDINE

20MG TABLET

02022133	TEVA-FAMOTIDINE	TEV	FGNQSW
02351102	FAMOTIDINE	SNS	FGNQSW
02507749	JAMP-FAMOTIDINE	JPC	FGNQSW

02538628	MINT-FAMOTIDINE	MNT	FGNQSW
02549107	FAMOTIDINE	SIV	FGNQSW

40MG TABLET

02022141	TEVA-FAMOTIDINE	TEV	FGNQSW
02351110	FAMOTIDINE	SNS	FGNQSW
02507757	JAMP-FAMOTIDINE	JPC	FGNQSW
02538636	MINT-FAMOTIDINE	MNT	FGNQSW
02549115	FAMOTIDINE	SIV	FGNQSW

NIZATIDINE

150MG CAPSULE

00778338	AXID	PEN	FNQSW

RANITIDINE HCL

150MG TABLET

00733059	APO-RANITIDINE	APX	FGNQSW
02242453	PMS-RANITIDINE	PMS	FGNQSW
02336480	RAN-RANITIDINE	RAN	FGNQSW
02353016	RANITIDINE	SNS	FGNQSW
02443708	MAR-RANITIDINE	MAR	FGNQSW
02463717	JAMP-RANITIDINE	JPC	FGNQSW
02526379	MINT-RANITIDINE	MNT	FGNQSW

300MG TABLET

00733067	APO-RANITIDINE	APX	FGNQSW
02242454	PMS-RANITIDINE	PMS	FGNQSW
02336502	RAN-RANITIDINE	RAN	FGNQSW
02353024	RANITIDINE	SNS	FGNQSW
02443716	MAR-RANITIDINE	MAR	FGNQSW
02463725	JAMP-RANITIDINE	JPC	FGNQSW
02526387	MINT-RANITIDINE	MNT	FGNQSW

15MG/ML ORAL SOLUTION

02280833	APO-RANITIDINE	APX	FGNQSW

56:28.28 PROSTAGLANDINS

MISOPROSTOL

100MCG TABLET

02244022	MISOPROSTOL	AAA	FGNQSW

200MCG TABLET

02244023

MISOPROSTOL

AAA FGNQSW

56:28.32 PROTECTANTS**SUCRALFATE**

1G TABLET

02045702 TEVA-SUCRALFATE

02100622 SULCRATE

02125250 APO-SUCRALFATE

TEV FGNQSW

ALL FNQSW

APX FGNQSW

200MG/ML ORAL SUSPENSION

02103567 SULCRATE PLUS

AVN FNQSW

56:28.36 PROTON PUMP INHIBITORS**LANSOPRAZOLE**[SEE APPENDIX A](#) FOR SA CRITERIA[SEE PROTON PUMP INHIBITORS IN APPENDIX A](#) FOR SA CRITERIA **FOR DOSAGES GREATER THAN ONE UNIT/DAY.**

15MG DELAYED RELEASE CAPSULE

02165503 PREVACID (SA)

02280515 TEVA-LANSOPRAZOLE (SA)

02293811 APO-LANSOPRAZOLE (SA)

02353830 MYLAN-LANSOPRAZOLE (SA)

02357682 LANSOPRAZOLE (SA)

02385643 SANDOZ-LANSOPRAZOLE (SA)

02385767 LANSOPRAZOLE DR (SA)

02395258 PMS-LANSOPRAZOLE (SA)

02402610 TARO-LANSOPRAZOLE (SA)

02433001 LANSOPRAZOLE (SA)

ABB FNQSW

TEV FGNQSW

APX FGNQSW

MYL FGNQSW

SNS FGNQSW

SDZ FGNQSW

SIV FGNQSW

PMS FGNQSW

SUN FGNQSW

PMS FGNQSW

30MG DELAYED RELEASE CAPSULE

02165511 PREVACID (SA)

02280523 TEVA-LANSOPRAZOLE (SA)

02293838 APO-LANSOPRAZOLE (SA)

02353849 MYLAN-LANSOPRAZOLE (SA)

02357690 LANSOPRAZOLE (SA)

02385651 SANDOZ-LANSOPRAZOLE (SA)

02395266 PMS-LANSOPRAZOLE (SA)

02402629 TARO-LANSOPRAZOLE (SA)

02410389 LANSOPRAZOLE (SA)

ABB FNQSW

TEV FGNQSW

APX FGNQSW

MYL FGNQSW

SNS FGNQSW

SDZ FGNQSW

PMS FGNQSW

SUN FGNQSW

SIV FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA
[SEE PROTON PUMP INHIBITORS IN APPENDIX A](#) FOR SA CRITERIA **FOR DOSAGES
GREATER THAN ONE UNIT/DAY.**

02249472	PREVACID FASTAB (SA)	ABB	FNQSW

02470780	AA-LANSOPRAZOLE-AMOXICILLIN-CLARITHROMYCIN	AAA	FGNQSW

02296438	SANDOZ-OMEPRazole	SDZ	FGN QSW

02411857	OMEPRazole-20	SIV	FGNQSW

02504294	OMEPRazole MAGNESIUM	SNS	FGNQSW

02440628	TEVA-PANTOPRAZOLE MAGNESIUM	TEV	FGNQSW

02441853	PANTOPRAZOLE MAGNESIUM	ALH	FGNQSW
02466147	PANTOPRAZOLE T	SNS	FGNQSW
02519534	PANTOPRAZOLE T	SIV	FGNQSW

PANTOPRAZOLE SODIUM

[SEE PROTON PUMP INHIBITORS IN APPENDIX A](#) FOR SA CRITERIA **FOR DOSAGES GREATER THAN ONE UNIT/DAY**

20MG ENTERIC TABLET

02241804	PANTOLOC	TAK	FNQSW
02285479	TEVA-PANTOPRAZOLE	TEV	FGNQSW
02292912	APO-PANTOPRAZOLE	APX	FGNQSW
02301075	SANDOZ-PANTOPRAZOLE	SDZ	FGNQSW
02392615	JAMP-PANTOPRAZOLE SODIUM	JPC	FGNQSW
02408414	JAMP-PANTOPRAZOLE EC	JPC	FGNQSW
02428172	PANTOPRAZOLE	SIV	FGNQSW
02431327	PANTOPRAZOLE	RIV	FGNQSW
02536137	PANTOPRAZOLE	SNS	FGNQSW

40MG ENTERIC TABLET

02229453	PANTOLOC	TAK	FNQSW
02285487	TEVA-PANTOPRAZOLE	TEV	FGNQSW
02292920	APO-PANTOPRAZOLE	APX	FGNQSW
02301083	SANDOZ-PANTOPRAZOLE	SDZ	FGNQSW
02305046	RAN-PANTOPRAZOLE	RAN	FGNQSW
02307871	PMS-PANTOPRAZOLE	PMS	FGNQSW
02357054	JAMP-PANTOPRAZOLE EC	JPC	FGNQSW
02370808	PANTOPRAZOLE	SNS	FGNQSW
02392623	JAMP-PANTOPRAZOLE SODIUM	JPC	FGNQSW
02415208	AURO-PANTOPRAZOLE	ARO	FGNQSW
02416565	MAR-PANTOPRAZOLE	MAR	FGNQSW
02417448	MINT-PANTOPRAZOLE	MNT	FGNQSW
02428180	PANTOPRAZOLE	SIV	FGNQSW
02467372	M-PANTOPRAZOLE SODIUM	MRA	FGNQSW
02471825	NRA-PANTOPRAZOLE	NRA	FGNQSW
02481588	AG-PANTOPRAZOLE SODIUM	ANG	FGNQSW

RABEPRAZOLE SODIUM

[SEE PROTON PUMP INHIBITORS IN APPENDIX A](#) FOR SA CRITERIA **FOR DOSAGES GREATER THAN 20MG/DAY**

10MG ENTERIC COATED TABLET

02243796	PARIET	JAN	FNQSW
02314177	SANDOZ-RABEPRAZOLE	SDZ	FGNQSW
02345579	APO-RABEPRAZOLE	APX	FGNQSW
02356511	RABEPRAZOLE	SNS	FGNQSW
02385449	RABEPRAZOLE	SIV	FGNQSW
02415283	JAMP-RABEPRAZOLE	JPC	FGNQSW

20MG ENTERIC COATED TABLET

02243797	PARIET
02314185	SANDOZ-RABEPRAZOLE
02356538	RABEPRAZOLE
02385457	RABEPRAZOLE
02415291	JAMP-RABEPRAZOLE

JAN	FNQSW
SDZ	FGNQSW
SNS	FGNQSW
SIV	FGNQSW
JPC	FGNQSW

56:32.00 MISCELLANEOUS G.I. DRUGS**DOMPERIDONE MALEATE****10MG TABLET**

01912070	TEVA-DOMPERIDONE
02103613	APO-DOMPERIDONE
02238341	DOMPERIDONE
02268078	RAN-DOMPERIDONE
02350440	DOMPERIDONE
02369206	JAMP-DOMPERIDONE
02403870	MAR-DOMPERIDONE
02462834	PRZ-DOMPERIDONE

TEV	FGNQSW
APX	FGNQSW
SIV	FGNQSW
RAN	FGNQSW
SNS	FGNQSW
JPC	FGNQSW
MAR	FGNQSW
PRZ	FGNQSW

METOCLOPRAMIDE HCL**5MG TABLET**

02230431	PMS-METOCLOPRAMIDE
02517795	MAR-METOCLOPRAMIDE

PMS	FGNQSW
MAR	FGNQSW

1MG/ML ORAL SOLUTION

02230433	PMS-METOCLOPRAMIDE

PMS	FGNQSW

5MG/ML INJECTION SOLUTION (2ML)

02185431	METOCLOPRAMIDE HCL
02243563	METOCLOPRAMIDE
02537397	METOCLOPRAMIDE HCL

SDZ	NQ
OMG	NQ
JPC	NQ

OBETICHOLIC

[SEE APPENDIX A](#) FOR SA CRITERIA

5MG TABLET

02463121	OCALIVA (SA)

INT	NMQW

10MG TABLET

02463148	OCALIVA (SA)

INT	NMQW

SULFASALAZINE

500MG ENTERIC COATED TABLET

00598488	PMS-SULFASALAZINE E.C.
02064472	SALAZOPYRIN

PMS	FGNQSW
PFI	FNQSW

500MG TABLET

00598461	PMS-SULFASALAZINE
02064480	SALAZOPYRIN

PMS	FGNQSW
PFI	FNQSW

TRIMEBUTINE MALEATE

100MG TABLET

02245663	APO-TRIMEBUTINE
02538202	MINT-TRIMEBUTINE

APX	FGNQSW
MNT	FGNQSW

200MG TABLET

02245664	APO-TRIMEBUTINE
02538210	MINT-TRIMEBUTINE

APX	FGNQSW
MNT	FGNQSW

56:36.00 ANTI-INFLAMMATORY AGENTS**5-AMINOSALICYLIC ACID (MESALAZINE)**

400MG ENTERIC COATED TABLET

02171929	TEVA-5 ASA

TEV	FGNQSW

500MG ENTERIC COATED TABLET

02112787	SALOFALK
02524481	MEZERA

ALL	FNQSW
AVI	FNQSW

500MG DELAYED RELEASE TABLET

02099683	PENTASA

FEI	FNQSW

1G EXTENDED RELEASE TABLET

02399466	PENTASA

FEI	FNQSW

500MG RECTAL SUPPOSITORY

02112760	SALOFALK

APT	FNQSW

1G/ACTUATION RECTAL FOAM

02474026	MEZERA

AVI	FNQSW

1G RECTAL SUPPOSITORY

02242146	SALOFALK
02153564	PENTASA

APT	FNQSW
FEI	FNQSW

02474018	MEZERA	AVI	FNQSW
1G/100ML RECTAL ENEMA			
02153521	PENTASA	FEI	FNQSW
4G/100ML RECTAL ENEMA			
02153556	PENTASA	FEI	FNQSW
2G/60G RETENTION ENEMA (60G)			
02112795	SALOFALK	APT	FNQSW
4G/60G RETENTION ENEMA (60G)			
02112809	SALOFALK	APT	FNQSW
BETAMETHASONE DISODIUM PHOSPHATE			
5MG/100ML ENEMA (100ML)			
02060884	BETNESOL	PAL	FNQSW
MESALAMINE			
500MG TABLET			
02524481	MEZARA	AVI	FNQSW
1000MG TABLET			
02545012	MEZARA	AVI	FNQSW
1.2GM DELAYED RELEASE TABLET			
02297558	MEZAVANT	SHI	FNQSW
800MG DELAYED RELEASE TABLET			
02465758	OCTASA	PEN	FNQSW
1600MG DELAYED RELEASE TABLET			
02529610	OCTASA	PEN	FNQSW
OLSALAZINE SODIUM			
250MG CAPSULE			
02063808	DIPENTUM	ATN	FNQSW

56:44.00 IMMUNOMODULATOR AGENTS

MIRIKIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

300MG/15ML VIAL

02539861	OMVOH (SA)	LIL	NMQW

100MG/ML PREFILLED SYRINGE			
02539853	OMVOH (SA)	LIL	NMQW

100MG/ML PREFILLED PEN			
02539845	OMVOH (SA)	LIL	NMQW

64:00.00 HEAVY METAL ANTAGONISTS

DEFERASIROX

[SEE APPENDIX A](#) FOR SA CRITERIA

90MG TABLET

02485265	APO-DEFERASIROX (TYPE J)	APX	NMQW
02489899	SANDOZ-DEFERASIROX (TYPE J)	SDZ	NMQW
02507315	TARO-DEFERASIROX (TYPE J)	TAR	NMQW
02527774	AURO-DEFERASIROX (TYPE J)	ARO	NMQW
02528290	PMS-DEFERASIROX (TYPE J)	PMS	NMQW

180MG TABLET

02485273	APO-DEFERASIROX (TYPE J)	APX	NMQW
02489902	SANDOZ-DEFERASIROX (TYPE J)	SDZ	NMQW
02507323	TARO-DEFERASIROX (TYPE J)	TAR	NMQW
02527782	AURO-DEFERASIROX (TYPE J)	ARO	NMQW
02528304	PMS-DEFERASIROX (TYPE J)	PMS	NMQW

360MG TABLET

02485281	APO-DEFERASIROX (TYPE J)	APX	NMQW
02489910	SANDOZ-DEFERASIROX (TYPE J)	SDZ	NMQW
02507331	TARO-DEFERASIROX (TYPE J)	TAR	NMQW
02527790	AURO-DEFERASIROX (TYPE J)	ARO	NMQW
02528312	PMS-DEFERASIROX (TYPE J)	PMS	NMQW

125MG DISPERSIBLE TABLETS

02287420	EXJADE (SA)	NVR	NMQW
02461544	APO-DEFERASIROX (SA)	APX	NMQW
02464454	SANDOZ-DEFERASIROX (SA)	SDZ	NMQW

250MG DISPERSIBLE TABLETS

02287439	EXJADE (SA)	NVR	NMQW
02461552	APO-DEFERASIROX (SA)	APX	NMQW
02464462	SANDOZ-DEFERASIROX (SA)	SDZ	NMQW

500MG DISPERSIBLE TABLETS

02287447	EXJADE (SA)	NVR	NMQW
02461560	APO-DEFERASIROX (SA)	APX	NMQW

02464470	SANDOZ-DEFERASIROX (SA)	SDZ	NMQW

PENICILLAMINE

250MG CAPSULE

00016055	CUPRIMINE	BSL	FNQSW

68:04.00 CORTICOSTEROIDS

BECLOMETHASONE DIPROPIONATE

50MCG/INHALER

02242029	QVAR	BSL	FNQSW

100MCG/INHALER

02242030	QVAR	BSL	FNQSW

BETAMETHASONE

6MG/ML VIAL

00028096	CELESTONE SOLUSPAN	ORG	FNQSW

BUDESONIDE

100MCG/DOSE INHALER POWDER (200 DOSE)

00852074	PULMICORT TURBUHALER	AZE	FQW

200MCG/DOSE INHALER POWDER (200 DOSE)

00851752	PULMICORT TURBUHALER	AZE	CFNQSW

400MCG/DOSE INHALER POWDER (200 DOSE)

00851760	PULMICORT TURBUHALER	AZE	CFNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA (NURSING HOME PROGRAM AND CYSTIC FIBROSIS PROGRAM DOES NOT REQUIRE AN SA REQUEST)

0.125MG/ML INHALATION SOLUTION (2ML)

02229099	PULMICORT NEBUAMP (SA)	AZE	CFNQSW
02465949	TEVA-BUDESONIDE (SA)	TEV	CFGNQSW
02494264	TARO-BUDESONIDE (SA)	TAR	CFGNQSW

0.25MG/ML INHALATION SOLUTION (2ML)

01978918	PULMICORT NEBUAMP (SA)	AZE	CFNQSW
02494272	TARO-BUDESONIDE (SA)	TAR	CFGNQSW

0.5MG/ML INHALATION SOLUTION (2ML)

01978926	PULMICORT NEBUAMP (SA)	AZE	CFNQSW
02465957	TEVA-BUDESONIDE (SA)	TEV	CFGNQSW

02494280	TARO-BUDESONDE (SA)	TAR	CFGNSQSW
2MG/ACTUATION RECTAL FOAM			
02498057	UCERIS	BLO	FNQSW
3MG DELAYED AND EXTENDED RELEASE CAPSULE			
02229293	ENTOCORT	TPG	FNQSW
0.02MG/ML RECTAL ENEMA			
02052431	ENTOCORT	TPG	FNQSW
CICLESONIDE			
100MCG/DOSE INHALATION AEROSOL			
02285606	ALVESCO	COV	FGNSQSW
200MCG/DOSE INHALATION AEROSOL			
02285614	ALVESCO	COV	FGNSQSW
CORTISONE ACETATE			
25MG TABLET			
00280437	CORTISONE	BSL	CFNSQSW
DEXAMETHASONE			
0.5MG TABLET			
01964976	PMS-DEXAMETHASONE	PMS	CFGNSQSW
02261081	APO-DEXAMETHASONE	APX	CFGNSQSW
0.75MG TABLET			
01964968	PMS-DEXAMETHASONE	PMS	FGNSQSW
2MG TABLET			
02279363	PMS-DEXAMETHASONE	PMS	FGNSQSW
4MG TABLET			
01964070	PMS-DEXAMETHASONE	PMS	CFGNSQSW
02250055	APO-DEXAMETHASONE	APX	CFGNSQSW
DEXAMETHASONE 21 PHOSPHATE			
4MG/ML INJECTION SOLUTION (5ML)			
00664227	DEXAMETHASONE	SDZ	FGNSQSW
01977547	DEXAMETHASONE	STE	FGNSQSW
FLUDROCORTISONE ACETATE			
0.1MG TABLET			
02086026	FLORINEF	PAL	FNQSW
02552248	JAMP-FLUDROCORTISONE	JPC	FGNSQSW

FLUTICASONE FUROATE

100MCG POWDER FOR INHALATION
02446561 ARNUITY ELLIPTA

GSK **FNQSW**

200MCG POWDER FOR INHALATION
02446588 ARNUITY ELLIPTA

GSK **FNQSW**

FLUTICASONE PROPIONATE

55MCG/DOSE AEROSOL POWDER
02467895 AERMONY RESPICLICK

TEV **FGNQSW**

113MCG/DOSE AEROSOL POWDER
02467909 AERMONY RESPICLICK

TEV **FGNQSW**

232MCG/DOSE AEROSOL POWDER
02467917 AERMONY RESPICLICK

TEV **FGNQSW**

50MCG/DOSE INHALATION AEROSOL HYDROFLUOROALKANE (HFA)

02244291 FLOVENT HFA
02503115 PMS-FLUTICASONE HFA
02528428 APO-FLUTICASONE HFA

GSK **CFNQSW**
PMS **CFGNQSW**
APX **CFGNQSW**

125MCG/DOSE INHALATION AEROSOL HYDROFLUOROALKANE (HFA)

02244292 FLOVENT HFA
02503123 PMS-FLUTICASONE HFA
02526557 APO-FLUTICASONE HFA

GSK **CFNQSW**
PMS **CFGNQSW**
APX **CFGNQSW**

250MCG/DOSE INHALATION AEROSOL HYDROFLUOROALKANE (HFA)

02244293 FLOVENT HFA
02503131 PMS-FLUTICASONE HFA
02510987 APO-FLUTICASONE HFA

GSK **CFNQSW**
PMS **CFGNQSW**
APX **CFGNQSW**

100MCG/DOSE AEROSOL POWDER DISK (60)

02237245 FLOVENT DISKUS

GSK **FNQSW**

250MCG/DOSE AEROSOL POWDER DISK (60)

02237246 FLOVENT DISKUS

GSK **FNQSW**

500MCG/DOSE AEROSOL POWDER DISK (60)

02237247 FLOVENT DISKUS

GSK **FNQSW**

HYDROCORTISONE

10MG TABLET

00030910 CORTEF
02524465 AURO-HYDROCORTISONE

PFI **CFNQSW**
ARO **CFGNQSW**

20MG TABLET			
00030929	CORTEF	PFI	CFNQSW
02524473	AURO-HYDROCORTISONE	ARO	CFGNQSW

HYDROCORTISONE SODIUM SUCCINATE

250MG INJECTION POWDER			
00030619	SOLU-CORTEF	PFI	NQ

METHYLPREDNISOLONE

4MG TABLET			
00030988	MEDROL	PFI	CFNQSW

16MG TABLET			
00036129	MEDROL	PFI	FNQSW

METHYLPREDNISOLONE ACETATE

40MG/ML INJECTION SUSPENSION (1ML)			
00030759	DEPO MEDROL	PFI	FNQSW

40MG/ML INJECTION SUSPENSION (2ML)			
01934333	DEPO MEDROL	PFI	FNQSW

80MG/ML INJECTION SUSPENSION (1ML)			
00030767	DEPO MEDROL	PFI	FNQSW

MOMETASONE FUROATE

100MCG DRY POWDER INHALER			
02438690	ASMANEX	ORG	FNQSW

200MCG DRY POWDER INHALER			
02243595	ASMANEX	ORG	FNQSW

400MCG DRY POWDER INHALER			
02243596	ASMANEX	ORG	FNQSW

PREDNISOLONE SODIUM PHOSPHATE

1MG/ML ORAL LIQUID			
02245532	PMS-PREDNISOLONE	PMS	CFGNQSW

PREDNISONE

1MG TABLET			
00271373	WINPRED	AAA	CFNQSW

5MG TABLET			
00021695	TEVA-PREDNISONE	TEV	CFGNQSW

00312770	APO-PREDNISONE	APX	CFGNQSW

50MG TABLET

00232378	TEVA-PREDNISONE	TEV	CFGNQSW
00550957	APO-PREDNISONE	APX	CFGNQSW

TRIAMCINOLONE ACETONIDE

10MG/ML VIAL

01999761	KENALOG-10	BMS	FNQSW

40MG/ML VIAL

01999869	KENALOG-40	BMS	FNQSW
01977563	TRIAMCINOLONE ACETONIDE	STE	FNQSW

TRIAMCINOLONE HEXACETONIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG/ML AMPULE

02470632	TRISPAN (SA)	MED	FQW

68:08.00 ANDROGENS

DANAZOL

100MG CAPSULE

02018152	CYCLOMEN	AVN	FQW

200MG CAPSULE

02018160	CYCLOMEN	AVN	FQW

TESTOSTERONE

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG/2.5GM TRANSDERMAL GEL

02245345	ANDROGEL (SA)	BGP	FNQSW
02463792	TARO-TESTOSTERONE (SA)	TAR	FNQSW

50MG/5GM TRANSDERMAL GEL

02245346	ANDROGEL (SA)	BGP	FNQSW
02463806	TARO-TESTOSTERONE (SA)	TAR	FNQSW

50MG/5GM TRANSDERMAL GEL

02245346	ANDROGEL (SA)	BGP	FNQSW
02280248	TESTIM (SA)	PAL	FNQSW

TESTOSTERONE CYPIONATE

100MG/ML VIAL

00030783	DEPO-TESTOSTERONE
02496003	TARO-TESTOSTERONE

PFI	FQW
TAR	FQW

TESTOSTERONE UNDECANOATE

[SEE APPENDIX A](#) FOR SA CRITERIA

40MG CAPSULE

02322498	PMS-TESTOSTERONE (SA)
02421186	TARO-TESTOSTERONE (SA)

PMS	FNQSW
TAR	FNQSW

68:12.00 CONTRACEPTIVES

ESTRADIOL & ETONOGESTREL

2MG & 11.4MG VAGINAL INSERT

02253186	NUVARING
02520028	HALOETTE

MSD	National
SLP	National

ETHINYL ESTRADIOL & DESOGESTREL

0.025MG & 0.10MG TABLET (21 DAY)

02272903	LINESSA

ASN	National

0.025MG & 0.10MG TABLET (28 DAY)

02257238	LINESSA

ASN	National

0.03MG & 0.15MG TABLET (21 DAY)

02042487	MARVELON
02317192	APRI 21
02396491	FREYA 21
02410249	MIRVALA 21

MSD	National
TEV	National
MYL	National
APX	National

0.03MG & 0.15MG TABLET (28 DAY)

02042479	MARVELON
02317206	APRI 28
02396610	FREYA 28
02410257	MIRVALA 28

MSD	National
TEV	National
MYL	National
APX	National

ETHINYL ESTRADIOL & DROSPIRENONE

3MG & 0.02MG TABLET

02321157	YAZ
02415380	MYA
02462060	DROSPIRENONE-ETHINYL ESTRADIOL

BAY	National
APX	National
GLM	National

3.0MG & 0.03MG TABLET (21 DAY)

02261723	YASMIN 21	BAY	National
02410788	ZAMINE 21	APX	National
02421437	DROSPIRENONE-ETHINYL ESTRADIOL	GLM	National

3.0MG & 0.03MG TABLET (28 DAY)

02261731	YASMIN 28	BAY	National
02410796	ZAMINE 28	APX	National
02421445	DROSPIRENONE-ETHINYL ESTRADIOL	GLM	National

ETHINYL ESTRADIOL & L-NORGESTREL

0.2MG & 0.1MG TABLET (21 DAY)

02236974	ALESSE	PFI	National
02298538	AVIANE 21	TEV	National
02387875	ALYSENA	APX	National
02532174	AUDRINA (21)	JPC	National

0.2MG & 0.1MG TABLET (28 DAY)

02236975	ALESSE	PFI	National
02298546	AVIANE 28	TEV	National
02387883	ALYSENA	APX	National
02532182	AUDRINA (28)	JPC	National

0.03MG & 0.05MG (6); 0.04MG & 0.075MG (5); 0.03MG & 0.125MG (10) TABLET (21 DAY)

00707600	TRIQUILAR	BAY	National

0.03MG & 0.05MG (6); 0.04MG & 0.075MG (5); 0.03MG & 0.125MG (10); INERT TABLETS (7) TABLET (28 DAY)

00707503	TRIQUILAR	BAY	National

0.03MG & 0.15MG TABLET (21 DAY)

02042320	MIN-OVRAL	PFI	National
02295946	PORTIA	TEV	National
02387085	OVIMA	APX	National

0.03MG & 0.15MG TABLET (28 DAY)

02042339	MIN-OVRAL	PFI	National
02295954	PORTIA	TEV	National
02387093	OVIMA	APX	National

ETHINYL ESTRADIOL & NORETHINDRONE

0.035MG & 0.5MG TABLET (21 DAY)

02187086	BREVICON	PFI	National

0.035MG & 0.5MG TABLET (28 DAY)

02187094	BREVICON	PFI	National

0.035MG & 0.5MG (7); 0.035MG & 1.0MG (7); 0.035MG & 0.5MG (7) TABLET (21 DAY)			
02187108	SYNPHASIC	PFI	National

0.035MG & 0.5MG (7); 0.035MG & 1.0MG (7); 0.035MG & 0.5MG (7); INERT TABLETS (7) TABLET (28 DAY)			
02187116	SYNPHASIC	PFI	National

0.035MG & 1.0MG TABLET (21 DAY)			
02189054	BREVICON 1/35	PFI	National
02197502	SELECT 1/35	PFI	National

0.035MG & 1.0MG TABLET (28 DAY)			
02189062	BREVICON 1/35	PFI	National
02199297	SELECT 1/35	PFI	National

ETHINYL ESTRADIOL & NORGESTIMATE

0.025MG & 0.180MG (7); 0.025MG & 0.215MG (7); 0.025MG & 0.250MG (7) TABLET (21 DAY)			
02401967	TRICIRA LO	APX	National

0.025MG & 0.180MG (7); 0.025MG & 0.215MG (7); 0.025MG & 0.250MG (7); INERT TABLETS (7) TABLET (28 DAY)			
02401975	TRICIRA LO	APX	National

0.035MG & 0.180MG (7); 0.035MG & 0.215MG (7); 0.035MG & 0.250MG (7) TABLET (21 DAY)			
02486296	TRI-JORDYNA 21	GLM	National
02508087	TRI-CIRA 21	APX	National

0.035MG & 0.180MG (7); 0.035MG & 0.215MG (7); 0.035MG & 0.250MG (7); TABLET (28 DAY)			
02486318	TRI-JORDYNA 28	GLM	National
02508095	TRI-CIRA 28	APX	National

ETONOGESTREL

68MG SC IMPLANT			
02499509	NEXPLANON	ORG	National

LEVONORGESTROL

1.5MG TABLET			
02293854	PLAN B	PAL	National
02425009	CONTINGENCY ONE	MYL	National
02433532	BACKUP PLAN ONESTEP	APX	National
02548461	MYSTEP	JPC	National

19.5MG INTRAUTERINE SYSTEM			
02459523	KYLEENA	BAY	National
52MG INTRAUTERINE SYSTEM			
02243005	MIRENA	BAY	National
MEDROXYPROGESTERONE ACETATE			
150MG/ML INJECTION SUSPENSION (1ML)			
02523493	DEPO-PROVERA	PFI	National
NORETHINDRONE			
0.35MG TABLET (28 DAY)			
02410303	MOVISSE	MYL	National
02441306	JENCYCLA	LUP	National
INTRAUTERINE DEVICES (COPPER)			
66127954	FLEXI-T 300	UNK	National
66128087	FLEXI-T +300	UNK	National
66128088	FLEXI-T +380	UNK	National
66128089	LIBERTE UT 380 SHORT	UNK	National
66128090	LIBERTE UT 380 STANDARD	UNK	National
66128091	LIBERTE TT 380 SHORT	UNK	National
66128092	LIBERTE TT 380 STANDARD	UNK	National
66128387	LIBERTE UT 380 SC STANDARD	UNK	National
66128388	LIBERTE UT 380 SC SHORT	UNK	National
66128153	MONA LISA 10	UNK	National
66128154	MONA LISA 5 MINI	UNK	National
66128390	MONA LISA 5 STANDARD	UNK	National
66128158	MONA LISA N	UNK	National

68:16.00 ESTROGENS

CONJUGATED ESTROGENS

0.3MG TABLET			
02414678	PREMARIN	PFI	FNQSW
0.625MG TABLET			
02414686	PREMARIN	PFI	FNQSW
1.25MG TABLET			
02414694	PREMARIN	PFI	FNQSW
0.625MG/G VAGINAL CREAM			
02043440	PREMARIN	PFI	FNQSW

ESTRADIOL**0.5MG TABLET**

02225190	ESTRACE	ACS	FNQSW
02449048	LUPIN-ESTRADIOL	LUP	FGNQSW

1MG TABLET

02148587	ESTRACE	ACS	FNQSW
02449056	LUPIN-ESTRADIOL	LUP	FGNQSW

2MG TABLET

02148595	ESTRACE	ACS	FNQSW
02449064	LUPIN-ESTRADIOL	LUP	FGNQSW

25MCG TRANSERMAL PATCH

02245676	ESTRADOT	SDZ	FNQSW

50MCG TRANSDERMAL PATCH

02244000	ESTRADOT	SDZ	FNQSW
02246967	SANDOZ-ESTRADIOL DERM	SDZ	FGNQSW

75MCG TRANSDERMAL PATCH

02244001	ESTRADOT	SDZ	FNQSW
02246968	SANDOZ-ESTRADIOL DERM	SDZ	FGNQSW

100MCG TRANSDERMAL PATCH

02244002	ESTRADOT	SDZ	FNQSW
02246969	SANDOZ-ESTRADIOL DERM	SDZ	FGNQSW

7.5MCG/24 HOUR VAGINAL RING

02168898	ESTRING	PAL	FNQSW

4MCG VAGINAL INSERT

02503689	IMVEXXY	KNI	FNQSW

10MCG VAGINAL INSERT

02503697	IMVEXXY	KNI	FNQSW

10MCG VAGINAL TABLET

02325462	VAGIFEM	NNO	FNQSW

0.06% TOPICAL GEL

02238704	ESTROGEL	ORG	FNQSW

ESTRADIOL & NORETHINRONE ACETATE**50MCG & 140MCG TRANSDERMAL PATCH**

02241835	ESTALIS	SDZ	FNQSW

50MCG & 250MCG TRANSDERMAL PATCH
02241837 ESTALIS

SDZ **FNQSW**

ESTRADIOL & PROGESTERONE

1 MG & 100 MG CAPSULE
02505223 BIJUVA

KNI **FQW**

ESTRONE

0.1% VAGINAL CREAM
00727369 ESTRAGYN

SLP **FNQSW**

68:18.00 GONADOTROPINS

GOSERELIN ACETATE

3.6MG DEPOT INJECTION
02049325 ZOLADEX

TRT **FNQSW**

10.8MG DEPOT INJECTION
02225905 ZOLADEX LA

TRT **FNQSW**

68:20.00 ANTIDIABETIC DRUGS (ORAL HYPOGLYCEMICS)

⑤ACARBOSE

50MG TABLET
02493780 ACARBOSE
02494078 MAR-ACARBOSE

STR **DNQW**
MAR **DNQW**

100MG TABLET
02493799 ACARBOSE
02494086 MAR-ACARBOSE

STR **DNQW**
MAR **DNQW**

⑤CANAGLIFLOZIN

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG TABLET
02425483 INVOKANA (SA)

JAN **DNQW**

300MG TABLET
02425491 INVOKANA (SA)

JAN **DNQW**

DAPAGLIFLOZIN

5MG TABLET

02435462	FORXIGA	AZE	National
02518732	SANDOZ-DAPAGLIFLOZIN	SDZ	National
02519852	GLN-DAPAGLIFLOZIN	GLM	National
02527189	APO-DAPAGLIFLOZIN	APX	National
02531364	JAMP-DAPAGLIFLOZIN	JPC	National
02531402	AURO-DAPAGLIFLOZIN	ARO	National
02531550	PMS-DAPAGLIFLOZIN	PMS	National
02535297	M-DAPAGLIFLOZIN	MRA	National

10MG TABLET

02435470	FORXIGA	AZE	National
02518740	SANDOZ-DAPAGLIFLOZIN	SDZ	National
02519860	GLN-DAPAGLIFLOZIN	GLM	National
02527197	APO-DAPAGLIFLOZIN	APX	National
02531372	JAMP-DAPAGLIFLOZIN	JPC	National
02531410	AURO-DAPAGLIFLOZIN	ARO	National
02531569	PMS-DAPAGLIFLOZIN	PMS	National
02535300	M-DAPAGLIFLOZIN	MRA	National

⑤DAPAGLIFLOZIN & METFORMIN HYDROCHLORIDE**5MG/850MG TABLET**

02449935	XIGDUO	AZE	DNQW
02533073	AURO-DAPAGLIFLOZIN-METFORMIN	ARO	DNQW
02536153	APO-DAPAGLIFLOZIN-METFORMIN	APX	DNQW

5MG/1000MG TABLET

02449943	XIGDUO	AZE	DNQW
02533081	AURO-DAPAGLIFLOZIN-METFORMIN	ARO	DNQW
02536161	APO-DAPAGLIFLOZIN-METFORMIN	APX	DNQW

⑤EMPAGLIFLOZIN[SEE APPENDIX A](#) FOR SA CRITERIA**10MG TABLET**

02443937	JARDIANCE (SA)	BOE	DNQW

25MG TABLET

02443945	JARDIANCE (SA)	BOE	DNQW

EMPAGLIFLOZIN & METFORMIN HCL**5MG & 500MG TABLET**

02456575	SYNJARDY	BOE	National

5MG & 850MG TABLET

02456583	SYNJARDY	BOE	National

5MG & 1000MG TABLET			
02456591	SYNJARDY	BOE	National

12.5MG & 500MG TABLET			
02456605	SYNJARDY	BOE	National

12.5MG & 850MG TABLET			
02456613	SYNJARDY	BOE	National

12.5MG & 1000MG TABLET			
02456621	SYNJARDY	BOE	National

GLICLAZIDE

30MG MODIFIED RELEASE TABLET			
02242987	DIAMICRON MR	SEV	National
02297795	APO-GLICLAZIDE MR	APX	National
02423286	MINT-GLICLAZIDE MR	MNT	National
02429764	JAMP-GLICLAZIDE MR	JPC	National
02438658	MYLAN-GLICLAZIDE MR	MYL	National
02461323	SANDOZ-GLICLAZIDE MR	SDZ	National
02463571	TARO-GLICLAZIDE MR	SUN	National
02524856	GLICLAZIDE MR	SNS	National

80MG TABLET			
02238103	TEVA-GLICLAZIDE	TEV	National
02245247	APO-GLICLAZIDE	APX	National
02287072	GLICLAZIDE	SNS	National

60MG EXTENDED RELEASE TABLET			
02356422	DIAMICRON MR	SEV	National
02407124	APO-GLICLAZIDE MR	APZ	National
02423294	MINT-GLICLAZIDE MR	MNT	National
02429772	JAMP-GLICLAZIDE MR	JPC	National
02439328	TARO-GLICLAZINE MR	SUN	National
02461331	SANDOZ-GLICLAZIDE MR	SDZ	National
02524864	GLICLAZIDE MR	SNS	National

GLIMEPIRIDE

1MG TABLET			
02269589	SANDOZ-GLIMEPIRIDE	SDZ	DNQW

2MG TABLET			
02269597	SANDOZ-GLIMEPIRIDE	SDZ	DNQW

4MG TABLET			
02269619	SANDOZ-GLIMEPIRIDE	SDZ	DNQW

GLYBURIDE**2.5MG TABLET**

01913654	APO-GLYBURIDE	APX	National
01913670	TEVA-GLYBURIDE	TEV	National

5MG TABLET

01913662	APO-GLYBURIDE	APX	National
01913689	TEVA-GLYBURIDE	TEV	National
02350467	GLYBURIDE	SNS	National

⑤LINAGLIPTIN[SEE APPENDIX A](#) FOR SA CRITERIA**5MG TABLET**

02370921	TRAJENTA (SA)	BOE	DNQW

LINAGLIPTIN & METFORMIN HYDROCHLORIDE**2.5MG/500MG TABLET**

02403250	JENTADUETO	BOE	National

2.5MG/850MG TABLET

02403269	JENTADUETO	BOE	National

2.5MG/1000MG TABLET

02403277	JENTADUETO	BOE	National

METFORMIN**500MG TABLET**

02099233	GLUCOPHAGE	AVN	National
02223562	PMS-METFORMIN	PMS	National
02246820	SANDOZ-METFORMIN FC	SDZ	National
02257726	TEVA-METFORMIN	TEV	National
02353377	METFORMIN	SNS	National
02378620	MAR-METFORMIN	MAR	National
02380196	JAMP-METFORMIN	JPC	National
02385341	METFORMIN	SIV	National
02388766	MINT-METFORMIN	MNT	National
02438275	AURO-METFORMIN	ARO	National
02520303	PMSC-METFORMIN	PMS	National
02531895	PRZ-METFORMIN	PRZ	National
02547767	M-METFORMIN	MRA	National

850MG TABLET

02162849	GLUCOPHAGE	AVN	National
02242589	PMS-METFORMIN	PMS	National
02246821	SANDOZ-METFORMIN FC	SDZ	National
02257734	TEVA-METFORMIN	TEV	National

02353385	METFORMIN	SNS	National
02378639	MAR-METFORMIN	MAR	National
02380218	JAMP-METFORMIN	JPC	National
02385368	METFORMIN	SIV	National
02388774	MINT-METFORMIN	MNT	National
02438283	AURO-METFORMIN	ARO	National
02520311	PMSC-METFORMIN	PMS	National
02531909	PRZ-METFORMIN	PRZ	National
02547775	M-METFORMIN	MRA	National

1000MG TABLET

02534673	PRZ-METFORMIN	PRZ	National
02548275	M-METFORMIN	MRA	National

PIOGLITAZONE HCL

15MG TABLET

02297906	SANDOZ-PIOGLITAZONE	SDZ	DNQW
02302861	ACT-PIOGLITAZONE	TEV	DNQW
02302942	APO-PIOGLITAZONE	APX	DNQW
02326477	MINT-PIOGLICAZONE	MNT	DNQW
02375850	RAN-PIOGLITAZONE	RAN	DNQW
02391600	PIOGLITAZONE HYDROCHLORIDE	ACH	DNQW
02397307	JAMP-PIOGLITAZONE	JPC	DNQW

30MG TABLET

02297914	SANDOZ-PIOGLITAZONE	SDZ	DNQW
02302888	ACT-PIOGLITAZONE	TEV	DNQW
02302950	APO-PIOGLITAZONE	APX	DNQW
02326485	MINT-PIOGLITAZONE	MNT	DNQW
02339587	PIOGLITAZONE	ACH	DNQW
02365529	JAMP-PIOGLITAZONE	JPC	DNQW
02375869	RAN-PIOGLITAZONE	RAN	DNQW

45MG TABLET

02297922	SANDOZ-PIOGLITAZONE	SDZ	DNQW
02302896	ACT-PIOGLITAZONE	TEV	DNQW
02302977	APO-PIOGLITAZONE	APX	DNQW
02326493	MINT-PIOGLITAZONE	MNT	DNQW
02339595	PIOGLITAZONE	ACH	DNQW
02365537	JAMP-PIOGLITAZONE	JPC	DNQW
02375877	RAN-PIOGLITAZONE	RAN	DNQW

⑤SAXAGLIPTIN

[SEE APPENDIX A](#) FOR SA CRITERIA

2.5MG TABLET

02375842	ONGLYZA (SA)	AZE	DNQW

02468603	SANDOZ-SAXAGLIPTIN (SA)	SDZ	DNQW
02507471	APO-SAXAGLIPTIN (SA)	APX	DNQW

5MG TABLET

02333554	ONGLYZA (SA)	AZE	DNQW
02468611	SANDOZ-SAXAGLIPTIN (SA)	SDZ	DNQW
02507498	APO-SAXAGLIPTIN (SA)	APX	DNQW

SAXAGLIPTIN & METFORMIN HYDROCHLORIDE

2.5MG/500MG TABLET

02389169	KOMBOGLYZE	AZE	National

2.5MG/850MG TABLET

02389177	KOMBOGLYZE	AZE	National

2.5MG/1000MG TABLET

02389185	KOMBOGLYZE	AZE	National

⑤SITAGLIPTIN

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG TABLET

02388839	JANUVIA (SA)	MSD	DNQW
02503840	PMS-SITAGLIPTIN (SA)	PMS	DNQW
02504049	SANDOZ-SITAGLIPTIN (SA)	SDZ	DNQW
02508656	APO-SITAGLIPTIN MALATE (SA)	APX	DNQW
02512475	ACH-SITAGLIPTIN (SA)	ACH	DNQW
02522705	TEVA-SITAGLIPTIN MALATE (SA)	TEV	DNQW
02529033	SITAGLIPTIN (SA)	SIV	DNQW
02529866	AURO-SITAGLIPTIN HCL (SA)	ARO	DNQW
02531631	TARO-SITAGLIPTIN FUMERATE (SA)	TAR	DNQW
02534134	JAMP SITAGLIPTIN (SA)	JPC	DNQW
02548550	SITAGLIPTIN (SA)	SNS	DNQW

50MG TABLET

02388847	JANUVIA (SA)	MSD	DNQW
02503859	PMS-SITAGLIPTIN (SA)	PMS	DNQW
02504057	SANDOZ-SITAGLIPTIN (SA)	SDZ	DNQW
02508664	APO-SITAGLIPTIN MALATE (SA)	APX	DNQW
02512483	ACH-SITAGLIPTIN (SA)	ACH	DNQW
02522713	TEVA-SITAGLIPTIN MALATE (SA)	TEV	DNQW
02529041	SITAGLIPTIN (SA)	SIV	DNQW
02529874	AURO-SITAGLIPTIN HCL (SA)	ARO	DNQW
02531658	TARO-SITAGLIPTIN FUMERATE (SA)	TAR	DNQW
02534142	JAMP SITAGLIPTIN (SA)	JPC	DNQW
02548569	SITAGLIPTIN (SA)	SNS	DNQW

100MG TABLET

02303922	JANUVIA (SA)	MSD	DNQW
02503867	PMS-SITAGLIPTIN (SA)	PMS	DNQW
02504065	SANDOZ-SITAGLIPTIN (SA)	SDZ	DNQW
02508672	APO-SITAGLIPTIN MALATE (SA)	APX	DNQW
02512491	ACH-SITAGLIPTIN (SA)	ACH	DNQW
02522721	TEVA-SITAGLIPTIN MALATE (SA)	TEV	DNQW
02529068	SITAGLIPTIN (SA)	SIV	DNQW
02529882	AURO-SITAGLIPTIN HCL (SA)	ARO	DNQW
02531666	TARO-SITAGLIPTIN FUMERATE (SA)	TAR	DNQW
02534150	JAMP SITAGLIPTIN (SA)	JPC	DNQW
02548577	SITAGLIPTIN (SA)	SNS	DNQW

⑤SITAGLIPTIN & METFORMIN HYDROCHLORIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG/500MG TABLET

02333856	JANUMET (SA)	MSD	DNQW
02503956	SANDOZ SITAGLIPTIN-METFORMIN (SA)	SDZ	DNQW
02509415	APO-SITAGLIPTIN MAL-METFORMIN (SA)	APX	DNQW
02520494	TEVA-SITAGLIPTIN-METFORMIN (SA)	TEV	DNQW
02529157	SITAGLIPTIN-METFORMIN (SA)	SIV	DNQW
02540118	REDDY-SITAGLIPTIN-METFORMIN (SA)	RCH	DNQW
02547805	AURO-SITAGLIPTIN-METFORMIN (SA)	ARO	DNQW
02556189	JAMP-SITAGLIPTIN-METFORMIN HCL (SA)	JPC	DNQW

50MG/850MG TABLET

02333864	JANUMET (SA)	MSD	DNQW
02503964	SANDOZ SITAGLIPTIN-METFORMIN (SA)	SDZ	DNQW
02509423	APO-SITAGLIPTIN MAL-METFORMIN (SA)	APX	DNQW
02520508	TEVA-SITAGLIPTIN-METFORMIN (SA)	TEV	DNQW
02529165	SITAGLIPTIN-METFORMIN (SA)	SIV	DNQW
02540126	REDDY-SITAGLIPTIN-METFORMIN (SA)	RCH	DNQW
02547813	AURO-SITAGLIPTIN-METFORMIN (SA)	ARO	DNQW
02556197	JAMP-SITAGLIPTIN-METFORMIN HCL (SA)	JPC	DNQW

50MG/1000MG TABLET

02333872	JANUMET (SA)	MSD	DNQW
02503972	SANDOZ SITAGLIPTIN-METFORMIN (SA)	SDZ	DNQW
02509431	APO-SITAGLIPTIN MAL-METFORMIN (SA)	APX	DNQW
02520516	TEVA-SITAGLIPTIN-METFORMIN (SA)	TEV	DNQW
02529173	SITAGLIPTIN-METFORMIN (SA)	SIV	DNQW
02540134	REDDY-SITAGLIPTIN-METFORMIN (SA)	RCH	DNQW
02547821	AURO-SITAGLIPTIN-METFORMIN (SA)	ARO	DNQW
02556200	JAMP-SITAGLIPTIN-METFORMIN HCL (SA)	JPC	DNQW

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG/500MG EXTENDED RELEASE TABLET		
02416786	JANUMET XR (SA)	MSD DNQW
02506270	APO-SITAGLIPTIN-METFORMIN XR	APX DNQW
02529106	SANDOZ SITAGLIPTIN-METFORMIN XR	SDZ DNQW
50MG/1000MG EXTENDED RELEASE TABLET		
02416794	JANUMET XR (SA)	MSD DNQW
02506289	APO-SITAGLIPTIN-METFORMIN XR	APX DNQW
02529114	SANDOZ SITAGLIPTIN-METFORMIN XR	SDZ DNQW
100MG/1000MG EXTENDED RELEASE TABLET		
02416808	JANUMET XR (SA)	MSD DNQW
02506297	APO-SITAGLIPTIN-METFORMIN XR	APX DNQW
02529122	SANDOZ SITAGLIPTIN-METFORMIN XR	SDZ DNQW

68:20.06 ANTIDIABETIC DRUGS (INCRETIN MIMETICS)

⑤ SEMAGLUTIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

0.25-0.5MG PER DOSE (2MG/1.5ML) PEN INJECTOR

02471477	OZEMPIC (SA)	NNO DNQW

0.25-0.5MG PER DOSE (2MG/3ML) PEN INJECTOR

02540258	OZEMPIC (SA)	NNO DNQW

1MG/0.75ML (4MG/3ML) PEN INJECTOR

02471469	OZEMPIC (SA)	NNO DNQW

[SEE APPENDIX A](#) FOR SA CRITERIA

3MG TABLET

02497581	RYBELSUS (SA)	NNO DNQW

7MG TABLET

02497603	RYBELSUS (SA)	NNO DNQW

14MG TABLET

02497611	RYBELSUS (SA)	NNO DNQW

68:20.08 ANTIDIABETIC DRUGS (INSULINS-HUMAN BIOSYNTHETIC)

INSULIN (DEGLUDEC)

100 UNIT/ML PREFILLED PEN		
02467879	TRESIBA FLEXTOUCH	NNO National

100 UNIT/ML CARTRIDGE		
02467860	TRESIBA PENFILL	NNO National

200 UNIT/ML PREFILLED PEN		
02467887	TRESIBA FLEXTOUCH	NNO National

INSULIN (DETEMIR)

[SEE APPENDIX A](#) FOR SA CRITERIA

100 UNIT/ML CARTRIDGE		
02271842	LEVEMIR (SA)	NNO National

INSULIN (GLARGINE)

100 UNIT/ML CARTRIDGE		
02444844	BASAGLAR	LIL National

100 UNIT/ML PREFILLED PEN (80 UNIT)		
02461528	BASAGLAR	LIL National
02526441	SEMGLEE	BGP National

[SEE APPENDIX A](#) FOR SA CRITERIA

300 UNIT/ML PREFILLED PEN		
02441829	TOUJEO SOLOSTAR (SA)	AVN National

300 UNIT/ML PREFILLED PEN		
02493373	TOUJEO DOUBLESTAR (SA)	AVN National

INSULIN (GLULISINE)

100 UNIT/ML CARTRIDGE		
02279479	APIDRA	AVN National

100 UNIT/ML VIAL		
02279460	APIDRA	AVN National

100 UNIT/ML PREFILLED PEN		
02294346	APIDRA	AVN National

INSULIN (ASPART)

100IU/ML INJECTION SOLUTION (10ML)		
02529254	TRURAPI*	AVN National

*Please ensure pump compatibility before switching to a biosimilar insulin

⑤ [SEE APPENDIX A](#) FOR SA CRITERIA

100IU/ML INJECTION SOLUTION (10ML)

02245397	NOVORAPID (SA)	NNO	DNQW
100IU/ML INJECTION SOLUTION (CARTRIDGE)			
02506564	TRURAPI	AVN	National
100IU/ML INJECTION SOLUTION (PEN)			
02506572	TRURAPI SOLOSTAR	AVN	National
02520974	KIRSTY	EMD	National
INSULIN (ISOPHANE) HUMAN BIOSYNTHETIC			
100U/ML INJECTION SUSPENSION (10ML)			
00587737	HUMULIN-N	LIL	National
02024225	NOVOLIN GE NPH	NNO	National
100U/ML INJECTION SUSPENSION (CARTRIDGE)			
01959239	HUMULIN-N CARTRIDGE	LIL	National
02024268	NOVOLIN GE NPH PENFILL	NNO	National
100U/ML INJECTION SUSPENSION (KWIKPEN)			
02403447	HUMULIN-N KWIKPEN	LIL	National
INSULIN (REGULAR) HUMAN BIOSYNTHETIC			
100U/ML INJECTION SOLUTION (10ML)			
00586714	HUMULIN-R	LIL	National
02024233	NOVOLIN GE TORONTO	NNO	National
100U/ML INJECTION SOLUTION (CARTRIDGE)			
01959220	HUMULIN-R CARTRIDGE	LIL	National
02024284	NOVOLIN GE TORONTO PENFILL	NNO	National
SEE APPENDIX A FOR SA CRITERIA			
500U/ML INJECTION SOLUTION (PEN)			
02466864	ENTUZITY (SA)	LIL	National
INSULIN (REGULAR/ISOPHANE) HUMAN BIOSYNTHETIC			
100U/ML INJECTION SUSPENSION 30%/70% (10ML)			
00795879	HUMULIN 30/70	LIL	National
02024217	NOVOLIN GE 30/70	NNO	National
100U/ML INJECTION SUSPENSION 30%/70% (CARTRIDGE)			
01959212	HUMULIN 30/70 CARTRIDGE	LIL	National
02025248	NOVOLIN GE 30/70 PENFILL	NNO	National
INSULIN (LISPRO)			
100U/ML INJECTION SOLUTION (10ML)			

02469901	ADMELOG	AVN	National
100U/ML INJECTION SOLUTION (CARTRIDGE)			
02469898	ADMELOG	AVN	National
100U/ML INJECTION SOLUTION (KWIKPEN)			
02469871	ADMELOG SOLOSTAR	AVN	National
INSULIN (REGULAR/PROTAMINE) LISPRO			
100U/ML INJECTION SUSPENSION 25%/75% (CARTRIDGE)			
02240294	HUMALOG MIX 25 CARTRIDGE	LIL	National
100U/ML INJECTION SUSPENSION 25%/75% (KWIKPEN)			
02403420	HUMALOG MIX 25 KWIKPEN	LIL	National

68:28.00 PITUITARY AGENTS

DESMOPRESSIN

[SEE APPENDIX A](#) FOR SA CRITERIA

10U/DOSE INTRANASAL SOLUTION (SPRAY PUMP)			
02242465	DEMOPRESSIN (SA)	AAA	FGNQSW
0.1MG TABLET			
00824305	DDAVP (SA)	FEI	FNQSW
02284030	APO-DESMOPRESSIN (SA)	APX	FGNQSW
02304368	PMS-DESMOPRESSIN (SA)	PMS	FGNQSW
0.2MG TABLET			
00824143	DDAVP (SA)	FEI	FNQSW
02284049	APO-DESMOPRESSIN (SA)	APX	FGNQSW
02304376	PMS-DESMOPRESSIN (SA)	PMS	FGNQSW
60MCG ORAL DISINTEGRATING TABLET			
02284995	DDAVP MELT (SA)	FEI	FNQSW
120MCG ORAL DISINTEGRATING TABLET			
02285002	DDVAP MELT (SA)	FEI	FNQSW
240MCG ORAL DISINTEGRATING TABLET			
02285010	DDVAP MELT (SA)	FEI	FNQSW

SOMATROGON

[SEE APPENDIX A](#) FOR SA CRITERIA

24 MG/1.2 ML PREFILLED PEN			
02521679	NGENLA (SA)	PFI	Y
60 MG 1.2 ML PREFILLED PEN			
02521687	NGENLA (SA)	PFI	Y
SOMATROPIN			
5.3 MG/ML SYRINGE			
02401703	GENOTROPIN GOQUICK	PFI	Y
12 MG/ML SYRINGE			
02401711	GENOTROPIN GOQUICK	PFI	Y
0.6 MG/0.25 ML			
02401762	GENOTROPIN MINIUICK	PFI	Y
0.8 MG/0.25 ML			
02401770	GENOTROPIN MINIUICK	PFI	Y
1 MG/0.25 ML			
02401789	GENOTROPIN MINIUICK	PFI	Y
1.2 MG/0.25 ML			
02401797	GENOTROPIN MINIUICK	PFI	Y
1.4 MG/0.25 ML			
02401800	GENOTROPIN MINIUICK	PFI	Y
1.6 MG/0.25 ML			
02401819	GENOTROPIN MINIUICK	PFI	Y
1.8 MG/0.25 ML			
02401827	GENOTROPIN MINIUICK	PFI	Y
2 MG/0.25 ML			
02401835	GENOTROPIN MINIUICK	PFI	Y
SOMATROPIN			
6 MG INJECTION (CARTRIDGE)			
02243077	HUMATROPE CARTRIDGE	LIL	Y
12 MG INJECTION (CARTRIDGE)			
02243078	HUMATROPE CARTRIDGE	LIL	Y
24 MG INJECTION (CARTRIDGE)			
02243079	HUMATROPE CARTRIDGE	LIL	Y

SOMATROPIN

5 MG/1.5 ML CARTRIDGE

02325063 OMNITROPE

SDZ Y

10 MG/1.5 ML CARTRIDGE

02325071 OMNITROPE

SDZ Y

15 MG/1.5 ML CARTRIDGE

02459647 OMNITROPE

SDZ Y

SOMATROPIN

5 MG/1.5 ML PREFILLED PEN

02334852 NORDITROPIN NORDIFLEX

NNO Y

10 MG/1.5 ML PREFILLED PEN

02334860 NORDITROPIN NORDIFLEX

NNO Y

15 MG/1.5 ML PREFILLED PEN

02334879 NORDITROPIN NORDIFLEX

NNO Y

SOMATROPIN

6 MG CARTRIDGE

02350122 SAIZEN

EMD Y

12 MG CARTRIDGE

02350130 SAIZEN

EMD Y

20 MG CARTRIDGE

02350149 SAIZEN

EMD Y

68:30.04 SOMATOTROPIN AGONISTS[SEE APPENDIX A](#) FOR SA CRITERIA

MECASERMIN

10MG/ML VIAL

02509733 INCRELEX (SA)

IPS Y

68:32.00 PROGESTOGENS**DIENOGEST**[SEE APPENDIX A](#) FOR SA CRITERIA

2MG TABLET

02374900	VISANNE (SA)	BAY	FQW
02493055	ASPEN-DIENOGEST (SA)	ASN	FGQW
02498189	JAMP-DIENOGEST (SA)	JPC	FGQW
02543613	M-DIENOGEST (SA)	MRA	FGQW
02551683	MAR-DIENOGEST (SA)	MAR	FGQW

MEDROXYPROGESTERONE ACETATE**2.5MG TABLET**

00708917	PROVERA	PFI	FNQSW
02221284	TEVA-MEDROXYPROGESTERONE	TEV	FGNQSW
02244726	AA-MEDROXY	AAA	FGNQSW

5MG TABLET

00030937	PROVERA	PFI	FNQSW
02221292	TEVA-MEDROXYPROGESTERONE	TEV	FGNQSW
02244727	AA-MEDROXY	AAA	FGNQSW

10MG TABLET

00729973	PROVERA	PFI	FNQSW
02277298	AA-MEDROXY	AAA	FGNQSW

PROGESTERONE**100MG CAPSULE**

02166704	PROMETRIUM	ORG	FNQSW
02439913	TEVA-PROGESTERONE	TEV	FGNQSW
02463113	REDDY-PROGESTERONE	RCH	FGNQSW
02476576	PMS-PROGESTERONE	PMS	FGNQSW
02493578	AURO-PROGESTERONE	ARO	FGNQSW
02516187	PROGESTERONE	SNS	FGNQSW
02551268	M-PROGESTERONE	MRA	FGNQSW

68:36.04 THYROID AGENTS**DESICCATED THYROID****30MG TABLET**

00023949	THYROID	SLP	FNQSW

60MG TABLET

00023957	THYROID	SLP	FNQSW

125MG TABLET

00023965	THYROID	SLP	FNQSW

LEVOTHYROXINE SODIUM**25MCG TABLET**

02172062	SYNTHROID	BGP	FNQSW
02550709	APO-LEVOTHYROXINE	APX	FGNQSW

50MCG TABLET

02172070	SYNTHROID	BGP	FNQSW
02213192	ELTROXIN	ASN	FNQSW
02550717	APO-LEVOTHYROXINE	APX	FGNQSW

75MCG TABLET

02172089	SYNTHROID	BGP	FNQSW
02550725	APO-LEVOTHYROXINE	APX	FGNQSW

88MCG TABLET

02172097	SYNTHROID	BGP	FNQSW
02550733	APO-LEVOTHYROXINE	APX	FGNQSW

100MCG TABLET

02172100	SYNTHROID	BGP	FNQSW
02213206	ELTROXIN	ASN	FNQSW
02534681	APO-LEVOTHYROXINE	APX	FGNQSW

112MCG TABLET

02171228	SYNTHROID	BGP	FNQSW
02550741	APO-LEVOTHYROXINE	APX	FGNQSW

125MCG TABLET

02172119	SYNTHROID	BGP	FNQSW
02550768	APO-LEVOTHYROXINE	APX	FGNQSW

137MCG TABLET

02233852	SYNTHROID	BGP	FNQSW
02550776	APO-LEVOTHYROXINE	APX	FGNQSW

150MCG TABLET

02172127	SYNTHROID	BGP	FNQSW
02213214	ELTROXIN	ASN	FNQSW
02550784	APO-LEVOTHYROXINE	APX	FGNQSW

175MCG TABLET

02172135	SYNTHROID	BGP	FNQSW
02550792	APO-LEVOTHYROXINE	APX	FGNQSW

200MCG TABLET

02172143	SYNTHROID	BGP	FNQSW

02213222	ELTROXIN	ASN	FNQSW
02550806	APO-LEVOTHYROXINE	APX	FGNQSW

300MCG TABLET			
02172151	SYNTHROID	BGP	FNQSW
02534703	APO-LEVOTHYROXINE	APX	FGNQSW

LIOOTHYRONINE			
5MCG TABLET			
02494337	TEVA-LIOOTHYRONINE	TEV	FGNQSW

25MCG TABLET			
02494345	TEVA-LIOOTHYRONINE	TEV	FGNQSW

PROPYLTHIOURACIL			
50MG TABLET			
02521059	HALYCIL	ARN	FGNQSW
02523019	PROPYLTHIOURACIL	PCI	FGNQSW

68:36.08 ANTI-THYROID AGENTS

METHIMAZOLE			
5MG TABLET			
00015741	TAPAZOLE	PAL	FNQSW
02480107	MAR-METHIMAZOLE	MAR	FGNQSW
02490625	JAMP-METHIMAZOLE	JPC	FGNQSW

10MG TABLET			
02296039	TAPAZOLE	PAL	FNQSW
02480115	MAR-METHIMAZOLE	MAR	FGNQSW
02490633	JAMP-METHIMAZOLE	JPC	FGNQSW

72:00.00 LOCAL ANESTHETICS

LIDOCAINE HCL			
1% INJECTION SOLUTION			
00001732	XYLOCAINE	ASN	NQ

2% INJECTION SOLUTION			
00036641	XYLOCAINE	ASN	NQ

2% ORAL SOLUTION			
01968823	LIDODAN VISCOUS	ODN	FNQSW

84:04.04 ANTI INFECTIVES (ANTIBIOTICS)

CLINDAMYCIN PHOSPHATE

1% TOPICAL SOLUTION

02266938 TARO-CLINDAMYCIN

TAR **FQW**

FRAMYCETIN SULFATE

1% OINTMENT DRESSING (10CM X 10CM)

01988840 SOFRA TULLE

ERF **FNQSW**

FUSIDIC ACID

2% TOPICAL CREAM

00586668 FUCIDIN

02528096 TARO-FUSIDIC ACID

LEO **FNQSW**

TAR **FGNQSW**

METRONIDAZOLE

0.75% VAGINAL GEL

02125226 NIDAGEL

BLO **FNQSW**

1% TOPICAL CREAM

02156091 NORITATE

BSL **FNQSW**

MUPIROCIN

2% TOPICAL OINTMENT

02279983 TARO-MUPIROCIN

TAR **FGNQSW**

POLYMYXIN B & BACITRACIN

10,000U & 500U/G TOPICAL OINTMENT

02181908 POLYDERM

02237227 POLYSPORIN

02357569 JAMPOLYCIN

TAR **N**

JJM **N**

JPC **N**

POLYMYXIN B & GRAMICIDIN

10,000U & 250U/G TOPICAL CREAM

02230844 POLYSPORIN

JJM **N**

SODIUM FUSIDATE

2% TOPICAL OINTMENT

00586676 FUCIDIN

LEO **FNQSW**

84:04.08 ANTI INFECTIVES (FUNGICIDES)

CICLOPIROX OLAMINE

1% TOPICAL CREAM

02221802 LOPROX

BSL **FNQSW**

1% TOPICAL LOTION

02221810 LOPROX

BSL **FNSQW**

CLOTRIMAZOLE

1% TOPICAL CREAM

00812382 CLOTRIMADERM

TAR **NSW**

02150867 CANESTEN

BAY **NSW**

1% VAGINAL CREAM

00812366 CLOTRIMADERM

TAR **NSW**

02150891 CANESTEN 6

BAY **NSW**

2% VAGINAL CREAM

00812374 CLOTRIMADERM

TAR **NSW**

02150905 CANESTEN 3

BAY **NSW**

KETOCONAZOLE

2% TOPICAL CREAM

02245662 KETODERM

TAR **FNQSW**

2% SHAMPOO

02182920 NIZORAL

JJM **N**

MICONAZOLE NITRATE

2% TOPICAL CREAM

02085852 MICATIN

WES **NSW**

02126567 MONISTAT DERM

JJM **NSW**

2% VAGINAL CREAM

02084309 MONISTAT-7

JJM **NSW**

02231106 MICOZOLE

TAR **NSW**

400MG VAGINAL OVULE

02126605 MONISTAT-3

JJM **NSW**

100MG VAGINAL SUPPOSITORY & 2% TOPICAL CREAM (COMBINATION PACKAGE)

02126257 MONISTAT-7

JJM **NSW**

400MG VAGINAL OVULE & 2% TOPICAL CREAM (COMBINATION PACKAGE)		
02126249	MONISTAT-3 COMBINATION	JJM NSW

NYSTATIN

100,000U/G TOPICAL CREAM		
00716871	NYADERM	TAR GNSW

25,000U/G VAGINAL CREAM		
00716901	NYADERM	TAR GNSW

100,000U/G VAGINAL CREAM		
02194163	TEVA-NYSTATIN	TEV GNSW

TERBINAFINE HCL

1% TOPICAL CREAM		
02031094	LAMISIL	NVR FNQSW

1% TOPICAL SPRAY		
02238703	LAMISIL	NVR FNQSW

TOLNAFTATE

1% TOPICAL CREAM		
00576034	TINACTIN	BAY NW

1% TOPICAL POWDER		
00576042	TINACTIN	BAY N

84:04.12 ANTI-INFECTIVES, SCABICIDES, AND PEDICULICIDES

ISOPROPYL MYRISTATE

50% TOPICAL LIQUID		
02279592	RESULTZ	MFI NW

PERMETHRIN

1% CREME RINSE		
00771368	NIX CREME RINSE	GSK NW
02231480	KWELLADA-P CREME RINSE	GSK NW

5% TOPICAL CREAM		
02219905	NIX DERMAL CREAM	GSK NW

5% TOPICAL LOTION		
02231348	KWELLADA-P LOTION	GSK NW

84:04.16 ANTI INFECTIVES, OTHER ANTI INFECTIVES

METRONIDAZOLE

1% TOPICAL GEL

02297809 METROGEL

GAC FNQSW

SILVER SULFADIAZINE

1% TOPICAL CREAM

00323098 FLAMAZINE

SNE FNQSW

84:06.00 ANTI INFLAMMATORY AGENTS

APPROXIMATE RELATIVE POTENCIES OF TOPICAL STEROID PREPARATIONS

ULTRA HIGH POTENCY

GROUP N

Betamethasone dipropionate 0.05% glycol cream, ointment, lotion

Betamethasone dipropionate 0.05% & Salicylic Acid 3%, ointment

Clobetasol propionate 0.05% cream, ointment, scalp lotion

HIGH POTENCY

GROUP II

Amcinonide 0.1% ointment

Betamethasone dipropionate 0.05% ointment

Clobetasone butyrate 0.05% cream, ointment

Desoximetasone 0.25% cream, ointment

Desoximetasone 0.05% gel

Fluocinonide 0.05% cream, ointment, gel

GROUP III

Betamethasone dipropionate 0.05% cream, lotion

Betamethasone valerate 0.1% ointment

Diflucortolone valerate 0.1% oily cream

Triamcinolone acetonide 0.1% ointment

MID POTENCY

GROUP IV

Amcinonide 0.1% cream, lotion

Beclomethasone dipropionate 0.025% cream, lotion (lotion d/c=d)

Flucinolone acetonide 0.025% ointment

Desoximetasone 0.05% cream

Mometasone furoate 0.1% cream, ointment
Triamcinolone acetonide 0.1% cream

GROUP V

Betamethasone valerate 0.1% cream, lotion, scalp lotion
Betamethasone valerate 0.05% cream, ointment, lotion
Triamcinolone acetonide 0.25% cream

LOW POTENCY

GROUP VI

Desonide 0.05% cream, ointment

GROUP VII

Hydrocortisone 0.5% cream, ointment, lotion
Hydrocortisone 1% cream, ointment, lotion
Hydrocortisone 1% & Urea 10% cream, lotion

The classification of products in this table is based upon the >WHO Model Prescribing Information: Drugs Used in Dermatology (1995).

In general, ointments, as a result of their more occlusive property, tend to exhibit higher potency than creams containing the same concentration of the same anti-inflammatory agent. Cream formulations, in turn, appear to be more potent than lotions of the same strength.

AMCINONIDE

0.1% TOPICAL CREAM

02246714	TARO-AMCINONIDE	TAR	FGNQSW

BECLOMETHASONE DIPROPIONATE

0.025% TOPICAL CREAM

02089602	PROPADERM	BSL	FNQSW

BETAMETHASONE DIPROPIONATE

0.05% TOPICAL CREAM

00323071	DIPROSONE	MSD	FNQSW
01925350	TARO-SONE	TAR	FGNQSW
00804991	TEVA-TOPISONE	TEV	FGNQSW

0.05% TOPICAL LOTION

00417246	DIPROSONE	MSD	FNQSW
00809187	TEVA-TOPISONE	TEV	FGNQSW

0.05% TOPICAL OINTMENT

00344923	DIPROSONE	MSD	FNQSW
00805009	TEVA-TOPISONE	TEV	FGNQSW

0.05% TOPICAL GLYCOL BASE CREAM			
00849650	TEVA-TOPILENE GLYCOL	TEV	GFNQSW
0.05% TOPICAL GLYCOL BASE OINTMENT			
00629367	DIPROLENE	ORG	FNQSW
00849669	TEVA-TOPILENE GLYCOL	TEV	FGNQSW
0.05% TOPICAL GLYCOL LOTION			
01927914	TEVA-TOPILENE	TEV	FGNQSW
BETAMETHASONE DIPROPIONATE & CALCIPOTRIOL			
50MCG/0.5MG/GM TOPICAL GEL			
02319012	DOVOBET	LEO	FNQSW
02525178	TARO-CALCIPOTRIOL/BETAMETHASONE	TAR	FGNQSW
50MCG/0.5MG/GM TOPICAL OINTMENT			
02427419	TEVA-BETAMETHASONE/CALCIPOTRIOL	TEV	FGNQSW
50MCG/0.5MG/GM TOPICAL FOAM			
02457393	ENSTILAR	LEO	FNQSW
BETAMETHASONE DIPROPIONATE & SALICYLIC ACID			
0.05% & 2% TOPICAL LOTION			
02245688	RATIO-TOPISALIC	TEV	FGNQSW
0.05% & 3% TOPICAL OINTMENT			
00578436	DIPROSALIC	MSD	FNQSW
BETAMETHASONE VALERATE			
0.05% TOPICAL CREAM			
00535427	TEVA-ECTOSONE	TEV	FGNQSW
00716618	BETADERM	TAR	FGNQSW
0.1% TOPICAL CREAM			
00535435	TEVA-ECTOSONE	TEV	FGNQSW
00716626	BETADERM	TAR	FGNQSW
0.05% TOPICAL OINTMENT			
00716642	BETADERM	TAR	FGNQSW
0.1% TOPICAL OINTMENT			
00716650	BETADERM	TAR	FGNQSW
0.05% TOPICAL LOTION			
00653209	TEVA-ECTOSONE	TEV	FGNQSW

0.1% TOPICAL LOTION			
00750050	TEVA-ECTOSONE	TEV	FGNQSW

0.1% SCALP LOTION			
00653217	TEVA-ECTOSONE	TEV	FGNQSW
00716634	BETADERM	TAR	FGNQSW

CLOBETASOL 17 PROPIONATE

0.05% TOPICAL CREAM			
01910272	TEVA-CLOBETASOL	TEV	FGNQSW
02024187	MYLAN-CLOBETASOL	MYL	FGNQSW
02213265	DERMOVATE	TAR	FGNQSW
02245523	TARO-CLOBETASOL	TAR	FGNQSW

0.05% TOPICAL OINTMENT			
01910280	TEVA-CLOBETASOL	TEV	FGNQSW
02026767	MYLAN-CLOBETASOL	MYL	FGNQSW
02213273	DERMOVATE	TAR	FGNQSW
02245524	TARO-CLOBETASOL	TAR	FGNQSW

0.05% SCALP LOTION			
01910299	TEVA-CLOBETASOL	TEV	FGNQSW
02213281	DERMOVATE	TAR	FGNQSW
02216213	MYLAN-CLOBETASOL	MYL	FGNQSW
02245522	TARO-CLOBETASOL	TAR	FGNQSW

CLOBETASONE BUTYRATE

0.05% TOPICAL CREAM			
02214415	SPECTRO ECZEMA CARE	GSK	FNQSW

DESONIDE

0.05% TOPICAL CREAM			
02229315	PDP-DESONIDE	PEN	FGNQSW

0.05% TOPICAL OINTMENT			
02229323	PDP-DESONIDE	PEN	FGNQSW

DESOXIMETASONE

0.05% TOPICAL EMOLLIENT CREAM			
02221918	TOPICORT MILD	BSL	FNQSW

0.25% TOPICAL EMOLLIENT CREAM			
02221896	TOPICORT	BSL	FNQSW

0.05% TOPICAL GEL			
02221926	TOPICORT	BSL	FNQSW

0.25% TOPICAL OINTMENT			
02221934	TOPICORT	BSL	FNQSW
FLUOCINONIDE			
0.05% TOPICAL CREAM			
00716863	LYDERM	TAR	FGNQSW
0.05% TOPICAL GEL			
02236997	LYDERM	TAR	FGNQSW
0.05% TOPICAL OINTMENT			
02236996	LYDERM	TAR	FGNQSW
HALOBETASOL PROPIONATE			
0.01% LOTION			
02506262	BRYHALI	BAU	FNQSW
HYDROCORTISONE			
0.5% TOPICAL CREAM			
00716820	HYDERM	TAR	NW
1% TOPICAL CREAM			
00716839	HYDERM	TAR	FGNQSW
02412926	HYDROCORTISONE	SDZ	FGNQSW
80057178	JAMP-HC	JPC	FGNQSW
80057189	JAMP-HYDROCORTISONE	JPC	FGNQSW
1% OINTMENT			
00716693	CORTODERM	TAR	FGNQSW
HYDROCORTISONE ACETATE/UREA			
1%-10% TOPICAL CREAM			
00681989	DERMAFLEX HC	PAL	FNQSW
80061501	JAMP-HYDROCORTISONE ACET-UREA	JPC	FGNQSW
80073645	M-HC	MRA	FGNQSW
1%-10% TOPICAL LOTION			
00681997	DERMAFLEX HC	PAL	FNQSW
HYDROCORTISONE & PRAMOXINE & ZINC			
0.5% & 1% & 0.5% RECTAL OINTMENT			
02234466	PROCTODAN HC	ODN	FGNQSW
HYDROCORTISONE & ZINC SULFATE			
0.5% & 0.5% RECTAL OINTMENT			

02128446	ANODAN-HC	ODN	FGNQSW
02387239	JAMPZINC-HC	JPC	FGNQSW

0.5% & 0.5% RECTAL SUPPOSITORY			
02236399	ANODAN-HC	ODN	FGNQSW

MOMETASONE FUROATE

0.1% TOPICAL CREAM			
00851744	ELOCOM	MSD	FNQSW
02367157	TARO-MOMETASONE	TAR	FGNQSW

0.1% TOPICAL OINTMENT			
00851736	ELOCOM	MSD	FNQSW
02248130	TEVA-MOMETASONE	TEV	FGNQSW

0.1% LOTION			
00871095	ELOCOM	ORG	FNQSW

TRIAMCINOLONE ACETONIDE

0.1% TOPICAL CREAM			
00716960	TRIADERM	TAR	FGNQSW
02194058	ARISTOCORT R	BSL	FNQSW

0.1% TOPICAL OINTMENT			
02194031	ARISTOCORT R	BSL	FNQSW

0.1% ORAL TOPICAL OINTMENT			
01964054	ORACORT	TAR	FGNQSW

CLIOQUINOL & HYDROCORTISONE

3% & 1% TOPICAL CREAM			
00074500	VIOFORM HYDROCORTISONE	PAL	FNQSW

TRIAMCINOLONE & NYSTATIN & NEOMYCIN & GRAMICIDIN

2.5MG & 0.25MG & 100,000U & 1MG/G TOPICAL CREAM			
00717002	VIADERM K C	TAR	FGNQSW

2.5MG & 0.25MG & 100,000U & 1MG/G TOPICAL OINTMENT			
00717029	VIADERM K C	TAR	FGNQSW

84:08.00 ANTIPRURITICS AND TOPICAL ANESTHETICS

CALAMINE

TOPICAL LOTION

00999829 CALAMINE LOTION

N

Note: The Drug Identification Number listed is for billing purposes only.

LIDOCAINE HCL

2% TOPICAL GEL

00001694 XYLOCAINE

ASN **FNQSW**

2% TOPICAL JELLY (SYRINGE)

00385484 XYLOCAINE

ASN **NQ**

02143879 LIDODAN

ODN **NQ**

5% OINTMENT

02083795 LIDODAN

ODN **NW**

84:16.00 CELL STIMULANTS AND PROLIFERANTS

TRETINOIN

0.05% TOPICAL CREAM

00443794 RETIN A

BSL **FQW**

0.025% TOPICAL GEL

00443816 RETIN A

BSL **FQW**

84:24.00 EMOLLIENTS, DECMULCENTS, AND PROTECTANTS

DIMETHYLPOLYSILOXANE

20% TOPICAL CREAM

02060841 BARRIERE

WES **NW**

84:28.00 KERATOLYTIC AGENTS

UREA

10% TOPICAL CREAM

80005397	URISEC 10	ODN	NW
12% TOPICAL LOTION			
00514896	URISEC	ODN	NW
22% TOPICAL CREAM			
00396125	URISEC 22	ODN	NW

84:32.00 KERATOPLASTIC AGENTS

COAL TAR

1% TOPICAL SHAMPOO			
02307146	T/GEL THERAPEUTIC	JJM	NW

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ACITRETIN

10MG CAPSULE

02070847	SORIATANE	HLR	FNQSW
02466074	TARO-ACITRETIN	TAR	FGNQSW
02468840	MINT-ACITRETIN	MNT	FGNQSW

25MG CAPSULE

02070863	SORIATANE	HLR	FNQSW
02466082	TARO-ACITRETIN	TAR	FGNQSW
02468859	MINT-ACITRETIN	MNT	FGNQSW

AZELAIC ACID

15% TOPICAL GEL

02270811	FINACEA	LEO	FNQSW

BIMEKIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

160MG/ML PREFILLED SYRINGE

02525267	BIMZELX (SA)	UCB	NMQW

160MG/ML AUTOINJECTOR

02525275	BIMZELX (SA)	UCB	NMQW

320MG/2ML PREFILLED SYRINGE

02553619	BIMZELX (SA)	UCB	NMQW
320MG/2ML AUTOINJECTOR			
02553627	BIMZELX (SA)	UCB	NMQW
BRODALUMAB			
SEE APPENDIX A FOR SA CRITERIA			
210MG/1.5ML SYRINGE			
02473623	SILIQ (SA)	VAL	NMQW
CALCIPOTRIOL			
50MCG/G TOPICAL OINTMENT			
01976133	DOVONEX	LEO	FNQSW
DUPILUMAB			
SEE APPENDIX A FOR SA CRITERIA			
200MG/1.14ML PREFILLED PEN (SA)			
02524252	DUPIXENT (SA)	AVN	NMQW
200MG/1.14ML SYRINGE			
02492504	DUPIXENT (SA)	AVN	NMQW
300MG/2ML PREFILLED PEN			
02510049	DUPIXENT (SA)	AVN	NMQW
300MG/2ML SYRINGE			
02470365	DUPIXENT (SA)	AVN	NMQW
FLUOROURACIL			
5% TOPICAL CREAM			
00330582	EFUDEX	BSL	FNQSW
GUSELKUMAB			
SEE APPENDIX A FOR SA CRITERIA			
100MG/ML AUTOINJECTOR			
02487314	TREMFYA (SA)	JAN	NMQW
100MG/ML PREFILLED SYRINGE			
02469758	TREMFYA (SA)	JAN	NMQW
IMIQUIMOD			
5% TOPICAL CREAM			
02239505	ALDARA	BSL	FNQSW
02482983	TARO-IMIQUIMOD	TAR	FGNQSW

ISOTRETINOIN

COVERAGE IS LIMITED TO 30 DAYS AT A TIME

10MG CAPSULE

00582344	AC CUTANE	XPI	FQW
02257955	CLARUS	MYL	FGQW

10MG CAPSULE

02396971	EPURIS	CIP	FQW

20MG CAPSULE

02396998	EPURIS	CIP	FQW

30MG CAPSULE

02397005	EPURIS	CIP	FQW

40MG CAPSULE

00582352	AC CUTANE	XPI	FQW
02257963	CLARUS	MYL	FGQW

40MG CAPSULE

02397013	EPURIS	CIP	FQW

IXEKIZUMAB[SEE APPENDIX A](#) FOR SA CRITERIA**80MG/ML AUTOINJECTOR**

02455102	TALTZ (SA)	LIL	NMQW

80MG/ML SYRINGE

02455110	TALTZ (SA)	LIL	NMQW

RISANKIZUMAB[SEE APPENDIX A](#) FOR SA CRITERIA**75MG/0.83ML****PREFILLED SYRINGE**

02487454	SKYRIZI (SA)	ABV	NMQW

150MG/ML PREFILLED PEN

02519291	SKYRIZI (SA)	ABV	NMQW

150MG/ML PREFILLED SYRINGE

02519283	SKYRIZI (SA)	ABV	NMQW

360MG/2.4ML PREFILLED CARTRIDGE

02532093	SKYRIZI (SA)	ABV	NMQW

600MG/10ML VIAL		
02532107	SKYRIZI (SA)	ABV NMQW

SECUKINUMAB

SEE APPENDIX A	FOR SA CRITERIA	
75MG/0.5ML PREFILLED SYRINGE		
02525569	COSENTYX (SA)	NVR NMQW

150MG/ML PREFILLED SYRINGE		
02547724	COSENTYX (SA)	NVR NMQW

150MG/ML PEN INJECTOR		
02438070	COSENTYX (SA)	NVR NMQW

TACROLIMUS

SEE APPENDIX A	FOR SA CRITERIA	
0.1% OINTMENT		
02244148	PROTOPIC (SA)	LEO FNQSW

SEE APPENDIX A	FOR SA CRITERIA	
0.03% TOPICAL OINTMENT		
02244149	PROTOPIC (SA)	LEO FNQSW

TAZAROTENE

0.045% LOTION		
02517868	ARAZLO	BAU FNQSW

TAZAROTENE/HALOBETASOL PROPIONATE

SEE APPENDIX A	FOR SA CRITERIA	
0.01%/0.045% LOTION		
02499967	DUOBRII (SA)	BLO FNQSW

TILDRAKIZUMAB

SEE APPENDIX A	FOR SA CRITERIA	
100MG/ML PREFILLED SYRINGE		
02516098	ILUMYA (SA)	SUN NMQW

USTEKINUMAB

SEE APPENDIX A	FOR SA CRITERIA	
45MG/0.5ML SYRINGE		
02543036	JAMTEKI (SA)	JPC NMQW
02544180	WEZLANA (SA)	AMG NMQW
02550245	STEQEYMA (SA)	VTX NMQW

45MG/0.5ML VIAL		
02544202	WEZLANA (SA)	AMG NMQW
90MG/ML SYRINGE		
02543044	JAMTEKI (SA)	JPC NMQW
02544199	WEZLANA (SA)	AMG NMQW
02550253	STEQEYMA (SA)	VTX NMQW
130MG/26ML VIAL		
02544210	WEZLANA I.V. (SA)	AMG NMQW
02550261	STEQEYMA (SA)	VTX NMQW

86:12.00 GENITOURINARY SMOOTH MUSCLE RELAXANTS

DARIFENACIN

[SEE APPENDIX A](#) FOR SA CRITERIA

7.5MG EXTENDED RELEASE TABLET

02273217	ENABLEX (SA)	MRS FNQSW
02452510	APO-DARIFENACIN (SA)	APX FGNQSW
02491869	JAMP-DARIFENACIN (SA)	JPC FGNQSW

15MG EXTENDED RELEASE TABLET

02273225	ENABLEX (SA)	MRS FNQSW
02452529	APO-DARIFENACIN (SA)	APX FGNQSW
02491877	JAMP-DARIFENACIN (SA)	JPC FGNQSW

FESOTERODINE FUMARATE

[SEE APPENDIX A](#) FOR SA CRITERIA

4MG EXTENDED RELEASE TABLET

02380021	TOVIAZ (SA)	PFI FNQSW
02521768	SANDOZ-FESOTERODINE (SA)	SDZ FGNQSW

8MG EXTENDED RELEASE TABLET

02380048	TOVIAZ (SA)	PFI FNQSW
02521776	SANDOZ-FESOTERODINE (SA)	SDZ FGNQSW

MIRABEGRON

[SEE APPENDIX A](#) FOR SA CRITERIA

25MG EXTENDED RELEASE TABLET

02402874	MYRBETRIQ (SA)	AST FNQSW

50MG EXTENDED RELEASE TABLET

02402882	MYRBETRIQ (SA)	AST	FNQSW
OXYBUTYNIN CHLORIDE			
1MG/ML SYRUP			
02223376	PMS-OXYBUTYNIN	PMS	FGNQSW
5MG TABLET			
02163543	APO-OXYBUTYNIN	APX	FGNQSW
02230394	TEVA-OXYBUTYNIN	TEV	FGNQSW
02240550	PMS-OXYBUTYNIN	PMS	FGNQSW
02350238	OXYBUTYNIN	SNS	FGNQSW
PROPIVERINE			
5MG TABLET			
SEE APPENDIX A FOR SA CRITERIA			
02460289	MICTORYL PEDIATRIC	DUI	FQW
SOLIFENACIN			
5MG TABLET			
02277263	VESICARE	AST	FNQSW
02397900	TEVA-SOLIFENACIN	TEV	FGNQSW
02399032	SANDOZ-SOLIFENACIN	SDZ	FGNQSW
02417723	PMS-SOLIFENACIN	PMS	FGNQSW
02423375	APO-SOLIFENACIN	APX	FGNQSW
02424339	JAMP-SOLIFENACIN	JPC	FGNQSW
02428911	JAMP-SOLIFENACIN	JPC	FGNQSW
02437988	TARO-SOLIFENACIN	RAN	FGNQSW
02439344	ACH-SOLIFENACIN	ACH	FGNQSW
02446375	AURO-SOLIFENACIN	ARO	FGNQSW
02458241	SOLIFENACIN	SNS	FGNQSW
02493039	PRZ-SOLIFENACIN	PRZ	FGNQSW
02529696	M-SOLIFENACIN SUCCINATE	MRA	FGNQSW
10MG TABLET			
02277271	VESICARE	AST	FNQSW
02397919	TEVA-SOLIFENACIN	TEV	FGNQSW
02399040	SANDOZ-SOLIFENACIN	SDZ	FGNQSW
02417731	PMS-SOLIFENACIN	PMS	FGNQSW
02423383	APO-SOLIFENACIN	APX	FGNQSW
02424347	JAMP-SOLIFENACIN	JPC	FGNQSW
02428938	JAMP-SOLIFENACIN	JPC	FGNQSW
02437996	TARO-SOLIFENACIN	RAN	FGNQSW
02439352	ACH-SOLIFENACIN	ARO	FGNQSW
02446383	AURO-SOLIFENACIN	ARO	FGNQSW
02458268	SOLIFENACIN	SNS	FGNQSW
02493047	PRZ-SOLIFENACIN	PRZ	FGNQSW

02529718	M-SOLIFENACIN SUCCINATE	MRA	FGNQSW

TOLTERODINE

1MG TABLET

02239064	DETROL	UJC	FNQSW
02423308	MINT-TOLTERODINE	MNT	FGNQSW
02496836	JAMP-TOLTERODINE	JPC	FGNQSW

2MG TABLET

02239065	DETROL	UJC	FNQSW
02299607	TEVA-TOLTERODINE	TEV	FGNQSW
02423316	MINT-TOLTERODINE	MNT	FGNQSW
02496844	JAMP-TOLTERODINE	JPC	FGNQSW

2MG EXTENDED RELEASE CAPSULE

02244612	DETROL LA	UJC	FNQSW
02412195	TEVA-TOLTERODINE	TEV	FGNQSW
02413140	SANDOZ-TOLTERODINE	SDZ	FGNQSW

4MG EXTENDED RELEASE CAPSULE

02244613	DETROL LA	UJC	FNQSW
02412209	TEVA-TOLTERODINE	TEV	FGNQSW
02413159	SANDOZ-TOLTERODINE	SDZ	FGNQSW

TROSPIUM

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG TABLET

02275066	TROSEC (SA)	SNV	FNQSW
02488353	MAR-TROSPIUM (SA)	MAR	FGNQSW
02506661	JAMP-TROSPIUM (SA)	JPC	FGNQSW

86:16.00 RESPIRATORY SMOOTH MUSCLE RELAXANTS

THEOPHYLLINE ANHYDROUS

100MG SUSTAINED RELEASE TABLET

00692689	AA-THEO-LA	AAA	FGNQSW

200MG SUSTAINED RELEASE TABLET

00692697	AA-THEO-LA	AAA	FGNQSW

300MG SUSTAINED RELEASE TABLET

00692700	AA-THEO-LA	AAA	FGNQSW

400MG SUSTAINED RELEASE TABLET
02360101 THEO ER

AAA FGNQSW

600MG SUSTAINED RELEASE TABLET
02360128 THEO ER

AAA FGNQSW

5.33MG/ML ORAL SOLUTION
01966219 THEOLAIR

VAL FNQSW

88:08.00 VITAMIN B

CYANOCOBALAMIN
1MG/ML INJECTION SOLUTION (10ML)
00521515 VITAMIN B12
01987003 CYANOCOBALAMIN

SDZ NW
STE NW

FOLIC ACID

1MG TABLET
00999899 FOLIC ACID

OW

Note: The Drug Identification Number listed is for billing purposes only.

5MG TABLET
00426849 FOLIC ACID
02366061 JAMP-FOLIC ACID

AAA FGNQW
JPC FGNQW

NIACIN

100MG TABLET
00999879 NIACIN

NW

Note: The Drug Identification Number listed is for billing purposes only.

500MG TABLET
00999889 NIACIN

NW

Note: The Drug Identification Number listed is for billing purposes only.

PYRIDOXINE

25 MG Tablet
00268607 VITAMIN B6

VAL OX

88:16.00 VITAMIN D

ALFACALCIDOL

0.25MCG CAPSULE

02533316	SANDOZ-ALFACALCIDOL	SDZ	FGNQSW

1MCG CAPSULE

00474525	ONE-ALPHA	XPI	FNQSW
02533324	SANDOZ-ALFACALCIDOL	SDZ	FGNQSW

CALCITRIOL

0.25MCG CAPSULE

00481823	ROCALTROL	HLR	FNQSW
02431637	CALCITRIOL-ODAN	ODN	FGNQSW
02485710	TARO-CALCITRIOL	TAR	FGNQSW
02495899	CALCITRIOL	STR	FGNQSW

0.5MCG CAPSULE

00481815	ROCALTROL	HLR	FNQSW
02431645	CALCITRIOL-ODAN	ODN	FGNQSW
02485729	TARO-CALCITRIOL	TAR	FGNQSW
02495902	CALCITRIOL	STR	FGNQSW

VITAMIN D

1000IU TABLET

00999869	VITAMIN D	N

Note: The Drug Identification Number listed is for billing purposes only.

88:20.00 VITAMIN E

VITAMIN E (D-ALPHA TOCOPHERYL ACETATE)

200 UNIT CAPSULE

00999849	VITAMIN E	CN

Note: The Drug Identification Number listed is for billing purposes only.

400 UNIT CAPSULE

00999859	VITAMIN E	CN

Note: The Drug Identification Number listed is for billing purposes only.

88:24.00 VITAMIN K ACTIVITY

PHYTONADIONE (VITAMIN K1)

10MG/ML INJECTION SOLUTION (1ML)

00804312

VITAMIN K1

SDZ NQ

92:00.00 MISCELLANEOUS THERAPEUTIC AGENTS

ABROCITINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

50MG TABLET

02528363

CIBINQO (SA)

PFI NMQW

100MG TABLET

02528371

CIBINQO (SA)

PFI NMQW

200MG TABLET

02528398

CIBINQO (SA)

PFI NMQW

AMIFAMPRIDINE

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET

02503034

RUZURGI (SA)

MDU NMQW

AMIFAMPRIDINE PHOSPHATE

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET

02502984

FIRDAPSE (SA)

KYE NMQW

ANIFROLUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG/ML VIAL

02522845

SAPHNELO (SA)

AZE NMQW

BEROTRALSTAT HCL

[SEE APPENDIX A](#) FOR SA CRITERIA

150MG CAPSULE

02527693

ORLADEYO (SA)

BCP NMQW

00900037

ORLADEYO (SA)*

NMQW

90109475

ORLADEYO (SA)*

NMQW

*use when drug cost in excess of CPHA maximum

BUROSUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG/ML VIAL			
02483629	CRYSVITA (SA)	ULT	NMQW

20MG/ML VIAL			
02483637	CRYSVITA (SA)	ULT	NMQW

30MG/ML VIAL			
02483645	CRYSVITA (SA)	ULT	NMQW
00904749	CRYSVITA (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

CINACALCET

[SEE APPENDIX A](#) FOR CRITERIA

30MG TABLET

02441624	TEVA-CINACALCET (SA)	TEV	FGNQSW
02452693	APO-CINACALCET (SA)	APX	FGNQSW
02478900	AURO-CINACALCET (SA)	ARO	FGNQSW
02480298	MAR-CINACALCET (SA)	MAR	FGNQSW
02481987	M-CINACALCET (SA)	MRA	FGNQSW
02500094	JAMP-CINACALCET (SA)	JPC	FGNQSW
02517604	PMS-CINACALCET (SA)	PMS	FGNQSW
02524880	CINACALCET (SA)	SNS	FGNQSW

60MG TABLET

02441632	TEVA-CINACALCET (SA)	TEV	FGNQSW
02452707	APO-CINACALCET (SA)	APX	FGNQSW
02478919	AURO-CINACALCET (SA)	ARO	FGNQSW
02480301	MAR-CINACALCET (SA)	MAR	FGNQSW
02481995	M-CINACALCET (SA)	MRA	FGNQSW
02500108	JAMP-CINACALCET (SA)	JPC	FGNQSW
02517612	PMS-CINACALCET (SA)	PMS	FGNQSW

90MG TABLET

02441640	TEVA-CINACALCET (SA)	TEV	FGNQSW
02452715	APO-CINACALCET (SA)	APX	FGNQSW
02478943	AURO-CINACALCET (SA)	ARO	FGNQSW
02480328	MAR-CINACALCET (SA)	MAR	FGNQSW
02482002	M-CINACALCET (SA)	MRA	FGNQSW
02500116	JAMP-CINACALCET (SA)	JPC	FGNQSW
02517620	PMS-CINACALCET (SA)	PMS	FGNQSW

DIMETHYL FUMARATE

[SEE APPENDIX A](#) FOR SA CRITERIA

120MG DELAYED RELEASE CAPSULE

02404508	TECFIDERA (SA)	BIG	NMQW
02494809	GLN-DIMETHYL FUMARATE	GLM	NMQW

02495341	ACH-DIMETHYL FUMARATE	ACH	NMQW
02497026	PMS-DIMETHYL FUMARATE	PMS	NMQW
02502690	MAR-DIMETHYL FUMARATE	MAR	NMQW
02505762	APO-DIMETHYL FUMARATE	APX	NMQW
02513781	SANDOZ-DIMETHYL FUMARATE	SDZ	NMQW
02516047	JAMP-DIMETHYL FUMARATE	JPC	NMQW
02540746	AURO-DIMETHYL FUMARATE	ARO	NMQW

240MG DELAYED RELEASE CAPSULE

02420201	TECFIDERA (SA)	BIG	NMQW
02494817	GLN-DIMETHYL FUMARATE	GLM	NMQW
02495368	ACH-DIMETHYL FUMARATE	ACH	NMQW
02497034	PMS-DIMETHYL FUMARATE	PMS	NMQW
02502704	MAR-DIMETHYL FUMARATE	MAR	NMQW
02505770	APO-DIMETHYL FUMARATE	APX	NMQW
02513803	SANDOZ-DIMETHYL FUMARATE	SDZ	NMQW
02516055	JAMP-DIMETHYL FUMARATE	JPC	NMQW
02540754	AURO-DIMETHYL FUMARATE	ARO	NMQW

ETHINYL ESTRADIOL & CYPROTERONE

0.035MG & 2MG TABLET

02233542	DIANE-35	BAY	FQW
02290308	CYESTRA-35	PAL	FGQW
02309556	TEVA-CYPROTERONE/ETHINYL ESTRADIOL	TEV	FGQW

FINGOLIMOD

[SEE APPENDIX A](#) FOR CRITERIA

0.5MG CAPSULE

02365480	GILENYA (SA)	NVR	NMQW
02469561	TEVA-FINGOLIMOD (SA)	TEV	NMQW
02469618	TARO-FINGOLIMOD (SA)	TAR	NMQW
02469715	MYLAN-FINGOLIMOD (SA)	MYL	NMQW
02469782	PMS-FINGOLIMOD (SA)	PMS	NMQW
02469936	APO-FINGOLIMOD (SA)	APX	NMQW
02474743	MAR-FINGOLIMOD (SA)	MAR	NMQW
02482606	SANDOZ-FINGOLIMOD (SA)	SDZ	NMQW
02487772	JAMP-FINGOLIMOD (SA)	JPC	NMQW

GLATIRAMER ACETATE

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG PRE-FILLED SYRINGE

02460661	GLATECT (SA)	PMS	NMQW

⑤GLUCAGON

[SEE APPENDIX A](#) FOR SA CRITERIA

3MG NASAL SPRAY

APM DNQW

⑤ GLUCAGON (RECOMBINANT DNA ORIGIN)

INJECTION KIT

LIL DNQW

⑤ GLUCAGON (HUMAN RECOMBINANT)

INJECTION VIAL

PAL DNQW

PAL DNQW

INTERFERON BETA-1A

30MCG PREFILLED SYRINGE, 30MCG PEN WITH AUTO-INJECTOR

BIG NMQW

SRO NMQW

SRO NMQW

SRO NMQW

SRO NMQW

INTERFERON BETA-1B

0.3MG INJECTION POWDER

BAY NMQW

LANADELUMAB[SEE APPENDIX A](#) FOR SA CRITERIA

300MG/2ML VIAL

02480948 TAKHZYRO (SA)

00904577 TAKHZYRO (SA)*

00904578 TAKHZYRO (SA)*

*use when drug cost in excess of CPHA maximum

TAK NMQW
NMQW
NMQW

300MG/2ML PREFILLED SYRINGE

02505614 TAKHZYRO (SA)

00904638 TAKHZYRO (SA)*

00904639 TAKHZYRO (SA)*

*use when drug cost in excess of CPHA maximum

TAK NMQW
NMQW
NMQW**LANREOTIDE**

60MG/0.2ML PREFILLED SYRINGE

02283395 SOMATULINE AUTOGEL

IPS MNQW

90MG/0.3MG PREFILLED SYRINGE

02283409 SOMATULINE AUTOGEL

IPS MNQW

120MG/0.5ML PREFILLED SYRINGE

02283417 SOMATULINE AUTOGEL

IPS MNQW

LEFLUNOMIDE

10MG TABLET

02241888 ARAVA

02256495 APO-LEFLUNOMIDE

02261251 TEVA-LEFLUNOMIDE

02283964 SANDOZ-LEFLUOMIDE

02351668 LEFLUNOMIDE

02543575 LEFLUNOMIDE

02551918 MAR-LEFLUNOMIDE

AVN FNQSW
APX FGNQSW
TEV FGNQSW
SDZ FGNQSW
SNS FGNQSW
SIV FGNQSW
MAR FGNQSW

20MG TABLET

02241889 ARAVA

02256509 APO-LEFLUNOMIDE

02261278 TEVA-LEFLUNOMIDE

02283972 SANDOZ -EFLUOMIDE

02351676 LEFLUNOMIDE

02543583 LEFLUNOMIDE

02551926 MAR-LEFLUNOMIDE

AVN FNQSW
APX FGNQSW
TEV FGNQSW
SDZ FGNQSW
SNS FGNQSW
SIV FGNQSW
MAR FGNQSW**LEUCOVORIN**

5MG TABLET

02493357 RIV-LEUCOVORIN

RIV FGNQSW

02496828	MINT- LEUCOVORIN	MNT	FGNQSW
02548208	JAMP-LEUCOVORIN	JPC	FGNQSW

LEVOCARNITINE

[SEE APPENDIX A](#) FOR SA CRITERIA

330MG TABLET

02144328	CARNITOR (SA)	LBI	FNQSW

100MG/ML ORAL SOLUTION

02144336	CARNITOR (SA)	LBI	FNQSW
02492105	ODAN-LEVOCARNITINE (SA)	ODN	FGNQSW

MONTELUKAST

4MG CHEWABLE TABLET

02243602	SINGULAIR	MSD	FQW
02330385	SANDOZ-MONTELUKAST	SDZ	FGQW
02354977	PMS-MONTELUKAST	PMS	FGQW
02355507	TEVA-MONTELUKAST	TEV	FGQW
02377608	APO-MONTELUKAST	APX	FGQW
02382458	MONTELUKAST	SIV	FGQW
02399865	MAR-MONTELUKAST	MAR	FGQW
02408627	MINT-MONTELUKAST	MNT	FGQW
02422867	AURO-MONTELUKAST	ARO	FGQW
02442353	JAMP-MONTELUKAST	JPC	FGQW
02514877	JAMP-MONTELUKAST	JPC	FGQW
02522101	NAT-MONTELUKAST	NAT	FGQW

5MG CHEWABLE TABLET

02238216	SINGULAIR	MSD	FQW
02330393	SANDOZ-MONTELUKAST	SDZ	FGQW
02354985	PMS-MONTELUKAST	PMS	FGQW
02355515	TEVA-MONTELUKAST	TEV	FGQW
02377616	APO-MONTELUKAST	APX	FGQW
02379325	MONTELUKAST	SNS	FGQW
02382466	MONTELUKAST	SIV	FGQW
02399873	MAR-MONTELUKAST	MAR	FGQW
02408635	MINT-MONTELUKAST	MNT	FGQW
02422875	AURO-MONTELUKAST	ARO	FGQW
02442361	JAMP-MONTELUKAST	JPC	FGQW
02514885	JAMP-MONTELUKAST	JPC	FGQW
02522128	NAT-MONTELUKAST	NAT	FGQW

10MG TABLET

02238217	SINGULAIR	MSD	FNQSW
02328593	SANDOZ-MONTELUKAST	SDZ	FGNQSW
02355523	TEVA-MONTELUKAST	TEV	FGNQSW

02373947	PMS-MONTELUKAST	PMS	FGNQSW
02374609	APO-MONTELUKAST	APX	FGNQSW
02379236	MONTELUKAST SODIUM	ACH	FGNQSW
02379333	MONTELUKAST	SNS	FGNQSW
02382474	MONTELUKAST	SIV	FGNQSW
02389517	RAN-MONTELUKAST	RAN	FGNQSW
02391422	JAMP-MONTELUKAST	JPC	FGNQSW
02401274	AURO-MONTELUKAST	ARO	FGNQSW
02399997	MAR-MONTELUKAST	MAR	FGNQSW
02408643	MINT-MONTELUKAST	MNT	FGNQSW
02488183	M-MONTELUKAST	MRA	FGNQSW
02489821	NRA-MONTELUKAST	NRA	FGNQSW
02522136	NAT-MONTELUKAST	NAT	FGNQSW

4MG GRANULES IN PACKET

02247997	SINGULAIR	MSD	FQW
02358611	SANDOZ-MONTELUKAST	SDZ	FGQW

NATALIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

300MG & 15ML VIAL

02286386	TYSABRI (SA)	BIG	NMQW

NUSINERSEN

[SEE APPENDIX A](#) FOR SA CRITERIA

2.4MG/ML INTRATHECAL VIAL

02465663	SPINRAZA (SA)	BIG	NMQW
00904366	SPINRAZA (SA)*		NMQW
00904367	SPINRAZA (SA)*		NMQW
00904368	SPINRAZA (SA)*		NMQW
00904369	SPINRAZA (SA)*		NMQW
00904370	SPINRAZA (SA)*		NMQW
00904371	SPINRAZA (SA)*		NMQW
00904372	SPINRAZA (SA)*		NMQW
00904373	SPINRAZA (SA)*		NMQW
00904374	SPINRAZA (SA)*		NMQW
00904375	SPINRAZA (SA)*		NMQW
00904376	SPINRAZA (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

OCTREOTIDE

200MCG/ML INJECTION (5ML)

02248642	OCTREOTIDE OMEGA	OMG	FGNQSW

10MG PREFILLED SYRINGE

02239323	SANDOSTATIN LAR	NVR	MNQW

02503751	OCTREOTIDE	TEV	MNQW

20MG PREFILLED SYRINGE

02239324	SANDOSTATIN LAR	NVR	MNQW

02503778	OCTREOTIDE	TEV	MNQW

30MG PREFILLED SYRINGE

02239325	SANDOSTATIN LAR	NVR	MNQW

02503786	OCTREOTIDE	TEV	MNQW

OCRELIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

300 MG/10 ML (VIAL)

02467224	OCREVUS (SA)	HLR	NMQW

00904527	OCREVUS (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

OFATUMUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG/0.4ML PREFILLED PEN

02511355	KESIMPTA (SA)	NVR	NMQW

ONABOTULINUMTOXINA

[SEE APPENDIX A](#) FOR SA CRITERIA

200 UNITS/VIAL

02531585	BOTOX (SA)	ALL	FNQSW

OZANIMOD

[SEE APPENDIX A](#) FOR SA CRITERIA

0.23 MG (4)-0.46 MG (3) INITIATION PACK

02506009	ZEPOSIA (SA)	BMS	NMQW

0.92MG CAPSULE

02505991	ZEPOSIA (SA)	BMS	NMQW

PAMIDRONATE DISODIUM

[SEE APPENDIX A](#) FOR SA CRITERIA

30MG INJECTION

02244550	PAMIDRONATE DISODIUM (SA)	PFI	FNQSW

60MG INJECTION

02244551	PAMIDRONATE DISODIUM (SA)	PFI	FNQSW

90MG INJECTION

02244552	PAMIDRONATE DISODIUM (SA)	PFI	FNQSW

PEGINTERFERON BETA-1A[SEE APPENDIX A](#) FOR SA CRITERIA

63/94MCG/0.5ML

02444402 PLEGRIDY (SA)

BIG NMQW

125MCG/0.5ML

02444399 PLEGRIDY (SA)

BIG NMQW

PENTOSAN POLYSULFATE SO4[SEE APPENDIX A](#) FOR SA CRITERIA

100MG CAPSULE

02029448 ELMIRON (SA)

JAN FNQSW

PHENYLALANINE-REDUCED FOODS

NUTRITIONAL FORMULA

00030800 PHENEX-1

ROS P

04444444 PHENEX-2

ROS P

00368020 PHENYL-FREE

MJS P

RAVULIZUMAB[SEE APPENDIX A](#) FOR SA CRITERIA

300 MG/3 ML VIAL

02533448 ULTOMIRIS (SA)

ALX NMQW

00904866 ULTOMIRIS (SA)*

NMQW

00904867 ULTOMIRIS (SA)*

NMQW

*use when drug cost in excess of CPHA maximum

300 MG/30 ML VIAL

02491559 ULTOMIRIS (SA)

ALX NMQW

00904864 ULTOMIRIS (SA)*

NMQW

00904865 ULTOMIRIS (SA)*

NMQW

*use when drug cost in excess of CPHA maximum

1,100 MG/11 ML VIAL

02533456 ULTOMIRIS (SA)

ALX NMQW

00904869 ULTOMIRIS (SA)*

NMQW

00904868 ULTOMIRIS (SA)*

NMQW

*use when drug cost in excess of CPHA maximum

RISDIPLAM[SEE APPENDIX A](#) FOR SA CRITERIA

Note: Risdiplam claims must be billed in mgs

0.75MG/ML POWDER FOR ORAL SOLUTION

02514931 EVRYSDI (SA)

HLR NMQW

00904768 EVRYSDI (SA)*

NMQW

00904769	EVRYSDI (SA)*		NMQW
00904770	EVRYSDI (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

SATRALIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

120MG/ML PREFILLED SYRINGE

02499681	ENSPRYNG (SA)	HLR	NMQW

SIPONIMOD

[SEE APPENDIX A](#) FOR SA CRITERIA

0.25MG TABLET

02496429	MAYZENT (SA)	NVR	NMQW

2MG TABLET

02496437	MAYZENT (SA)	NVR	NMQW

SODIUM CHLORIDE

7% INHALATION LIQUID

80029414	HYPERSAL 7%	KEG	C

SODIUM CROMOGLYCATE

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG CAPSULE

00500895	NALCROM (SA)	AVN	FQSW

SORAFENIB TOSYLATE

[SEE APPENDIX A](#) FOR SA CRITERIA

200MG TABLET

02284227	NEXAVAR (SA)	BAY	NMQW

TERIFLUNOMIDE

[SEE APPENDIX A](#) FOR SA CRITERIA

14MG TABLET

02416328	AUBAGIO (SA)	GZY	NMQW
02500310	NAT-TERIFLUNOMIDE (SA)	NAT	NMQW
02500434	PMS-TERIFLUNOMIDE (SA)	PMS	NMQW
02500469	MAR-TERIFLUNOMIDE (SA)	MAR	NMQW
02500639	APO-TERIFLUNOMIDE (SA)	APX	NMQW
02501090	TEVA-TERIFLUNOMIDE (SA)	TEV	NMQW
02502933	ACH-TERIFLUNOMIDE (SA)	ACH	NMQW
02504170	JAMP-TERIFLUNOMIDE (SA)	JPC	NMQW
02505843	SANDOZ-TERIFLUNOMIDE (SA)	SDZ	NMQW
02523833	M-TERIFLUNOMIDE (SA)	MRA	NMQW

TETRABENAZINE

25MG TABLET

02199270	NITOMAN	BSL	FNQSW
02402424	PMS-TETRABENAZINE	PMS	FGNQSW
02407590	APO-TETRABENAZINE	APX	FGNQSW
02410338	TETRABENAZINE	STE	FGNQSW

TOCILIZUMAB[SEE APPENDIX A](#) FOR SA CRITERIA

80MG/4ML IV VIAL

02350092	ACTEMRA (SA)	HLR	NMQW
02552450	TYENNE (SA)	FKB	NMQW

200MG/10ML IV VIAL

02350106	ACTEMRA (SA)	HLR	NMQW
02552469	TYENNE (SA)	FKB	NMQW

400MG/20ML IV VIAL

02350114	ACTEMRA (SA)	HLR	NMQW
02552477	TYENNE (SA)	FKB	NMQW

162MG/0.9ML SYRINGE

02424770	ACTEMRA (SA)	HLR	NMQW
02552493	TYENNE (SA)	FKB	NMQW

162MG/0.9ML PREFILLED AUTOINJECTOR

02483327	ACTEMRA (SA)	HLR	NMQW
02552485	TYENNE (SA)	FKB	NMQW

TRIENTINE[SEE APPENDIX A](#) FOR SA CRITERIA

250MG CAPSULE

02504855	MAR-TRIENTINE (SA)	MAR	NMQW
02515067	WAYMADE-TRIENTINE (SA)	WMD	NMQW

TRIMEPRAZINE TARTRATE

2.5MG TABLET

01926306	PANECTYL	ERF	FNQW

5MG TABLET

01926292	PANECTYL	ERF	FNQW

UPADACITINIB

[SEE APPENDIX A](#) FOR SA CRITERIA

15MG EXTENDED RELEASE TABLET

02495155 RINVOQ (SA)

ABV **MNQW**

30MG EXTENDED RELEASE TABLET

02520893 RINVOQ (SA)

ABV **MNQW**

45MG EXTENDED RELEASE TABLET

02539721 RINVOQ (SA)

ABV **MNQW**

VEDOLIZUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

300MG VIAL

02436841 ENTYVIO (SA)

TAK **NMQW**

108MG/0.68ML PREFILLED SYRINGE

02497875 ENTYVIO (SA)

TAK **NMQW**

108MG/0.68ML PREFILLED PEN

02497867 ENTYVIO (SA)

TAK **NMQW**

ZOLEDRONIC ACID

5MG/100ML INJECTION

02269198 ACLASTA

02422433 ZOLEDRONIC ACID

SDZ **FNQSW**
RCH **FGNQSW**

92:00.08 ALFA REDUCTASE INHIBITORS

DUTASTERIDE

0.5MG CAPSULE

02247813 AVODART

GSK **FNQSW**

02393220 PMS-DUTASTERIDE

PMS **FGNQSW**

02404206 APO-DUTASTERIDE

APX **FGNQSW**

02408287 TEVA-DUTASTERIDE

TEV **FGNQSW**

02416298 MED-DUTASTERIDE

GMP **FGNQSW**

02424444 SANDOZ-DUTASTERIDE

SDZ **FGNQSW**

02428873 MINT-DUTASTERIDE

MNT **FGNQSW**

02429012 DUTASTERIDE

SIV **FGNQSW**

02443058 DUTASTERIDE

SNS **FGNQSW**

02469308 AURO-DUTASTERIDE

ARO **FGNQSW**

02484870 JAMP-DUTASTERIDE

JPC **FGNQSW**

02546167 JAMP-DUTASTERIDE

JPC **FGNQSW**

FINASTERIDE**5MG TABLET**

02010909	PROSCAR	MDS	FNQSW
02348500	TEVA-FINASTERIDE	TEV	FGNQSW
02322579	SANDOZ-FINASTERIDE	SDZ	FGNQSW
02310112	PMS-FINASTERIDE	PMS	FGNQSW
02355043	FINASTERIDE	ACH	FGNQSW
02357224	JAMP-FINASTERIDE	JPC	FGNQSW
02365383	APO-FINASTERIDE	APX	FGNQSW
02389878	MINT-FINASTERIDE	MNT	FGNQSW
02405814	AURO-FINASTERIDE	ARO	FGNQSW
02445077	FINASTERIDE	SNS	FGNQSW
02447541	FINASTERIDE	SIV	FGNQSW
02455013	RIVA-FINASTERIDE	RIV	FGNQSW
02522489	M-FINASTERIDE	MRA	FGNQSW

92:16.00 ANTIGOUT AGENTS**ALLOPURINOL****100MG TABLET**

00402818	APO-ALLOPURINOL	APX	FGNQSW
02396327	MAR-ALLOPURINOL	MAR	FGNQSW
02402769	APO-ALLOPURINOL	APX	FGNQSW

200MG TABLET

00479799	APO-ALLOPURINOL	APX	FGNQSW
02396335	MAR-ALLOPURINOL	MAR	FGNQSW
02402777	APO-ALLOPURINOL	APX	FGNQSW

300MG TABLET

00402796	APO-ALLOPURINOL	APX	FGNQSW
02396343	MAR-ALLOPURINOL	MAR	FGNQSW
02402785	APO-ALLOPURINOL	APX	FGNQSW

COLCHICINE**0.6MG TABLET**

00287873	SANDOZ-COLCHICINE	SDZ	FGNQSW
00572349	COLCHICINE-ODAN	ODN	FGNQSW
02373823	JAMP-COLCHICINE	JPC	FGNQSW
02402181	PMS-COLCHICINE	PMS	FGNQSW

FEBUXOSTAT**SEE APPENDIX A** FOR SA CRITERIA

80MG TABLETS

02466198	TEVA-FEBUXOSTAT	TEV	FGNQSW
02473607	MAR-FEBUXOSTAT	MAR	FGNQSW
02490870	JAMP-FEBUXOSTAT	JPC	FGNQSW
02533243	AURO-FEBUXOSTAT	ARO	FGNQSW
02539837	FEBUXOSTAT	SNS	FGNQSW

92:22:00 BONE ANABOLIC AGENTS**ROMOSOZUMAB**

[SEE APPENDIX A](#) FOR SA CRITERIA
 105 MG/1.17 ML PREFILLED SYRINGE
 02489597 EVENITY (SA)

AMG **FNQSW**

92:24:00 BONE RESORPTION INHIBITORS**ALENDRONATE & CHOLECALCIFEROL****70MG/5600 UNIT TABLET**

02314940	FOSAVANCE	MSD	FNQSW
02454475	APO-ALENDRONATE/VITAMIN D3	APX	FGNQSW
02519836	JAMP-ALENDRONATE/VITAMIN D3	JPC	FGNQSW

ALENDRONATE SODIUM**10MG TABLET**

02248728	APO-ALENDRONATE	APX	FGNQSW
02381486	ALENDRONATE SODIUM	ACH	FGNQSW
02384701	RAN-ALENDRONATE	RAN	FGNQSW
02388545	AURO-ALENDRONATE	ARO	FGNQSW

70MG TABLET

02245329	FOSAMAX	MSD	FNQSW
02248730	APO-ALENDRONATE	APX	FGNQSW
02261715	TEVA-ALENDRONATE	TEV	FGNQSW
02270889	RIVA-ALENDRONATE	RIV	FGNQSW
02284006	PMS-ALENDRONATE	PMS	FGNQSW
02288109	SANDOZ-ALENDRONATE	SDZ	FGNQSW
02299712	ALENDRONATE	SIV	FGNQSW
02352966	ALENDRONATE	SNS	FGNQSW
02381494	ALENDRONATE SODIUM	ACH	FGNQSW
02385031	JAMP-ALENDRONATE	JPC	FGNQSW
02388553	AURO-ALENDRONATE	ARO	FGNQSW
02394871	MINT-ALENDRONATE	MNT	FGNQSW

02485184	AG-ALENDRONATE	ANG	FGNQSW
02500175	JAMP-ALENDRONATE	JPC	FGNQSW
02529394	M-ALENDRONATE	MRA	FGNQSW

DENOSUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

60MG/ML PREFILLD SYRINGE

02343541	PROLIA (SA)	AMG	FNQSW

02545411	JUBBONTI (SA)	SND	FNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

120MG/1.7ML VIAL

02545764	WYOST (SA)	SDZ	FNQSW

RALOXIFENE

60MG TABLET

02279215	APO-RALOXIFENE	APX	FGNQSW

02358840	ACT-RALOXIFENE	TEV	FGNQSW

02540681	JAMP-RALOXIFENE	JPC	FGNQSW

RISEDRONATE SODIUM

5MG TABLET

02298376	TEVA-RISEDRONATE	TEV	FGNQSW

[SEE APPENDIX A](#) FOR SA CRITERIA

30MG TABLET

02298384	TEVA-RISEDRONATE (SA)	TEV	FGNQSW

35MG TABLET

02246896	ACTONEL	ALL	FNQSW

02298392	TEVA-RISEDRONATE	TEV	FGNQSW

02302209	PMS-RISEDRONATE	PMS	FGNQSW

02327295	SANDOZ-RISEDRONATE	SDZ	FGNQSW

02353687	APO-RISEDRONATE	APX	FGNQSW

02368552	JAMP-RISEDRONATE	JPC	FGNQSW

02370255	SANIS-RISEDRONATE	SNS	FGNQSW

02406306	AURO-RISEDRONATE	ARO	FGNQSW

02411407	RISEDRONATE	SIV	FGNQSW

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

ABATACEPT

[SEE APPENDIX A](#) FOR SA CRITERIA

250 MG VIAL

02282097 ORENCIA (SA)

BMS **NMQW**

125MG/ML PREFILLED SC SYRINGE

02402475 ORENCIA (SA)

BMS **NMQW**

ADALIMUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

20MG/0.2 ML PREFILLED SYRINGE

02542315 HYRIMOZ (SA)

SDZ **NMQW**

20MG/0.4 ML PREFILLED SYRINGE

02459310 AMGEVITA (SA)

AMG **NMQW**

02502380 HULIO (SA)

BGP **NMQW**

02511061 ABRILADA (SA)

PFI **NMQW**

40MG/0.4 ML PREFILLED SYRINGE

02523760 YUFLYMA (SA)

LIL **NMQW**

02523949 SIMLANDI (SA)

JPC **NMQW**

02533472 HADLIMA (SA)

MER **NMQW**

02542323 HYRIMOZ (SA)

SDZ **NMQW**

40MG/0.4 ML PEN INJECTOR

02523779 YUFLYMA (SA)

LIL **NMQW**

02523957 SIMLANDI (SA)

JPC **NMQW**

02533480 HADLIMA PUSHTOUCH (SA)

MER **NMQW**

02542331 HYRIMOZ (SA)

SDZ **NMQW**

40MG/0.8 ML PREFILLED SYRINGE

02459299 AMGEVITA (SA)

AMG **NMQW**

02473097 HADLIMA (SA)

MER **NMQW**

02502399 HULIO (SA)

BGP **NMQW**

02502682 IDACIO (SA)

FKB **NMQW**

02511053 ABRILADA (SA)

PFI **NMQW**

40MG/0.8 ML PREFILLED PEN

02459302	AMGEVITA (SA)	AMG	NMQW
02473100	HADLIMA PUSHTOUCH (SA)	MER	NMQW
02502402	HULIO (SA)	BGP	NMQW
02502674	IDACIO (SA)	FKB	NMQW
02511045	ABRILADA (SA)	PFI	NMQW

80MG/0.8 ML PREFILLED SYRINGE			
02523965	SIMLANDI (SA)	JPC	NMQW
02535076	YUFLYMA (SA)	CLT	NMQW
02542358	HYRIMOZ (SA)	SDZ	NMQW

80MG/0.8 ML PEN INJECTOR			
02535084	YUFLYMA (SA)	CLT	NMQW
02542366	HYRIMOZ (SA)	SDZ	NMQW

BOSENTAN

[SEE APPENDIX A](#) FOR CRITERIA

62.5 MG TABLET

02244981	TRACLEER (SA)	JAN	MNSQW
02383012	PMS-BOSENTAN (SA)	PMS	GMNSQW
02467984	NAT-BOSENTAN (SA)	NAT	GMNSQW
02483130	TARO-BOSENTAN (SA)	TAR	GMNSQW

125 MG TABLET

02244982	TRACLEER (SA)	JAN	MNSQW
02383020	PMS-BOSENTAN (SA)	PMS	GMNSQW
02467992	NAT-BOSENTAN (SA)	NAT	GMNSQW
02483149	TARO-BOSENTAN (SA)	TAR	GMNSQW

CANAKINUMAB

[SEE APPENDIX A](#) FOR SA CRITERIA

02460351	ILARIS (SA)	NVR	NMQW
00904405	ILARIS (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

CERTOLIZUMAB

[SEE APPENDIX A](#) FOR CRITERIA

200MG/ML SYRINGE KIT

02331675	CIMZIA (SA)	UCB	NMQW

200MG/ML AUTO-INJECTOR KIT

02465574	CIMZIA (SA)	UCB	NMQW

ETANERCEPT[SEE APPENDIX A](#) FOR SA CRITERIA

25MG/0.5ML PEN INJECTOR

02462877 ERELZI (SA) SDZ **NMQW**

50MG/ML PEN INJECTOR

02455331 BRENZYS (SA) MSD **NMQW**02462850 ERELZI (SA) SDZ **NMQW**02530309 RYMTI (SA) LUP **NMQW**

50MG/ML PRE-FILLED SYRINGE

02455323 BRENZYS (SA) MSD **NMQW**02462869 ERELZI (SA) SDZ **NMQW**02530309 RYMTI (SA) LUP **NMQW****GOLIMUMAB**[SEE APPENDIX A](#) FOR SA CRITERIA

50MG/0.5ML SYRINGE

02324776 SIMPONI (SA) JAN **NMQW**

50MG/0.5ML AUTO-INJECTOR

02324784 SIMPONI (SA) JAN **NMQW****ICATIBANT**[SEE APPENDIX A](#) FOR SA CRITERIA

30MG/3ML SC SYRINGE

02425696 FIRAZYR (SA) SHR **NMQW**02547562 ICATIBANT (SA) JPC **NMQW****INFLIXIMAB**[SEE APPENDIX A](#) FOR SA CRITERIA

100MG/VIAL INJECTION

02419475 REMDANTRY (SA) CLT **NMQW**02470373 RENFLEXIS (SA) MSD **NMQW**02496933 AVSOLA (SA) AGA **NMQW**02523191 IXIFI (SA) PFI **NMQW**

120MG/ML PREFILLED SYRINGE

02511576 REMSIMA SC (SA) CLT **NMQW**

120MG/ML PREFILLED PEN

02511584 REMSIMA SC (SA) CLT **NMQW**

SARILUMAB[SEE APPENDIX A](#) FOR SA CRITERIA

150MG/1.14ML PEN

02472961 KEVZARA (SA)

AVN NMQW

200MG/1.14ML SYRINGE

02460548 KEVZARA (SA)

AVN NMQW

200MG/1.14ML PEN

02472988 KEVZARA (SA)

AVN NMQW

TOFACITINIB[SEE APPENDIX A](#) FOR SA CRITERIA

5MG TABLET

02423898 XELJANZ (SA)

PFI NMQW

02511304 TARO-TOFACITINIB (SA)

TAR NMQW

02522799 PMS-TOFACITINIB (SA)

PMS NMQW

02522896 JAMP-TOFACITINIB (SA)

JPC NMQW

02530007 AURO-TOFACITINIB (SA)

ARO NMQW

10MG TABLET

02480786 XELJANZ (SA)

PFI NMQW

02511312 TARO-TOFACITINIB (SA)

TAR NMQW

02530015 AURO-TOFACITINIB (SA)

ARO NMQW

11MG TABLET

02470608 XELJANZ XR (SA)

PFI NMQW

02553988 TARO-TOFACITINIB XR (SA)

TAR NMQW

92:44.00 IMMUNOSUPPRESSIVE AGENTS**AZATHIOPRINE**

50MG TABLET

00004596 IMURAN

ASN FNQSW

02236819 TEVA-AZATHIOPRINE

TEV FGNQSW

02242907 APO-AZATHIOPRINE

APX FGNQSW

BARICITINIB[SEE APPENDIX A](#) FOR SA CRITERIA

2MG TABLET

02480018 OLUMIANT (SA)

LIL NMQW

CLADRIBINE

[SEE APPENDIX A](#) FOR SA CRITERIA

10MG TABLET

02470179	MAVENCLAD (SA)	EMD	NMQW
00904524	MAVENCLAD (SA)*		NMQW
00904525	MAVENCLAD (SA)*		NMQW
00904526	MAVENCLAD (SA)*		NMQW

*use when drug cost in excess of CPHA maximum

CYCLOSPORINE

10MG CAPSULE

02237671	NEORAL	NVR	FNQSTW

25MG CAPSULE

02150689	NEORAL	NVR	FNQSTW
02247073	SANDOZ-CYCLOSPORINE	SDZ	FGNQSTW

50MG CAPSULE

02150662	NEORAL	NVR	FNQSTW
02247074	SANDOZ-CYCLOSPORINE	SDZ	FGNQSTW

100MG CAPSULE

02150670	NEORAL	NVR	FNQSTW
02242821	SANDOZ-CYCLOSPORINE	SDZ	FGNQSTW

100MG/ML ORAL SOLUTION

02150697	NEORAL	NVR	FNQSTW
02244324	APO-CYCLOSPORINE	APX	FGNQSTW

MYCOPHENOLATE MOFETIL

250MG CAPSULE

02192748	CELLCEPT	HLR	T
02320630	SANDOZ-MYCOPHENOLATE	SDZ	T
02352559	APO-MYCOPHENOLATE	APX	T
02364883	TEVA-MYCOPHENOLATE	TEV	T
02383780	MYCOPHENOLATE MOFETIL	ACH	T
02386399	JAMP-MYCOPHENOLATE	JPC	T
02457369	MYCOPHENOLATE MOFETIL	SNS	T

500MG TABLET

02237484	CELLCEPT	HLR	T
02313855	SANDOZ-MYCOPHENOLATE	SDZ	T
02352567	APO-MYCOPHENOLATE	APX	T
02348675	TEVA-MYCOPHENOLATE	TEV	T
02378574	MYCOPHENOLATE MOFETIL	ACH	T
02380382	JAMP-MYCOPHENOLATE	JPC	T
02457377	MYCOPHENOLATE MOFETIL	SNS	T

MYCOPHENOLATE SODIUM

180MG ENTERIC-COATED TABLET

02264560	MYFORTIC	NVR	T
02372738	APO-MYCOPHENOLIC ACID	APX	T
02511673	MAR-MYCOPHENOLIC ACID	MAR	T
02518538	JAMP-MYCOPHENOLIC ACID	JPC	T

360MG ENTERIC-COATED TABLET

02264579	MYFORTIC	NVR	T
02372746	APO-MYCOPHENOLIC ACID	APX	T
02511681	MAR-MYCOPHENOLIC ACID	MAR	T
02518511	JAMP-MYCOPHENOLIC ACID	JPC	T

NINTEDANIB

[SEE APPENDIX A](#) FOR SA CRITERIA

100MG CAPSULE

02443066	OFEV (SA)	BOE	NMQW

150MG CAPSULE

02443074	OFEV (SA)	BOE	NMQW

PIRFENIDONE

[SEE APPENDIX A](#) FOR SA CRITERIA

267MG CAPSULE

02393751	ESBRIET (SA)	HLR	NMQW
02488833	SANDOZ-PIRFENIDONE (SA)	SDZ	NMQW
02509938	JAMP-PIRFENIDONE (SA)	JPC	NMQW

267MG TABLET

02464489	ESBRIET (SA)	HLR	NMQW
02488507	SANDOZ-PIRFENIDONE (SA)	SDZ	NMQW
02514702	JAMP-PIRFENIDONE (SA)	JPC	NMQW
02531526	PMS-PIRFENIDONE (SA)	PMS	NMQW
02537753	AURO-PIRFENIDONE (SA)	ARO	NMQW
02550644	M-PIRFENIDONE (SA)	MRA	NMQW

801MG TABLET

02464500	ESBRIET (SA)	HLR	NMQW
02488515	SANDOZ-PIRFENIDONE (SA)	SDZ	NMQW
02514710	JAMP-PIRFENIDONE (SA)	JPC	NMQW
02531534	PMS-PIRFENIDONE (SA)	PMS	NMQW
02537761	AURO-PIRFENIDONE (SA)	ARO	NMQW
02550652	M-PIRFENIDONE (SA)	MRA	NMQW

SIROLIMUS

1MG/ML ORAL SOLUTION

02243237	RAPAMUNE	PFI	T
1MG TABLET			
02247111	RAPAMUNE	PFI	T
TACROLIMUS			
0.5MG CAPSULE			
02243144	PROGRAF	AST	T
02416816	SANDOZ-TACROLIMUS	SDZ	T
02454068	ACH-TACROLIMUS	ACH	T
1MG CAPSULE			
02175991	PROGRAF	AST	T
02416824	SANDOZ-TACROLIMUS	SDZ	T
02456095	ACH-TACROLIMUS	ACH	T
5MG CAPSULE			
02175983	PROGRAF	AST	T
02416832	SANDOZ-TACROLIMUS	SDZ	T
02456109	ACH-TACROLIMUS	ACH	T
0.5MG EXTENDED RELEASE CAPSULE			
02296462	ADVAGRAF	AST	T
1MG EXTENDED RELEASE CAPSULE			
02296470	ADVAGRAF	AST	T
3MG EXTENDED RELEASE CAPSULE			
02331667	ADVAGRAF	AST	T
5MG EXTENDED RELEASE CAPSULE			
02296489	ADVAGRAF	AST	T
0.75MG EXTENDED RELEASE TABLET			
02485877	ENVARUSUS PA	END	T
1MG EXTENDED RELEASE TABLET			
02485885	ENVARUSUS PA	END	T
4MG EXTENDED RELEASE TABLET			
02485893	ENVARUSUS PA	END	T

92:92 OTHER MISCELLANEOUS AGENTS

SAPROPTERIN[SEE APPENDIX A](#) FOR SA CRITERIA

100 MG POWDER FOR ORAL SOLUTION

02534533 REDDY-SAPROPTERIN (SA)

96599937 SAPROPTERIN (SA)*

RCH MNQW
MNQW

500 MG POWDER FOR ORAL SOLUTION

02535610 REDDY-SAPROPTERIN (SA)

96599936 SAPROPTERIN (SA)*

RCH MNQW
MNQW

*use when drug cost in excess of CPHA maximum

PROFESSIONAL SERVICES**MEDICATION REVIEW**

93899926	BASIC MEDICATION REVIEW	SW
93899924	BASIC MEDICATION REVIEW FOLLOW-UP	SW
93899925	DIABETES MEDICATION REVIEW	DW
93899923	DIABETES MEDICATION REVIEW FOLLOW-UP	DW

OTHER SERVICES

93899914	COMPLIANCE PACKAGING	DFSW
93899916	THERAPEUTIC SUBSTITUTION	PHARMACY PLUS
93899917	REFUSAL TO FILL	FLNSW
93899918	PRESCRIPTION ADAPTATION	PHARMACY PLUS

APPENDIX A Special Authorization Criteria

NOTES REGARDING SPECIAL AUTHORIZATION (SA) COVERAGE

The following prescribers are permitted to submit and sign special authorization requests:

- Authorized prescribers
- Hospital and community pharmacists for medications affiliated with a Common Ailment assessment (as per *Pharmacist and Pharmacy Technician Regulations*)
- Hospital pharmacists for medications prescribed under a practice directive approved by a regulatory licensing body in approved settings.

- Special Authorizations are reviewed by drug program staff.

- Not all medications currently approved for sale in Canada will be considered for Special Authorization coverage.

- Special Authorization coverage will not be considered for any medications approved for sale in Canada since January 2000 that have not been reviewed, and approved, for coverage by either the Canadian Expert Drug Advisory Committee (CEDAC), the Pan-Canadian Oncology Drug Review (P-CODR) or the Atlantic Expert Advisory Committee (AEAC).

- Special Authorization coverage will normally only be approved for the treatment of indications and in dosages listed in the official product monograph approved by Health Canada and published in the most recent edition of the Compendium of Pharmaceuticals and Specialties (CPS).

- Special Authorization coverage will potentially be considered for any drug not listed as an open benefit under the:
 - Family Health Benefit Drug Program
 - Financial Assistance Program
 - Nursing Home / Institutional Program
 - Seniors Drug Program

- Special Authorization coverage will be limited to selected drugs with specific criteria under the:
 - HIV Program
 - Diabetes Drug Program
 - Generic Drug Program
 - High Cost Drug Program
 - Home Oxygen Program
 - National Pharmacare Program
 - Substance Use Harm Reduction Drug Program
 - Transplant Drugs Program

- Special Authorization coverage will not be considered under the:
 - Community Mental Health Program
 - Cystic Fibrosis Program
 - Eprex Program
 - Growth Hormone Program

- Hepatitis Program
 - Phenylketonuria Program
 - Smoking Cessation Program
 - Sexually Transmitted Infections Program
 - Tuberculosis Program
- Prescribers may apply for Special Authorization coverage by mailing or faxing a completed Special Authorization to:

Special Authorizations
 PEI Pharmacare
 P.O. Box 2000
 Charlottetown, PEI, C1A 7N8
 Fax: 1-902-368-4905
 - Information that must be completed on, or included with the Special Authorization includes:
 - Patient's name, personal health number (PHN), date of birth, mailing address, and telephone number;
 - Name, dose, and dosage regimen of the medication requested;
 - Anticipated length of therapy of the medication requested;
 - Specific diagnosis or indication being treated using the medication requested;
 - Reason(s) for the request;
 - Other comments, including copies of culture and sensitivity reports for antibiotic requests, copies of relevant test results and relevant advice received from consultants or specialists; and
 - Prescriber's name, address, and signature. **No request will be considered without a valid prescriber's signature.**
 - Special Authorizations with insufficient information to properly assess the request will be returned to the prescriber.
 - Please allow up to three weeks for the processing of Special Authorizations.
 - Copies of the Special Authorization Forms are available by contacting the PEI Pharmacare office at 1-877-577-3737 or online at <http://www.princeedwardisland.ca/pharmacareforms>.
 - For some drugs a patient application is required in addition to the Special Authorization form. The patient application form is available by contacting the PEI Pharmacare office at 1-877-577-3737 or online at <http://www.princeedwardisland.ca/pharmacareforms>.
 - Patients and prescribers are notified by letter if coverage has been approved. Patients should take a copy of the approval letter to their pharmacy to initiate coverage.
 - The duration of approval of Special Authorization coverage may range from a one time only fill to coverage with no end date. This will be based upon the medication requested and the condition being treated.
 - Medications approved through the Special Authorization process are limited to a

maximum 30 (thirty) day supply per fill unless otherwise noted in drug criteria.

- If additional information is required **or** if the request is denied, a letter is sent to the patient and prescriber notifying them of the need for additional information **or** reason for the denial. Payment of the medication is the responsibility of the patient in these cases.
- If the request is approved, patients may be reimbursed for one fill of the medication received during the assessment period, after which all of the requested information has been received. **No reimbursement will be provided for medication received by the patient prior to receipt of the Special Authorization by the Drug Programs Office.**
- If it is anticipated that a patient will continue to require the product beyond the last day of approval, the prescriber is required **to request an extension of coverage at least four weeks before its expiration.** Coverage will not be continued automatically.

CRITERIA FOR COVERAGE OF SPECIFIC MEDICATIONS

The following are criteria for Special Authorization coverage of specific medications. Coverage may be granted for other products in certain instances.

Abatacept, vial, 250mg; syringe, 125mg/mL; syringe, 125mg/mL (Orencia-BMS)

Maximum IV adult dose is 500mg for patients < 60kg, 750mg for patients 60 to 100kg, 1000mg for patients > 100kg, given at 0, 2, 4, 8 weeks and every 4 weeks thereafter. Pediatric patients 6-17 years of age and < 75kg, coverage is for IV dose 10mg/kg based on weight at administration (pediatric patients > 75kg to be treated at adult dose) given at 0, 2, 4, 8 weeks and every 4 weeks thereafter.

For adult Orencia-naïve patients, a single loading dose of up to 1000mg, then 125mg sc injection should be given within a day, and once weekly thereafter.

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks AND

Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks;

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Initial Approval: 6 months
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Abemaciclib, tablet, 50mg, 100mg, 150mg (Verzenio-LIL)

In combination with endocrine therapy (ET) for the adjuvant treatment of adult patients with hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative, node-positive early breast cancer at high risk of disease recurrence and a Ki-67 score of at least 20%.

Clinical Notes:

- Patients should have a good performance status.
- Treatment should continue until disease progression, unacceptable toxicity, or completion of 2 years of adjuvant therapy. ET may be continued after abemaciclib is completed.
- Patients are not eligible if they have inflammatory breast cancer, or prior treatment with a cyclin-dependent kinases 4 and 6 (CDK4/6) inhibitor.

- Retreatment with a CDK4/6 inhibitor may be reasonable in the metastatic setting if disease recurrence occurs greater than or equal to 6 months after completion of adjuvant abemaciclib.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Abiraterone, tablet, 250mg, 500mg (Zytiga-JAN and generics)

1. In combination with prednisone for the treatment of metastatic prostate cancer (castration-resistant prostate cancer) in patients who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy or have received prior chemotherapy containing docetaxel after failure of androgen deprivation therapy.
2. In combination with androgen deprivation therapy (ADT) for the treatment of patients with metastatic castration sensitive prostate cancer who have had no prior ADT, or are within 6 months of beginning ADT, in the metastatic setting.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Abilify Maintena – see Aripiprazole

Abrilada – see Adalimumab

Abrocitinib, tablet, 50mg, 100mg, 200mg (Cibinqo-PFI)

For the treatment of moderate to severe atopic dermatitis (AD) in patients 12 years of age and older who meet all the following criteria:

- Patients must have had an adequate trial (with a documented refractory disease, including the relief of pruritis), or were intolerant (with documented intolerance), or are ineligible for each of the following therapies:
 - Maximally tolerated medical topical therapies for AD combined with phototherapy (where available), and
 - Maximally tolerated medical topical therapies for AD combined with at least 1 of the 4 systemic immunomodulators (methotrexate, cyclosporine, mycophenolate mofetil, or azathioprine)

- Baseline Physician Global Assessment score of 3 or greater and Eczema Area and Severity Index (EASI) of 7.1 or greater.

Renewal Criteria:

- Requests for renewal must provide proof of beneficial clinical effect defined as a 75% or greater improvement from baseline in the EASI score (EASI-75) six months after treatment initiation.
- Proof of maintenance of EASI-75 response from baseline must be provided for subsequent authorizations.

Clinical Note:

- Not to be used in combination with phototherapy or any immunomodulatory agents (including biologics or other janus kinase inhibitor treatment) for moderate to severe AD. Treatment should continue until disease progression or unacceptable toxicity.

Claim Notes:

- The patient must be under the care of a dermatologist, allergist, clinical immunologist, or pediatrician who has expertise in the management of moderate to severe AD.
- Approvals will be for a maximum of 200 mg once daily.
- Initial Approval Period: 6 months.
- Renewal Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Acalabrutinib, capsule, 100 mg ; tablet, 100mg (Calquence-AZE)

1. As monotherapy for adult patients with previously untreated chronic lymphocytic leukemia (CLL) / small lymphocytic lymphoma (SLL) for whom fludarabine-based treatment is inappropriate due to high-risk cytogenetic markers (i.e., del17p, TP53 mutation, or unmutated IGHV).
2. As monotherapy for adult patients with relapsed or refractory CLL / SLL who have received at least one prior therapy.

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

1. Patients must have a good performance status.

2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

Requests will not be considered for patients who experience disease progression on a Bruton's tyrosine kinase (BTK) inhibitor or idelalisib.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Acamprosate, delayed release, tablet, 333mg (Campral-MYL)

Note: For Substance Use Harm Reduction Drug Program, no Special Authorization is required.

For the treatment of alcohol use disorder.

Actemra – see Tocilizumab

Actonel 30mg - see Risedronate

Adalimumab, 20mg/0.2mL prefilled syringe (Hyrimoz-SDZ); 20mg/0.4mL prefilled syringe (Abrilada-PFI, Amgevita-AMG, Hulio-BGP); 40mg/0.4mL prefilled syringe, 40mg/0.4mL pen injector (Hadlima-MER, Hyrimoz-SDZ, Simlandi-JPC, Yuflyma-LIL) 40mg/0.8mL prefilled syringe (Abrilada-PFI, Amgevita-AMG, Hadlima-MER, Hulio-BGP, Idacio-FKB), 40mg/0.8mL prefilled pen (Abrilada-PFI, Amgevita-AMG, Hadlima-MER, Hulio-BGP, Idacio-FKB), 80mg/0.8mL prefilled syringe (Hyrimoz-SDZ, Simlandi-JPC, Yuflyma-CLT), 80mg/0.8mL pen injector (Hyrimoz-SDZ, Yuflyma-CLT)

Ankylosing Spondylitis

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- a) have axial symptoms* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR
- b) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for a maximum of 40 mg every two weeks.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Requests for renewal must include information showing the beneficial effects of the treatment, specifically:
 - a) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
 - b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as
 - c) Health Assessment Questionnaire (HAQ) or ability to return to work).
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Crohn's Disease

For the treatment of patients with moderate to severe Crohn's disease who have active disease and are refractory, intolerant or have contraindications to:

- Prednisone 40mg (or equivalent) daily for ≥ 2 weeks, AND
- Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
- Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
- Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:

- Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
- Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients

who have an aggressive/severe disease course (e.g. extensive disease, a modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.

Claim notes:

- Initial 12 week approval for an induction dose of 160mg followed by 80mg two weeks later, then 40mg every two weeks thereafter. Renewal of coverage will require reassessment of the patient and submission of a new Crohn's Disease Special Authorization form. Continued coverage may be approved at a dose not exceeding 40mg every 2 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a gastroenterologist using the Crohn's Disease Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Hidradenitis Suppurative

For the treatment of patients with active moderate to severe hidradenitis suppurativa (HS) who have not responded to conventional therapy and who meet all of the following criteria:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics

Claim Notes:

- Approvals will be for a maximum of 160mg followed by 80mg two weeks later, then 40mg every week beginning four weeks after the initial dose.
- Initial Approval: 12 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Must be prescribed by a dermatologist or physician with experience in the treatment of HS.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Plaque Psoriasis

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score; or
- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Concurrent use of biologics not approved.
- Approvals will be for a maximum dose of 80 mg administered once, followed by 40 mg after 1 week of initial dose, then 40mg every other week thereafter up to 16 weeks. If response criteria is met at 16 weeks, approval will be continued at a dose of 40 mg every two weeks up to one year.
- Initial Approval: 16 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.

The request must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The

patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Polyarticular Juvenile Idiopathic Arthritis (pJIA)

For the treatment of pJIA for patients aged 4-17 years with moderately or severe pJIA who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs). Treatment must be initiated by a rheumatologist who is familiar with the use of DMARDs and/or biologic DMARDs in children.

Claim Notes:

- Approvals will be for a maximum dose of 40mg every two weeks
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; and
 - Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum dose of 40mg every two weeks
- Initial Approval 16 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks

AND

Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks;

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Approvals will be for a maximum dose of 40mg every two weeks
- Must be prescribed by a rheumatologist.
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at

<http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at

<http://www.princeedwardisland.ca/pharmacareforms>.

Ulcerative Colitis

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone ≥ 40 mg daily for two weeks or IV equivalent for one week) OR
- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Initial Approval: 8 week approval is for an induction dose of 160 mg followed by 80 mg two weeks later, then 40 mg every two weeks thereafter. Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:
 - a decrease in the partial Mayo score ≥ 2 from baseline, and
 - a decrease in the rectal bleeding subscore ≥ 1 .
- Renewal Approval: Long term. Maximum approved dose is 40 mg every two weeks.
- Combined use of more than one biologic DMARD will not be reimbursed.

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo > 6) do not require a trial of 5-ASA

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Uveitis

For the treatment of patients with non-infectious uveitis who are refractory, intolerant or have contraindications to conventional therapy.

Claim Notes:

- Must be prescribed by, or in consultation with an ophthalmologist.
- Approvals will be for a maximum of 80 mg followed by 40mg in one week, then 40 mg every two weeks thereafter
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Adempas – see Riociguat

Advair - see Salmeterol & Fluticasone

Advair Diskus - see Salmeterol & Fluticasone

Afatinib, tablet, 20mg, 30mg, 40mg (Giotrif-BOE and generic)

For the first line treatment of patients with EGFR mutation positive advanced or metastatic adenocarcinoma of the lung and with an ECOG performance status of 0 or 1.

NOTE

Use of Afatinib precludes the use of any other EGFR inhibitor as a subsequent line of

therapy.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Aflibercept, vial, 2mg/0.5mL (Eylea-BAY)

1. Neovascular Age-Related Macular Degeneration:

Criteria For Initial Coverage:

For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) where all of the following apply:

- a) Best Corrected Visual Acuity (BCVA) is between 6/12 and 6/96 **AND**
- b) The lesion size is less than or equal to 12 disc areas in greatest linear dimension **AND**
- c) There is evidence of recent (<3 months) presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, optical coherence tomography (OCT), or recent visual acuity changes. The interval between doses should not be shorter than one month. Administration is to be done by a qualified ophthalmologist experienced in intravitreal injections.

Criteria For Continued Coverage:

Treatment with aflibercept should be continued only in people who maintain adequate response to therapy.

Aflibercept should be discontinued if any of the following occur:

- a) Reduction in BCVA in the treated eye to less than 15 letters (absolute) on 2 consecutive visits in the treated eye, attributed to AMD in the absence of other pathology Or
- b) Reductions in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect, adverse events, or both OR
- c) There is evidence of deterioration of the lesion morphology despite optimum treatment over 3 consecutive visits.

Coverage will not be approved for patients:

- a) Receiving concurrent treatment with verteporfin.
- b) With permanent retinal damage as defined by the Royal College of Ophthalmology guidelines.

Coverage is limited to a maximum of one vial per eye in any 30-day period. The request for coverage must be made by an ophthalmologist.

Approval Period: 1 year

2. Diabetic macular edema (DME)

Initial coverage:

For the treatment of visual impairment due to diabetic macular edema (DME) in patients who meet all of the following criteria:

- clinically significant centre-involving macular edema for whom laser photocoagulation is also indicated
- hemoglobin A1c test in the past 6 months with a value of less than or equal to 11%
- best corrected visual acuity of 20/32 to 20/400
- central retinal thickness greater than or equal to 250 micrometers

Renewal Criteria:

- confirm that a hemoglobin A1c test in the past 6 months had a value of less than or equal to 11%
- date of last visit and results of best corrected visual acuity at that visit
- date of last OCT and central retinal thickness on that examination
- if aflibercept is being administered monthly, please provide details on the rationale

Clinical Notes:

1. Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.
2. Treatment should be resumed when monitoring indicates a loss of visual acuity due to DME and continued until stable visual acuity is reached again for three consecutive months.
3. Treatment should be discontinued if there is no improvement of retinal thickness or visual acuity after five consecutive treatments.
4. Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year

3. Retinal vein occlusion (RVO)

For the treatment of visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (BRVO).

Clinical Notes:

1. Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.
2. Treatment should be resumed when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive months.
3. Treatment should be discontinued if there is no improvement after 6 months of initial treatment.
4. Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Agalsidase alfa – see Replagal

Agalsidase beta – see Fabrazyme

Agrylin - see Anagrelide

Ajovy – see Fremanezumab

Akynzeo – see Netupitant & Palonosetron

Alecensaro – see Alectinib

Alectinib, capsule, 150mg (Alecensaro-HLR)

For the treatment of patients with anaplastic lymphoma kinase (ALK)-positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer when used:

- as first-line therapy, or
- following disease progression on, or intolerance to, crizotinib.

Renewal Criteria:

- Confirmation that the patient is responding to treatment.

Claim Notes:

- Requests for alectinib will not be considered for patients who experience disease progression on any ALK inhibitor other than crizotinib.

- No further ALK inhibitor will be reimbursed following disease progression on alectinib.
- Initial Approval Period: 1 year.
- Renewal Approval Period: 1 year

* Claims that exceed the maximum claim amount of \$9999.99 must be divided as separate transactions, using DIN first and PDIN* second.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Alertec - see Modafinil

Alirocumab, prefilled pen, 75mg/mL, 150mg/mL, 300mg/2mL (Praluent-SAV)

For the treatment of heterozygous familial hypercholesterolemia (HeFH) in adult patients who require additional lowering of low-density lipoprotein cholesterol (LDL-C) if the following criteria are met:

- Definite or probable diagnosis of HeFH using the Simon Broome or Dutch Lipid Network criteria or genetic testing; and
- Patient is unable to reach LDL-C target (less than 2.0 mmol/L or at least a 50% reduction in LDL-C from untreated baseline) despite confirmed adherence to at least 3 months of continuous treatment with:
high-dose statin (e.g. atorvastatin 80 mg, rosuvastatin 40 mg) in combination with ezetimibe; or—ezetimibe alone, if high dose statin is not possible due to rhabdomyolysis, contraindication or intolerance.

Initial renewal criteria:

- A reduction in LDL-C of at least 40% from baseline or has reached a target LDL-C less than 2.0 mmol/L.

Subsequent renewal criteria:

- The patient continues to maintain a reduction in LDL-C of at least 40% from baseline or has reached a target LDL-C less than 2.0 mmol/L.

Clinical Notes:

1. LDL-C levels must be provided.
2. Intolerance to high dose statin will be considered if patient has developed documented myopathy or abnormal biomarkers (i.e. creatinine kinase greater than 5 times the upper limit of normal) after trial of at least two statins and—for

- each statin, dose reduction was attempted rather than statin discontinuation, and intolerance was reversible upon statin discontinuation, but reoccurred with statin re-challenge where clinically appropriate; and
 - at least one statin was initiated at the lowest daily starting dose; and
 - other known causes of intolerance have been ruled out.
- 3. For patients who cannot take ezetimibe due to an intolerance or contraindication, details must be provided.

Claim Notes:

- Approvals will be for a maximum of 300mg every 4 weeks.
- Initial Approval Period: 6 months.
- Renewal Approval Period: 1 year.

Alunbrig – see Brigatinib

Ambrisentan, 5mg, 10mg (Volibris-GSK and generics)

For treatment of patients with pulmonary arterial hypertension (PAH), of at least World Health Organization (WHO) functional class III, which is associated with either idiopathic or connective tissue disease and who have failed to respond to or who have contraindications to, or who are not a candidate for sildenafil.

Clinical Notes:

1. Diagnosis of PAH should be confirmed by cardiac catheterization
2. Ambrisentan will not be approved when used concurrently with other endothelin receptor antagonists, epoprostenol, treprostinil or sildenafil.
3. Coverage must be requested and medications prescribed by a Pulmonary Arterial Hypertension (PAH) specialist.

Claim Note:

The maximum dose of ambrisentan that will be reimbursed is 10mg daily

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Amerge - see Naratriptan HCl

Amgevita – see Adalimumab

Amifampridine, tablet, 10mg (Ruzurgi-MDU)

For the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in patients 6 years of age or older.

Initial Renewal Criteria:

- An improvement of at least 30% on the Triple Timed Up and Go (3TUG) test compared to baseline measurement.

Subsequent Renewal Criteria:

- The patient continues to maintain an improvement of at least 30% on the 3TUG test compared to baseline measurement.

Clinical Note:

1. The 3TUG test score must be provided with initial and renewal requests.

Claim Notes:

1. Must be prescribed by a neurologist.
2. Approvals will be up to a maximum daily dose of 40 mg for patients weighing less than 45 kg and 100 mg for patients weighing 45 kg or more.
3. Initial Approval Period: 3 months. Renewal Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Amifampridine phosphate, tablet, 10mg (Firdapse-KYE)

For the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in patients 18 years of age and older.

Initial Renewal Criteria:

- An improvement of at least 30% on the Triple Timed Up and Go (3TUG) test compared to baseline measurement.

Subsequent Renewal Criteria:

- The patient continues to maintain an improvement of at least 30% on the 3TUG test compared to baseline measurement.

Clinical Note:

1. The 3TUG test score must be provided with initial and renewal requests.

Claim Notes:

1. Must be prescribed by a neurologist.
2. Approvals will be up to a maximum daily dose of 80mg.
3. Initial Approval: 3 months. Renewal Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at

Amlodipine, oral solution, 1mg/mL (Generic)

- For patients who require administration through a feeding tube.
- For patients 19 years of age and younger, who cannot use a tablet or capsule.
- Pediatric patients 12 and under will not require written Special Authorization.

Anagrelide, capsule, 0.5mg (Agrylin-SHR and generics)

For the treatment of essential thrombocythemia (ET) in patients who have:

- a) Failed Hydroxyurea therapy (does not provide sufficient platelet reduction) or
- b) Have intolerable side effects to Hydroxyurea therapy.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Anifrolumab, vial, 150mg/mL (Saphnelo-AZE)

For the treatment of adult patients with moderate to severe autoantibody positive, systemic lupus erythematosus (SLE) who meet all of the following criteria:

- Systemic lupus erythematosus disease activity index 2000 (SLEDAI-2K) score of 6 or greater.
- Refractory to oral corticosteroids (OCS) at a dose of at least 10 mg per day of prednisone or its equivalent, in addition to standard of care.

Renewal criteria:

- OCS dose has decreased to less than or equal to 7.5 mg per day of prednisone or its equivalent OR OCS dose decreased by at least 50% from baseline; and
- Reduction in disease activity as measured by:
 - Reduction in the SLEDAI-2K index score to 5 or less; or
 - British Isles lupus assessment group (BILAG)-2004 index score improvement in involved organ systems and no new worsening in other organ systems.

Subsequent renewal criteria:

- Initial response achieved after the first twelve months of treatment with anifrolumab has been maintained.

Clinical notes:

- Standard of care is defined as using an immunosuppressive drug (e.g., rituximab, hydroxychloroquine, mycophenolic acid, or azathioprine) with or without NSAIDs.

- A baseline SLEDAI-2K must be provided. If BILAG-2004 is used for assessment on renewal, then a baseline BILAG-2004 assessment of organ systems must also be provided. The same scale should be used on all subsequent renewals.
- Improvement in organ systems is defined as a reduction of all severe BILAG-2004 A) or moderately severe BILAG-2004 B) to lower rating levels.
- Worsening in organ systems is defined as at least one new BILAG-2004 A item or at least two new BILAG-2004 B items.

Exclusion criteria:

- Severe or unstable neuropsychiatric SLE.
- Active severe SLE nephritis.

Claim notes:

- Patient should be under the care of a physician with expertise in the diagnosis and management of SLE.
- Combined use with other biologic drugs will not be reimbursed.
- Approvals will be for a maximum of 300 mg every four weeks.
- Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

AndroGel- see Testosterone

Anoro Ellipta – see Umeclidinium Bromide & Vilanterol Trifenatate

Apalutamide, tablet, 60mg, 240mg (Erleada-LIL)

1. In combination with androgen deprivation therapy (ADT) for the treatment of patients with castration-resistant prostate cancer (CRPC) who have no detectable distant metastasis (M0) by either CT, MRI or technetium-99m bone scan and who are at high risk of developing metastases¹.

Patients should have a good performance status and no risk factors for seizures. Treatment should continue until unacceptable toxicity or radiographic disease progression.

Clinical Notes:

- Castration-resistance must be demonstrated during continuous ADT and is defined as 3 PSA rises at least one week apart, with the last PSA > 2 ng/mL.
- Castrate levels of testosterone must be maintained.
- Patients with N1 disease, pelvic lymph nodes < 2cm in short axis located below the common iliac vessels are eligible for apalutamide.
- Apalutamide will not be funded for patients who experience disease progression on enzalutamide.

- Patients receiving apalutamide for the treatment of non-metastatic CRPC will be eligible for funding of abiraterone at the time of disease progression to metastatic CRPC. Enzalutamide is not funded for patients who experience disease progression to metastatic CRPC while on apalutamide.
- Either abiraterone or enzalutamide may be used to treat metastatic CRPC in patients who discontinued apalutamide in the non-metastatic setting due to intolerance without disease progression.

¹ High risk of developing metastases is defined as a prostate-specific antigen (PSA) doubling time of ≤ 10 months during continuous ADT

2. In combination with androgen deprivation therapy (ADT) for the treatment of patients with metastatic castration-sensitive prostate cancer (mCSPC). Patients must have had either no prior ADT, or are within six months of beginning ADT in the metastatic setting.

Clinical Notes:

- Patients should have a good performance status and no risk factors for seizures.
- Treatment should continue until unacceptable toxicity or disease progression.

Claim Notes:

- Patients receiving apalutamide for the treatment of metastatic CSPC will be eligible for funding of abiraterone at the time of disease progression to metastatic CRPC.
- Enzalutamide is not funded for patients who experience disease progression to metastatic CRPC while on apalutamide.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Aprepitant, capsule, 80mg, 125mg, 80mg & 125mg package (Emend, Emend Tri-Pack)

In combination with dexamethasone for the prevention of acute and delayed nausea and vomiting in patients receiving:

- highly emetogenic chemotherapy or
- moderately emetogenic chemotherapy who have had inadequate symptom control using a 5-HT₃ antagonist and dexamethasone in a previous cycle.

Clinical Notes:

- Highly emetogenic chemotherapy (HEC) includes but it not limited to : cisplatin regimens, anthracycline and cyclophosphamide combination regimens, and regimens containing carmustine, mechlorethamine, streptozocin, dacarbazine, and cyclophosphamide $> 1500\text{mg/m}^2$
- Patients who receive carboplatin-based regimens with $\text{AUC} \geq 4$ are also eligible to receive aprepitant in combination a 5-HT₃ antagonist and dexamethasone for

primary prevention of acute and delayed nausea and vomiting

Aptiom – see Eslicarbazepine Acetate

Aptivus – see Tipranavir

Aranesp - see Darbepoetin Alfa

Aripiprazole, injection, 300mg, 400mg (Abilify Maintena-OTS)

Note: For Community Mental Health Drug Program, no Special Authorization is required.

For the treatment of schizophrenia or schizoaffective disorder in patients who have:

- a) A history of non adherence
OR
- b) Inadequate control or significant side effects from two or more oral antipsychotic medications
OR
- c) Inadequate control or significant side effects from at least one long acting depot antipsychotic agent.

In accordance with the manufacturer's product monograph:

For patients who have never taken aripiprazole, establish tolerability with oral aripiprazole prior to initiating treatment with Abilify Maintena.

Asciminib, tablet, 20mg, 40mg (Scemblix-NVR)

For the treatment of adult patients with Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in the chronic phase who meet the following criteria:

- Treatment failure on or intolerance to a minimum of two prior tyrosine kinase inhibitor (TKI) therapies.
- No evidence of a T315I or V299L mutation.

Clinical Notes:

1. Patients should have a good performance status.
2. Not for use in the acute phase or blast phase.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Asenapine, sublingual tablet, 5mg, 10mg (Saphris-MSD)

For the acute treatment of manic or miXPI episodes associated with bipolar I disorder as either:

- Monotherapy, after a trial of lithium or divalproex sodium has failed, and trials of less expensive atypical antipsychotic agents have failed due to intolerance or lack of response.
- Co-therapy with lithium or divalproex sodium, after trials of less expensive atypical antipsychotic agents have failed due to intolerance or lack of response.

Atectura Breezhaler – see Indacaterol & Mometasone

Atogepant, tablet, 10mg, 30mg 60mg (Qulipta-ABV)

For the prevention of migraine in patients with a confirmed diagnosis of episodic or chronic migraine who have experienced an inadequate response, intolerance, or contraindication to at least two classes of oral prophylactic migraine medications.

Renewal Criteria:

- A reduction of at least 50% in the average number of migraine days per month at the time of initial renewal compared with baseline.
- At subsequent renewals, the patient continues to maintain the reduction of at least 50% in average number of migraine days per month.

Clinical Notes:

- The average number of headache and migraine days per month must be provided on initial and renewal requests.
- According to the International Headache Society criteria, episodic or chronic migraine are defined as:
 - Episodic migraine: migraine headaches on at least 4 days per month and less than 15 headache days per month for more than 3 months.
 - Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least eight days per month are with migraine.

Claim Notes:

- Initial Approval: 6 months
- Renewal Approval: 1 year

Aubagio – see Multiple Sclerosis Agents

Avonex - see Multiple Sclerosis Agents

Avsola – see Infliximab

Axitinib, tablet, 1 mg, 5 mg (Inlyta-PFI)

For the treatment of patients with advanced or metastatic renal cell carcinoma when

used as:

- As first-line therapy in combination with pembrolizumab; or
- Second-line therapy following disease progression on a vascular endothelial growth factor receptor tyrosine kinase inhibitor (i.e., sunitinib or pazopanib); or
- Third-line therapy following disease progression on first-line nivolumab and ipilimumab combination therapy and a second-line vascular endothelial growth factor receptor tyrosine kinase inhibitor.
- Patients must have a good performance status.
- Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Sequential use of axitinib and everolimus is not permitted except in the case of intolerability or contraindication.
- Sequential use of axitinib (as a single agent) and cabozantinib is not permitted for patients following progression on first-line axitinib + pembrolizumab.
- For patients treated with nivolumab + ipilimumab first-line and VEGFR TK1 second line, either cabozantinib or axitinib may be used as third-line therapy.
- Both clear cell and non-clear cell histology are eligible for treatment.
- Approval Period: 1 year

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Azacitidine, tablet, 200mg, 300mg (Onureg-CEL)

As maintenance therapy for adult patients with acute myeloid leukemia (AML) who meet all of the following criteria:

- Intermediate or poor risk cytogenetics
- Complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following induction therapy, with or without consolidation treatment
- Not eligible for hematopoietic stem cell transplantation (HSCT)

Clinical Notes:

1. Newly diagnosed includes patients with AML de novo or secondary to prior myelodysplastic syndrome (MDS) or chronic myelomonocytic leukemia (CMML).
2. Last dose of chemotherapy should be within 4 months of starting azacitidine maintenance.
3. Treatment should be discontinued upon disease relapse (i.e., appearance of

greater than 5% blasts in the bone marrow or peripheral blood), unacceptable toxicity, or if patient becomes eligible for allogeneic bone marrow or stem cell transplant during the treatment period.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Azithromycin, tablet, 250mg, 600mg; oral suspension, 20mg/mL, 40mg/mL (Zithromax-PFI and generics)

Note: For HIV, Cystic Fibrosis, Sexually Transmitted Infections, and Tuberculosis Programs, no Special Authorization is required.

- a) For the treatment of infections requiring a macrolide antibiotic when the patient has a documented intolerance to clarithromycin
- b) For the completion of hospital initiated treatment with azithromycin (maximum 5 days)
- c) For the treatment and prevention of non-tuberculosis mycobacterial
- d) For the treatment of infections requiring a macrolide antibiotic when the patient is taking medications that would significantly interact with erythromycin/clarithromycin

Aztreonam, inhalation vial, 75mg/mL (Cayston-GIL)

For the treatment of chronic pulmonary *Pseudomonas aeruginosa* infections, when used as a cyclic treatment, in patients with moderate to severe cystic fibrosis and deteriorating clinical condition despite treatment with inhaled tobramycin.

Clinical Note:

Cyclic treatment measured in 28-day cycles is defined as 28 days of treatment, followed by 28 days without treatment.

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Baqsimi – see Glucagon

Baraclude – see Entecavir

Baricitinib, tablet, 2mg (Olumiant-LIL)

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult

patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks AND

Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Approvals will be for a maximum adult dose of 2 mg daily.
- Must be prescribed by a rheumatologist.
- Initial Approval: 6 months
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Benralizumab, syringe, autoinjector, 30mg/mL (Fasenra-AZN)

As add-on maintenance treatment for adult patients with severe eosinophilic asthma, if the following criteria are met:

Initiation Criteria:

- Patient must have a documented diagnosis of asthma.
- Patient is inadequately controlled with high-dose inhaled corticosteroids, defined as greater or equal to 500mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists).
- Patient has one of the following:
 - blood eosinophil count of ≥ 300 cells/ μ L within the past 12 months AND has experienced two or more clinically significant asthma exacerbations in the past 12 months, or
 - blood eosinophil count of ≥ 150 cells/ μ L AND is receiving maintenance treatment with oral corticosteroids (OCS).

Renewal Criteria:

- The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue
- Reimbursement of treatment should be discontinued if:
 - the 12 months asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment, or
 - the asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
 - the number of clinically significant exacerbations has increased within the previous 12 months, or
 - in patients on maintenance treatment with OCS, there has been no decrease in the OCS dose in the first 12 months of treatment, or
 - in patients on maintenance treatment with OCS, the reduction in the dose of OCS achieved after the first 12 months of treatment is not maintained subsequently.

Clinical Notes:

- Benralizumab should not be used in combination with other biologics used to treat asthma.
- A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of benralizumab treatment.
- Patients should be managed by a physician with expertise in treating asthma.

Claim Notes:

- Approvals will be for a maximum of 30 mg every four weeks for 12 weeks, then every eight weeks thereafter.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Benzydamine HCl, oral rinse, 0.15% (Generic)

For oncology patients only.

Berotrastat HCL, capsule, 150mg (Orladeyo-BCP)

For the routine prevention of attacks of type I or II hereditary angioedema (HAE) in adults and pediatric patients 12 years of age and older, who have experienced at least three HAE attacks within any four-week period and required the use of an acute injectable treatment.

Discontinuation Criteria:

- No reduction in the number of HAE attacks for which acute injectable treatment was received during the first three months of treatment with berotrastat compared to the number of attacks observed before initiating treatment with berotrastat; or
- Increase in the number of HAE attacks for which acute injectable treatment was received compared to the number of attacks before initiating treatment with berotrastat.

Clinical Note:

- The pre-treatment attack rate must be provided. For those patients who are already receiving long-term prophylactic treatment for HAE and intend to transition to berotrastat, pre-treatment attack rate prior to long-term prophylactic treatment must be provided.

Claim Notes:

- The patient must be under the care of a physician experienced in the diagnosis and treatment of HAE.
- Not be used in combination with other medications used for long-term prophylaxis (LTP) treatment of angioedema (e.g., C1-esterase inhibitors or lanadelumab).
- Approvals will be for a maximum of 150mg daily.
- Initial approval period: 3 months.
- Renewal approval period: 6 months.

The Special Authorization form is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Betahistine HCL, tablet, 16mg, 24mg (Serc-BGP and generics)

For the symptomatic treatment of recurrent episodes of vertigo associated with Meniere's disease.

Betaseron - see Multiple Sclerosis Agents

Beovu – see Brolocizumab

Bimekizumab, prefilled syringe, 160mg/mL, 320mg/2mL; autoinjector, 160mg/mL, 320mg/2mL (Bimzelx-UCB)

Ankylosing Spondylitis

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- a) have axial symptoms* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR
- b) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for 160mg by subcutaneous injection every 4 weeks.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: maximum of 12 months. Requests for renewal must include information showing the beneficial effects of the treatment, specifically:
 - a) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
 - b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Plaque Psoriasis

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score ; or
- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Concurrent use of biologics not approved.
- Approvals will be for 320mg given every 4 weeks for 16 weeks then 320 mg every 8 weeks thereafter
- Initial Approval: 16 weeks.
- Renewal Approval: 1 year.

The request must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.

- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
- Sequential use of at least two NSAIDs for a minimum of two weeks each; and
 - Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Approvals will be for 160mg by subcutaneous injection every 4 weeks.
- Initial Approval: 6 months
- Renewal Approval: 1 year

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Bimzelx – see Bimekizumab

Biphentin - see Methylphenidate

Binimetinib, tablet, 15mg (Mektovi-PFI)

For the treatment of patients with BRAF V600 mutation-positive locally advanced unresectable or metastatic melanoma when used in combination with encorafenib.

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

1. Patients must have a good performance status.
2. If brain metastases are present, patients should be asymptomatic or have stable symptoms.
3. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Binimetinib will not be reimbursed in patients who have progressed on BRAF targeted therapy
- Requests will be considered for patients who received adjuvant BRAF targeted therapy if disease progression occurred at least 6 months following completion of therapy

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Bisacodyl, suppository (water based), 10mg (Magic Bullet)

For the treatment of bowel incontinence where alternative therapies have failed.

For use as part of a bowel program for neurogenic bowel dysfunction in patients with spinal cord injuries.

Bosentan, tablet, 62.5mg, 125mg (Tracleer-ACT and generics)

For treatment of pulmonary arterial hypertension (PAH) in patients with World Health Organization (WHO) functional class III or IV.

Clinical Notes:

- Idiopathic pulmonary arterial hypertension (IPAH) in patients who do not demonstrate vasoreactivity on testing or who demonstrate vasoreactivity on testing but fail a trial of, or are intolerant to, calcium channel blockers.
- Pulmonary arterial hypertension associated with connective tissue disease or congenital heart disease or human immunodeficiency virus (HIV) who do not respond adequately to conventional therapy.

Coverage must be requested and medications prescribed by a Pulmonary Arterial Hypertension (PAH) specialist.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at

<http://www.princeedwardisland.ca/pharmacareforms>

Bosulif – see Bosutinib

Bosutinib, tablet, 100mg, 500mg (Bosulif-PFI)

For treatment of adult patients with chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with resistance or intolerance to prior TKI therapy.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Braftovi – see Encorafenib

Breztri Aerosphere – see Budesonide Glycopyrronium Formoterol

Brigatinib, tablet, 30mg, 90mg, 180mg; initiation kit, 90mg (7) & 180mg (21) (Alunbrig-TAK)

For the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer who have not been previously treated with an ALK inhibitor.

Renewal Criteria:

- Written confirmation that the patient is responding to treatment.

Clinical Note:

- Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.

Claim Notes:

- No further ALK inhibitor will be reimbursed following disease progression on brigatinib.
- Initial Approval Period: 1 year.
- Renewal Approval Period: 1 year

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at

<http://www.princeedwardisland.ca/pharmacareforms>

Brilinta – see Ticagrelor

Brivaracetam, tablet, 10mg, 25mg 50mg, 75mg, 100mg (Brivlera-UCB and generics)

For the treatment of partial onset seizures in patients with epilepsy who are not satisfactorily controlled with conventional therapy if the following clinical criteria and conditions are met:

1. Patients are currently receiving two or more antiepileptic drugs (AEDs).
2. Patients are not receiving concurrent therapy with levetiracetam.
3. Patients are those for whom less costly AEDs are ineffective or not clinically appropriate.

Brivlera – see Brivaracetam

Breo Ellipta – see Fluticasone Furoate/Vilanterol

Brenzys - see Etanercept

Brolucizumab, prefilled syringe, 6 mg/0.05 mL (Beovu-NVR)

1. Neovascular Age-Related Macular Degeneration

Initial Coverage:

For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD).

Discontinuation Criteria:

- Reduction in Best Corrected Visual Acuity (BCVA) in the treated eye of 15 letters or more on 2 consecutive visits, attributed to AMD in the absence of other pathology, or
- Reduction in BCVA in the treated eye of 30 letters or more compared to either baseline and/or best recorded level, or
- There is evidence of deterioration of the lesion morphology despite optimum treatment over 3 consecutive visits.

Clinical Note:

- BCVA must be provided with initial request and with subsequent renewal requests.

Claim Notes:

- Approvals will be for a maximum of 1 prefilled syringe per eye every 4 weeks for 12 weeks, followed by 1 prefilled syringe per eye every 8 weeks thereafter.
- Approval Period: 1 year.

2. Diabetic Macular Edema (DME)

Initial coverage:

For the treatment of visual impairment due to diabetic macular edema (DME) in patients who meet all of the following criteria:

- clinically significant centre-involving macular edema for whom laser photocoagulation is also indicated
- hemoglobin A1c test in the past 6 months with a value of less than or equal to 11%
- best corrected visual acuity of 20/32 to 20/400
- central retinal thickness greater than or equal to 250 micrometers

Renewal Criteria:

- confirm that a hemoglobin A1C test in the past 6 months had a value of less than or equal to 11%
- date of last visit and results of best corrected visual acuity at that visit
- date of last OCT and central retinal thickness on that examination

Clinical Notes:

- Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.
- Treatment should be resumed when monitoring indicates a loss of visual acuity due to DME and continued until stable visual acuity is reached again for three consecutive months.
- Treatment should be discontinued if there is no improvement of retinal thickness or visual acuity after three consecutive treatments.
- Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Brodalumab, syringe, 210mg/1.5mL (Siliq-VAL)

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;

- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A $>75\%$ reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score ; or
- A $>50\%$ reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Concurrent use of biologics not approved.
- Approvals will be for a maximum adult dose of 210mg administered at 0, 1 and 2 weeks followed by 210mg every 2 weeks. If response criteria is met at 16 weeks, approval will be continued at a dose of 210mg every two weeks up to one year.
- Initial Approval Period: 16 weeks
- Renewal Approval Period: 1 year

Requests must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Brukina – see Zanubrutinib

Budesonide, inhalation solution, 0.125mg/mL , 0.25mg/mL , 0.5mg/mL (Pulmicort Nebuamp-AZE and generics)

Note: For Nursing Home Program, no Special Authorization is required.

- For use in patients on the Nursing Home Program.
- For use in children under 6 years of age. The pharmacy must call the drug programs office to have coverage set up initially. Coverage will be in place until the child's sixth birthday.
- Other uses will be considered on a case by case basis where there are extreme circumstances.

Burosumab, vial, 10mg/mL, 20mg/mL, 30mg/mL (Crysvita-ULT)

For the treatment of patients with X-linked hypophosphatemia (XLH) who meet the following criteria:

- Initiated in a pediatric patient who is at least one year of age and in whom epiphyseal closure has not yet occurred
- Fasting hypophosphatemia
- Normal renal function (defined as a serum creatinine below the age-adjusted upper limit of normal)
- Radiographic evidence of rickets with a rickets severity score (RSS) of two or greater
- Confirmed phosphate-regulating endopeptidase homolog, X-linked (PHEX) gene variant in either the patient or in a directly related family member with appropriate X-linked inheritance

Discontinuation Criteria:

In pediatric patients under 18 years of age in whom epiphyseal closure has not yet occurred and who met the above criteria, treatment should be discontinued if

- there is no demonstrated improvement in the 12-month RSS total score from baseline RSS total score; or
- the patient's RSS total score achieved after the first 12 months of therapy has not been maintained subsequently.

In adolescent patients who are 13 to 17 years of age in whom epiphyseal closure has occurred and who met the above criteria and initiated treatment as a pediatric patient, treatment should be discontinued if any of the following occur:

- Hyperparathyroidism; or
- Nephrocalcinosis; or
- Evidence of fracture or pseudo-fracture based on radiographic assessment.

In adult patients who met the above criteria and initiated treatment as a pediatric patient, treatment should be discontinued if any of the following occur:

- Hyperparathyroidism; or
- Nephrocalcinosis; or
- Evidence of fracture or pseudo-fracture based on radiographic assessment.

Claim Notes:

- Requests will not be considered for treatment-naïve adults
- Must be prescribed by a physician working in a multidisciplinary team of health care providers who are experienced in the diagnosis and management of XLH
- Approvals for children (1-17 years of age) will be up to a maximum of 90mg every 2 weeks
- Approvals for adults (18 years of age and older) will be up to a maximum of 90mg every 4 weeks.
- Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Byooviz – see Ranibizumab

Cabenuva – see Cabotegravir & Rilpivirine

Cabometyx – see Cabozantinib

Cabotegravir, tablet, 30mg (Vocabria-VII)

For the treatment of adult patients with HIV-1 infection who are virologically stable and suppressed (HIV-1 RNA less than 50 copies per mL).

Cabotegravir & Rilpivirine, vial, 400mg/600mg, 600mg/900mg (Cabenuva-VII)

For the treatment of adult patients with HIV-1 infection who are virologically stable and suppressed (HIV-1 RNA less than 50 copies per mL).

Cabozantinib, tablet, 20mg, 40mg, 60mg (Cabometyx-IPS)

Advanced or Metastatic Renal Cell Carcinoma (RCC)

For the treatment of patients with advanced or metastatic renal cell carcinoma who have received at least one prior vascular endothelial growth factor receptor (VEGFR) tyrosine kinase inhibitor (TKI) therapy when used as:

- second-line therapy following disease progression on sunitinib, pazopanib or pembrolizumab in combination with axitinib; or
- third-line therapy following disease progression on immunotherapy and VEGFR TKI (i.e., sunitinib or pazopanib), used in any sequence.

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no

evidence of clinically meaningful disease progression.

Clinical Note:

- Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.

Claim Notes:

- Requests for cabozantinib will not be considered for patients who experience disease progression on everolimus or axitinib monotherapy.
- Initial Approval Period: 1 year.
- Renewal Approval Period: 1 year

Differentiated Thyroid Carcinoma (DTC)

For the treatment of adult patients with locally advanced or metastatic differentiated thyroid carcinoma (DTC) who have progressed on at least one prior line of vascular endothelial growth factor receptor (VEGFR)-targeted tyrosine kinase inhibitor (TKI) therapy.

Clinical Notes:

- Patients should have a good performance status.
- Patients should be refractory to radioactive iodine therapy (RAI-R) or not eligible for radioactive iodine therapy.
- Treatment should continue until disease progression or unacceptable toxicity.
- Patients will be eligible for funding if intolerant to the prior line of VEGFR-targeted TKI therapy.
- Cabozantinib may be used in the third line setting for RET fusion positive patients after progression on or intolerance to selpercatinib.

Unresectable Hepatocellular Carcinoma (HCC)

For the second-line treatment of adult patients with unresectable hepatocellular carcinoma who meet all of the following criteria:

- Disease progression on sorafenib or lenvatinib
- Child-Pugh class status of A
- ECOG performance status of 0 or 1

Clinical Note:

- Treatment should continue until the patient no longer experiences clinical benefit or experiences unacceptable toxicity.

Claim Notes:

- Requests for cabozantinib will not be considered for patients who experience disease progression on regorafenib or atezolizumab in combination with bevacizumab.

- Approval Period: 6 months

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Calquence – see Acalabrutinib

Campral – see Acamprosate

Camzyos – see Mavacamten

Canagliflozin, tablet, 100mg, 300mg (Invokana-JAN)

For the treatment of patients with type 2 diabetes when added to metformin for patients who have inadequate glycemic control on metformin.

Clinical Notes:

For patients who cannot take metformin due to contraindications or intolerances, details must be provided.

Canakinumab, vial, 150mg/mL (Ilaris-NVR)

For the treatment of active systemic juvenile idiopathic arthritis, in patients 2 years of age or older, who have an inadequate response or intolerance to systemic corticosteroids (with or without methotrexate) and tocilizumab.

Clinical Note:

- Intolerance is defined as a serious adverse effect as described in the product monograph. The nature of the intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by, or in consultation with, a rheumatologist, who is familiar with the use of biologic DMARDs in children.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Approvals will be for 4 mg/kg for patients > 9 kg, to a maximum of 300mg, administered every four weeks.
- Initial Approval Period: 16 weeks.
- Renewal Approval Period: 1 year. Confirmation of continued response is required.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Caprelsa – see Vandetanib

Carbamazepine, suspension, 100mg/5mL (Tegretol-NVR and generics)

For use in patients for indications as defined in the CPS, and who cannot use carbamazepine chewable, regular and controlled release tablets.

Carbidopa & Levodopa & Entacapone, tablet, 12.5mg/50mg/200mg, 25mg/100mg/200mg, 37.5mg/150mg/200mg, 18.75mg/75mg/200mg, 31.25mg/125mg/200mg (Stalevo-NVR)

For the treatment of Parkinson's disease in patients who are not well controlled and are experiencing significant "wearing off" symptoms despite optimal therapy with levodopa/carbidopa and are currently stabilized on levodopa/carbidopa and entacapone separately.

Cariprazine, capsules, 1.5mg, 3mg, 4.5mg, 6mg (Vraylar-ABV)

For the treatment of schizophrenia in adults.

Carnitor – see Levocarnitine

Caripul – see Epoprostentol

Cayston – see Aztreonam

Ceritinib, capsule, 150mg (Zykadia-NVR)

As monotherapy treatment for patients with anaplastic lymphoma kinase (ALK)-positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer who experience disease progression on, or intolerance to, crizotinib.

Renewal Criteria:

- Confirmation that the patient is responding to treatment.

Clinical Note:

- Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Certolizumab, syringe kit, 400mg/2mL; auto-injector kit, 400mg/2mL (Cimzia-UCB)

Ankylosing Spondylitis

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- c) have axial symptoms* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR
- d) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for a maximum adult dose of 400 mg (given as two SC injections of 200 mg) given at 0, 2, 4 weeks then 200 mg every two weeks thereafter.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: maximum of 12 months. Requests for renewal must include information showing the beneficial effects of the treatment, specifically:
 - c) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
 - d) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:

- Sequential use of at least two NSAIDs for a minimum of two weeks each; and
- Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
- Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 400 mg (given as two SC injections of 200 mg) given at 0, 2, 4 weeks then 200 mg every two weeks thereafter.
- Initial Approval 16 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of $\geq 20\text{ mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age), for a minimum of 12 weeks AND

Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Approvals will be for a maximum adult dose of 400 mg (given as two SC injections of 200 mg) given at 0, 2, 4 weeks then 200 mg every two weeks thereafter.
- Must be prescribed by a rheumatologist.
- Initial Approval: 6 months
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Cesamet - see Nabilone

Chlorhexidine, oral rinse, 0.12% (Peridex-MDA, Perichlor-PMS)

For the treatment of periodontal disease in long term care residents who need assistance in mouth care upon request or recommendation from a dentist. **A copy of the recommendation from the dentist may be required.**

Cholinesterase Inhibitors (ChEI)

**Galantamine, extended-release capsule, 8mg, 16mg, 24mg (Generics)
Rivastigmine, capsule, 1.5mg, 3mg, 4.5mg, 6mg (Exelon-NVR and generics)**

For the treatment of patients with mild to moderate dementia who have had an

intolerance to donepezil and who meet the following criteria:

- Mini-Mental State Exam (MMSE) score of 10 to 30 OR
- An InterRAI-Cognitive Performance Scale score of 0 to 4

Clinical Notes:

1. Requests must contain an updated MMSE score completed within 6 months of the request.
2. The nature of the intolerance must be described.

Claim Note:

Approval Period: 1 year

Chronic Obstructive Pulmonary Disease Medications

Aclidinium Bromide, aerosol powder for inhalation, 400mcg/dose (Tudorza Genuair-ALM)

Aclidinium Bromide & Formoterol Fumarate Dihydrate, aerosol powder, 400mcg/12mcg actuation (Duaklir Genuair-AZE)

Budesonide & Glycopyrronium & Formoterol, metered dose inhaler, 160mcg-7.2mcg-5mcg (Breztri Aerosphere-AZE)

Fluticasone & Umeclidinium & Vilanterol, dry powder for inhalation, 100mcg-62.5mcg-25mcg/dose (Trelegy Ellipta-GSK)

Fluticasone Furoate/Vilanterol, blister with inhalation device, 100mcg-25mcg/dose (Breo Ellipta-GSK)

Formoterol Fumarate, powder for inhalation (inhaler), 6mcg/dose, 12mcg/dose (Oxeze Turbuhaler-AZE)

Formoterol & Budesonide, powder for inhalation, 6mcg & 100mcg per dose, 6mcg & 200mcg per dose (Symbicort Turbuhaler-AZE)

Glycopyrronium Bromide, capsule for inhalation, 50mcg (Seebri Breezhaler-NVR)

Indacaterol & Glycopyrronium powder for inhalation (capsule), 110mcg-50mcg (Ultibro Breezhaler – NVR)

Salmeterol Xinafoate, aerosol powder disk, 50µg/dose (Serevent Diskus-GSK)

Salmeterol & Fluticasone, aerosol inhalation, 25mcg & 125mcg per dose, 25mcg & 250mcg per dose (Advair-GSK); inhaled powder disk, 50mcg & 100mcg per dose, 50mcg & 250mcg per dose, 50mcg & 500mcg per dose (Advair Diskus- GSK)

Tiotropium, capsule for inhalation, 18mcg/dose (Spiriva-BOE and generics); mist inhaler, 2.5mcg/dose (Spiriva Respimat-BOE)

Tiotropium & Olodaterol mist inhaler, 2.5mcg-2.5mcg, (Inspiroto Respimat - BOE)

Umeclidinium Bromide, blister with inhalation device, 62.5mcg (Incruse Ellipta-GSK)

Umeclidinium Bromide & Vilanterol Trifenatate, blister, 62.5mcg/25mcg (Anoro Ellipta-GSK)

Table 1 (of 4)	
Formoterol fumarate dehydrate (Oxeze Turbuhaler)	Aclidinium (Tudorza Genuair)

Salmeterol (Serevent)	Glycopyrronium Bromide (Seebri) Tiotropium (Spiriva and generics) 18mcg; (Spiriva Respimat) 2.5mcg Umeclidinium Bromide (Incruse Ellipta)

For any one agent listed in Table 1:

For the treatment of chronic obstructive pulmonary disease (COPD) as defined by spirometryⁱ in patients

AND

- Experiencing persistent symptoms, as defined by Medical Research Council (MRC) score ≥ 3 or Modified Medical Research Council (mMRC) score ≥ 2 ⁱⁱ or a COPD Assessment Test (CAT) score ≥ 10 ⁱⁱⁱ and a post-bronchodilator FEV₁ <80% predicted OR
- Experiencing 2 or more moderate exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids OR at least 1 acute severe exacerbation of COPD (AECOPD) requiring hospitalization.

NOTE: Coverage for both a LABA and a LAAC as separate inhalers will not be considered. See below for combination LABA/LAAC coverage criteria.

Table 2 (of 4)
Acclidinium Bromide & Formoterol Fumarate Dihydrate (Duaklir Genuair)
Indacaterol/Glycopyrronium (Ultibro Breezhaler)
Tiotropium/Olodaterol (Inspiralto Respimat)
Umeclidinium Bromide & Vilanterol Trifenatate (Anoro Ellipta)

For any one agent listed in Table 2:

- For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometryⁱ, in patients with inadequate control^{iv} with either a long-acting beta-2 agonist (LABA) or long-acting anticholinergic (LAAC).

Coverage for both a LABA and a LAAC as separate inhalers will not be considered. LABA/LAAC inhalers are not intended to be used in combination with an inhaled corticosteroid (ICS) unless criteria for triple therapy^v is fulfilled.

Table 3 (of 4)
Budesonide/formoterol (Symbicort)
Fluticasone/umeclidinium/vilanterol (Trelegy Ellipta)
Fluticasone/vilanterol (Breo Ellipta)
Salmeterol /fluticasone (Advair)

For any one agent listed in Table 3:

- For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometryⁱ
AND
- When the LABA/ICS is part of triple therapy^v in patients with COPD
OR
- In patients with asthma/COPD (ACO) overlap, based on patient history and lung function studies indicating an ACO diagnosis

Table 4 (of 4)
Budesonide/glycopyrronium/formoterol (Breztri Aerosphere)

For agent listed in Table 4:

- For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometryⁱ, in patients who experience inadequate control^{iv} while being treated with a long-acting beta-2 agonist/long-acting muscarinic antagonist (LABA/LAMA).

Patients should not be started on a LABA, LAMA and an inhaled corticosteroid (triple inhaled therapy) as initial therapy.

Clinical Notes:

- COPD is defined by spirometry as a post bronchodilator FEV₁/FVC ratio of < 0.70. Spirometry reports from any point in time will be accepted.
- MRC Grade 3 or mMRC Grade 2 are described as: walks slower than people of the same age on the level because of shortness of breath from COPD or has to stop for breath when walking at own pace on the level because of COPD.

- (iii) The COPD Assessment Test (CAT) is an 8-item tool for measuring health status impairment with scores from 0-40. It is available online at <http://www.catestonline.org/images/pdfs/CATest.pdf>
- (iv) Inadequate control is defined as persistent symptoms after at least 1 month of long- acting beta-agonist (LABA) or long-acting anticholinergic therapy (LAAC); and an MRC score ≥ 3 , mMRC score ≥ 2 , or a CAT score ≥ 10 .
- (v) Triple therapy criteria:
Combination therapy with LABA/LAAC/ICS will be considered for patients who experience inadequate control (persistent symptoms or experiencing 2 or more exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids or at least 1 exacerbation requiring hospitalization) while being treated with a LABA/LAAC combination for at least two months.
- (vi) Prescriptions written by PEI respirologists do not require written Special Authorization.

Cibinqo – see Abrocitinib

Ciloxan - see Ciprofloxacin, ophthalmic solution

Cimzia – see Certolizumab

Cinacalcet, tablet, 30mg, 60mg 90mg (Generics)

For the treatment of dialysis patients with severe hyperparathyroidism (PTH > 88 pmol/L measured twice in 3 months at least 6 weeks apart) who have maximized phosphate binder therapy and vitamin D therapy.

Patients must have one of the following:

- corrected serum calcium > 2.54mmol/L; serum phosphate > 1.8mmol/L; **or**
- presence of symptoms related to hyperparathyroidism (i.e. bone pain)

Ciprodex - see Ciprofloxacin & Dexamethasone

Ciprofloxacin, ophthalmic solution, 0.3%; ophthalmic ointment, 0.3% (Ciloxan-ALC and generics)

For the treatment of ophthalmic infections caused by susceptible bacteria and not responding to alternative agents.

Ciprofloxacin HCl, tablet, 250mg, 500mg, 750mg; (Generics) oral suspension, 100mg/mL (Cipro-BAY)

Note: For Cystic Fibrosis, Nursing Home and Tuberculosis Programs, no Special Authorization is required.

- For treatment of complicated urinary tract infections (UTI), early pyelonephritis, or bacterial prostatitis.
- For treatment of severe (malignant) otitis externa
- For empiric treatment of acute exacerbations of chronic obstructive pulmonary disease (AECOPD) in patients at risk of *Pseudomonas* infection (e.g. previously isolated *Pseudomonas*, end stage lung disease, concomitant bronchiectasis, frequent or recent broad spectrum antibiotic use).
- For empiric treatment of outpatient febrile neutropenia.
- For the prevention of endophthalmitis in patients who have had cataract surgery with unplanned vitrectomy.
- For treatment of lung infections in patients with cystic fibrosis.
- *Pseudomonas aeruginosa* susceptible disease (or if previous *Pseudomonas* susceptible disease).
- For the oral treatment of multi-resistant, aerobic, gram-negative infections traditionally requiring parenteral therapy for which other oral agents are not effective or available.
- For the treatment of patients intolerant or allergic (hypersensitivity reaction) to all other effective oral agents.
- For the empiric treatment of peritonitis in patients currently receiving peritoneal dialysis.

Ciprofloxacin & Dexamethasone, otic suspension, 0.3% / 0.1% (Ciprodex-ALC and generics)

- For the treatment of patients with acute otitis media with otorrhea through tympanostomy tubes; or with known or suspected tympanic membrane perforation with otorrhea.
- For the treatment of patients with acute otitis externa in the presence of tympanostomy tubes or known perforation of the tympanic membrane.

Cladribine, tablet, 10mg (Mavenclad-EMD)

For the treatment of adult patients with relapsing-remitting multiple sclerosis (RRMS) who meet all the following criteria:

- Confirmed diagnosis based on McDonald criteria.
- Has experienced one or more disabling relapses or new MRI activity in the past year.
- Ambulatory with or without aid (i.e. has a recent Expanded Disability Status Scale (EDSS) score of less than or equal to 6.5).
- Refractory or intolerant to at least one disease modifying therapy (e.g., interferon, glatiramer, dimethyl fumarate, teriflunomide, ocrelizumab).

Clinical Notes:

- Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.
- A relapse is defined as the appearance of new or worsening neurological symptoms in the absence of fever or infection, lasting at least 24 hours yet preceded by stability for at least one month and accompanied by new objective neurological findings observed through evaluation by a neurologist.

Claim Notes:

- Must be prescribed by a neurologist with experience in the treatment of multiple sclerosis.
- Approvals will be for 1.75mg/kg to a maximum of 200mg per treatment year.
- Approval Period: 2 years

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Clozapine, tablet, 25mg, 50mg, 100mg, 200mg (Clozaril-NVR and generics)

Clozapine is only available upon registration of the patient, prescriber, and pharmacy with a Clozapine-Support and Assistance Network.

Clozapine is only to be dispensed to patients upon receipt of 7 day, 14 day or 28 day hematological test results by the pharmacy.

For the treatment of patients with schizophrenia refractory to other treatments upon written request or recommendation of a psychiatrist. **A copy of the recommendation must accompany the Special Authorization.**

Clozaril - see Clozapine

Cobimetinib – tablet, 20mg (Cotellic-HLR)

In combination with vemurafenib, for the treatment of patients with previously untreated BRAF V600 mutation-positive unresectable stage III or stage IV melanoma who have a good performance status. Treatment should continue until unacceptable toxicity or disease progression. If brain metastases are present, patients should be asymptomatic or have stable symptoms.

Approvals are for a maximum daily dose of 60mg during 21 consecutive days per 28 day cycle.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a

patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Codeine, controlled release tablet, 50mg, 100mg, 150mg, 200mg (Codeine Contin-PFR)

For the treatment of documented mild to moderate chronic pain that is not well controlled by short-acting codeine products or where patients are well controlled on acetaminophen or ASA combinations but the codeine dose is limited by the amount of acetaminophen or ASA. **The maximum dose of Codeine Contin that will be reimbursed is 200mg every 12 hours.**

Codeine Contin - see Codeine

Cosentyx – see Secukinumab

Cotellic – see Cobimetinib

Cresemba – see Isavuconazole

Crizotinib, capsule, 200mg, 250mg (Xalkori-PFI)

1. For the treatment of patients with anaplastic lymphoma kinase (ALK)-positive locally advanced non-small cell lung cancer (NSCLC) with an ECOG performance status ≤ 2 when used as:
 - a) first line therapy or
 - b) second line therapy following chemotherapy

2. For the first-line treatment of patients with ROS-1 positive non-small cell lung cancer (NSCLC).

Clinical Notes:

- Eligible patients should be previously untreated and have a good performance status.
- Treatment may continue until disease progression or unacceptable toxicity.
- Patients with ROS-1 positive NSCLC who are currently receiving first-line chemotherapy or have been previously treated with chemotherapy or immunotherapy will be eligible for treatment with crizotinib.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Crysvita – see Burosumab

Cyclobenzaprine, tablet, 10mg (Generics)

As an adjunct to rest and physical therapy for relief of muscle spasm associated with acute, painful musculoskeletal conditions not responding or experiencing severe adverse reactions to alternative therapy. **A maximum of three weeks (21 days) of therapy will be considered.**

Cyclosporine, ophthalmic emulsion, 0.1% (Verkazia-APX)

For the treatment of pediatric patients between the age of 4 and 18 years of age with severe vernal keratoconjunctivitis (VKC) who meet the following criteria:

- Grade 3 (severe) or 4 (very severe) on the Bonini scale, *OR*
- Grade 4 (marked) or 5 (severe) on the modified Oxford scale.

Discontinuation Criteria:

- Treatment should be discontinued if no improvement in signs and symptoms of VKC is observed, *OR*
- Treatment should be discontinued if signs and symptoms of VKC have resolved.

Clinical Note:

- Documentation of the severity of signs and symptoms of VKC at treatment initiation and renewal must be provided.

Claim Notes:

- The patient must be under the care of a physician experienced in the diagnosis and treatment of VKC.
- Initial Approval Period: 6 months.
- Renewal Approval Period: 1 year

Cystadrops – see Cysteamine

Cysteamine, vial, 3.8mg/mL (Cystadrops-RRD)

For the treatment of corneal cystine crystal deposits (CCCDs) in patients 2 years of age and older with cystinosis.

Clinical Note:

- Diagnosis of cystinosis confirmed by cystinosis (lysosomal cystine transporter) gene mutation or elevated white blood cell cystine levels. Documentation must be provided.

Claim Note:

- Must be prescribed by an ophthalmologist experienced in the treatment of CCCDs.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Dabigatran, capsule, 110mg, 150mg (Pradaxa-BOE and generic)

For the prevention of stroke and systemic embolism in at-risk patients with non-valvular atrial fibrillation for whom:

- a) Anticoagulation is inadequate following at least a two month trial of warfarin; or
- b) Warfarin is contraindicated or not possible due to inability to regularly monitor through International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

The following patient groups are **excluded** from coverage for dabigatran for atrial fibrillation:

- a) Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate < 30mL/min)
- b) Patients 75 years of age or older without documented stable renal function
- c) Patients with hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis
- d) Patients with prosthetic heart valves

Notes:

- 1. At-risk patients with atrial fibrillation are defined as those with a CHADS₂ score of ≥ 1 .
- 2. Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
- 3. Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see dabigatran product monograph).
- 4. Documented stable renal function is defined as creatinine clearance or estimated glomerular filtration rate that maintained for at least three months (i.e. 30-49 mL/min for 110 mg twice daily dosing or ≥ 50 mL/min for 150 mg twice daily dosing).
- 5. There is currently no data to support that dabigatran provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so dabigatran is not recommended in these populations.
- 6. Patients starting dabigatran should have ready access to appropriate medical services to manage a major bleeding event.

Dabrafenib, capsule, 50mg, 75mg (Tafinlar-NVR)

Adjuvant Melanoma

In combination with trametinib for the adjuvant treatment of patients with cutaneous melanoma who meet all of the following criteria:

- Stage IIIA (limited to lymph node metastases of greater than 1 mm) to stage IIID disease (AJCC 8th edition)
- BRAF V600-mutation positive
- Completely resected disease including in-transit metastases

Clinical Notes:

1. Patients must have a good performance status.
2. Treatment should continue until disease recurrence, unacceptable toxicity, or up to a maximum of 12 months.

Claim Notes:

1. Requests will be considered for patients with regional lymph nodes with micrometastases after sentinel lymph node biopsy.
2. Requests will not be considered for patients who received adjuvant immunotherapy for greater than three months. Patients may switch to BRAF targeted therapy within the first three months of initiating immunotherapy to complete a total of 12 months of adjuvant treatment.
3. Approval Period: up to 12 months

Metastatic Melanoma

For the treatment of patients with BRAF V600 mutation-positive unresectable or metastatic melanoma when used alone or in combination with trametinib.

Clinical Notes:

1. Patients must have a good performance status.
2. If brain metastases are present, patients should be asymptomatic or have stable symptoms.
3. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Dalteparin - see Low Molecular Weight Heparins

Darbepoetin Alfa, pre-filled syringe 25mcg/mL, 40mcg/mL, 100mcg/mL, 200mcg/mL (Aranesp-AMG)

For the treatment of severe anemia related to chronic renal failure in patients with:

- a) Normocytic normochromic anemia, requiring transfusions in patients who have evidence of iron overload (Ferritin > 1000 ng/mL), **OR**
- b) Anemia requiring blood transfusions in patients having symptomatic angina and/or heart failure, **OR**
- c) Anemia requiring transfusion in patients with difficulties in blood grouping and febrile reactions due to antibodies, **OR**
- d) Anemia requiring transfusions in patients who have high levels of panel reactive anti HLA antibodies, **OR**
- e) Severe normocytic normochromic anemia (Hb < 100 g/L) whose only symptom is fatigue and have never received transfusions.

The request for coverage must be made by or in consultation with a nephrologist, internal medicine specialist, or oncologist. A copy of the consultation must accompany the request.

The request for coverage must be made using the Erythropoietin Program Approval Form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Darifenacin, extended release tablet, 7.5mg, 15mg (Enablex-NVR and generic)

For the treatment of over-active bladder (not stress incontinence) in patients who cannot tolerate or have an insufficient response to an adequate trial (e.g. 3 months) of immediate release oxybutynin, solifenacin, or tolterodine.

Darolutamide, tablet, 300mg (Nubeqa-BAY)

Non-Metastatic Castration-Resistant Prostate Cancer (nmCRPC)

In combination with androgen deprivation therapy (ADT) for the treatment of patients with non-metastatic castration-resistant prostate cancer (nmCRPC) who are at high risk of developing metastases¹.

- Patients should have a good performance status. Treatment should continue until unacceptable toxicity or radiographic disease progression.

Clinical Notes:

- Castration-resistance must be demonstrated during continuous ADT and is defined as 3 PSA rises at least one week apart, with the last PSA > 2 ng/mL.
- Patients should have no detectable distant metastases by either CT, MRI or technetium-99m bone scan.
- Castrate levels of testosterone must be maintained.
- Patients with N1 disease, pelvic lymph nodes < 2cm in short axis located below the aortic bifurcation are eligible for darolutamide.
- Darolutamide will not be funded for patients who experience disease progression on apalutamide or enzalutamide.

- Patients receiving darolutamide for the treatment of non-metastatic CRPC will be eligible for funding of abiraterone at the time of disease progression to metastatic CRPC. Enzalutamide is not funded for patients who experience disease progression to metastatic CRPC while on darolutamide.
- Either abiraterone or enzalutamide may be used to treat metastatic CRPC in patients who discontinued darolutamide in the non-metastatic setting due to intolerance without disease progression.

¹High risk of developing metastases is defined as a prostate-specific antigen (PSA) doubling time of ≤ 10 months during continuous ADT.

Metastatic Castration-Sensitive Prostate Cancer (mCSPC)

In combination with docetaxel and androgen deprivation therapy (ADT) for the treatment of patients with metastatic castration-sensitive prostate cancer (mCSPC). Patients must have had either no prior ADT or are within six months of beginning ADT in the metastatic setting.

Renewal Criteria:

- Confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

- Patients should have a good performance status.
- Treatment should continue until unacceptable toxicity or disease progression.

Claim Notes:

- Requests will not be considered for patients who are within 1 year of completing adjuvant ADT in the nonmetastatic setting.
- Patients who experience disease progression on apalutamide or enzalutamide are not eligible.
- Approval Period: 1 year.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Dasatinib, tablet, 20mg, 50mg, 70mg, 80mg, 100mg, 140mg (Sprycel-BMS and generics)

For use as a single agent for the treatment of adults with chronic, accelerated or blast phase chronic myelogenous leukemia (CML) and Philadelphia chromosome acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy including Imatinib.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

DDAVP - see Desmopressin

Decitabine & Cedazuridine, tablet, 35mg & 100mg (Inqovi-TAI)

For the treatment of patients with myelodysplastic syndromes (MDS), including previously treated and untreated, who meet all of the following criteria:

- De novo or secondary MDS including all French-American-British subtypes (i.e., refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, and chronic myelomonocytic leukemia)
- Intermediate-1, intermediate-2, or high-risk MDS, according to the International Prognostic Scoring System
- Have not experienced disease progression on a hypomethylating agent

Clinical Notes:

1. Patients should have a good performance status.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Deferasirox, tablet, 90mg, 180mg, 360mg; dispersible tablet, 125mg, 250mg, 500mg (Exjade – NVR and generics)

For the treatment of patients who require iron chelation.

Denosumab, pre-filled syringe, 60mg/mL (Jubbonti – SDZ, Prolia – AMG)

For denosumab-naïve patients whose denosumab therapy is initiated after December 3, 2024, the denosumab biosimilar will be the product approved. Patients with existing PEI Pharmacare coverage for Prolia® will need to switch to a biosimilar version before August 31, 2025, to maintain coverage through PEI Pharmacare.

For the treatment of osteoporosis in patients who have:

- A high fracture risk, and
- a contraindication, severe gastrointestinal intolerance, or are refractory to bisphosphonates.

Clinical Notes:

- Refractory is defined as a fragility fracture or evidence of a decline in bone mineral density below pre-treatment baseline levels, despite adherence for one year to other available osteoporosis therapies.
- High fracture risk is defined as:
 - Moderate 10-year fracture risk (10% to 20%) as defined by the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) tool or the World Health Organization's Fracture Risk Assessment (FRAX) tool with a prior fragility fracture; or
 - High 10-year fracture risk ($\geq 20\%$) as defined by the CAROC or FRAX tool.

Denosumab, vial, 120mg/1.7mL (Wyost-SDZ)

For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer (CRPC) with one or more documented bone metastases and an ECOG performance status of 0-2.

Desmopressin, oral disintegrating tablet, 60mcg, 120mcg, 240mcg (DDAVP Melt-FEI); tablet, 0.1mg, 0.2mg (DDAVP-FEI and generics)

1. For the treatment of diabetes insipidus in patients unable to tolerate the intranasal solution or when the intranasal solution is ineffective.
2. For the treatment of enuresis in children over 5 years and under 16 years of age.

Desmopressin, intranasal solution (spray pump), 10mcg/dose (Generic)

For the treatment of diabetes insipidus. The maximum recommended daily dosage is 40µg.

Diacomit – see Stiripentol

Dienogest, tablet, 2mg (Visanne-BAY and generics)

For the management of pelvic pain associated with endometriosis in patients for whom one or more less costly options are either ineffective or cannot be used.

Dificid – see Fidaxomicin

Dojolvi – see Triheptanoin

Dornase Alfa, inhalation solution, 1mg/mL (Pulmozyme-HLR)

For cystic fibrosis patients with a FEV1<70% predicted with clinically significant decline in FEV1 not responsive to usual treatment.

Duaklir Genuair – see Acclidinium Bromide & Formoterol Fumarate Dihydrate

Duobrii – see Tazarotene/Halobetasol propionate

Duodopa – see Levodopa/Carbidopa

Dupilumab, syringe, prefilled pen, 200mg/1.14mL; syringe, prefilled pen, 300mg/2mL (Dupixent-AVN)

Atopic Dermatitis

For the treatment of moderate to severe atopic dermatitis (AD) in patients 12 years of age and older who meet all of the following criteria:

Patients must have had an adequate trial (with a documented refractory disease), or were intolerant (with documented intolerance), or are ineligible for each of the following therapies:

- maximally tolerated medical topical therapies for AD combined with phototherapy (where available), and;
- maximally tolerated medical topical therapies for AD combined with at least 1 of the 4 systemic immunomodulators (methotrexate, cyclosporine, mycophenolate mofetil, or azathioprine).

AND

Baseline Physician Global Assessment score of 3 or greater and Eczema Area and Severity Index (EASI) of 7.1 or greater.

Renewal criteria:

- Requests for renewal must provide proof of beneficial clinical effect defined as a 75% or greater improvement from baseline in the Eczema Area and Severity Index (EASI-75) score six months after treatment initiation.
- Proof of maintenance of EASI-75 response from baseline must be provided for subsequent authorizations.

Clinical Note:

- Not to be used in combination with phototherapy or any immunomodulatory drugs (including biologics) or a Janus kinase inhibitor treatment for moderate-to-severe AD.

Claim Notes:

- The patient must be under the care of a dermatologist, allergist, clinical immunologist, or pediatrician who has expertise in the management of moderate to severe AD.
- Approvals will be for a maximum of 600 mg at week 0, then 300 mg every two weeks thereafter.
- Initial Approval Period: 6 months.
- Renewal Approval Period: 1 year.

Asthma

1. For the adjunctive treatment of severe asthma with a type 2 or eosinophilic phenotype in patients aged 6 to 11 years of age who are inadequately controlled with medium-to high-dose inhaled corticosteroids (ICS) and one or more additional asthma controller(s) (e.g., long-acting beta-agonist) or high-dose ICS alone and meet the following criteria:
 - blood eosinophil count $\geq 0.15 \times 10^9/L$ within the past 12 months; and
 - uncontrolled asthma with at least one clinically significant asthma exacerbation in the past 12 months.

Initial Discontinuation Criteria:

- Baseline asthma control questionnaire score has not improved at 12 months since initiation of treatment, or
- The number of clinically significant asthma exacerbations has increased within the previous 12 months

Subsequent Discontinuation Criteria:

- Asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
- The number of clinically significant asthma exacerbations has increased within the previous 12 months.

Clinical Notes:

1. A baseline and annual assessment of asthma symptom control using a validated asthma control questionnaire must be provided.
2. Medium dose ICS is defined as between 200 mcg and 400 mcg of fluticasone propionate or equivalent daily dose and high-dose ICS is defined as greater than 400 mcg of fluticasone propionate or equivalent daily dose.
3. A significant clinical exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized.

Claim Notes:

- Must be prescribed by a pediatric respirologist or allergist experienced in the treatment of severe asthma.
 - Combined use of dupilumab with other biologics used to treat asthma will not be reimbursed.
 - Approvals will be for a maximum of 200 mg every two weeks or 300 mg every four weeks.
 - Approval Period: 1 year.
2. For the adjunctive treatment of severe asthma with a type 2 or eosinophilic phenotype or oral corticosteroid (OCS) dependent severe asthma in patients 12 years of age and older who are inadequately controlled with high-dose inhaled corticosteroids (ICS) and one or more additional asthma controller(s) (e.g., long-acting beta-agonist) and meets one of the following criteria:
- blood eosinophil count $\geq 0.15 \times 10^9/L$ within the past 12 months, or
 - have OCS dependent asthma.

Initial Discontinuation Criteria:

- Baseline asthma control questionnaire score has not improved at 12 months since initiation of treatment, or
- No decrease in the daily maintenance OCS dose in the first 12 months of treatment, or
- Number of clinically significant asthma exacerbations has increased within the previous 12 months.

Subsequent Discontinuation Criteria:

- Asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
- Reduction in the daily maintenance OCS dose achieved after the first 12 months of treatment is not maintained subsequently, or
- Number of clinically significant asthma exacerbations has increased within the previous 12 months.

Clinical Notes:

- A baseline and annual assessment of asthma symptom control using a validated asthma control questionnaire must be provided.
- A baseline and annual number of clinically significant asthma exacerbations must be provided.
- High-dose ICS is defined as greater than or equal to 500 mcg of fluticasone propionate or equivalent daily dose.
- A significant clinical exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized.

Claim Notes:

- Must be prescribed by a respirologist, clinical immunologist, allergist or internist experienced in the treatment of severe asthma.
- Combined use of dupilumab with other biologics used to treat asthma will not be reimbursed.
- Approvals will be for a maximum of 600 mg at week 0, then 300 mg every two weeks thereafter.
- Approval Period: 1 year.

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Dupixent – see Dupilumab

Edaravone, oral solution, 105mg/5mL (Radicava-BMT)

For the treatment of patients with probable or definite amyotrophic lateral sclerosis (ALS) who meet all of the following criteria:

Initiation criteria:

- Scores of at least two points on each item of the ALS Functional Rating Scale-Revised (ALSFRS-R).
- Forced vital capacity is greater than or equal to 80% of predicted.
- ALS symptoms for two years or less.
- Not currently requiring permanent non-invasive or invasive ventilation.

Discontinuation Criteria:

- Patient becomes non-ambulatory (ALSFRS-R score ≤ 1 for item 8) AND is unable to cut food and feed themselves without assistance, irrespective of whether a gastrostomy is in place (ALSFRS-R score < 1 for item 5a or 5b); or
- Patient requires permanent non-invasive or invasive ventilation.

Clinical Note :

- Patient must be under the care of a specialist with experience in the diagnosis and management of ALS.
- Approval Period: 6 months

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Elexacaftor & Tezacaftor & Ivacaftor, granules, 80mg/40mg/60mg and 59.5mg; 100mg/50mg/75mg and 75mg; tablets, 50mg/25mg/37.5mg and 75mg; 100mg/50mg/75mg

and 150mg (Trikafta-VTX)

For the treatment of cystic fibrosis (CF) in patients aged two (2) years and older who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to lexacaftor/tezacaftor/ivacaftor and ivacaftor based on clinical and/or in vitro data. Patients should be optimized with best supportive care for their CF at the time of initiation.

For patients aged 2 to 5 years of age:

Initial Renewal Criteria:

The patient must meet one of the following criteria:

- Decrease in the total number of days for which the patient received treatment with oral and/or intravenous (IV) antibiotics for pulmonary exacerbations compared with the 6-month period prior to initiating treatment. OR
- Decrease in the total number of pulmonary exacerbations requiring oral and/or IV antibiotics compared with the 6-month period prior to initiating treatment. AND
- No decrease in Body Mass Index (BMI) z-score compared with baseline.

Subsequent Renewal Criteria:

Evidence of continued benefit must be provided for at least one of the parameters noted above at the end of each 12-month period.

Clinical Notes:

1. The following baseline measurements must be provided prior to initiation of treatment:
 - a. Total number of days treated with oral and/or IV antibiotics for pulmonary exacerbations in the 6 months prior to initiation of treatment
 - b. Total number of pulmonary exacerbations requiring oral and/or IV antibiotics in the 6 months prior to initiation of treatment
 - c. BMI z-score
2. Requests will not be considered for patients who have undergone lung transplantation.

Claim Notes:

- The patient must be under the care of a physician with experience in the diagnosis and management of CF.
- Combined use of more than one CFTR modulator will not be reimbursed.
- Approval period: 1 year.

For patients aged 6 years and older who:

Initial renewal criteria:

For the initial renewal, the patient must meet at least ONE of the following criteria:

- Improvement of lung function by 5% of predicted or more (ppFEV1 compared to baseline (baseline lung function should be measured within a 3-month period prior to beginning treatment with Trikafta); OR
- A decrease in the total number of days for which the patient received treatment with oral and/or IV antibiotics for pulmonary exacerbations compared with the 6-month period prior to initiating treatment; OR
- A decrease in the total number of pulmonary exacerbations requiring oral and/or IV antibiotics compared with the 6-month period prior to initiating treatment; OR
- Decreased number of CF-related hospitalizations at 6 months compared with the 6-month period prior to initiating Trikafta treatment; OR
- No decline in BMI (BMI z score in children) at 6 months compared with the baseline BMI assessment; OR
- Improvement by 4 points or more in the CF Questionnaire-Revised (CFQ-R) Respiratory Domain scale compared to baseline.

Subsequent Renewal Criteria:

Evidence of continued benefit from treatment with Trikafta for subsequent renewals (e.g. ppFEV1, CFQ-R, pulmonary exacerbations).

Clinical Notes:

1. The following measurements must be completed prior to initiating treatment with Trikafta:
 - a. Baseline spirometry measurements of FEV1 and ppFEV1 within the last 90 days prior to initiating treatment ;
 - b. Number of days treated with oral and IV antibiotics for pulmonary exacerbations in the previous 6 months;
 - c. Number of pulmonary exacerbations requiring oral and/or IV antibiotics in the previous 6 months;
 - d. Number of CF-related hospitalizations in the previous 6 months;
 - e. Weight, height, and BMI; and
 - f. CFQ-R Respiratory Domain score.
2. Requests will not be considered for patients who have undergone lung transplantation

Claim Notes:

- The patient must be under the case of a physician with experience in the diagnosis and management of CF.
- Combined use of more than one CFTR modulator will not be reimbursed.
- Initial approval: 6 months.
- Renewal approval period: 1 year
- Approved dose:
 - 6 to < 12 years of age weighing < 30kg: Two tablets (each containing elexacaftor 50 mg/tezacaftor 25 mg/ivacaftor 37.5 mg) in the morning & one tablet (ivacaftor 75 mg) taken in the evening with fat-containing food, approximately 12 hours apart.

- 6 to < 12 years of age weighing $\geq 30\text{kg}$: 2 tablets (each containing elexacaftor/ tezacaftor/ ivacaftor 100mg/ 50mg/ 75mg) taken in the morning & one tablet (ivacaftor 150mg) taken with fat-containing food, in the evening approximately 12 hours apart.
- 12 years and older: 2 tablets (each containing elexacaftor/ tezacaftor/ ivacaftor 100mg/ 50mg/ 75mg) taken in the morning & one tablet (ivacaftor 150mg) taken in the evening with fat-containing food, approximately 12 hours apart.

Elmiron - see Pentosan Polysulfate Sodium

Emend - see Aprepitant

Emerade – see Epinephrine Bitartrate

Emgality – see Galcanezumab

Empagliflozin, tablet, 10mg, 25mg (Jardiance-BOE)

For the treatment of patients with type 2 diabetes when added to metformin for patients who have inadequate glycemic control on metformin.

OR

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with type 2 diabetes mellitus and established cardiovascular disease, if the following criteria are met:

- Patients have inadequate glycemic control despite an adequate trial of metformin

Clinical Notes:

For patients who cannot take metformin due to contraindications or intolerances, details must be provided.

Established cardiovascular disease is defined as one of the following (details must be provided):

- History of myocardial infarction (MI).
- Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status).
- Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within 12 months prior to selection.
- Last episode of unstable angina ≥ 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease.
- History of ischemic or hemorrhagic stroke.
- Occlusive peripheral artery disease.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special

Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Enablex – see Darifenacin

Encorafenib, capsule, 75mg (Braftovi-PFI)

Metastatic Colorectal Cancer

In combination with panitumumab for the treatment of patients with metastatic colorectal cancer who meet all of the following criteria:

- Presence of BRAF V600E mutation
- Disease progression following at least one prior therapy in the metastatic setting
- No previous treatment with an EGFR inhibitor

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

1. Patients must have a good performance status.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Encorafenib will not be reimbursed in patients who have progressed on BRAF targeted therapy.

Metastatic Melanoma

For the treatment of patients with BRAF V600 mutation-positive unresectable or metastatic melanoma when used in combination with binimetinib.

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

1. Patients must have a good performance status.
2. If brain metastases are present, patients should be asymptomatic or have stable symptoms.
3. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Encorafenib will not be reimbursed in patients who have progressed on BRAF targeted therapy.
- Requests will be considered for patients who received adjuvant BRAF targeted therapy if disease progression occurred at least 6 months following completion of therapy.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Energair Breezhaler – see Indacaterol & Glycopyrronium & Mometasone

Enfuvirtide, injection kit, 90mg/mL (Fuzeon-HLR)

For patients:

- a) Who have a CD4 count greater than 100 cells/mm³; **AND**
- b) Who have a viral load less than 100,000 copies/mL; **AND**
- c) Who have previously received less than 11 antiretroviral agents; **AND**
- d) Where therapy with Enfuvirtide is planned in combination with at least one other antiretroviral drug to which sensitivity has been demonstrated on resistance testing.

Requests for Enfuvirtide (Fuzeon-HLR) must be made using the Enfuvirtide Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Enoxaparin - see Low Molecular Weight Heparins

Enspryng – see Satralizumab

Entecavir, tablet, 0.5mg (Baraclude – BMS and generics)

For the treatment of chronic hepatitis B infection in patients with cirrhosis documented on radiologic or histologic grounds and a HBV DNA concentration above 2,000 IU/mL.

Entrectinib, capsule, 100mg, 200 mg (Rozlytrek-HLR)

ROS-1 Positive Non-Small Cell Lung Cancer or Metastatic Non-Small Cell Lung Cancer

For the first-line treatment of patients with ROS-1 positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC).

Clinical Notes:

- Patients should have a good performance status.

- Treatment should continue until disease progression or unacceptable toxicity.

Unresectable Locally Advanced or Metastatic Extracranial Solid Tumors with a NTRK Gene Fusion

- For the treatment of adult patients with unresectable locally advanced or metastatic extracranial solid tumors with NTRK gene fusion without a known acquired resistance mutation. Eligible patients are not candidates for surgery and/or radiation due to risk of substantial morbidity and have no satisfactory treatment options.

Clinical Notes:

- Patients should have a good performance status.
- Treatment should be discontinued upon disease progression or unacceptable toxicity.
- CNS metastases are stable if present.
- Patients with prior progression on an NTRK inhibitor are not eligible.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Entresto – see Sacubitril & Valsartan

Entuzity – see Insulin Regular

Entyvio - see Vedolizumab

Enzalutamide, capsule, 40mg (Xtandi-AST)

1. For treatment of patients with metastatic castration resistant prostate cancer who:
 - Are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy with an ECOG performance status ≤ 1 and have not received prior chemotherapy and would be an alternative to abiraterone for patients and not sequential therapy in this asymptomatic or mildly symptomatic patient population **OR**
 - Have progressed on docetaxel-based chemotherapy with an ECOG performance status ≤ 2 and no risk factors for seizures and would be an alternative to abiraterone for patients and not sequential therapy in this symptomatic post docetaxel chemotherapy setting

Notes:

- Enzalutamide will not be reimbursed in combination with abiraterone.
- Use of enzalutamide in the past docetaxel setting is not permitted if previously

used in the prechemotherapy setting

2. In combination with androgen deprivation therapy (ADT) for the treatment of patients with metastatic castration-sensitive prostate cancer (mCSPC). Patients must have had either no prior ADT or are within six months of beginning ADT in the metastatic setting.

Clinical Notes:

- Patients should have a good performance status and no risk factors for seizures.
- Treatment should continue until unacceptable toxicity or disease progression.

3. In combination with androgen deprivation therapy (ADT) for the treatment of patients with non-metastatic castration-resistant prostate cancer (nmCRPC) who are at high risk of developing metastases¹.

- Patients should have a good performance status and no risk factors for seizures. Treatment should continue until unacceptable toxicity or radiographic disease progression.

Clinical Notes:

- Castration-resistance must be demonstrated during continuous ADT and is defined as 3 PSA rises at least one week apart, with the last PSA > 2 ng/mL.
- Castrate levels of testosterone must be maintained.
- Patients with N1 disease, pelvic lymph nodes < 2cm in short axis located below the common iliac vessels are eligible for enzalutamide.
- Enzalutamide will not be funded for patients who experience disease progression on apalutamide.
- Patients receiving enzalutamide for the treatment of non-metastatic CRPC will be eligible for funding of abiraterone at the time of disease progression to metastatic CRPC.

¹High risk of developing metastases is defined as a prostate-specific antigen (PSA) doubling time of ≤ 10 months during continuous ADT

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Epclusa – see Sofosbuvir & Velpatasvir

Epinephrine, auto-injector, 0.15mg per dose, 0.3mg per dose (EpiPen-ALX)

For the emergency treatment of anaphylactic reactions, when out of reach of immediate medical attention.

Note:

- Regular benefit, but with a quantity limit of two injections per 12 month period (one unit per dispense). Additional units require an exception status request.

Epinephrine, pre-filled pen, 0.15mg per dose, 0.3mg per dose, 0.5mg per dose (Emerade-BAU)

For the emergency treatment of anaphylactic reactions, when out of reach of immediate medical attention.

Note:

- Regular benefit, but with a total quantity limit of two injections per 12 month period. Additional units require an exception status request.

EpiPen - see Epinephrine

EpiPen Jr. - see Epinephrine

Eplerenone, tablet, 25mg, 50mg (Generic)

For the treatment of patients with New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction (with ejection fraction $\leq 35\%$), as a complement to standard therapy.

Clinical Note:

Patients must be on optimal therapy with an angiotensin-converting-enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), and a beta-blocker (unless contraindicated) at the recommended dose or maximal tolerated dose.

Epoetin Alfa, pre-filled syringe, 10,000IU/mL (Eprex-JAN)

For the treatment of severe anemia related to chronic renal failure in patients with:

- a) Normocytic normochromic anemia, requiring transfusions in patients who have evidence of iron overload (Ferritin > 1000 ng/mL), **OR**
- b) Anemia requiring blood transfusions in patients having symptomatic angina and/or heart failure, **OR**
- c) Anemia requiring transfusion in patients with difficulties in blood grouping and febrile reactions due to antibodies, **OR**
- d) Anemia requiring transfusions in patients who have high levels of panel reactive anti HLA antibodies, **OR**
- e) Severe normocytic normochromic anemia (Hb < 100 g/L) whose only symptom is fatigue and have never received transfusions.

The request for coverage must be made by or in consultation with a nephrologist, internal medicine specialist, or oncologist. A copy of the consultation must accompany the request.

The request for coverage must be made using the Erythropoietin Program Approval Form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Epoprostenol, vials, 0.5mg, 1.5mg (Caripul-ACT, Flolan-GSK)

For the treatment of World Health Organization (WHO) class III or IV idiopathic pulmonary arterial hypertension in patients who do not demonstrate vasoreactivity on testing or who demonstrate vasoreactivity on testing but fail a trial of, or are intolerant to, calcium channel blockers.

For the treatment of WHO class III or IV pulmonary arterial hypertension associated with scleroderma in patients who do not respond adequately to conventional therapy.

Note: Coverage will be limited to medication and associated diluent costs only. No coverage will be provided for equipment or medical supplies (e.g. pumps, IV tubing, IV catheters, etc.).

Coverage must be requested and medications prescribed by a Pulmonary Arterial Hypertension (PAH) specialist.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Eprex - see Epoetin Alfa

Eptinezumab, vial, 100mg/1.0mL, 300mg/3mL (Vyepti-LUD)

For the prevention of migraine in patients with a confirmed diagnosis of episodic or chronic migraine who have experienced an inadequate response, intolerance, or contraindication to at least two classes of oral prophylactic migraine medications.

Renewal Criteria:

- A reduction of at least 50% in the average number of migraine days per month at the time of initial renewal compared with baseline.
- At subsequent renewals, the patient continues to maintain the reduction of at least 50% in average number of migraine days per month.

Clinical Notes:

- The average number of headache and migraine days per month must be provided on initial and renewal requests.
- According to the International Headache Society criteria, episodic or chronic migraine are defined as:

- Episodic migraine: migraine headaches on at least 4 days per month and less than 15 headache days per month for more than 3 months.
- Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least eight days per month are with migraine.

Claim Notes:

- Initial Approval Period: 6 months
- Renewal Approval Period: 1 year

Erelzi – see Etanercept

Erivedge – see Vismodegib

Erleada – see Apalutamide

Erlotinib, tablet, 25mg, 100mg, 150mg (Generics)

For use as monotherapy for the treatment of patients with locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen and whose EGFR expression status is positive or unknown.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage under the High Cost Drug Program must apply to this program using the application that is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Esbriet – see Pirfenidone

Eslicarbazepine Acetate, tablet, 200mg, 400mg, 600mg, 800mg (Aptiom-SNV and generics)

For the treatment of partial-onset seizures in patients with epilepsy who are currently receiving two or more antiepileptic drugs (AEDs) and for whom less costly AEDs are ineffective or not clinically appropriate.

Etanercept, pre-filled syringe, 50mg/mL (Brenzys-MSD; Erelzi-SDZ; Rymti-LUP); pen injector, 25mg/0.5mL (Erelzi-SDZ); 50mg/mL (Brenzys-MSD; Erelzi-SDZ; Rymti-LUP)

Ankylosing Spondylitis

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- have axial symptoms* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR

- b) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for a maximum adult dose of 50 mg weekly or 25 mg twice weekly.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.
- Requests for renewal must include information showing the beneficial effects of the treatment, specifically:
 - a) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
 - b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Plaque Psoriasis

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score ; or

- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 50 mg twice weekly for 12 weeks. If response criteria is met at 12 weeks, approval will be continued at a dose of 50 mg weekly.
- Initial Approval: 12 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Concurrent use of biologics not approved.

Requests must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Polyarticular Juvenile Idiopathic Arthritis (pJIA)

For the treatment of pJIA for patients aged 4-17 years with moderately or severe pJIA who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs). Treatment must be initiated by a rheumatologist who is familiar with the use of DMARDs and/or biologic DMARDs in children.

Claim Notes:

- Approvals will be for a dose of 0.8 mg/kg weekly to a maximum of 50 mg weekly.
- Initial Approval: 6 months.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

Patients must also apply for coverage through the High Cost Drug Program. The

patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 3) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 4) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; and
 - Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 50 mg per week or 25 mg twice weekly.
- Initial Approval 16 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks
AND

Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Approvals will be for a maximum adult dose of 50 mg weekly or 25 mg twice weekly.
- Must be prescribed by a rheumatologist.
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Evenity – see Romosozumab

Everolimus, tablet, 2.5mg, 5mg, 10mg (Generics)

Metastatic Renal Cell Carcinoma (RCC)

For the treatment of patients with advanced or metastatic renal cell carcinoma following

disease progression on tyrosine kinase inhibitor therapy.

Clinical Notes:

- Patients must have a good performance status.
- Treatment should be discontinued upon disease progression or unacceptable toxicity.
- Requests for everolimus will not be considered for patients who experience disease progression on axitinib, cabozantinib or nivolumab monotherapy.

Claim Notes:

- Initial Approval Period: 6 months
- Renewal Approval Period: 1 year

Hormone Receptor Positive, HER2 Negative-Advanced Breast Cancer

In combination with exemestane for postmenopausal patients (ECOG PS ≤ 2) with documented hormone receptor positive, HER2 negative-advanced breast cancer after recurrence or progression following a non-steroidal aromatase inhibitor (NSAI).

Clinical Notes:

- Patients must have a good performance status.
- Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Requests for everolimus will not be considered for patients who experience disease progression on CDK4/6 inhibitor therapy.
- Approval Period: 1 year

Metastatic Pancreatic Neuroendocrine Tumors (pNET)

For the treatment of patients with progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors (pNET) with good performance status (ECOG 0-2), until disease progression.

Claim Notes:

- Patients whose disease progresses on sunitinib are not eligible for funded treatment with everolimus for pNET
- Approval Period: 1 year

Neuroendocrine Tumors of Gastrointestinal Or Lung Origin

As a single agent treatment for patients with unresectable, locally advanced or metastatic; well-differentiated nonfunctional neuroendocrine tumors (NETs) of

gastrointestinal or lung origin (GIL) in adults with documented radiological disease progression within six months and with a good performance status.

- Treatment should continue until confirmed disease progression or unacceptable toxicity.

Claim Notes:

- Approval Period: 1 year.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Evolocumab, prefilled autoinjector, 140mg/mL (Repatha-AMG)

For the treatment of heterozygous familial hypercholesterolemia (HeFH) in adult patients who require additional lowering of low-density lipoprotein cholesterol (LDL-C) if the following criteria are met:

- Definite or probable diagnosis of HeFH using the Simon Broome or Dutch Lipid Network criteria or genetic testing; and
- Patient is unable to reach LDL-C target (less than 2.0 mmol/L or at least a 50% reduction in LDL-C from untreated baseline) despite confirmed adherence to at least 3 months of continuous treatment with:
 - high-dose statin (e.g. atorvastatin 80 mg, rosuvastatin 40 mg) in combination with ezetimibe; or
 - ezetimibe alone, if high dose statin is not possible due to rhabdomyolysis, contraindication or intolerance

Initial renewal criteria:

- A reduction in LDL-C of at least 40% from baseline or has reached a target LDL-C less than 2.0 mmol/L.

Subsequent renewal criteria:

- The patient continues to maintain a reduction in LDL-C of at least 40% from baseline or has reached a target LDL-C less than 2.0 mmol/L

Clinical Notes:

1. LDL-C levels must be provided.
2. Intolerance to high dose statin will be considered if patient has developed documented myopathy or abnormal biomarkers (i.e. creatinine kinase greater than 5 times the upper limit of normal) after trial of at least two statins and
 - for each statin, dose reduction was attempted rather than statin discontinuation, and intolerance was reversible upon statin discontinuation, but reoccurred with statin re-challenge where clinically appropriate; and

- at least one statin was initiated at the lowest daily starting dose; and
 - other known causes of intolerance have been ruled out.
3. For patients who cannot take ezetimibe due to an intolerance or contraindication, details must be provided.

Claim Notes:

- Approvals will be for a maximum of 140mg every 2 weeks or 420mg monthly.
- Initial Approval Period: 6 months.
- Renewal Approval Period: 1 year

Evrysdi – see Risdiplam

Exelon - see Cholinesterase Inhibitors (ChEI)

Eylea – see Aflibercept

Fabrazyme – vial, 5mg, 25mg (AVN)

Coverage may be available for Fabrazyme for the treatment of Fabry Disease through the High Cost Drug Plan and Catastrophic Drug Plan, for eligible patients who meet the criteria set out in the Canadian Fabry Disease Treatment Guidelines.

The treatment guidelines are supported by the Canadian Fabry Disease Initiative (CFDI), and may be amended by the CFDI from time to time.

Please contact the PEI Pharmacare Program office at 1-877-577-3737 for more information regarding coverage availability and the Special Authorization application process for this product.

Faricimab, vial, 6mg/0.05mL (Vabysmo-HLR)

Neovascular Age-Related Macular Degeneration

Criteria For Initial Coverage:

For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) where all of the following apply:

- a) Best Corrected Visual Acuity (BCVA) is between 6/12 and 6/96 **AND**
- b) The lesion size is less than or equal to 12 disc areas in greatest linear dimension **AND**
- c) There is evidence of recent (<3 months) presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, optical coherence tomography (OCT), or recent visual acuity changes.

The interval between doses should not be shorter than one month. Administration is to be done by a qualified ophthalmologist experienced in intravitreal injections.

Criteria For Continued Coverage:

Treatment with faricimab should be continued only in people who maintain adequate response to therapy.

Faricimab should be discontinued if any of the following occur:

- a) Reduction in BCVA in the treated eye to less than 15 letters (absolute) on 2 consecutive visits in the treated eye, attributed to AMD in the absence of other pathology **OR**
- b) Reductions in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect, adverse events, or both **OR**
- c) There is evidence of deterioration of the lesion morphology despite optimum treatment over 3 consecutive visits.

Coverage will not be approved for patients:

- a) Receiving concurrent treatment with verteporfin.
- b) With permanent retinal damage as defined by the Royal College of Ophthalmology guidelines. Coverage is limited to a maximum of one vial per eye in any 30-day period. The request for coverage must be made by an ophthalmologist.

Approval Period: 1 year

Diabetic macular edema (DME)

Criteria For Initial Coverage:

For the treatment of visual impairment due to diabetic macular edema (DME) in patients who meet all of the following criteria:

- clinically significant centre-involving macular edema for whom laser photocoagulation is also indicated
- hemoglobin A1c test in the past 6 months with a value of less than or equal to 11%
- best corrected visual acuity of 20/32 to 20/400
- central retinal thickness greater than or equal to 250 micrometers

Criteria For Continued Coverage:

- confirm that a hemoglobin A1c test in the past 6 months had a value of less than or equal to 11%
- date of last visit and results of best corrected visual acuity at that visit
- date of last OCT and central retinal thickness on that examination
- if faricimab is being administered monthly, please provide details on the rationale.

Clinical Notes:

- Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.
- Treatment should be resumed when monitoring indicates a loss of visual acuity due to DME and continued until stable visual acuity is reached again for three consecutive months.
- Treatment should be discontinued if there is no improvement of retinal thickness or visual acuity after three consecutive treatments.
- Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.
- Approval Period: 1 year

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Fasenra – see Benralizumab

Febratinib, capsule, 100mg (Inrebic-CEL)

For the treatment of splenomegaly and/or disease-related symptoms in adult patients with intermediate-2 or high-risk primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis, who have a contraindication or intolerance to ruxolitinib.

Clinical Notes:

1. Patients should have a good performance status.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Febuxostat, tablet, 80mg (Generics)

For the treatment of symptomatic gout in patients who have documented hypersensitivity to allopurinol.

Note: Intolerance or lack of response to allopurinol will not be covered by these criteria.

Fentanyl, transdermal patch, 12mcg/hr, 25mcg/hr, 37mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr (Generics)

For the treatment of severe chronic pain that is not well controlled by short and long-acting Morphine and Hydromorphone products.

Fesoterodine Fumarate, extended release tablet, 4mg,8mg (Toviaz-PFI)

For the treatment of over active bladder (not stress incontinence) in patients who cannot tolerate or have an insufficient response to an adequate trial (e.g. 3 months) of immediate release oxybutynin, solifenacin, or tolterodine.

Fidaxomicin, tablet, 200mg (Dificid-MER)

For the treatment of patients with Clostridium Difficile Infection (CDI) where the patient has:

- a second or subsequent recurrence following treatment with oral vancomycin; OR
- treatment failure with oral vancomycin for the current CDI episode; OR
- an intolerance or contraindication to oral vancomycin.

Re-treatment criteria:

- Re-treatment with fidaxomicin will only be considered for an early relapse occurring within 8 weeks of the start of the most recent fidaxomicin course.

Clinical Notes:

- Treatment failure is defined as 14 days of vancomycin therapy without acceptable clinical improvement.
- Intolerance is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Should be prescribed by, or in consultation with, an infectious disease specialist/medical microbiologist (preferred) or an internist (if infectious disease or medical microbiology consult is not available).
- Requests will be approved for 200mg twice a day for 10 days.

Filgrastim, prefilled syringe, 300mcg/0.5mL, 480mcg/0.8mL (Grastofil-APX, Nivestym-PFI, Nypozi-TAV), vial, 300mcg/mL, 480mcg/1.6mL (Nivestym-PFI)

Chemotherapy Support

For the prevention of febrile neutropenia in patients receiving myelosuppressive chemotherapy with curative intent who:

- are at high risk of febrile neutropenia due to chemotherapy regimen, co-morbidities or pre-existing severe neutropenia; or
- have had an episode of febrile neutropenia, neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; or
- have had a dose reduction, or treatment delay greater than one week due to neutropenia.

Clinical Note:

- Patients with non-curative cancer receiving chemotherapy with palliative intent are not eligible for coverage of filgrastim for prevention of febrile neutropenia.

High Dose Chemotherapy with Stem Cell Support:

For use in mobilizing stem cells in preparation for stem cell collection.

Must be requested and prescribed by a specialist in hematology or medical oncology.

Claim Notes:

- All requests for coverage of filgrastim will be approved for the biosimilar versions only.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Fingolimod - See Multiple Sclerosis Agents

Firazyr – see Icatibant

Firdapse – see Amifampridine Phosphate

Finerenone, tablet, 10mg, 20mg (Kerendia-BAY)

For the treatment of patients with chronic kidney disease (CKD) and type 2 diabetes (T2D) who have an estimated glomerular filtration rate (eGFR) level of at least 25mL/min/1.73 m² and albuminuria level of at least 30mg/g (or 3mg/mmol).

Exclusion Criteria:

- Patients with chronic heart failure (CHF) New York Heart Association (NYHA) class II to IV; OR
- Patients receiving a mineralocorticoid receptor antagonist (MRA).

Discontinuation Criteria:

- eGFR less than 15 mL/min/1.73 m²; OR
- Urinary albumin-to-creatinine ratio (UACR) increased from baseline level.

Claim Notes:

- Must be prescribed by, or in consultation with, a nephrologist or prescriber with experience in the diagnosis and management of patients with CKD and T2D.
- Approval Period: 1 year

Flolan - see Epoprostenol

Fludara - see Fludarabine

Fludarabine, tablet, 10mg (Fludara-BAY)

For the treatment of chronic lymphocytic leukemia (CLL) in patients with an ECOG performance status of 0 to 2 when the patient has failed to respond to, or relapsed during/ after previous therapy with an alkylating agent and intravenous administration is not desirable.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Fluoxetine, oral solution, 20mg/5mL (Generics)

For use in patients for whom oral capsules are not an option. Pediatric patients 12 and under will not require written Special Authorization.

Fluticasone Furoate/Vilanterol, Inhaler, 100/25mcg/dose, 200/25mcg/dose (Breo Ellipta-GSK)

- a. For the treatment of asthma in patients who are not well controlled on a regular and adequate course of inhaled steroid therapy prior to the request for combination therapy.

NOTE

Patients using this product must also have access to a short acting beta-2 agonist bronchodilator for the relief of acute symptoms.

- b. For the treatment of COPD, see Chronic Obstructive Pulmonary Disease.

Formoterol Fumarate, powder for inhalation (inhaler), 6mcg/dose, 12mcg/dose (Oxeze Turbuhaler-AZE)

- a) For the treatment of asthma when used in patients on concurrent steroid therapy.
- b) For the treatment of COPD, see Chronic Obstructive Pulmonary Disease.

Note: Patients using these products must also have access to a short-acting beta-2 agonist bronchodilator for the relief of acute symptoms.

Formoterol & Budesonide, powder for inhalation, 6mcg & 100mcg per dose, 6mcg & 200mcg per dose (Symbicort Turbuhaler-AZE)

- a) For the treatment of asthma in patients who are not well controlled on a regular and

adequate course of inhaled steroid therapy prior to the request for combination therapy.

b) For the treatment of COPD, see Chronic Obstructive Pulmonary Disease.

Note: Patients using this product must also have access to a short-acting beta-2 agonist bronchodilator for the relief of acute symptoms.

Fosfomycin, sachet, 3g (Monurol-PAL & generic)

For the treatment of uncomplicated urinary tract infections in adult female patients where:

- The infecting organism is resistant to other oral agents, or
- Other less costly treatments are not tolerated

Note: Regular benefit, but with a quantity limit of 3 doses per 12 month period (one sachet per dispense). Additional sachets require an exception status request.

Foslevodopa & Foscarbidopa, 240mg/mL & 12mg/mL (Vyalev-ABV)

For the treatment of patients with advanced levodopa-responsive Parkinson disease (PD) who meet all of the following criteria:

- Experiences severe disability associated with at least 25% of the waking day in the off state and/or ongoing, bothersome levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day).
- Have received an adequate trial of maximally tolerated doses of levodopa, with previously demonstrated clinical response.
- Have failed an adequate trial of the following adjunctive medications, if not contraindicated and/or contrary to the clinical judgment of prescriber: maximally tolerated doses of levodopa in combination with carbidopa, a COMT inhibitor, a dopamine agonist, a MAO-B inhibitor, and amantadine.
- Must be able to administer the medication and correctly use the delivery system. Alternatively, trained personnel or a care partner must be available to perform these tasks reliably.

Exclusion Criteria:

- Patients with severe psychosis or severe dementia.

Renewal Criteria:

- Patients continue to demonstrate a significant reduction in the time spent in the off state and/or in ongoing levodopa-induced dyskinesias, along with an improvement in the related disability.

Claim Note:

- Must be prescribed by neurologists who are movement disorder subspecialists or who have expertise in managing advanced PD.
- Approval Period: 1 year

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Fragmin - see Low Molecular Weight Heparins

Fremanezumab, prefilled syringe, autoinjector, 225mg/1.5 mL (Ajovy-TEV)

For the prevention of migraine in patients with a confirmed diagnosis of episodic or chronic migraine who have experienced an inadequate response, intolerance, or contraindication to at least two classes of oral prophylactic migraine medications.

Renewal Criteria:

- A reduction of at least 50% in the average number of migraine days per month at the time of initial renewal compared with baseline.
- At subsequent renewals, the patient continues to maintain the reduction of at least 50% in average number of migraine days per month.

Clinical Notes:

- The average number of headache and migraine days per month must be provided on initial and renewal requests.
- According to the International Headache Society criteria, episodic or chronic migraine are defined as:
 - Episodic migraine: migraine headaches on at least 4 days per month and less than 15 headache days per month for more than 3 months.
 - Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least eight days per month are with migraine.

Claim Notes:

- Initial Approval Period: 6 months.
- Renewal Approval Period: 1 year.

Fulphila – see Pegfilgrastim

Fulvestrant, syringe, 250mg/5mL (Generics)

See palbociclib criteria

See ribociclib criteria

Fuzeon - see Enfuvirtide

Fycompa – see Perampanel

Galantamine - see Cholinesterase Inhibitors (ChEI)

Galcanezumab, 120mg/mL, prefilled pen, prefilled syringe (Emgality-LIL)

For the prevention of migraine in patients with a confirmed diagnosis of episodic or chronic migraine who have experienced an inadequate response, intolerance, or contraindication to at least two classes of oral prophylactic migraine medications.

Renewal Criteria:

- A reduction of at least 50% in the average number of migraine days per month at the time of initial renewal compared with baseline.
- At subsequent renewals, the patient continues to maintain the reduction of at least 50% in average number of migraine days per month.

Clinical Notes:

- The average number of headache and migraine days per month must be provided on initial and renewal requests.
- According to the International Headache Society criteria, episodic or chronic migraine are defined as:
 - Episodic migraine: migraine headaches on at least 4 days per month and less than 15 headache days per month for more than 3 months.
 - Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least eight days per month are with migraine.

Claim Notes:

- Combined use with other calcitonin gene-related peptide (CGRP) antagonists will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: 1 year

Gatifloxacin, ophthalmic drops, 0.3% (Zymar-ALL and generic)

For the treatment/prevention of bacterial conjunctivitis associated with eye surgery.

Glatect - see Multiple Sclerosis Agents

Glatiramer Acetate - see Multiple Sclerosis Agents

Gleevec - see Imatinib

Gilenya – see Multiple Sclerosis Agents

Gilteritinib, tablet, 40 mg (Xospata-AST)

As monotherapy for the treatment of adult patients with relapsed or refractory FMS-like tyrosine kinase 3 (FLT3)-mutated acute myeloid leukemia who meet all of the following criteria:

- Confirmed positive for FLT3 mutation at the time of relapse or determination of refractory disease

- Presence of FLT3-ITD, FLT3-TKD/D835 or FLT3-TKD/I836 mutation

Renewal Criteria:

- Written confirmation that the patient is responding to treatment.

Clinical Notes:

- Patients must have a good performance status.
- Treatment should continue as long as clinical benefit is observed or until unacceptable toxicity occurs.

Claim notes:

- Claims that exceed the maximum claim amount of \$9,999.99 must be divided and submitted as separate transactions using the DIN first, and then PDINs.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Giotrif – see Afatinib

Glecaprevir & Pibrentasvir, granules, 50mg/20mg ; tablets, 100mg/40mg (Maviret-ABV)

For treatment-naïve or treatment-experienced adult patients with chronic hepatitis C virus (HCV) who meet the following criteria:

	Approval Period
Genotypes 1, 2, 3, 4, 5 or 6 ▪ Treatment-naïve	▪ 8 weeks
Genotypes 1, 2, 4, 5 or 6 ▪ Treatment-experienced with regimens containing peginterferon/ribavirin (PR) and/or sofosbuvir (SOF)	▪ 8 weeks (12 weeks with cirrhosis)
Genotype 1 ▪ NS5A inhibitor treatment-naïve and treatment experienced with regimens containing: ▪ Boceprevir/PR; or ▪ Simeprevir (SMV)/SOF; or ▪ SMV/PR; or ▪ Telaprevir/PR	▪ 12 weeks
Genotype 1	▪ 16 weeks

▪ NS3/4A inhibitor treatment-naïve and treatment experienced with regimens containing: ▪ Daclatasvir (DCV)/SOF; or ▪ DCV/PR; or ▪ Ledipasvir/SOF	
Genotype 3 ▪ Treatment-experienced with regimens containing PR and/or SOF	▪ 16 weeks

The following information is also required:

- Lab-confirmed hepatitis C genotype 1, 2, 3, 4, 5 or 6 (note: not required for treatment-naïve patients)
- Quantitative HCV RNA value within the last 6 months

Claim Notes:

- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other physician experienced in treating a patient with hepatitis C infection).
- Sachets will only be considered for pediatric patients 3 years of age and older weighing between 12 kg and 45 kg.

Glucagon – see Glucagon (Human Recombinant)

Glucagon, nasal spray, 3mg (Baqsimi-LIL)

Regular benefit up to two devices per 12 months. Additional units require patient meets criteria as below:

For the treatment of severe hypoglycemia (SH) reactions in patients with diabetes mellitus receiving insulin and at high risk for SH, when impaired consciousness precludes oral carbohydrate administration.

- Request should detail the clinical need for greater than 2 glucagon devices per 12 months, including the number of devices anticipated
- Request must be from a medical practitioner or nurse practitioner
- Special authorization requests for additional doses will be considered for up to one dose per month
- SA is valid for 12 months
- Coverage is limited to one unit at a time

Glucagon (Human Recombinant), vial, 1mg; kit, 1mg (Glucagen - PAL)

Note: IM administration only.

Regular benefit up to two devices per 12 months. Additional units require patient meets

criteria as below:

For the treatment of severe hypoglycemia (SH) reactions in patients with diabetes mellitus receiving insulin and at high risk for SH, when impaired consciousness precludes oral carbohydrate administration.

- Request should detail the clinical need for greater than 2 glucagon devices per 12 months, including the number of devices anticipated
- Request must be from a medical practitioner or nurse practitioner
- Special authorization requests for additional doses will be considered for up to one dose per month
- SA is valid for 12 months
- Coverage is limited to one unit at a time

Glucagon – see Glucagon (Recombinant DNA Origin)

Glucagon (Recombinant DNA Origin), vial, 1mg (Glucagon – LIL)

Regular benefit up to two devices per 12 months. Additional units require patient meets criteria as below:

For the treatment of severe hypoglycemia (SH) reactions in patients with diabetes mellitus receiving insulin and at high risk for SH, when impaired consciousness precludes oral carbohydrate administration.

- Request should detail the clinical need for greater than 2 glucagon devices per 12 months, including the number of devices anticipated
- Request must be from a medical practitioner or nurse practitioner
- Special authorization requests for additional doses will be considered for up to one dose per month.
- SA is valid for 12 months
- Coverage is limited to one unit at a time

Golimumab, Syringe, 50mg/0.5mL; auto-injector, 50mg/0.5mL (Simponi-JAN)

Ankylosing Spondylitis

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- a) have axial symptoms* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR
- b) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for a maximum adult dose of 50 mcg once monthly.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: maximum of 12 months. Requests for renewal must include information showing the beneficial effects of the treatment, specifically:
 - a) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
 - b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; and
 - Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 50 mcg monthly.
- Initial Approval 16 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks
AND
Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Approvals will be for a maximum adult dose of 50 mcg once monthly.
- Must be prescribed by a rheumatologist.

- Initial Approval: 6 months
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Granisetron, tablet, 1 mg (Generic)

For the treatment of emesis in cancer patients receiving highly emetogenic chemotherapy (i.e. containing Cisplatin); receiving moderately emetogenic chemotherapy (i.e. containing Cyclophosphamide, Doxorubicin, Epirubicin, or Melphalan); or receiving radiation therapy and who have:

- a) Experienced adverse effects to Metoclopramide, Prochlorperazine, or Dexamethasone or have a specific contraindication which does not allow use of these drugs as antiemetics or,
- b) Continued episodes of nausea and vomiting related to chemotherapy which have not responded to therapeutic doses of Metoclopramide, Prochlorperazine, or Dexamethasone.

A maximum of 10 tablets per cycle of chemotherapy will be approved.

Grastofil – see Filgrastim

Guselkumab, autoinjector, prefilled syringe, 100mg/mL (Tremfya-JAN)

Plaque Psoriasis

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score; or

- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet, or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Concurrent use of biologics not approved.
- Approvals will be for 100mg by subcutaneous injection at weeks 0,4 followed by maintenance dosing of 100mg every 8 weeks.
- Initial Approval: 16 weeks.
- Renewal Approval: 1 year

The request must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; and
 - Methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 12 weeks, loading dose of 100mg at weeks 0, 4, and 8 weeks
- Maximum dose of 100mg every 8 weeks
- Renewal Approval: 1 year. Confirmation of continued response required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Hadlima - see Adalimumab

Harvoni – see Sofosbuvir & Ledipasvir

Hemangirol – see Propranolol

Hulio - see Adalimumab

Hydromorph Contin - see Hydromorphone, controlled-release capsule

Hydromorphone HCl, controlled-release capsule, 3mg, 4.5mg, 6mg, 9mg, 12mg, 18mg, 24mg, 30mg (Hydromorph Contin-PFR)

For the treatment of patients with documented severe chronic pain that is not well controlled by short and long-acting Morphine and short-acting Hydromorphone products. Maximum reimbursable coverage is for twice daily dosing.

Hydromorphone HCl, injection solution, 10mg/mL, 20mg/mL, 50mg/mL (Generic)

Note: For Nursing Home Program, no Special Authorization is required.

For the treatment of severe chronic pain that is not well controlled by short and long-acting oral Morphine and Hydromorphone products:

For other patients upon written request or recommendation from a palliative care or pain clinic. A copy of the recommendation must accompany the Special Authorization.

Hydromorphone HP - see Hydromorphone, injection solution

Hyrimoz - see Adalimumab

Ibrance – see Palbociclib

Ibrutinib, capsule, 140mg (Imbruvica-JAN)

1. For the treatment of patients with previously untreated chronic lymphocytic leukemia (CLL) / small lymphocytic lymphoma (SLL) for whom fludarabine-based treatment is considered inappropriate due to high risk of relapse or refractory disease (includes 17p deletion, TP3 mutation, 11q deletion and unmutated IGHV) based on prognostic biomarkers.
2. For the treatment of patients with CLL/SLL who have received at least one prior therapy and are considered inappropriate for treatment of retreatment with a fludarabine-based regimen.
3. For the treatment of patients with relapsed or refractory mantle cell lymphoma.

Clinical Notes:

1. Patients must have a good performance status.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Ibrutinib will not be reimbursed when used in combination with rituximab.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage under the High Cost Drug Program must apply to this program using the application that is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Icatibant, syringe, 30mg/3mL (Firazyr-SHR and generic)

For the treatment of acute attacks of hereditary angioedema (HAE) in adults with lab confirmed c1-esterase inhibitor deficiency (type I or type II) if the following conditions are met:

- Treatment of non-laryngeal attacks of at least moderate severity, or

- Treatment of acute laryngeal attacks

Limited to a single dose for self-administration per attack AND prescribed by physicians with experience in the treatment of HAE

The Special Authorization form is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Iclusig – see Ponatinib

Icosapent ethyl, capsule, 1g (Vascepa-HLS)

To reduce the risk of cardiovascular events (cardiovascular death, non-fatal myocardial infarction, non-fatal stroke, coronary revascularization, or hospitalization for unstable angina) in statin treated patients with elevated triglycerides who meet all of the following criteria:

- 45 years of age and older
- Established cardiovascular disease
- Baseline fasting triglyceride between 1.7 mmol/L and 5.6 mmol/L measured within the three months prior to initiating treatment with icosapent ethyl
- Baseline low-density lipoprotein cholesterol (LDL-C) between 1.0 mmol/L and 2.6 mmol/L
- Receiving a maximally tolerated statin dose for a minimum of 4 weeks, targeted to achieve an LDL-C lower than 2.0 mmol/L

Renewal Criteria:

- Patient continues to be treated with a maximally tolerated statin dose

Clinical Note:

- LDL-C and triglyceride levels must be provided.

Claim Notes:

- Approvals will be for a maximum of 4 g daily.
- Approval period: 1 year

Idacio - see Adalimumab

Idelalisib, tablet, 100mg, 150mg (Zydelig-GIL)

In combination with rituximab for the treatment of patients with relapsed chronic lymphocytic leukemia (CLL). Treatment should continue until unacceptable toxicity or

disease progression.

The Special Authorization form is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Ilaris – see Canakinumab

Ilumya – see Tildrakizumab

Imatinib, tablet, 100mg, 400mg (Gleevec-NVR and generics)

- a) For the treatment of patients who have documented evidence of Philadelphia chromosome positive (Ph+) chronic myeloid leukemia (CML), with an ECOG performance status of 0 - 2*.
- b) For the treatment of adult patients with newly diagnosed Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) when used as a single agent for induction and maintenance phase therapy.
- c) For the treatment of patients with C-Kit positive (CD117), metastatic or locally advanced, inoperable gastrointestinal stromal tumours (GIST) and who have an ECOG performance status of 0 - 2*.
- d) For the adjuvant treatment of adult patients who are at intermediate to high risk of relapse following complete resection of Kit (CD117) positive GIST.

Must be prescribed by a hematologist or oncologist.

- Patients who are asymptomatic and those who are symptomatic and in bed less than 50% of the time.

Initial Approval: 12 months

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage under the High Cost Drug Program must apply to this program using the application that is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Imbruvica – see Ibrutinib

Imitrex - see Sumatriptan

Increlex – see Mecasermin

Incruse Ellipta – see Umeclidinium Bromide

Indacaterol & Glycopyrronium & Mometasone, inhalation capsule, 150mcg & 50mcg & 160mcg (Enerzair Breezhaler-NVR)

For the maintenance treatment of asthma in adult patients not adequately controlled with a maintenance combination of long-acting-beta₂-agonist and a medium or high dose of an inhaled corticosteroid who experienced one or more asthma exacerbations in the previous 12 months.

Indacaterol & Mometasone, inhalation capsule, 150mcg & 80mcg, 150mcg & 160mcg, 150mcg & 320mcg (Ateectura Breezhaler-NVR)

For the treatment of asthma in patients who are not well controlled on a regular and adequate course of inhaled steroid therapy prior to the request for combination therapy.

Infliximab, injection powder, 100mg/vial (Avsola-AGA; Ixifi-PFI; Remdantry-CLT; Renflexis-MSD); prefilled syringe, prefilled pen, 120mg/mL (Remsima SC-CLT)

Ankylosing Spondylitis

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- a) have axial symptoms* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR
- b) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for a maximum adult dose of 5mg/kg at 0,2 and 6 weeks then every 6 to 8 weeks.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.

Requests for renewal must include information showing the beneficial effects of the treatment, specifically:

- a) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
- b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Crohn's Disease

- 1) For the treatment of patients with moderate to severe Crohn's disease who have active disease and are refractory, intolerant or have contraindications to:
 - Prednisone 40mg (or equivalent) daily for ≥ 2 weeks, AND
 - Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
 - Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
 - Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:

- Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
- Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients who have an aggressive/severe disease course (e.g. extensive disease, a modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.

Claim notes:

- Combined use of more than one biologic DMARD will not be reimbursed.
- The patient who completed an induction regimen with three IV infliximab doses must have achieved a clinical response to induction therapy with infliximab IV at week 10 of treatment to continue to maintenance therapy with infliximab SC.
- Initial approval: 6 months
- Renewal of coverage will require reassessment of the patient and submission of a new Crohn's Disease Special Authorization form.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Approvals will be for both SC and IV formulations.

- Maintenance with SC will be for a maximum of 120 mg every two weeks.
- IV will be for 5 mg/kg/dose given at 0, 2 and 6 weeks for induction then every 8 weeks thereafter for maintenance.

The request for coverage must be made by a gastroenterologist using the Crohn's Disease Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

- 2) For the treatment of fistulizing Crohn's Disease in patients who:
 1. Have a Harvey Bradshaw Index score of 7 or more, AND
 2. Have an actively draining perianal or enterocutaneous fistula(e) that have recurred or persisted despite a course of appropriate antibiotic therapy (e.g. Ciprofloxacin with or without Metronidazole for a minimum of 3 weeks), AND
 3. Have not responded to or are intolerant to immunosuppressive therapy (Azathioprine, Mercaptopurine or Methotrexate) or where such therapy is contraindicated.

Claim notes:

- Initial Approval is for 3 doses of 5mg/kg/dose administered at 0, 2, and 6 weeks. Renewal of coverage will require reassessment of the patient and submission of a new Crohn's Disease Special Authorization form. Continued coverage will be approved at a dose not exceeding 5mg/kg every 8 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a gastroenterologist using the Crohn's Disease Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Plaque Psoriasis

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND

- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score ; or
- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 5 mg/kg at 0, 2, and 6 weeks then every 8 weeks for 12 weeks. If response criteria is met at 12 weeks, approval will be continued at a dose of 5 mg/kg every 8 weeks.
- Initial Approval: 12 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Concurrent use of biologics not approved.

Requests must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; and

- Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
- Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 5 mg/kg at 0, 2, and 6 weeks then every 8 weeks thereafter.
- Initial Approval 16 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of $\geq 20\text{ mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age), for a minimum of 12 weeks
AND

Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.

- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.
- Approvals will be for both SC and IV formulations.
- SC will be for a maximum of 120 mg once weekly at 0, 1, 2, 3, and 4 weeks for induction, and then every 2 weeks thereafter for maintenance.
- IV will be for 3mg/kg/dose at 0, 2 and 6 weeks for induction, then every 8 weeks thereafter for maintenance.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ulcerative Colitis

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone ≥ 40mg daily for two weeks or IV equivalent for one week) OR
- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Renewal of coverage will require reassessment of the patient and submission of a new Ulcerative Colitis Special Authorization form. Requests must include information demonstrating the beneficial effects of the treatment, specifically:

- a decrease in the partial Mayo score ≥ 2 from baseline, and
- a decrease in the rectal bleeding subscore ≥ 1.

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo > 6) do not require a trial of 5-ASA

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined use of more than one biologic DMARD will not be reimbursed.
- The patient who completed an induction regimen with three IV infliximab doses must have achieved a clinical response to induction therapy with infliximab IV at week 10 of treatment to continue to maintenance therapy with infliximab SC.
- Initial Approval: 6 months.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Approvals will be for both SC and IV formulations.
- Maintenance with SC will be for a maximum of 120 mg every two weeks.
- IV will be for 5 mg/kg/dose given at 0, 2 and 6 weeks for induction then every 8 weeks thereafter for maintenance.

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Inlyta - see Axitinib

Innohep – see Low Molecular Weight Heparins

Inqovi – see Decitabine and Cedazuridine

Inrebic – see Fedratinib

Inspiolto Respimat – see Tiotropium/Olodaterol

Insulin aspart, vial, 100unit/mL (Novorapid-NNO)

For patients who are unable to switch to a biosimilar brand of insulin aspart due to insulin pump compatibility, the patient or healthcare provider can complete the online biosimilar switching exemption form for continued coverage of Novorapid.

[Application for Biosimilar Switching Exemptions](#)

Insulin Detemir, cartridge, prefilled pen; 100 unit/mL (Levemir-NNO)

- For the treatment of pediatric and adolescent patients with type 1 diabetes requiring insulin. Requests for pediatric and adolescent patients will be approved with an automatic Special Authorization tool within the electronic claims system.
- For the treatment of pregnant individuals with diabetes requiring insulin therapy. Requests for pregnant patients will require a written Special Authorization.

Insulin Glargine, prefilled pen, 300 unit/mL (Toujeo Solostar & Toujeo Doublestar-AVN)

For the treatment of patients who have been diagnosed with type 1 or type 2 diabetes requiring insulin and have previously used **all eligible open benefit** long-acting insulin analogues at optimal dosing
AND have experienced unexplained hypoglycemia at least once a month despite optimal management

OR

For the treatment of patients who have been diagnosed with type 1 or type 2 diabetes requiring high dose insulin.

Insulin Regular, prefilled pen, 500 unit/mL (Entuzity-LIL)

For the treatment of diabetes mellitus in patients with unacceptable glycemic control who require more than 200 units of insulin per day, with or without other therapies.

- Treatment should be initiated by a specialist with experience in treating severe insulin resistance.

Interferon Beta-1A – see Multiple Sclerosis Agents

Interferon Beta-1B – see Multiple Sclerosis Agents

Invega Sustenna – see Paliperidone

Invega Trinza – see Paliperidone

Invokana – see Canagliflozin

Isavuconazole, capsule, 100mg (Cresemba-AVI)

- For the treatment of adult patients with invasive aspergillosis who have a contraindication, intolerance or have failed to respond to oral voriconazole and caspofungin.
- For the treatment of adult patients with invasive mucormycosis.

Claim Notes:

- Must be prescribed by a hematologist or specialist in infectious diseases or medical microbiology.
- Initial requests will be approved for a maximum of 3 months.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Itraconazole, oral solution, 10mg/mL (Generic)

For the treatment of immunocompromised adult patients with oral and/or esophageal candidiasis

Clinical Note:

- As per the drug monograph, Itraconazole capsules and oral solution should not be used interchangeably due to differences in bioavailability.

Ivabradine, tablet, 5mg, 7.5mg (Lancora-SER)

For the treatment of adult patients with New York Heart Association (NYHA) class II or III stable heart failure when administered in combination with standard chronic heart failure therapies to reduce the incidence of cardiovascular death and hospitalization, who meet all of the following criteria:

- Left ventricular ejection fraction (LVEF) of $\leq 35\%$
- Sinus rhythm with a resting heart rate ≥ 77 beats per minute (bpm)
- At least one hospitalization due to heart failure in the past year
- NYHA class II or III symptoms despite at least four weeks of treatment with the following:
 - a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor blocker (ARB)
 - a stable dose of a beta blocker
 - an aldosterone antagonist

Clinical Notes:

1. Resting heart rate must be documented as ≥ 77 bpm on average using either an ECG on at least three separate visits or by continuous monitoring.
2. For patients who have not received four weeks of therapy with an ACEI/ARB, beta blocker and aldosterone antagonist due to an intolerance or contraindication, details must be provided.

3. Initiation and up-titration should be under the supervision of a physician experienced in the treatment of heart failure.

Ivacaftor, tablet, 150mg (Kalydeco-VTX)

For the treatment of cystic fibrosis in patients who meet the following criteria:

- the patient is at least 6 years old and has one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, OR S549R; OR
- the patient is at least 18 years old with an R117H mutation in the CFTR gene.

Renewal requests will be considered in patients with documented response to treatment as evidenced by the following:

- a) In cases where the patient's sweat chloride levels prior to commencing therapy were above 60mmol/L:
 - the patient's sweat chloride level fell below 60mmol/L; or
 - the patient's sweat chloride level is 30% lower than the level reported in a previous test;
- b) In cases where the patient's sweat chloride levels prior to commencing therapy were below 60mmol/L:
 - the patient's sweat chloride level is 30% lower than the level reported in a previous test; or
 - the patient demonstrates a sustained absolute improvement in FEV₁ of at least 5% when compared to the FEV₁ test conducted prior to the commencement of therapy. FEV₁ will be compared with the baseline pre-treatment level one month and three months after starting treatment.

Clinical Notes:

- The patient's sweat chloride level and FEV₁ must be provided with each request.
- A sweat chloride test must be performed within a few months of starting ivacaftor therapy to determine if sweat chloride levels are reducing.
 - If the expected reduction occurs, a sweat chloride test must be performed again 6 months after starting therapy to determine if the full reduction has been achieved. Thereafter, sweat chloride levels must be checked annually.
 - If the expected reduction does not occur, a sweat chloride test should be performed again one week later. If the criteria are not met, coverage will be discontinued.

Claim Notes:

- Approved dose: 150mg every 12 hours
- Approval Period: 1 year

¹Please note:baseline sweat chloride levels and FEV₁ are not required to meet Initial Approval criteria for Kalydeco,but these parameters are used to evaluate the effect of Kalydeco at the time of renewal. To avoid delays, the prescriber should submit a copy of the mutation report, recent baseline sweat chloride levels before starting Kalydeco, and recent baseline FEV₁ with the initial

request for funding of Kalydeco. These baseline values will be used to evaluate the patient's response to therapy at the time of renewal and would be logistically difficult to obtain once treatment is initiated.

Ivacaftor/lumacaftor – see Orkambi

Ixekizumab, autoinjector, syringe, 80mg/mL (Taltz-LIL)

Plaque Psoriasis

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score ; or
- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 160 mg at week 0, followed by 80mg at week 2, 4, 6, 8, 10 and 12. If response criteria is met at 12 weeks, approval will be continued at a dose of 80 mg every 4 weeks up to one year.
- Initial Approval: 12 weeks.
- Renewal Approval: 1 year.
- Concurrent use of biologics not approved.

Requests must be made by a dermatologist using the Plaque Psoriasis Special

Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; and
 - Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 160 mg by subcutaneous injection (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks.
- Initial Approval 16 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ixifi – see Infliximab

Jakavi – see Ruxolitinib

Jamteki – see Ustekinumab

Januvia – see Sitagliptin

Janumet – see Sitagliptin & Metformin Hydrochloride

Janumet XR – see Sitagliptin & Metformin Hydrochloride

Jardiance – see Empagliflozin

Kalydeco – see Ivacaftor

Kerendia – see Finerenone

Kesimpta – see Ofatumumab

Kevzara – see Sarilumab

Kisqali – see Ribociclib

Koselugo – see Selumetinib

Lactulose, syrup, 667mg/mL

For the treatment of hepatic encephalopathy.

Lanadelumab, vial, prefilled syringe, 300mg/2mL (Takhzyro-TAK)

For the prevention of attacks of type I or II hereditary angioedema (HAE) in patients 12 years of age and older who have experienced at least three HAE attacks within any four-week period and required the use of an acute injectable treatment.

Discontinuation Criteria:

- No reduction in the number of HAE attacks for which acute injectable treatment was received during the first three months of treatment with lanadelumab compared to the number of attacks observed before initiating treatment with lanadelumab; or
- Increase in the number of HAE attacks for which acute injectable treatment was received compared to the number of attacks before initiating treatment with lanadelumab.

Clinical Note:

- The pre-treatment attack rate must be provided for those patients who are already

receiving long-term prophylactic treatment for HAE and intend to transition to lanadelumab.

Claim Notes:

- The patient must be under the care of a physician experienced in the diagnosis and treatment of HAE
- Not to be used in combination with other long-term prophylactic treatment of HAE (e.g., C1 esterase inhibitor).
- Approvals will be for a maximum of 300 mg every two weeks.
- Initial Approval Period: 3 months.
- Renewal Approval Period: 6 months.
- Claims that exceed the maximum claim amount of \$9,999.99 must be divided and submitted as separate transactions using the DIN first, and then PDINs.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Lancora – see Ivabradine

Lansoprazole – see Proton Pump Inhibitors

Lansoprazole & Clarithromycin & Amoxicillin, 7-day package, 30mg & 500mg & 500mg (Generics)

One week of therapy will be considered for individuals with documented duodenal or gastric ulcers and a recent documented positive helicobacter pylori test.

Lapelga – see Pegfilgrastim

Larotrectinib, capsule, 25mg, 100mg; oral liquid, 20mg/mL (Vitrakvi-BAY)

As monotherapy for the treatment of adult and pediatric patients with unresectable locally advanced or metastatic solid tumors who meet all of the following criteria:

- Tumors have a NTRK gene fusion without a known acquired resistance mutation
- No other satisfactory treatment options
- Not a candidate for surgery and/or radiation due to risk of substantial morbidity

Clinical Notes:

- Patients must have a good performance status.
- If brain metastases are present, patients must be asymptomatic.
- Treatment should be discontinued upon radiographic disease progression or unacceptable toxicity.
- Patients with prior disease progression on a NTRK inhibitor are not eligible.

Claim Notes:

- Approval Period: 6 months

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Lenalidomide, capsule, 2.5mg, 5mg, 10mg, 15mg, 20mg, 25mg (Revlimid-CEL and generics)

Multiple Myeloma

For the treatment of newly diagnosed Multiple Myeloma, in combination with daratumumab and dexamethasone, for patients who are not suitable for autologous stem cell transplant and have a good performance status.

For the treatment of Multiple Myeloma when used in combination with dexamethasone, in patients who:

- Are not candidates for autologous stem cell transplant;
AND
- Where the patient is either:
 - Refractory to or has relapsed after the conclusion of initial or subsequent treatments and who is suitable for further chemotherapy;
 - OR
 - Has completed at least one full treatment regimen therapy and is experiencing intolerance to their current chemotherapy.

For the Maintenance Treatment of patients with newly diagnosed Multiple Myeloma, following autologous stem-cell transplantation (ASCT), in patients who are with stable disease or better, with no evidence of disease progression.

Myelodysplastic Syndrome

For the treatment of Myelodysplastic Syndrome (MDS) in patients with:

- Demonstrated diagnosis of MDS on bone marrow aspiration
- Presence of 5-Q31 deletion documented by appropriate genetic testing
- International Prognostic Scoring System (IPSS) risk category low or intermediate (Calculator available on www.uptodate.com)
- Presence of symptomatic anemia (defined as transfusion dependent)
 - Initial Approval Period – 6 months
Renewal criteria:
 - For patients who were transfusion-dependent and have demonstrated a reduction in transfusion requirements of at least 50%.

- Renewal period – 1 year

Pharmacare will reimburse a single capsule per day per person.
Multiple strengths or multiple capsules per day will not be reimbursed.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Lenvatinib, capsule, 4mg/dose, 8mg/dose, 12mg/dose (Lenvima-EIS)

Advanced Endometrial Carcinoma

Lenvatinib combined with pembrolizumab for the treatment of adult patients with advanced endometrial carcinoma that is not microsatellite instability high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior platinum-based systemic therapy and are not candidates for curative surgery or radiation.

Advanced Hepatocellular Carcinoma

For the treatment of unresectable hepatocellular carcinoma (HCC), as first-line or second-line therapy after progression on immunotherapy (atezolizumab in combination with bevacizumab), for patients who meet all of the following criteria:

1. Child-Pugh class status of A.
2. ECOG performance status of 0 or 1.
3. Less than 50% liver involvement and no invasion of the bile duct or main portal vein.
4. No brain metastases or prior liver transplantation.

Clinical Notes:

- Treatment should be continued until disease progression or unacceptable toxicity. Patients who are unable to tolerate lenvatinib may be switched to sorafenib if there is no disease progression and provided all other funding criteria are met.
- Patients with disease progression on lenvatinib are not eligible for reimbursement of sorafenib.

Advanced and Metastatic Renal Cell Carcinoma

Lenvatinib combined with pembrolizumab for the treatment of adult patients with advanced (not amenable to curative surgery or radiation) or metastatic renal cell carcinoma (RCC) who have had no prior systemic therapy for metastatic disease.

Differentiated Thyroid Cancer
(Lenvima 10mg,14mg, 20mg and 24mg Compliance Pack)

For the treatment of patients with locally recurrent or metastatic, progressive, differentiated thyroid cancer (DTC) who meet the following criteria:

- Pathologically confirmed papillary or follicular thyroid cancer, and
- Disease that is refractory or resistant to radioactive iodine therapy, and
- Radiological evidence of disease progression within the previous 13 months, and
- Previous treatment with no more than one tyrosine kinase inhibitor (TKI).

Clinical Notes:

1. Patients must have a good performance status.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Hepatocellular Carcinoma
(Lenvima 4mg, 8mg and 12mg Compliance Pack)

For the first-line treatment of adult patients with unresectable metastatic hepatocellular carcinoma who meet all the following criteria:

1. Child-Pugh class status of A.
2. ECOG performance status of 0 or 1.
3. Less than 50% liver involvement and no invasion of the bile duct or main portal vein.
4. No brain metastases or prior liver transplantation.

Clinical Notes:

- Treatment should be continued until disease progression or unacceptable toxicity. Patients who are unable to tolerate lenvatinib may be switched to sorafenib if there is no disease progression and provided all other funding criteria are met.
- Patients with disease progression on lenvatinib are not eligible for reimbursement of sorafenib.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Lenvima – see Lenvatinib

Letermovir, tablet, 240mg, 480mg (Prevymis-MER)

For the prevention of cytomegalovirus (CMV) infection in adult CMV-seropositive

recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT) who have undetectable CMV viremia at baseline and meet one of the following criteria:

- umbilical cord blood as a stem cell source
- recipient of a haploidentical transplant
- recipient of T-cell depleted transplant
- treated with antithymocyte globulin (ATG) for conditioning
- requiring high-dose steroids or other immunosuppression for acute graft versus host disease (GVHD)
- treated with ATG for steroid-refractory acute GVHD
- documented history of CMV disease prior to transplantation

Clinical Note:

- High-dose steroids is defined as the use of greater than or equal to 1 mg/kg/day of prednisone or equivalent dose of another corticosteroid.

Claim Notes:

- Must be prescribed by a medical oncologist, hematologist, or infectious disease specialist or other physician with experience in the management of HSCT.
- Approvals will be for a maximum dose of 480mg per day.
- Approval Period: 100 days per HSCT

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Levemir – see Insulin Detemir

Levetiracetam, oral solution, 100mg/mL (Generic)

- For patients who require administration through a feeding tube.
- For patients 19 years of age and younger, who cannot use a tablet or capsule.
- Pediatric patients 12 and under will not require written Special Authorization.

Levocarnitine, tablet, oral solution, 330mg, 100mg/mL (Carnitor-SIG and generic)

- For the treatment of patients with primary systemic carnitine deficiency.
- For the treatment of patients with an inborn error of metabolism that results in secondary carnitine deficiency.

Levodopa & Carbidopa, intestinal gel cassette, 20mg/mL & 5mg (Duodopa-ABV)

For the treatment of patients with advanced levodopa-responsive Parkinson's Disease (PD) who meet all of the following criteria:

- Experiences severe disability with at least 25% of the waking day in the off state and/or ongoing levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day).

- Received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response.
- Failed an adequate trial of the following adjunctive medications, if not contraindicated and/or contrary to the clinical judgement of prescriber: entacapone, a dopamine agonist, a monoamine oxidase-B (MAO-B) inhibitor and amantadine.
- Must be able to administer the medication and care for the administration port and infusion pump. Alternatively, trained personnel or care partner must be available to perform these tasks reliably.

Exclusion Criteria:

- Patients with a contraindication to the insertion of a PEG-J tube.
- Patients with severe psychosis or dementia.

Renewal Criteria:

- Patients continue to demonstrate a significant reduction in the time spent in the off state and/or ongoing levodopa-induced dyskinesias, along with and an improvement in the related disability.

Clinical Note:

- Time in the off state, frequency of motor fluctuations, and severity of associated disability should be assessed by a movement disorder subspecialist and be based on an adequate and reliable account from longitudinal speciality care, clinical interview of a patient and/or care partner, or motor symptom diary.

Claim Notes:

- Must be prescribed by a movement disorder subspecialist who has appropriate training in the use of Duodopa and is practicing in a movement disorder clinic that provides ongoing management and support for patients receiving treatment with Duodopa.
- Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Levofloxacin, tablet, 250mg, 500mg, 750mg (Generics)

Note: For Cystic Fibrosis and Nursing Home Programs, no Special Authorization is required.

- a) For the treatment of infections in persons allergic to alternative agents. Up to 10 days of therapy will be considered.
- b) For the treatment of infections in patients with asthma or COPD not responding to first-line antibiotics. Up to 10 days of therapy will be considered.

- c) For the treatment of infections caused by organisms known to be resistant to alternative antibiotics. Up to 10 days of therapy will be considered.
- d) For the completion of treatment started in the hospital inpatient setting. Up to 7 days of therapy will be considered.

Linagliptin, tablet, 5mg (Trajenta-BOE)

For the treatment of patients with type 2 diabetes when added to metformin for patients who have inadequate glycemic control on metformin.

Clinical Notes:

For patients who cannot take metformin due to contraindications or intolerances, details must be provided.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Linezolid, tablet, 600mg (Generics)

- (a) For the treatment of proven VRE (Vancomycin-Resistant Enterococcus) infections. Must be prescribed in consultation with a specialist in infectious diseases. A copy of a C&S report demonstrating Vancomycin resistance must accompany the request. Up to 28 days of therapy will be considered.
- (b) For the treatment of proven MRSA (Methicillin-Resistant Staph. Aureus) and MRSE (Methicillin-Resistant Staph. Epidermidis) infections in patients who are unresponsive or intolerant to Vancomycin. Must be prescribed in consultation with a specialist in infectious diseases. A copy of a C&S report demonstrating Vancomycin resistance must accompany the request. Up to 28 days of therapy will be considered.

Lisdexamfetamine, capsule, chewable tablet, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg (Vyvanse-TAK and generics)

For treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who have tried extended release methylphenidate, dexamphetamine or mixed salts amphetamine with unsatisfactory results.

Claim Note:

The maximum dose reimbursed is 60mg daily.

Lonsurf – see Trifluridine & Tipiracil

Lorbrena – see Lorlatinib

Lorlatinib, tablet, 25mg, 100mg (Lorbrena-PFI)

As monotherapy for the first-line treatment of adult patients with anaplastic lymphoma kinase (ALK)- positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer.

Clinical Note:

1. Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.

Claim Notes:

1. Approval Period: 1 year.
2. No further ALK inhibitor will be reimbursed following disease progression on lorlatinib.

* Claims that exceed the maximum claim amount of \$9999.99 must be divided as separate transactions, using DIN first and PDIN* second.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Losec - see Proton Pump Inhibitors

Low Molecular Weight Heparins

Dalteparin, pre-filled syringe, 2500 iu, 5000 iu, 7500 iu, 10000 iu, 12500 iu, 15000 iu, 18000 iu; multi-dose vial (3.8mL), 25000 iu/mL (Fragmin-PFI)

Tinzaparin, vial, 10000 IU/mL, 20000 IU/mL; syringe, 2500 IU/0.25mL, 3500 IU/0.35mL, 4500 IU/0.45mL, 10000 IU/0.5mL, 14000 IU/0.7mL, 18000unit/0.9mL (Innohep-LEO)

Note: For Nursing Home Program, no Special Authorization is required.

For the acute treatment of deep vein thrombosis (DVT) and/or pulmonary embolism (PE) for a maximum of 30 days.

For prophylaxis in hip replacement and hip fracture surgery, approval is limited to a maximum of 35 days.

For prophylaxis in knee replacement surgery, approval is limited to a maximum of 10 days.

For prophylaxis in high risk surgery, approval is limited to maximum of 10 days.

For the extended treatment of recurrent symptomatic venous thromboembolism (VTE) that has occurred while patients are on therapeutic doses of warfarin.

For the treatment and secondary prevention of symptomatic venous thromboembolism (VTE) or pulmonary embolism (PE) for a period of up to 6 months in patients with cancer.

Lucentis - see Ranibizumab

Luspatercept, vial, 25mg, 75mg (Reblozyl)

Beta-Thalassemia Anemia

For the treatment of adult patients with RBC transfusion-dependent anemia associated with beta-thalassemia. Patients must be receiving regular transfusions, defined as:

- 6 to 20 RBC units in the 24 weeks prior to initiating treatment with luspatercept, AND
- No transfusion-free period greater than 35 days in the 24 weeks prior to initiating treatment with luspatercept.

Renewal Criteria:

- Patients must demonstrate an initial response, defined as a $\geq 33\%$ reduction in transfusion burden (RBC units/time) compared to the pre-treatment baseline RBC transfusion burden, measured over 24 weeks prior to initiating treatment with luspatercept.
- For continued coverage, patients should maintain a reduction in transfusion burden of $\geq 33\%$ compared to the pre-luspatercept transfusion burden.
- Luspatercept should be discontinued if a patient does not respond after nine weeks of treatment (three doses) at the maximum dose.

Claim Notes:

- The patient should be under the care of a specialist with experience in managing patients with beta-thalassemia.
- The maximum dose of luspatercept should not exceed 1.25mg/kg (or 120mg total dose) once every three weeks.
- Initial Approval: 6 months
- Renewal Approval: 1 year

Myelodysplastic Syndromes

For the treatment of adult patients with red blood cell (RBC) transfusion-dependent anemia associated with very low- to intermediate-risk MDS who have ring sideroblasts and who have failed or are not suitable for erythropoietin-based therapy.

Renewal Criteria:

- Patients should be RBC transfusion independent over a minimum of 16 consecutive weeks within the first 24 weeks of treatment initiation.
- For continued coverage, patients should be RBC transfusion independent over a minimum of 16 consecutive weeks within the previous Approval Period.

Claim Notes:

- Treatment should be initiated by a specialist with expertise in managing and treating patients with MDS.
- The maximum dose of luspatercept should not exceed 1.75mg/kg (or 168mg total dose) once every three weeks.
- Approval: 6 months

* Claims that exceed the maximum claim amount of \$9999.99 must be divided as separate transactions, using DIN first and PDIN* second.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Lynparza – see Olaparib

Macitentan, tablet, 10mg (Opsumit-JAN)

For the treatment of patients with Group 1 pulmonary arterial hypertension (PAH) with a World Health Organization (WHO) functional class of at least II.

Clinical Note:

- The diagnosis of PAH should be confirmed by right heart catheterization.

Claim Notes:

- Must be prescribed by, or in consultation with, a physician experienced in the treatment of PAH.
- Combined use of more than one endothelin receptor antagonists will not be reimbursed.
- The maximum dose of macitentan that will be reimbursed is 10mg daily.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Magic Bullet - see Bisacodyl

Mavacamten, capsule, 2.5mg, 5mg, 10mg, 15mg (Camzyos-BMS)

For the treatment of patients with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) of New York Heart Association (NYHA) class II to III who meet all of the following criteria:

- Documented left ventricular ejection fraction (LVEF) $\geq 55\%$ at rest determined by echocardiography.
- Left ventricular (LV) wall thickness ≥ 15 mm (or ≥ 13 mm with a family history of hypertrophic cardiomyopathy).
- Left ventricular outflow tract (LVOT) peak gradient ≥ 50 mm Hg at rest, after Valsalva maneuver, or post exercise, as confirmed by echocardiography.
- Must be receiving beta-blocker or calcium channel blocker therapy and experience clinical deterioration in symptoms or echocardiography while receiving either of these treatments or for patients who have an intolerance or contraindication to treatments, details must be provided.

Renewal Criteria:

- Patients must not have any of the following:
 - LVEF $\leq 30\%$
 - Received septal reduction therapy.

Claim Notes:

- Must be prescribed by, or in consultation with a specialist in cardiology.
- Approvals will be for a maximum of up to 5mg daily for 12 weeks, then up to 15mg daily thereafter.
- Initial Approval: 12 weeks
- Renewal Approval: 1 year

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Mavenclad – see Cladribine

Maviret – see Glecaprevir & Pibrentasvir

Mayzent – see Siponimod

Mecasernin, vial, 10mg/mL (Increlex-IPS)

For the treatment of growth failure in children and adolescents from 2 to 18 years with confirmed severe primary insulin-like growth factor-1 deficiency (SPIGFD) who meet the following criteria:

- Epiphyseal closure has not yet occurred; AND
- Have a confirmed diagnosis of SPIGFD, defined by:

- a known genetic mutation recognized as a cause of SPIGFD, AND/OR
- has clinical and biochemical features of SPIGFD

Renewal Criteria:

- Treatment with mecasermin must be discontinued upon the occurrence of any of the following:
 - Height velocity is less than 1cm per 6 months or less than 2cm per year, OR
 - Bone age is more than 16 years in boys and 14 years in girls.

Claim Notes:

- The patient must be under the care of a pediatric endocrinologist.
- Mecasermin must not be prescribed concomitantly with recombinant GH treatment.
- Approvals: 1 year

Mekinist – see Trametinib

Mektovi – see Binimetinib

Mepolizumab, 100mg, vial, 100mg/mL, autoinjector, syringe (Nucala-GSK)

Eosinophilic Asthma

As add-on maintenance treatment for adult patients with severe eosinophilic asthma, if the following criteria are met:

Initiation Criteria:

- Patient must have a documented diagnosis of asthma.
- Patient is inadequately controlled with high-dose inhaled corticosteroids, defined as greater or equal to 500mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists).
- Patient has one of the following:
 - blood eosinophil count of ≥ 300 cells/ μ L within the past 12 months AND has experienced two or more clinically significant asthma exacerbations in the past 12 months, or
 - blood eosinophil count of ≥ 150 cells/ μ L AND is receiving maintenance treatment with oral corticosteroids (OCS).

Renewal Criteria:

- The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue
- Reimbursement of treatment should be discontinued if:
 - the 12 months asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment, or
 - the asthma control questionnaire score achieved after the first 12 months

of therapy has not been maintained subsequently, or the number of clinically significant exacerbations has increased within the previous 12 months, or

- in patients on maintenance treatment with OCS, there has been no decrease in the OCS dose in the first 12 months of treatment, or
- in patients on maintenance treatment with OCS, the reduction in the dose of OCS achieved after the first 12 months of treatment is not maintained subsequently.

Clinical Notes:

- Mepolizumab should not be used in combination with other biologics used to treat asthma.
- A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of benralizumab treatment.
- Patients should be managed by a physician with expertise in treating asthma.

Severe Chronic Rhinosinusitis with Nasal Polyps

For the treatment of patients with severe chronic rhinosinusitis with nasal polyps (CRSwNP) who meet all of the following criteria:

- have endoscopically or CT-documented bilateral nasal polyps, and
- have undergone at least 1 prior surgical intervention for nasal polyps or have a contraindication to surgery, and
- are tolerant and able to continue use of inhaled nasal corticosteroids but have refractory symptoms despite use of inhaled corticosteroids for 3 months at maximally tolerated doses.

Renewal Criteria:

- Requests for renewal must exhibit a clinically meaningful response defined as:
 - a decrease of 8.9 points or greater on the Sino-nasal Outcome Test (SNOT-22) relative to their baseline score, or
 - a decrease of 1 point or greater on the endoscopic Nasal Polyp Score (NPS) relative to their baseline score.

Clinical Notes:

- A baseline and annual SNOT-22 or endoscopic NPS must be provided.
- Patients should be assessed for a response to mepolizumab every 12 months.
- Maximum dose approved: 100mg every 4 weeks
- Renewal Approval: 12 months

Claim Note:

- Must be prescribed by an otolaryngologist, allergist or respirologist with expertise in managing severe CRSwNP

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Metadol - see Methadone

Methadone, tablet, 1mg, 5mg, 10mg, 25mg (Metadol-PMS and generic)

For the management of severe chronic or malignant pain that is not well controlled by short and long-acting Morphine and Hydromorphone as well as Fentanyl products.

Methylphenidate HCl, controlled release capsule, 10mg, 15mg, 20mg, 30mg, 40mg, 50mg, 60mg, 80mg (Biphentin-PFR and generic)

For the treatment of patients with Attention Deficit Hyperactivity Disorder who have tried extended-release methylphenidate with unsatisfactory results.

Claim Note: The maximum dose reimbursed is 80 mg daily

Mictoryl Pediatric – see Propiverine

Midostaurin, capsule, 25mg (Rydapt-NVR)

For the treatment of adult patients with newly diagnosed FMS-like tyrosine kinase 3 (FLT3)-mutated acute myeloid leukemia (AML) when used in combination with standard cytarabine and daunorubicin (7+3) induction and cytarabine consolidation chemotherapy.

Claim Notes:

- Requests for midostaurin will not be considered when used as maintenance therapy, or as part of re-induction and/or re-consolidation.
- Requests for midostaurin in combination with idarubicin containing 7+3 induction and cytarabine consolidation chemotherapy will be considered.
- Approval Period: Up to 6 cycles (maximum of 2 cycles of induction and 4 cycles of consolidation)

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Mirabegron, extended release tablet, 25mg, 50mg (Myrbetriq-AST)

For the treatment of overactive bladder (not stress incontinence) in patients who cannot tolerate or have an insufficient response to an adequate trial (eg. 3 months) of immediate release oxybutynin, solifenacin, tolterodine, or tolterodine XL.

Modafinil, tablet, 100mg (Alertec-SHR and generics)

For the treatment of patients with a confirmed sleep-laboratory diagnosis of narcolepsy or idiopathic CNS hypersomnia.

Mometasone Furoate/Formoterol Fumarate Dihydrate, inhaler, 50mcg/5mcg, 100mcg/5mcg, 200mcg/5mcg (Zenhale-MSD)

For the treatment of asthma in patients who are not well controlled on a regular and adequate course of inhaled steroid therapy prior to the request for combination therapy. Continuation of current coverage requires regular use of an adequate dose of this medication.

Maximum dose is 800mcg/20mcg (4 puffs) per day

Monurol – see Fosfomycin

Morphine Sulfate, injection solution, 50mg/mL (Morphine Sulfate-SAB)

For the treatment of severe chronic pain that is not well controlled by short and long-acting oral Morphine and Hydromorphone products:

- a) For patients covered by the Nursing Home Program without a Special Authorization.
- b) For other patients upon written request or recommendation from a palliative care or pain clinic. **A copy of the recommendation must accompany the Special Authorization.**

Moxifloxacin, ophthalmic drops, 0.5% (Vigamox-ALC and generics)

For the treatment/prevention of bacterial conjunctivitis associated with eye surgery.

Moxifloxacin, tablet, 400mg (Generics)

Note: For the Cystic Fibrosis Program, no Special Authorization is required.

- a) For the treatment of severe pneumonia in nursing home patients
- b) For the completion of therapy instituted in the hospital setting for the treatment of severe community acquired pneumonia.

Multiple Sclerosis Agents

Dimethyl Fumarate, delayed release capsule, 120mg, 240mg (Tecfidera-BIG & generics)

Glatiramer Acetate, syringe, 20mg/mL (Glatect-PMS)

Interferon Beta-1A, pre-filled syringe, 30mcg (Avonex PS-BIG); pre-filled cartridge,

66mcg/1.5mL, 132mcg/1.5mL (Rebif-SRO); pre-filled syringe, 22mcg, 44mcg (Rebif-SRO)

Interferon Beta-1B, injection powder, 0.3mg (Betaseron-BAY)

Peginterferon Beta-1A, SC injection, 63/94mcg/0.5mL, 125mcg/0.5mL (Plegridy-BIG)

Teriflunomide, tablet, 14mg (Aubagio-GZY & generics)

For the treatment of patients 18 years of age or older, diagnosed with relapsing-remitting and secondary progressive multiple sclerosis (if applicable), who have had two attacks within the past two years, and have an EDSS score of 6.5 or less.

The request for coverage of any of the above medications must be made by a neurologist.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Fingolimod, capsule, 0.5mg (Gilenya-NVR and generics)

For the treatment of patients with Relapsing Remitting Multiple Sclerosis (RRMS) who meet **all** of the following criteria:

- a) Failure to respond to full and adequate courses* of at least one disease modifying therapy (DMT) publicly insured under PEI Pharmacare as an initial therapy, or has intolerance** to at least two initial publicly funded therapies.
- b) One or more clinically disabling relapses in the previous year.
- c) Significant increase in T2 lesion load compared with that from a previous MRI scan (i.e. 3 or more new lesions) or at least one gadolinium-enhancing lesion.
- d) Requested and followed by a neurologist experienced in the management of RRMS.
- e) Recent Expanded Disability Status Scale (EDSS) score of less than or equal to 5.5 (i.e. patients must be able to ambulate at least 100 meters without assistance)

*Failure to respond to full and adequate courses: defined as a trial of at least 6 months of a publicly funded DMT **AND** experienced at least one disabling relapse (attack) while on a publicly funded DMT (MRI report does not need to be submitted with the request).

**Intolerance is defined as: documented serious adverse effects or contraindications that are incomplete with further use of that class of drug.

Dosage: 0.5 mg once daily

Approval Period: Up to 12 months

Exclusion Criteria:

- a) Do not fund combination therapy of Gilenya with other disease modifying therapies (e.g. Avonex, Betaseron, Rebif, Tysabri) nor in combination with Fampyra.
- b) Do not fund in patients with EDSS > 5.5
- c) Do not fund in patients who have had a heart attack or stroke in the last 6 months of funding request, history of sick sinus syndrome, atrioventricular block, significant QT prolongation, bradycardia, ischemic heart disease, or congestive heart failure
- d) Patients < 18 years of age
- e) Needle phobia or preference for oral therapy over injection in patients without clinical contraindication to interferon or glatiramer therapy
- f) Skin reactions at the site of injection do NOT qualify as a contraindication to interferon or glatiramer therapy

Renewal:

- a) Date and details of the most recent neurological examination and EDSS scores must be provided (exam must have occurred within that last 90 days).
- b) Patients must be stable or have experienced no more than 1 disabling attack/relapse in the past year; **AND**
- c) Recent Expanded Disability Status Scale (EDSS) score of less than or equal to 5.5 (i.e. patients must be able to ambulate at least 100 meters without assistance)

Dosage: 0.5 mg once daily

Renewal period: 12 months

The request for coverage must be made by a neurologist.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Mirikizumab, vial, 300mg/15mL; prefilled syringe, prefilled pen, 100mg/mL (OmvoH-LIL)

Ulcerative Colitis

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone $\geq$ 40mg daily for two weeks or IV equivalent for one week) OR
- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo $>$ 6) do not require a trial of 5-ASA

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined therapy with biologic therapies or JAK inhibitors for UC will not be reimbursed.
- Initial Approval: 6 months
- Initial reimbursement will be for 300mg intravenous dose at Week 0, Week 4, and Week 8. If patients do not have adequate therapeutic response at Week 12, 300mg will be reimbursed at Weeks 12, 16 and 20. Subsequent reimbursement for maintenance dosing will be for a maximum dose of 200mg every 4 weeks.
- Renewal Approval: 1 year.
- Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:
 - a decrease in the partial Mayo score $\geq$ 2 from baseline, and
 - a decrease in the rectal bleeding subscore $\geq$ 1.

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Myrbetriq – see Mirabegron

Nabilone, capsules, 0.5mg, 1mg (Cesamet-VAL and generics)

- For the treatment of severe nausea and vomiting associated with cancer chemotherapy in patients who have not been well controlled by standard stepwise antiemetic therapy.
- For the treatment of acquired immune deficiency syndrome (AIDS)-related anorexia associated with weight loss.

Nalcrom - see Sodium Cromoglycate

Naltrexone, tablet, 50mg (Revia-TEV and generics)

Note: For Substance Use Harm Reduction Drug Program, no Special Authorization is required.

For the treatment of alcohol use disorder.

Naratriptan HCl, tablet, 1mg, 2.5mg (Amerge-GSK and generics)

For the treatment of migraine headaches where other standard therapies, such as oral analgesics have failed **AND** the patient has not responded to Zolmitriptan or Rizatriptan.

Coverage is limited to 6 tablets per 30 day period. Anyone requiring more than 6 doses per 30 day period should be considered for migraine prophylaxis therapy if they are not already receiving such therapy.

Natalizumab, vial, 300mg & 15mL (Tysabri-BIG)

Initial Request:

For the treatment of Relapsing-Remitting Multiple Sclerosis (RRMS) who meet all the following criteria:

- The patient's physician is a neurologist experienced in the management of relapsing-remitting multiple sclerosis (RRMS); AND the patient;
 - has a current EDSS less than or equal to 5.0; AND
 - has failed to respond to a full and adequate course¹ (at least six months) of at least ONE disease modifying therapy OR has contraindications/intolerance to at least TWO disease modifying therapies; AND
 - has had ONE of the following types of relapses in the past year:
 - the occurrence of one relapse with partial recovery during the past year AND has at least ONE gadolinium-enhancing lesion on brain MRI, OR significant increase in T2 lesion load compared to a previous MRI; OR
 - the occurrence of two or more relapses with partial recovery during the past year; OR
 - the occurrence of two or more relapses with complete recovery during the past year AND has at least ONE gadolinium- enhancing

lesion on brain MRI, OR significant increase in T2 lesion load compared to a previous MRI.

- Approval Period: 1 year.

Requirements for Initial Requests:

- the patient's physician provides documentation setting out the details of the patient's most recent neurological examination within ninety (90) days of the submitted request. This must include a description of any recent attacks, the dates, and the neurological findings.
- MRI reports do NOT need to be submitted with the initial request.

Renewal:

Date and details of the most recent neurological examination and EDSS scores must be provided (exam must have occurred within the last 90 days); AND

- Patients must be stable or have experienced no more than 1 disabling attack/relapse in the past year; AND
- Recent Expanded Disability Status Scale (EDSS) score less than or equal to 5.0.

1.Failure to respond to a full and adequate course is defined as a trial of at least one approved first line therapy for a minimum of 6 months AND experienced at least one disabling relapse (attack) while on this

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Netupitant & Palonosetron, capsule, 300mg/0.5mg (Akynzeo-PFR)

In combination with dexamethasone for the prevention of acute and delayed nausea and vomiting in patients receiving:

- highly emetogenic chemotherapy or
- moderately emetogenic chemotherapy who have had inadequate symptom control using a 5-HT₃ antagonist and dexamethasone in a previous cycle.

Clinical notes:

- Highly emetogenic chemotherapy (HEC) includes but it not limited to : cisplatin regimens, anthracycline and cyclophosphamide combination regimens, and regimens containing carmustine, mechlorethamine, streptozocin, dacarbazine, and cyclophosphamide > 1500mg/m²
- Patients who receive carboplatin-based regimens with AUC ≥ 4 are also eligible to receive netupitant/palonosetron in combination with dexamethasone for primary prevention of acute and delayed nausea and vomiting

Neupro – see Rotigotine

Nexavar - see Sorafenib

Ngenla – see Somatogon

Nilotinib, capsule, 150mg, 200mg (Tasigna-NVR and generics)

For the treatment of leukemia (CML, progressed or intolerant of imatinib)

- a) As a single second line agent for the treatment of adults with chronic or accelerated phase CML with resistance or intolerance to prior therapy.

These second line criteria include:

- Patients with CML in chronic phase who are intolerant to oral tyrosine kinase inhibitors (TKIs) (i.e. imatinib or dasatinib or both)
 - Patients with CML in chronic phase who are resistant to imatinib
 - Patients with CML that have progressed to accelerated phase while on imatinib therapy
- b) In any one patient, only two of the TKIs will be funded within these criteria during their lifetime.
- c) If a patient develops grade 3 or 4 toxicity to one of the TKIs used within 3 months of initiating therapy, access to a third agent will be funded.
- d) Sequential use of nilotinib and dasatinib is not permitted except in the circumstance described above (i.e. grade 3 or 4 toxicity).

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Nintedanib, capsule, 100mg, 150mg (Ofev-BOE)

Chronic Fibrosing Interstitial Lung Disease

For the treatment of adult patients with chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype and a forced vital capacity (FVC) greater than or equal to 45% of predicted.

Renewal criteria:

Patient must not demonstrate progression of a disease defined as an absolute decline in percent predicted FVC of greater than or equal to 10% over the preceding 12 months of treatment with nintedanib.

Claim Notes:

- Must be prescribed by, or in consultation with a physician experience in the treatment of ILD.
- Combination therapy of Ofev (nintedanib) and Esbriet (pirfenidone) will not be reimbursed

- Approval Period: 1 year

Idiopathic Pulmonary Fibrosis

For the treatment of mild to moderate idiopathic pulmonary fibrosis in adult patients confirmed by a respirologist and a high-resolution CT scan within the previous 24 months. All other causes of restrictive lung disease should be excluded. Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.

Initial renewal criteria (at 6 months):

Patients must not demonstrate progression of disease defined as an absolute decline in percent predicted forced vital capacity (FVC) of $\geq 10\%$ 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.

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 $\geq 10\%$ 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.

Excluded criteria:

Combination therapy of Ofev (nintedanib) and Esbriet (perfenidone) will not be reimbursed.

Note:

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

Requests for Nintedanib (Ofev-BOE) must be made using the Nintedanib/Pirfenidone Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Niraparib, capsule, 100mg; tablet, 100mg (Zejula-GSK)

1. As monotherapy maintenance treatment of patients with newly-diagnosed ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to at least 4 cycles of first-line platinum-based chemotherapy. Eligible patients should have high-grade serous or endometrioid tumours classified as stage III or IV according to the International Federation of Gynecology and Obstetrics (FIGO) criteria.

Clinical Notes:

- Patients should have a good performance status.
 - Maintenance therapy with niraparib should begin within 12 weeks of completion of platinum-based chemotherapy and may continue for up to 3 years, or until disease progression or unacceptable toxicity, whichever occurs first.
 - Patients who have stable brain metastases are eligible for treatment with niraparib.
 - Patients who are unable to tolerate platinum-based chemotherapy (due to allergic reaction) and otherwise meet criteria, will be assessed on a case by case basis to determine eligibility for treatment with niraparib.
 - Niraparib in combination with bevacizumab is not funded
2. As monotherapy maintenance treatment for patients with relapsed, platinum-sensitive high grade serous epithelial ovarian, fallopian tube, or primary peritoneal cancer who have completed at least two previous lines of platinum-based chemotherapy, and have achieved a complete or partial response to the most recent platinum-based chemotherapy regimen.

Clinical Notes:

- Platinum-sensitive disease is defined as disease progression occurring at least six months after completion of platinum-based chemotherapy.
- Patients should have a good performance status.
- Patients must have received at least 4 cycles of the most recent platinum-based chemotherapy before starting treatment with niraparib.
- Maintenance therapy with niraparib should begin within 12 weeks of the last chemotherapy treatment and may continue until disease progression or unacceptable toxicity, whichever occurs first.
- Patients who have stable brain metastases are eligible for treatment with niraparib.
- Patients who are unable to tolerate platinum-based chemotherapy (due to allergic reaction) and otherwise meet criteria, will be assessed on a case by case basis to determine eligibility for treatment with niraparib.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Nirmatrelvir & Ritonavir, tablet, 150mg & 100mg (Paxlovid-PFI)

For the treatment of mild to moderate coronavirus disease 2019 (COVID-19) in adult patients with a positive COVID-19 test who are within 5 days of symptom onset and meet one of the following criteria:

- Severely immunosuppressed due to one or more of the following conditions:

- Solid organ transplant
 - Receiving treatment for a malignant hematologic condition
 - Bone marrow transplant, stem cell transplant or transplant-related immunosuppressant use
 - Received an anti-CD20 therapy or B-cell depleting therapy (such as rituximab) in the previous two years
 - Severe primary immunodeficiencies
- Moderately immunosuppressed due to one or more of the following conditions:
 - Receiving treatment for cancer, including solid tumors
 - Receiving treatment with significantly immunosuppressing drugs (e.g., biologic in the past three months, oral immune-suppressing drug in the past month, oral steroid [20 mg per day of prednisone equivalent taken on an ongoing basis] in the past month, or immune-suppressing infusion or injection in the past three months)
 - Advanced HIV infection
 - Moderate primary immunodeficiencies
 - Renal conditions (i.e., hemodialysis, peritoneal dialysis, glomerulonephritis treated with a steroid, eGFR less than 15 mL/min/1.73m²)
- Patients aged 65 years or older with at least one of the following chronic high-risk conditions:
 - Diabetes treated with insulin
 - Severe or end-stage lung conditions (eg. cystic fibrosis, severe chronic obstructive pulmonary disease, asthma)
 - Rare blood and genetic disorders such as sickle cell disease, thalassemia, urea cycle defects
 - Severe intellectual or developmental disability
 - Glomerular Filtration Rate less than 30

Clinical Notes:

- COVID-19 testing to confirm diagnosis can be performed by polymerase chain reaction (PCR) or point-of-care test (POCT).
- Treatment should be initiated as soon as possible after a diagnosis of COVID-19 is confirmed.
- Patients are not eligible for coverage if they are asymptomatic or if more than 5 days have elapsed since symptom onset.
- Requests for patients who are moderately or severely immunosuppressed due to other conditions may be considered.

Claim Notes:

- Pharmacists must verify eligibility criteria prior to dispensing and provide a copy of the Pharmacist Initiated Treatment of COVID-19 Paxlovid Special Authorization form to Pharmacare.
- Approval Period: 5 days.

Pharmacist Prescribers:

- Completion of the Pharmacist Initiated Treatment of Covid-19 Paxlovid Special Authorization Form is required. The completed form must be faxed to Pharmacare the day of dispensing.
- Pharmacies do not have to wait for special authorization approval by Pharmacare prior to dispensing.
- Please contact Pharmacare if considering Paxlovid coverage for patients who are moderately or severely immunosuppressed due to other conditions not defined above.

Note: Non-pharmacist prescribers are not required to submit a Special Authorization form when prescribing Paxlovid

Nivestym – see Filgrastim

Norfloxacin, tablet, 400mg (Generics)

Note: For Nursing Home program no Special Authorization is required.

- a) For the treatment of urinary tract infections caused by *Pseudomonas aeruginosa*. Up to 10 days of therapy will be considered.
- b) For the treatment of urinary tract infections not responding to alternative therapy. Up to 10 days of therapy will be considered.
- c) For the treatment of urinary tract infections in persons allergic to alternative agents. Up to 10 days of therapy will be considered.
- d) Prophylaxis of chronic urinary tract infections in persons allergic to alternative agents or where prophylaxis with alternative agents has failed.

(Note: Recommended dosage is 200mg at bedtime)

Novorapid – see insulin aspart

Nubeqa – see Darolutamide

Nucala – see Mepolizumab

Nusinersen, intrathecal vial, 2.4mg/mL (Spinraza-BIG)

For patients diagnosed with 5q Spinal Muscular Atrophy (SMA) if the following clinical criteria are met:

- 1) Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote, AND
- 2) Patients who:

- are pre-symptomatic with two or three copies of SMN2, OR
 - have had disease duration of less than six months, two copies of SMN2, and symptom onset after the first week after birth and on or before seven months of age, OR
 - are under the age of 18 with symptom onset after six months of age, AND
- 3) Patient is not currently requiring permanent invasive ventilation*, AND
 - 4) A baseline assessment using an age-appropriate scale (the Hammersmith Infant Neurological Examination [HINE] Section 2, Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND], or Hammersmith Functional Motor Scale-Expanded [HFMSE] must be completed prior to initiation of nusinersen treatment.

Other patients with SMA type 2 or 3 who are over the age of 18 may be considered on a case by case basis.

For continued coverage, the patient must meet the following criteria:

- 1) There is demonstrated achievement or maintenance of motor milestone function (as assessed using age-appropriate scales: the [HINE] Section 2), CHOP INTEND, or HFMSE since treatment initiation in patients who were pre- symptomatic at the time of treatment initiation; OR
There is demonstrated maintenance of motor milestone function (as assessed using age-appropriate scales: the HINE Section 2, CHOP INTEND, or HFMSE since treatment initiation in patients who were symptomatic at the time of treatment initiation;
AND
- 2) Patient does not require permanent invasive ventilation*.

Treatment should be discontinued if, prior to the fifth dose or every subsequent dose of nusinersen, the above renewal criteria are not met.

* Permanent invasive ventilation is defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Claim Notes:

- The patient must be under the care of a specialist experienced in the treatment of SMA.
- Approval Period: 1 year.
- Claims that exceed the maximum claim amount of \$9,999.99 must be divided and submitted as separate transactions using the DIN first, and then PDINs.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at www.healthpei.ca/pharmacareforms

Nyvepria – see Pegfilgrastim

Obeticholic, tablet, 5mg, 10mg (Ocaliva-INT)

For the treatment of adult patients with primary biliary cholangitis (PBC) as either:

- combination therapy with ursodeoxycholic acid (UDCA) in patients who have experienced an inadequate response to a minimum of 12 months of UDCA treatment; or
- monotherapy in patients who have experienced unmanageable intolerance to UDCA.

Requirement for Initial Requests:

- Alkaline phosphatase (ALP) and bilirubin levels prior to initiation of treatment with obeticholic acid must be provided.

Renewal Criteria:

- Requests for renewal will be considered if the patient achieved:
 - a reduction in the ALP to less than 1.67 times the upper limit of normal (ULN); or
 - at least a 15% reduction in the ALP level from baseline (i.e. prior to initiation of treatment with obeticholic acid).

Clinical Notes:

- Diagnosis confirmed by positive antimitochondrial antibodies or liver biopsy results consistent with PBC.
- An inadequate response is defined as:
 - $ALP \geq 1.67$ times ULN, or
 - bilirubin $> ULN$ and < 2 times the ULN, or
 - evidence of compensated cirrhosis.
- For patients who experience unmanageable intolerance to UDCA, details must be provided.

Claim Notes:

- Must be prescribed by, or in consultation with, a gastroenterologist, hepatologist or other physician experienced in the treatment of PBC.
- Approval Period: 12 months.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ocaliva – see Obeticholic

Ocrelizumab, vial, 300 mg/10 mL (Ocrevus- HLR)

Relapsing Remitting Multiple Sclerosis

For the treatment of adult patients with relapsing remitting multiple sclerosis (RRMS) who meet all of the following criteria:

- Confirmed diagnosis based on McDonald criteria
- Experienced one or more disabling relapses or new MRI activity in the last two years
- Ambulatory with or without aid (i.e. has a recent Expanded Disability Status Scale (EDSS) score of less than or equal to 6.5)
- Must be prescribed by a neurologist with experience in the diagnosis and management of multiple sclerosis.

Clinical Note:

- Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.

Primary Progressive Multiple Sclerosis

For the treatment of adult patients with early primary progressive multiple sclerosis (PPMS) who meet all of the following criteria:

- Confirmed diagnosis based on McDonald criteria
- Recent Expanded Disability Status Scale (EDSS) score between 3.0 and 6.5
- Recent Functional Systems Scale (FSS) score of at least 2 for the pyramidal functions component due to lower extremity findings
- Disease duration of 10 years for those with an EDSS of less than or equal to 5 or disease duration less than 15 years for those with an EDSS greater than 5
- Diagnostic imaging features characteristic of inflammatory activity

Clinical Note:

- Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.
- Must be prescribed by a neurologist with experience in the diagnosis and management of multiple sclerosis.

Claim Note:

- Claims that exceed the maximum claim amount of \$9,999.99 must be divided and submitted as separate transactions using the DIN first, and then the PDIN.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ocrevus – see Ocrelizumab

Ocuflox - see Ofloxacin

Ofatumumab, prefilled pen, 20mg/0.4mL (Kesimpta-NVR)

For the treatment of adult patients with relapsing remitting multiple sclerosis (RRMS) who meet all of the following criteria:

- An Expanded Disability Status Scale (EDSS) score of less than 6.0
- Evidence of active disease defined as at least one of the following:
 - One relapse during the previous year
 - Two relapses during the previous 2 years
 - A positive gadolinium (Gd)-enhancing MRI scan during the year before starting treatment with ofatumumab.

Renewal Criteria:

- EDSS score less than 6.0. Date and details of the most recent neurological examination and EDSS score must be provided (exam must have occurred within the last 90 days); AND
- Patients must be stable or have experienced no more than 1 disabling attack/relapse in the past year.

Claim Notes:

- Approval: 1 year.
- Combined use with other disease modifying therapies to treat multiple sclerosis will not be reimbursed.
- Must be prescribed by a neurologist with experience in the diagnosis and management of multiple sclerosis.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ofev – see Nintedanib

Olaparib, tablet, 100 mg, 150 mg (Lynparza- AZE)

High-Risk Early Breast Cancer

1. For the adjuvant treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated high-risk early breast cancer who have had upfront surgery followed by adjuvant chemotherapy and who meet one of the following criteria:
 - Triple negative breast cancer and either axillary node-positive or axillary node-negative with invasive primary tumor pathological size of at least 2 cm (> pT2 cm)
 - Hormone receptor positive, HER2-negative breast cancer with at least 4 pathologically confirmed positive lymph nodes.
2. For the adjuvant treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated high-risk early breast cancer who received neoadjuvant chemotherapy followed by surgery and who meet one of the following criteria:

- Triple negative breast cancer with residual invasive disease in the breast and/or resected lymph nodes (nonpCR)
- Hormone receptor positive, HER2-negative breast cancer with residual invasive disease in the breast, and/or the resected lymph nodes, and a CPS + EG score of 3 or higher.

Clinical Notes:

1. Patients must have completed neoadjuvant or adjuvant chemotherapy containing an anthracycline and/or taxane.
2. Treatment should be initiated within 12 weeks of completion of the last treatment (i.e., surgery, chemotherapy, or radiation therapy).
3. Patients must have a good performance status.
4. Treatment should be discontinued upon disease recurrence, unacceptable toxicity, or completion of 1 year of therapy, whichever occurs first.

Claim Notes:

- Requests for patients determined to be at high-risk for relapse using a disease scoring system other than CPS + EG will be considered.
- Approval Period: 1 year

Newly Diagnosed, Advanced, BRCA-Mutated

- As monotherapy maintenance treatment of patients with newly-diagnosed, advanced, BRCA-mutated (germline or somatic), high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to at least 4 cycles of first-line platinum-based chemotherapy.

Clinical Notes:

- Patients should have a good performance status.
- Maintenance therapy with olaparib should begin within 12 weeks of completion of platinum-based chemotherapy.
- Patients who are unable to tolerate platinum-based chemotherapy (due to allergic reaction) and otherwise meet criteria, will be assessed on a case by case basis to determine eligibility for treatment with olaparib.
- Treatment should continue until unacceptable toxicity, disease progression, or to a maximum of 2 years of therapy if no evidence of disease, whichever comes first.¹
- Imaging is required for patients who are delayed in starting olaparib therapy, i.e. greater than 12 weeks after completion of platinum-based chemotherapy, or who have had a break in therapy for more than 14 days, to rule out progression prior to starting or re-starting olaparib.
- Olaparib in combination with bevacizumab is not funded. Patients already on bevacizumab maintenance at the time of olaparib funding may be switched to

olaparib, as long as there is no evidence of progression on imaging and is within 12 weeks of completion of chemotherapy.

¹Patients with a partial response or stable disease at 2 years may continue to receive olaparib at the discretion of the treating physician.

Relapsed, BRCA-Mutated

- As monotherapy maintenance treatment for patients with platinum-sensitive, relapsed, BRCA-mutated (germline or somatic), high grade serous epithelial ovarian, fallopian tube, or primary peritoneal cancer who have completed at least two previous lines of platinum-based chemotherapy and are in radiologic response (complete or partial) to their most recent platinum-based chemotherapy regimen as per the SOLO-2 trial.
- Patients must have received at least four cycles of their most recent platinum-based chemotherapy before starting treatment with olaparib.

Clinical Notes:

- Treatment should continue until unacceptable toxicity or disease progression.
- Maintenance therapy with olaparib should begin within eight weeks of the last dose of platinum-based chemotherapy.
- Platinum-sensitive disease is defined as disease progression occurring at least six months after completion of platinum-based chemotherapy.
- Patients should have a good performance status.
- Patients who are unable to tolerate platinum-based chemotherapy (due to allergic reaction) and otherwise meet criteria, will be assessed on a case by case basis to determine eligibility for treatment with olaparib.

Metastatic Castrate-Resistant Prostate Cancer

- For the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who meet all of the following criteria:
 - deleterious or suspected deleterious germline and/or somatic mutations in the homologous recombination repair (HRR) genes BRCA1, BRCA2 or ATM; and
 - Disease progression on prior treatment with androgen-receptor-axis-targeted (ARAT) therapy.

Renewal Criteria:

Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

- Patients must have a good performance status.
- Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ofloxacin, ophthalmic solution, 0.3% (Ocuflox and generics)

Note: For Nursing Home Program, no Special Authorization is required.

For the treatment of ophthalmic infections caused by susceptible bacteria and not responding to alternative agents.

Olumiant – see Baricitinib

Omalizumab, vial, 150mg, prefilled syringe, 150mg (Xolair-NVR)

For the treatment of patients ≥ 12 years of age with moderate to severe chronic idiopathic urticaria (CIU) who remain symptomatic (presence of hives and/or associated itching) despite optimum management with H1 antihistamines.

Initiation Criteria:

- Documentation of the most recent Urticaria Activity Score over 7 days (UAS7) to be provided on the submitted request.
- Approvals will be for a maximum dose of 300mg every four weeks.
- Initial Approval Period: 24 weeks.

Renewal Criteria:

- Requests for renewal will be considered if the patient has achieved:
 - Complete symptom control for less than 12 consecutive weeks; or
 - Partial response to treatment, defined as at least a ≥ 9.5 point reduction in baseline UAS7

Clinical Notes:

1. Moderate to severe CIU is defined as UAS7 ≥ 16 .
2. Treatment cessation could be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24 week treatment period.
3. In patients who discontinue treatment due to temporary symptom control, re-initiation can be considered if CIU symptoms reappear.
4. Optimal management is defined as H1 antihistamines at up to 4 times the standard daily dose.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Omeprazole - see Proton Pump Inhibitors

Omvoh – see Mirikizumab

Onabotulinumtoxina, injection, 200 units/vial (Botox-ALL)

For the treatment of urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis (MS) or subcervical spinal cord injury (SCI) if the following conditions are met:

- patient failed to respond to behavioural modification and anticholinergics and/or is intolerant to anticholinergics.
- subsequent treatments are provided at intervals no less than every 36 weeks.
- Patients who fail to respond to initial treatment with onabotulinumtoxinA should not be retreated.

Ondansetron, medicated film, 4mg, 8mg (Ondissolve-TAK and generic)

For the treatment of emesis in cancer patients receiving highly emetogenic chemotherapy (i.e. containing Cisplatin); receiving moderately emetogenic chemotherapy (i.e. containing Cyclophosphamide, Doxorubicin, Epirubicin, or Melphalan); or receiving radiation therapy and who have:

- a) Experienced adverse effects to Metoclopramide, Prochlorperazine, or Dexamethasone or have a specific contraindication which does not allow use of these drugs as antiemetics or,
- b) Continued episodes of nausea and vomiting related to chemotherapy which have not responded to therapeutic doses of Metoclopramide, Prochlorperazine, or Dexamethasone.

A maximum of 10 films per cycle of chemotherapy will be approved.

Ondansetron HCl, tablet, 4mg, 8mg (Zofran-GSK and generics)

For the treatment of emesis in cancer patients receiving highly emetogenic chemotherapy (i.e. containing Cisplatin); receiving moderately emetogenic chemotherapy (i.e. containing Cyclophosphamide, Doxorubicin, Epirubicin, or Melphalan); or receiving radiation therapy and who have:

- a) Experienced adverse effects to Metoclopramide, Prochlorperazine, or Dexamethasone or have a specific contraindication which does not allow use of these drugs as antiemetics or,
- b) Continued episodes of nausea and vomiting related to chemotherapy which have not responded to therapeutic doses of Metoclopramide, Prochlorperazine, or Dexamethasone.

A maximum of 10 tablets per cycle of chemotherapy will be approved.

Only requests for the oral dosage forms are eligible for consideration.

Ondansetron, oral disintegrating tablets, 4mg, 8mg (Generic)

For the treatment of emesis in cancer patients receiving highly emetogenic chemotherapy (i.e. containing Cisplatin); receiving moderately emetogenic chemotherapy (i.e. containing Cyclophosphamide, Doxorubicin, Epirubicin, or Melphalan); or receiving radiation therapy and who have:

- a) Experienced adverse effects to Metoclopramide, Prochlorperazine, or Dexamethasone or have a specific contraindication which does not allow use of these drugs as antiemetics or,
- b) Continued episodes of nausea and vomiting related to chemotherapy which have not responded to therapeutic doses of Metoclopramide, Prochlorperazine, or Dexamethasone.

A maximum of 10 tablets per cycle of chemotherapy will be approved.

Ondissolve – see Ondansetron

Onureg – see Azacitidine

Opsumit – see Macitentan

Orkambi – granule packet, 100 mg/125 mg, 150mg/188 mg; tablet, 100 mg/125 mg, 200 mg/125 mg; sachet, 94 mg/75 mg

Coverage may be available for Orkambi for the treatment of cystic fibrosis patients who meet certain medical criteria and drug program enrollment.

Please contact the PEI Pharmacare Program office at 1-877-577-3737 for more information regarding coverage availability and the Special Authorization application process for this product.

Orladeyo – see Berotralstat HCL

Osimertinib, tablet, 40mg, 80mg (Tagrisso-AZE)

1. For the first-line treatment of patients with locally advanced (not amenable to curative intent therapy) or metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) mutations (exon 19 deletions [exon 19 del] or exon 21 [L858R]).
2. In patients with locally advanced or metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC) who have progressed on EGFR tyrosine kinase inhibitor (TKI) therapy.

Clinical Notes:

- Eligible patients should be previously untreated in the locally advanced or metastatic setting and have a good performance status.

- Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.
 - Prior treatment with EGFR TKI therapy is not required in patients with de novo T790M mutation-positive NSCLC.
3. For adjuvant therapy after tumour resection in patients with Stage IB-IIIa (AJCC 7th edition or equivalent) non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions [exon 19 del] or exon 21 [L858R] substitution mutations.

Clinical Notes:

- Patients should have a good performance status.
- Treatment with osimertinib should continue for a total duration of 3 years, or until disease recurrence or unacceptable toxicity.
- Osimertinib treatment should be initiated within 10 weeks of complete surgical resection if adjuvant chemotherapy was not administered, or within 26 weeks if adjuvant chemotherapy was administered.
- Retreatment with osimertinib in the metastatic setting will be considered if disease recurrence is at least 6 months following completion of adjuvant therapy
- Program eligibility remains the same (Financial Assistance Drug Program, High Cost Drug Program, Nursing Home Drug Program, Catastrophic Drug Program).

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Oxeze - see Formoterol

Oxcarbazepine, tablet, 150mg, 300mg, 600mg (Trileptal-NVR and generics)

For use in patients who have a diagnosis of epilepsy and have had an inadequate response to or are intolerant to at least 3 other formulary agents (prior or current use), including Carbamazepine.

Ozanimod, capsule, 0.23mg & 0.46mg, 0.92mg (Zeposia-BMS)

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone ≥ 40mg daily for two weeks or IV equivalent for one week)

OR

- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Initial Approval: 12 weeks. Treatment has to be initiated in all patients with an initiation pack that lasts for 7 days.
 - Days 1-4 0.23 mg once daily
 - Days 5-7 0.46 mg once daily
 - Days 8 and thereafter 0.92 mg once daily.
- Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:
 - a decrease in the partial Mayo score ≥ 2 from baseline, and
 - a decrease in the rectal bleeding subscore ≥ 1 .
- Renewal Approval: 1 year. Maximum approved dose is 0.92mg once daily.
- Combined use of more than one biologic DMARD will not be reimbursed.

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo > 6) do not require a trial of 5-ASA.

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ozempic – see Semaglutide

Palbociclib, capsules & tablets, 75mg, 100mg, 125mg (Ibrance-PFI and generics)

1. In combination with an aromatase inhibitor for the treatment of estrogen receptor positive, HER2 negative advanced breast cancer in postmenopausal women who:
 - have not received prior therapy for metastatic disease and
 - are not resistant to (neo) adjuvant non-steroidal aromatase inhibitor (NSAI) therapy and

- do not have active or uncontrolled metastasis to the central nervous system.

Renewal criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

- Patients must have a good performance status.
- Resistance is defined as disease progression occurring during or within 12 months following NSAI therapy.
- Treatment should be discontinued up on disease progression or unacceptable toxicity.

Claim Notes:

Initial Approval Period: 1 year

Renewal Approval Period: 1 year

2. In combination with fulvestrant for the treatment of patients with hormone receptor (HR) positive, HER 2 negative advanced or metastatic breast cancer as initial endocrine-based therapy or following disease progression on endocrine therapy. Patients may have also received up to one prior line of chemotherapy for advanced disease. Patients should have a good performance status, without active or uncontrolled metastases to the central nervous system and in the case of women can be of any menopausal status (Perimenopausal and premenopausal women must be treated with an LHRH agonist).

Clinical Notes:

- Treatment should continue until unacceptable toxicity or disease progression.
- Patients who progress $\leq$ 12 months from (neo) adjuvant therapy are eligible for treatment with palbociclib plus fulvestrant.
- Patients who experience disease progression on prior CDK 4/6 inhibitor therapy, fulvestrant or everolimus are not eligible for treatment with palbociclib with fulvestrant.
- Patients currently receiving fulvestrant monotherapy, and who have not progressed may have palbociclib added, provided they are CDK 4/6 inhibitor naïve and otherwise meet funding criteria.
- Patients who previously received everolimus plus exemestane will be eligible for funding of palbociclib plus fulvestrant on progression, provided that treatment was started prior to funding of CDK 4/6 + fulvestrant, patient must be CDK 4/6 naïve and otherwise meet funding criteria.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Paliperidone, injection, 50mg, 75mg, 100mg, 150mg (Invega Sustenna-JAN)

Note: For Community Mental Health Drug Program, no Special Authorization is required.

For the treatment of schizophrenia or schizoaffective disorder in patients who have:

- d) A history of non adherence
OR
- e) Inadequate control or significant side effects from two or more oral antipsychotic medications
OR
- f) Inadequate control or significant side effects from at least one long acting depot antipsychotic agent.

Note: Must be requested and prescribed by a psychiatrist. Only doses up to 150 mg monthly will be approved.

Paliperidone, prefilled pen, 175mg/0.875mL, 263mg/1.315mL, 350mg/1.75mL, 525mg/2.625mL (Invega Trinza-JAN)

Note: For Community Mental Health Drug Program, no Special Authorization is required.

For the maintenance treatment of schizophrenia and related psychotic disorders (not dementia related) in patients who have been stabilized on therapy with injectable paliperidone for at least four months.

Pamidronate Disodium, injection powder, 30mg, 60mg, 90mg vial (Generics)

For the management of tumour-induced hypercalcemia following adequate saline rehydration or conditions associated with increased osteoclast activity.

Pantoloc - see Proton Pump Inhibitors

Pantoprazole Magnesium - see Proton Pump Inhibitors

Pantoprazole Sodium - see Proton Pump Inhibitors

Pariet - see Proton Pump Inhibitors

Paxlovid – see Nirmatrelvir & Ritonavir

Pazopanib, tablet, 200mg (Votrient-GSK and generic)

1. As a first-line treatment for patients with advanced or metastatic clear cell renal carcinoma and good performance status.
2. For the treatment of advanced or metastatic renal cell (clear cell) carcinoma (mRCC) in patients who are unable to tolerate sunitinib and who have an ECOG performance status of 0 or 1.

Renewal criteria:

Written confirmation that the patient has benefited from therapy and is expected to continue to do so.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Pegfilgrastim, prefilled syringe, 6mg/0.6mL (Fulphila-BGP, Lapelga-APX, Nyvepria-PFI, Ziextenzo-SDZ); prefilled syringe, 10mg/1.0mL (Lapelga-APX)

For the prevention of febrile neutropenia in patients receiving myelosuppressive chemotherapy with curative intent who:

- are at high risk of febrile neutropenia due to chemotherapy regimen, co-morbidities or pre-existing severe neutropenia; or
- have had an episode of febrile neutropenia, neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; or
- have had a dose reduction, or treatment delay greater than one week due to neutropenia.

Clinical Note:

- Patients with non-curative cancer receiving chemotherapy with palliative intent are not eligible for coverage of pegfilgrastim for prevention of febrile neutropenia.

Must be requested and prescribed by a specialist in hematology or medical oncology.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Pentosan Polysulfate Sodium, capsule, 100mg (Elmiron-JAN)

For the treatment of interstitial cystitis where other treatments have failed.

Perampanel, tablet, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg (Fycompa-EIS and generic)

For the adjunctive treatment of refractory partial-onset seizures or primary generalized tonic-clonic seizures in patients who are currently receiving two or more antiepileptic

drugs, and who have had an inadequate response to at least three other antiepileptic drugs.

Perichlor - see Chlorhexidine

Peridex - see Chlorhexidine

Pilocarpine, tablet, 5mg (Salagen-PFI and generic)

For oncology patients only, for the treatment of the symptoms of xerostomia due to salivary gland hypofunction caused by radiotherapy for cancer of the head and neck.

Pirfenidone, capsule, 267mg, tablet, 267mg, tablet, 801mg (Esbriet-HLR and generics)

Initial Approval criteria:

For the treatment of mild to moderate idiopathic pulmonary fibrosis in adult patients confirmed by a respirologist and a high-resolution CT scan within the previous 24 months. All other causes of restrictive lung disease should be excluded. Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted.

Initial renewal criteria (at 6 months):

Patients must not demonstrate progression of disease defined as an absolute decline in percent predicted forced vital capacity (FVC) of $\geq 10\%$ 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.

Second and subsequent renewals (12 months and thereafter):

Patients must not demonstrate progression of disease defined as an absolute decline in percent predicted FVC of $\geq 10\%$ 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.

Excluded criteria:

Combination therapy of Ofev (nintedanib) and Esbriet (pirfenidone) will not be reimbursed.

Note:

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

Requests for Pirfenidone (Esbriet-HLR) must be made using the Nintedanib/Pirfenidone Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Plegridy – see Multiple Sclerosis Agents

Pomalidomide, capsule, 1mg, 2mg, 3mg, 4mg (Pomalyst-CEL and generics)

For patients with relapsed and/or refractory multiple myeloma who have previously failed at least two treatments, including both bortezomib and lenalidomide and demonstrated disease progression on the last treatment.

Note: Pomalidomide may be an option in rare instances where bortezomib is not tolerated or contraindicated but in all cases, patients should have failed lenalidomide.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Pomalyst – see Pomalidomide

Ponatinib – tablet, 15mg (Iclusig-ARI)

For the treatment of patients with chronic, accelerated or blast phase chronic myelogenous leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL) who have:

- resistance or intolerance to two or more tyrosine kinase inhibitors (TKIs), OR
- confirmed T315i mutation positive disease.

Clinical Notes:

1. Patients must have an ECOG performance status of ≤ 2 .
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Pulmozyme – see Dornase Alfa

Pradaxa – see Dabigatran

Praluent – see Alirocumab

Prevacid - see Proton Pump Inhibitors

Prevacid FasTab – see Proton Pump Inhibitors

Prevymis – see Letemovir

Prolia – see Denosumab

Propiverine, tablet, 5mg (Mictoryl Pediatric-DUI)

For the treatment of overactive bladder with symptoms of urgency incontinence and/or urinary frequency and urgency in pediatric patients under 18 years of age.

Propranolol, oral solution, 3.75mg/mL (Hemangiol-PFB)

For the treatment of patients with proliferating infantile hemangioma that is:

- Life-or function-threatening OR
- Ulcerated with pain or not responding to simple wound care measures OR
- At risk of permanent scarring or disfigurement

Proton Pump Inhibitors

For doses of proton pump inhibitors (PPIs) **greater than one unit per day:**

Up to 12 weeks of therapy will be considered for:

- Gastric and Duodenal Ulcers
- Esophagitis

Long term therapy will be considered for:

- Erosive Esophagitis
- Barrett's Esophagitis
- Zollinger-Ellison Syndrome

Helicobacter pylori Eradication – Up to 14 days of twice daily dosing for patients who are symptomatic and have a documented positive Helicobacter Pylori test.

Lansoprazole, delayed release capsule, 15mg, 30mg (Prevacid-ABB and generics)

For patients who have had a therapeutic failure with all proton pump inhibitors listed as regular benefits (e.g. omeprazole, pantoprazole, rabeprazole).

Therapeutic failure is defined as resistance to 12-week trials of a once daily standard dose of omeprazole, rabeprazole, or pantoprazole.

Claim Note:

- Pediatric patients 12 and under will not require written Special Authorization.

Lansoprazole, delayed release tablet, 15mg, 30mg (Prevacid FasTab-ABB)

For patients who require drugs to be administered through a feeding tube or cannot use a tablet or capsule.

Claim Note:

- Pediatric patients 12 and under will not require written Special Authorization.

Protopic - see Tacrolimus

Pulmicort Nebuamps - see Budesonide

Qulipta – see Atogepant

Qinlock – see Ripretinib

Rabeprazole - see Proton Pump Inhibitors

Radicava – see Edaravone

Ranibizumab, vial, 2.3mg/ 0.23mL (Lucentis-NVR); vial, 2.3mg/0.23mL (Byooviz-BIG); vial, 2.4mg/0.23mL (Ranopto-TEV)

1. Neovascular Age-Related Macular Degeneration

Initial Coverage:

For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) where all of the following apply:

- a) Best Corrected Visual Acuity (BCVA) is between 6/12 and 6/96 AND
- b) The lesion size is less than or equal to 12 disc areas in greatest linear dimension AND
- c) There is evidence of recent (< 3 months) presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, optical coherence tomography (OCT), or recent visual acuity changes.

The interval between doses should not be shorter than one month. Administration is to be done by a qualified ophthalmologist experienced in intravitreal injections.

Criteria For Continued Coverage:

Treatment with ranibizumab should be continued only in people who maintain adequate response to therapy.

Ranibizumab should be discontinued if any of the following occur:

- a) Reduction in BCVA in the treated eye to less than 15 letters (absolute) on 2 consecutive visits in the treated eye, attributed to AMD in the absence of other pathology **OR**
- b) Reductions in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect, adverse events, or both **OR**
- c) There is evidence of deterioration of the lesion morphology despite optimum treatment over 3 consecutive visits.

Coverage will not be approved for patients:

- a) Receiving concurrent treatment with verteporfin.
- b) With permanent retinal damage as defined by the Royal College of Ophthalmology guidelines.

Coverage is limited to a maximum of one vial per eye in any 30-day period. Coverage must be renewed every 12 months.

2. Diabetic Macular Edema (DME)

Initial coverage:

For the treatment of visual impairment due to diabetic macular edema (DME) in patients who meet all of the following criteria:

- clinically significant centre-involving macular edema for whom laser photocoagulation is also indicated
- hemoglobin A1c test in the past 6 months with a value of less than or equal to 11%
- best corrected visual acuity of 20/32 to 20/400
- central retinal thickness greater than or equal to 250 micrometers

Renewal Criteria:

- confirm that a hemoglobin A1C test in the past 6 months had a value of less than or equal to 11%
- date of last visit and results of best corrected visual acuity at that visit
- date of last OCT and central retinal thickness on that examination
- if ranibizumab is being administered monthly, please provide details on the rationale.

Clinical Notes:

- Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.

- Treatment should be resumed when monitoring indicates a loss of visual acuity due to DME and continued until stable visual acuity is reached again for three consecutive months.
- Treatment should be discontinued if there is no improvement of retinal thickness or visual acuity after three consecutive treatments.
- Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year

3. **Retinal Vein Occlusion (RVO)**

For the treatment of visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (BRVO).

Clinical Notes:

- Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.
- Treatment should be resumed when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive months.
- Treatment should be discontinued if there is no improvement after 6 months of initial treatment.
- Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year

4. **Choroidal Neovascularization**

For the treatment of patients with visual impairment due to choroidal neovascularization secondary to pathologic myopia.

1. Treatment is initiated with a single intravitreal injection. Monitoring is recommended monthly for the first 2 months and at least every 3 months thereafter during the first year.
2. Treatment should be resumed if monitoring reveals signs of disease activity (e.g. reduced visual acuity and/or signs of lesion activity), further treatment is recommended at a frequency of 1 injection per month until no disease activity is seen.
3. Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections

Approval Period: 1 year

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ravulizumab, vial, 300mg/3mL, 300mg/30mL, 1100mg/11mL (Ultomiris-ALX)

Paroxysmal Nocturnal Hemoglobinuria

Initiation Criteria:

For the treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) who meet the following criteria:

- The diagnosis of PNH has been made based on the following confirmatory results:
 - Flow cytometry/FLAER exam with granulocytes or monocyte clone $\geq 10\%$; AND
 - LDH > 1.5 ULN; AND
 - At least one of the following:
 - A thrombotic or embolic event which required the institution of therapeutic anticoagulant therapy,
 - Minimum transfusion requirement of 4 units of red blood cells in the previous 12 months,
 - 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 70g/L or by more than one measure of less than or equal to 100g/L with concurrent symptoms of anemia,
 - Pulmonary insufficiency: 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: History of renal insufficiency, demonstrated by an eGFR less than or equal to 60 mL/min/1.73m², where causes other than PNH have been excluded,
 - Smooth muscle spasm: Recurrent episodes of severe pain requiring hospitalization and/or narcotic analgesia, where causes other than PNH have been excluded.

Renewal Criteria:

- Renewals will be considered for patients who;
 - Demonstrate clinical improvement while on therapy or
 - Where therapy has been shown to stabilize the patient's condition
- Requests for renewal should be accompanied by confirmation of granulocyte clone size (by flow cytometry).

Exclusion Criteria:

Exclusion criteria for both initiation and renewal requests:

- Small granulocyte or monocyte clone size - the treatment of patients with a granulocyte and monocyte clone size below 10% will not be eligible for treatment; OR

- Aplastic anemia with two or more of the following: neutrophil count below $0.5 \times 10^9/L$, platelet count below $20 \times 10^9/L$, reticulocytes below $25 \times 10^9/L$, or severe bone marrow hypocellularity; OR
- Patients afflicted with PNH and another life-threatening or severe disease where the long term prognosis is unlikely to be influenced by therapy (for example acute myeloid leukemia or high-risk myelodysplastic syndrome);

OR

- The presence of another medical condition that might reasonably be expected to compromise a response to therapy.

Exclusion criteria for renewal requests:

- The patient or treating physician fails to comply adequately with treatment or measures, including monitoring requirements, taken to evaluate the effectiveness of the therapy; OR
- If therapy fails to relieve the symptoms of disease that originally resulted in the patient being approved for subsidized treatment.

Clinical Notes:

- Patients with insufficient initial response or who have failed treatment with eculizumab at the Health Canada– recommended dosage are not eligible for reimbursement of ravulizumab.
- All patients must receive meningococcal vaccination with a tetravalent vaccine at least two weeks prior to receiving the first dose of ravulizumab.

Claim Notes:

- Approvals will be for a maximum of

Body Weight Range (kg)	Loading Dose (mg)	Maintenance Dose (mg)	Dosing Interval
≥ 5 to < 10	600	300	Every 4 weeks
≥ 10 to < 20	600	600	Every 4 weeks
≥ 20 to < 30	900	2,100	Every 8 weeks
≥ 30 to < 40	1,200	2,700	Every 8 weeks
≥ 40 to < 60	2,400	3,000	Every 8 weeks
≥ 60 to < 100	2,700	3,300	Every 8 weeks
≥ 100	3,000	3,600	Every 8 weeks

- Supplemental dosing following treatment with plasma exchange, plasmapheresis, or intravenous immunoglobulin is approved.
- Initial Approval: 6 months
- Renewal Approval: 1 year
- The patient must be under the care of a pediatric nephrologist, a nephrologist, a pediatric hematologist or a hematologist.

Atypical Hemolytic Uremic Syndrome

Initiation Criteria:

- For the treatment of adult and pediatric patients 1 month of age and older with atypical hemolytic uremic syndrome (aHUS) who meet all of the following criteria:
 - Confirmed diagnosis of aHUS at initial presentation, defined by presence of thrombotic microangiopathy (TMA), who meet all the following criteria:
 - A disintegrin and metalloproteinase with a thrombospondin type 1 motif, member 13 (ADAMTS13) activity $\geq 10\%$ on blood samples taken before plasma exchange or plasma infusion (PE/PI); AND
 - Shiga toxin-producing *Escherichia coli* (STEC) test negative in patients with a history of bloody diarrhea in the preceding 2 weeks; and
 - TMA must be unexplained (not a secondary TMA).
 - Evidence of ongoing active TMA and progressing, defined by laboratory test abnormalities despite plasmapheresis, if appropriate. Patients must demonstrate:
 - Unexplained (not a secondary TMA) thrombocytopenia (platelet count $< 150 \times 10^9/L$); and hemolysis as indicated by the documentation of 2 of the following: schistocytes on the blood film; low or absent haptoglobin; or lactate dehydrogenase (LDH) above normal. OR
 - Tissue biopsy confirms TMA in patients who do not have evidence of platelet consumption and hemolysis.
 - Evidence of at least 1 of the following documented clinical features of active organ damage or impairment:
 - Kidney impairment, as demonstrated by one of the following:
 - A decline in estimated glomerular filtration rate (eGFR) of $> 20\%$ in a patient with preexisting renal impairment; AND/OR
 - Serum creatinine (SCr) $>$ upper limit of normal (ULN) for age or GFR $< 60\text{mL/min}$ and renal function deteriorating despite prior PE/PI in patients who have no history of preexisting renal impairment (i.e., who have no baseline eGFR measurement); OR
 - SCr $>$ the age-appropriate ULN in pediatric patients (as determined by or in consultation with a pediatric nephrologist) OR
 - The onset of neurological impairment related to TMA.
 - Other TMA-related manifestations, such as cardiac ischemia, bowel ischemia, pancreatitis, and retinal vein occlusion.
- For transplant patients with a documented history of aHUS (i.e., history of TMA [not a secondary TMA only] with ADAMTS 13 $> 10\%$) who meet the following criteria:
 - Develop TMA immediately (within hours to 1 month) following a kidney transplant; OR
 - Previously lost a native or transplanted kidney due to the development of TMA; OR
 - Have a history of proven aHUS and require prophylaxis with ravulizumab at the time of a kidney transplant
- Patients should not have a history of ravulizumab treatment failure (i.e., treated with ravulizumab with a previous aHUS recurrence). Treatment failure is defined as:

- Dialysis-dependent at 6 months, and failed to demonstrate resolution or stabilization of neurological or extrarenal complications if these were originally present; OR
- On dialysis for ≥ 4 of the previous 6 months while receiving ravulizumab and failed to demonstrate resolution or stabilization of neurological or extrarenal complications if these were originally present; OR
- Worsening of kidney function with a reduction in eGFR or increase in SCr $\geq 25\%$ from baseline.

Renewal Criteria:

- Treatment with ravulizumab can be renewed as long as the patient exhibits a response to treatment or as per physician discretion (e.g., long-term funding based on factors like limited organ reserve or high-risk genetic mutation such as Factor H deficiency).
 - Response to treatment is defined as, but not limited to, hematological normalization (e.g., platelet count, LDH), stabilization of end-organ damage (such as acute kidney injury and brain ischemia), transplant graft survival in susceptible individuals, and dialysis avoidance in patients who are pre- end-stage kidney disease (ESKD).
- Assessment of treatment response should be conducted at 6-months, at 12-months, then annually thereafter.
 - At the 6-month assessment, treatment response and no treatment failure (defined in Initiation Criteria) is required.
 - At the 12-month and annual assessments, treatment response, no treatment failure, and the patient has limited organ reserve or high-risk genetic mutation are required.
 - Limited organ reserve is defined as significant cardiomyopathy, neurological, gastrointestinal, or pulmonary impairment related to TMA; or Grade 4 or 5 chronic kidney disease (eGFR $< 30\text{mL/min}$) is required.
- A patient previously diagnosed with aHUS and who responded to treatment with ravulizumab and has not failed ravulizumab is eligible to restart ravulizumab if the patient redevelops a TMA related to aHUS and meets the following clinical conditions:
 - Significant hemolysis as evidenced by presence of schistocytes on the blood film, or low or absent haptoglobin, or LDH above normal; AND
 - EITHER
 - Platelet consumption as measured by either $\geq 25\%$ decline from patient baseline or thrombocytopenia (platelet count $< 150,000 \times 10^9/\text{L}$); OR
 - TMA-related organ impairment (e.g., unexplained rise in serum creatinine with onset of urine dipstick positive for hemoglobin) including on recent biopsy.

Claim Notes:

- Approvals will be for a maximum of:

Body Weight Range (kg)	Loading Dose (mg)	Maintenance Dose (mg)	Dosing Interval
≥ 5 to < 10	600	300	Every 4 weeks
≥ 10 to < 20	600	600	Every 4 weeks
≥ 20 to < 30	900	2,100	Every 8 weeks
≥ 30 to < 40	1,200	2,700	Every 8 weeks
≥ 40 to < 60	2,400	3,000	Every 8 weeks
≥ 60 to < 100	2,700	3,300	Every 8 weeks
≥ 100	3,000	3,600	Every 8 weeks

- Supplemental dosing following treatment with plasma exchange, plasmapheresis, or intravenous immunoglobulin is approved.
- The patient must be under the care of a pediatric nephrologist, a nephrologist, a pediatric hematologist or a hematologist.
- Initial Approval: 6 months
Renewal Approval: 1 year

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rebif - see Multiple Sclerosis Agents

Reblozyl – see Luspatercept

Regorafenib, tablet, 40mg (Stivarga-BAY)

1. For patients with metastatic and/or unresectable gastrointestinal stromal tumors (GIST) who have had disease progression on, or intolerance to, imatinib and sunitinib; AND has ECOG ≤ 1.
2. For the treatment of patients with unresectable hepatocellular carcinoma (HCC) who have experienced disease progression on sorafenib or lenvatinib and meet all of the following criteria:
 - Child-Pugh class status of A.
 - ECOG performance status of 0 or 1.

Clinical Notes:

- Treatment should continue until disease progression or unacceptable toxicity.
- Patients with disease progression on sorafenib must have tolerated a minimum dose of 400 mg per day for at least 20 of the last 28 days of treatment.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Remdantry – see Infliximab

Remsima SC – see Infliximab

Renagel - see Sevelamer

Renflexis – see Infliximab

Repatha – see Evolocumab

Replagal – agalsidase alfa, vial, 1 mg/mL (Takeda)

Coverage may be available for the treatment of Fabry Disease through the High Cost Drug Plan and Catastrophic Drug Plan, for eligible patients who meet the criteria set out in the Canadian Fabry Disease Treatment Guidelines.

The treatment guidelines are supported by the Canadian Fabry Disease Initiative (CFDI) and may be amended by the CFDI from time to time.

Please contact the PEI Pharmacare Program office at [1-877-577-3737](tel:1-877-577-3737) for more information regarding coverage availability and the Special Authorization application process for this product.

Retevmo – see Selpercatinib

Rexulti – see Brexpiprazole

Revatio - see Sildenafil

ReVia - see Naltrexone

Revlimid – see Lenalidomide

Ribociclib, tablet, 200mg (Kisqali-NVR)

1. In combination with an aromatase inhibitor for the treatment of patients with hormone receptor positive, HER2 negative or advanced or metastatic breast cancer who:
 - have not received prior endocrine therapy for advanced or metastatic disease, and
 - are not resistant to prior (neo) adjuvant non-steroidal aromatase inhibitor (NSAI) therapy and
 - do not have active or uncontrolled metastases to the central nervous system

Renewal criteria:

Confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

- Patients must have a good performance status
- Resistance is defined as disease progression occurring during or within 12 months following NSAI therapy
- Treatment should be discontinued upon disease progression or unacceptable toxicity

Claim Notes:

- Initial Approval Period: 1 year
- Renewal Approval Period: 1 year

2. In combination with fulvestrant for the treatment of patients with hormone receptor (HR) positive, HER2 negative advanced or metastatic breast cancer, as initial endocrine-based therapy or following disease progression on endocrine therapy. Patients may have also received up to one prior line of chemotherapy for advanced disease. Patients should have a good performance status, without active or uncontrolled metastases to the central nervous system and can be of any menopausal status (perimenopausal and premenopausal women must be treated with an LHRH agonist).

Clinical Notes:

- Treatment should continue until unacceptable toxicity or disease progression.
- Patients who progress $\leq$ 12 months from (neo) adjuvant therapy are eligible for treatment with ribociclib plus fulvestrant.
- Patients who experience disease progression on prior CDK 4/6 inhibitor therapy, fulvestrant or everolimus are not eligible for treatment with ribociclib with fulvestrant.
- Patients currently receiving fulvestrant monotherapy, and who have not progressed may have ribociclib added, provided they are CDK 4/6 inhibitor naïve and otherwise meet funding criteria.
- Patients who previously received everolimus plus exemestane will be eligible for funding of ribociclib plus fulvestrant on progression, provided that treatment was started prior to funding of CDK 4/6 + fulvestrant, patient must be CDK 4/6 naïve and otherwise meet funding criteria.

Claim Notes:

- Initial Approval Period: 1 year
- Renewal Approval Period: 1 year

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rifaximin, tablet, 550mg (Zaxine-LUP)

For reducing the risk of overt hepatic encephalopathy (HE) recurrence (i.e., 2 or more episodes), if the following clinical criteria are met:

Clinical Criteria:

- Patients are unable to achieve adequate control of HE recurrence with maximal tolerated dose of lactulose alone.
- Must be used in combination with maximal tolerated doses of lactulose.
- For patients not maintained on lactulose, information is required regarding the nature of the patient's intolerance to lactulose.

Rinvoq – see Upadacitinib

Riociguat, tablet, 0.5mg, 1mg, 1.5mg, 2mg, 2.5mg (Adempas-BAY and generic)

For the treatment of inoperable chronic thromboembolic pulmonary hypertension (CTEPH, World Health Organization [WHO] Group 4) or persistent or recurrent CTEPH after surgical treatment in adult patients (>18 years of age) with WHO Functional Class (FC) II or III pulmonary hypertension (PH).

Should be prescribed by a clinician with experience in the diagnosis and treatment of CTEPH.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ripretinib, tablet, 50mg (Qinlock-MDP)

For the treatment of adult patients with advanced gastrointestinal stromal tumours (GIST) who have progression on or intolerance to imatinib, sunitinib, and regorafenib.

Clinical Notes:

- Patients must have a good performance status and no active central nervous system metastases.
- Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Risankizumab, prefilled syringe, 75mg/0.83mL, 150mg/mL; prefilled pen, 150mg/mL; vial, 600mg/10mL; prefilled cartridge, 360mg/2.4mL (Skyrizi-ABV)

Crohn's Disease
(600mg/10mL vial and 360mg/2.4mL prefilled cartridge)

For the treatment of patients with moderate to severe Crohn's disease who have active disease and are refractory, intolerant or have contraindications to:

- Prednisone 40mg (or equivalent) daily for ≥ 2 weeks, AND
- Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
- Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
- Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:

- Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
- Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients who have an aggressive/severe disease course (e.g. extensive disease, a modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.

Claim Notes:

- Initial Approval is for 600mg administered by IV infusion at week 0, 4 and 8. Renewal of coverage will require reassessment of the patient and submission of a new Crohn's Disease Special Authorization form. Continued coverage will be approved at a dose of 360mg administered by subcutaneous infusion at week 12, and every 8 weeks thereafter.
- Initial Approval: 16 weeks
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a gastroenterologist using the Crohn's Disease Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at

<http://www.princeedwardisland.ca/pharmacareforms>.

Plaque Psoriasis

(75mg/0.83mL prefilled syringe and 150mg/mL prefilled syringe/pen)

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals.
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score; or
- A >50% reduction (provide baseline and current score) in PASI with a > 5-point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet, or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 150mg administered at week 0, week 4, and every 12 weeks thereafter. If response criteria is met at 16 weeks, approval will be continued to a maximum dose of 150mg every 12 weeks up to one year.
- Initial Approval: 16 weeks.
- Renewal Approval: 1 year.
- Concurrent use of biologics not approved.

Requests must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Risdiplam, powder for oral solution, 0.75mg/mL (Evrysdi-HLR)

For patients diagnosed with 5q Spinal Muscular Atrophy (SMA) under the care of a specialist with experience in the diagnosis and management of SMA, if the following clinical criteria are met:

- Genetic documentation of 5q SMA homozygous gene deletion or compound heterozygote, AND
- Patients who:
 - are symptomatic and have genetic documentation of two or three copies of the SMN2 gene, AND
 - aged between 2 months and 7 months (inclusive), OR
 - aged 8 months up to 25 years and are non-ambulatory
- Patient is not currently requiring permanent invasive ventilation*, AND
- A baseline assessment using an age-appropriate scale (the Hammersmith Infant Neurological Examination [HINE] Section 2, Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND], or Hammersmith Functional Motor Scale-Expanded [HFMSE]) must be completed prior to initiation of risdiplam treatment.
- For continued coverage, the patient must meet the following criteria:
There is demonstrated achievement or maintenance of motor milestone function (as assessed using age-appropriate scales: the [HINE] Section 2, CHOP INTEND, or HFMSE) after treatment initiation in patients aged between 2 months and 2 years at the time of treatment initiation; OR
 - There is demonstrated maintenance of motor milestone function (as assessed using age-appropriate scales: the HINE Section 2, CHOP INTEND, or HFMSE) after treatment initiation in patients aged between 2 years and 25 years at the time of treatment initiation; AND
 - Patient does not require permanent invasive ventilation*.

The decision to discontinue reimbursement should be based on 2 assessments separated by no longer than a 12-week interval.

Claim Notes:

- Approval: 12 months

* Permanent invasive ventilation is defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Risedronate, tablet, 30mg (Generic)

For the treatment of Paget's disease of the bone for a maximum 2 month period. One additional 2 month course of treatment may be considered after a drug holiday of at least 60 days.

Risperdal Consta - see Risperidone prolonged release injection

Risperidone, prolonged release injection, 12.5mg/2mL, 25mg/2mL, 37.5mg/2mL, 50mg/2mL (Risperdal Consta-JAN)

Note: For Community Mental Health Drug Program, no Special Authorization is required. For the treatment of schizophrenia or schizoaffective disorder in patients who have:

a) A history of non-adherence.

OR

b) Inadequate control or significant side-effects from two or more oral antipsychotic medications.

OR

c) Inadequate control or significant side-effects from at least one long-acting depot antipsychotic agent.

NOTE:

- **Must be requested and prescribed by a psychiatrist.**
- **Only doses up to 50mg every two weeks will be approved.**

Rituximab, vial, 10mg/mL (Riximyo-SDZ, Ruxience-PFI, Truxima-TEV)

For the treatment of patients with:

1. Rheumatoid arthritis who have a severe intolerance or other contraindication to an anti-TNF agent or failed an adequate trial of an anti-TNF agent.
2. Vasculitis who have a severe intolerance or other contraindication to cyclophosphamide or failed an adequate trial of cyclophosphamide.
3. Other autoimmune diseases whom have failed previous treatments.

Clinical Note: A detailed description of previously failed treatments must be provided.

Claim Notes:

1. Must be prescribed by a specialist.
2. Initial Approval: 6 months.
3. Renewal Approval: Long term. Confirmation of continued response is required.
4. Claims that exceed the maximum claim amount of \$9,999.99 must be divided and submitted as separate transactions using the DIN first, and then PDINs.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rivastigmine - see Cholinesterase Inhibitors (ChEI)

Riximyo – see Rituximab

Romosozumab, prefilled syringe, 105mg/1.17mL (Evenity-AMG)

For the treatment of osteoporosis in postmenopausal women who meet all of the following criteria:

- History of osteoporotic fracture
- High fracture risk
- Treatment naïve to osteoporosis medications, except for calcium and vitamin D

Clinical Note:

- High fracture risk is defined as a 10-year fracture risk ($\geq 20\%$) as defined by the Fracture Risk Assessment (FRAX) tool.

Claim Notes:

- Combined use of romosozumab with other osteoporosis medications will not be reimbursed.
- Approvals will be for a maximum of 210 mg monthly.
- Maximum Approval Period: 1 year

Rotigotine, transdermal patch, 2mg, 4mg, 6mg, 8mg (Neupro-UCB)

For the treatment of the signs and symptoms of Parkinson's Disease in patients who are experiencing motor fluctuations despite optimal treatment with Levodopa/Carboxylase therapy upon written request or recommendation of a neurologist. A copy of the recommendation must accompany the Special Authorization.

Rozlytrek – see Entrectinib

Rufinamide, tablet, 100mg, 200mg, 400mg (Banzel-EIS and generic)

For the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome for patients who meet all of the following criteria:

- are under the care of a physician experienced in treating Lennox-Gastaut syndrome-associated seizures, AND
- are currently receiving two or more antiepileptic drugs, AND
- in whom less costly antiepileptic drugs are ineffective or not appropriate.

Ruxience – see Rituximab

Ruxolitinib, tablet, 5mg, 10mg, 15mg, 20mg (Jakavi-NVR)

Acute Graft-Versus-Host Disease

For the treatment of steroid-refractory or steroid-dependent acute graft-versus-host disease (aGvHD) in adult and pediatric patients aged 12 years and older who meet all the following criteria:

- Clinically diagnosed grade II to IV aGvHD according to the NIH criteria (Harris et al. [2016]).
- Confirmed diagnosis of corticosteroid-refractory or corticosteroid-dependent aGvHD.

Renewal criteria:

- Achieved an overall response (i.e., CR, VGPR, PR, or stable disease with significant reduction in steroid doses), according to standard NIH criteria at day 28.
- For subsequent renewals, patients should be assessed for treatment response every 2 to 3 months, until the occurrence of any of the discontinuation criteria listed below.

Clinical Notes:

- Treatment should be discontinued upon the occurrence of any of the following:
 - progression of aGvHD, defined as worsening of aGvHD symptoms or occurrence of new aGvHD symptoms
 - unacceptable toxicity
 - addition of systemic therapies (other than calcineurin inhibitors) for aGvHD after day 28
 - recurrence or relapse of underlying hematological malignancy.

Claim Notes:

- Must be prescribed by clinicians who have experience in the diagnosis and management of patients with aGvHD.
- Must not be added to patients' concurrent treatment of systemic therapies for the treatment of aGvHD other than steroids with or without calcineurin inhibitors.
- Approval: 6 months

Chronic Graft-Versus-Host Disease

For the treatment of chronic graft-versus-host disease (cGvHD) in adults and pediatric patients aged 12 years and older who have inadequate response to corticosteroids or other systemic therapies who meet all the following criteria:

- Clinically diagnosed cGvHD staging of moderate to severe based on NIH consensus criteria
- Confirmed diagnosis cGvHD with inadequate response to corticosteroids or other systemic therapies

Renewal criteria:

- Achieved an overall response (i.e., CR or PR, or stable disease with significant reduction in steroid doses), according to NIH criteria, after 24 weeks of therapy.

Clinical Notes:

- Treatment should be discontinued upon the occurrence of any of the following:
 - Progression of cGvHD, defined as worsening of cGvHD symptoms or occurrence of new cGvHD symptoms
 - recurrence or relapse of underlying hematological malignancy

Claim Notes:

- Must be prescribed by clinicians who have experience in the diagnosis and management of patients with cGvHD.
- Must not be added to patients' concurrent treatment of systemic therapies other than steroids with or without calcineurin inhibitors.
- Initial Approval: 6 months

Myelofibrosis

For patients with intermediate to high risk symptomatic Myelofibrosis (MF) as assessed using the Dynamic International Prognostic Scoring System (DIPSS) Plus or patients with symptomatic splenomegaly. Patients should have ECOG performance status of ≤ 3 and be either previously untreated or refractory to other treatment.

Polycythemia Vera

For the treatment of patients with polycythemia vera who have demonstrated resistance or intolerance to hydroxyurea (HU).

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

- Patients must have a good performance status.
- Treatment should be discontinued upon disease progression or unacceptable toxicity.
- Resistance is considered if, after at least 3 months of HU therapy at the maximum tolerated dose, patients experience at least one of the following:
 - Need for phlebotomy to maintain hematocrit (HCT) $< 45\%$
 - Uncontrolled myeloproliferation (i.e., platelet count $> 400 \times 10^9/L$ and white blood cell count $> 10 \times 10^9/L$)
 - Failure to reduce massive splenomegaly by greater than 50%, as measured by palpation
- Intolerance to HU is considered if patients experience at least one of the following:

- Absolute neutrophil count < $1.0 \times 10^9/L$, platelet count < $100 \times 10^9/L$ or hemoglobin < 100g/L at the lowest dose of HU required to achieve a response (a response to HU is defined as HCT <45% without phlebotomy, and/or all of the following: platelet count < $400 \times 10^9/L$, white blood cell count < $10 \times 10^9/L$, and nonpalpable spleen).
- Presence of leg ulcers or other unacceptable HU-related non-hematological toxicities (defined as grade 3 or 4 or, more than one week of grade 2) such as mucocutaneous manifestations, gastrointestinal symptoms, pneumonitis, or fever.
- Toxicity requiring permanent discontinuation of HU, interruption of HU until toxicity resolved, or hospitalization due to HU toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ruzurgi – see Amifampridine

Rybelsus – see Semaglutide

Rydapt – see Midostaurin

Rymti – see Etanercept

Sabril – see Vigabatrin

Sacubitril & Valsartan, tablet, 24mg & 26mg, 49mg & 51mg, 97mg & 103mg (Entresto-NVR)

For the treatment of patients with New York Heart Association (NYHA) class II or III heart failure to reduce the incidence of cardiovascular death and heart failure hospitalization, who meet all of the following criteria:

- Left ventricular ejection fraction (LVEF) of <40%
- NYHA class II or III symptoms despite at least four weeks of treatment of the following:
 - a stable dose of an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB); and
 - a stable dose of a beta-blocker and other recommended therapies, including an aldosterone antagonist.
- Plasma B-type natriuretic peptide (BNP) $\geq 150\text{pg/mL}$ or N-terminal prohormone B-type natriuretic peptide (NTproBNP) $\geq 600\text{ pg/mL}$.

Clinical Notes:

1. A plasma BNP $\geq$ 100 pg/mL or NT-proBNP $\geq$ 400 pg/mL will be considered if the patient has been hospitalized for heart failure within the past 12 months.
2. For patients who have not received four weeks of therapy with a beta blocker or aldosterone antagonist due to an intolerance or contraindication, details must be provided.

Salagen - see Pilocarpine

Salmeterol Xinafoate, aerosol powder disk, 50µg/dose (Serevent Diskus-GSK)

- a) For the treatment of asthma when used in patients on concurrent steroid therapy.
- b) For the treatment of COPD, see Chronic Obstructive Pulmonary Disease.

Note: Patients using this product must also have access to a short-acting beta-2 agonist bronchodilator for the relief of acute symptoms.

Salmeterol & Fluticasone, aerosol inhalation, 25mcg & 125mcg per dose, 25mcg & 250mcg per dose (Advair-GSK); inhaled powder disk, 50mcg & 100mcg per dose, 50mcg & 250mcg per dose, 50mcg & 500mcg per dose (Advair Diskus- GSK and generics)

- a) For the treatment of asthma in patients who are not well controlled on a regular and adequate course of inhaled steroid therapy prior to the request for combination therapy.
- b) For the treatment of COPD, see Chronic Obstructive Pulmonary Disease.

Note: Patients using this product must also have access to a short-acting beta-2 agonist bronchodilator for the relief of acute symptoms.

Saphnelo – see Anifrolumab

Sapropterin, powder for oral solution, 100 mg, 500 mg (Reddy-Sapropterin-RCH)

For the ongoing treatment of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU) in conjunction with a phenylalanine (Phe)-restricted diet in patients who meet all of the following criteria:

- Confirmed diagnosis based on genetic testing.
- Response to sapropterin provided by the manufacturers initial 6 month trial through the Patient Support Program (PSP) 'Reddy-Sapropterin Support Program for Patients with HPA due to PKU'.
- Baseline blood Phe levels greater than 360 µmol/L despite compliance with a low protein diet and formulas (nonpregnant patients require at least 2 baseline levels and pregnant patients require at least 1 baseline level during a 3 to 6 month time frame).
- Achievement of the following during a 6-month trial of treatment:
 - For pregnant or non-pregnant patients, normal sustained blood Phe levels of 120 µmol/L to 360 µmol/L; or

- For non-pregnant patients, sustained blood Phe reduction of at least 30% compared to baseline if the baseline blood Phe level is less than 1200 umol/L; or
- For non-pregnant patients, sustained blood Phe reduction of at least 50% compared to baseline if the baseline blood Phe level is greater than 1200 umol/L.
- For non-pregnant patients, documented increase in dietary protein tolerance based on targets set between the clinician and patient.

Renewal Criteria:

- Confirmation of continued response to sapropterin based on Phe levels achieved during the 6-month trial. Two Phe levels taken at least 1 month apart must be provided.

Clinical Notes:

1. Patients must be initiated on treatment and followed in a specialized clinic with expertise in the diagnosis and management of PKU.
2. Phe blood levels and Phe tolerance levels must be provided.
3. Pregnant patients who have maintained a decrease in Phe levels below 360 umol/L during the 6-month trial period will be eligible for coverage of sapropterin for the duration of the pregnancy.
4. Confirmation of compliance with a low protein diet is required before initiation and in conjunction with ongoing use.

Claim Notes:

- Approvals will be for a maximum of 20 mg/kg per day.
- Renewals for sapropterin in pregnant patients will not be considered.
- Approval Period: 1 year

* Claims that exceed the maximum claim amount of \$9999.99 must be divided as separate transactions, using DIN first and PDIN* second.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Sarilumab, syringe, 150mg/1.14mL, 200mg/1.14mL; pen, 150mg/1.14mL, 200mg/1.14mL (Kevzara-AVN)

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks AND Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine

and sulfasalazine, for a minimum of 12 weeks;

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Approval for adults is 200 mg once every 2 weeks given as a subcutaneous injection. Reduction of dose to 150 mg once every 2 weeks is recommended for management of neutropenia, thrombocytopenia, and elevated liver enzymes.
- Must be prescribed by a rheumatologist.
- Initial Approval: 6 months
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Satralizumab, prefilled syringe, 120mg/mL (Enspryng-HLR)

For the treatment of patients 12 years of age and older with neuromyelitis optica spectrum disorder (NMOSD) who meet all of the following criteria:

- Are anti-aquaporin4 (AQP4) seropositive.
- Must have had at least one relapse of NMOSD in the previous 12 months:
 - despite an adequate trial of other accessible preventive treatments¹ for NMOSD, OR
 - because the patient cannot tolerate other preventive treatments¹ for NMOSD

- Patients must have an EDSS score of 6.5 points or less.
- Satralizumab should not be initiated during a NMOSD relapse episode.

Renewal:

- Requests for renewal will be considered for patients who maintain an EDSS score of less than 8 points.

Clinical Note:

- Must be prescribed by a neurologist with expertise in treating NMOSD.

Claim Notes:

1. Combined use of more than one biologic drug will not be reimbursed.
2. Approvals will be for a maximum of 120mg at week 0, 2 and 4, then 120 mg every four weeks thereafter.

¹Other accessible preventative treatments include, but are not limited to, monoclonal antibodies and other immunosuppressants.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Saxagliptin, tablet, 2.5mg, 5mg (Onglyza-AZE and generics)

For the treatment of patients with type 2 diabetes when added to metformin for patients who have inadequate glycemic control on metformin.

Clinical Notes:

For patients who cannot take metformin due to contraindications or intolerances, details must be provided.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Scemblix – see Asciminib

Secukinumab, pen, 150mg/mL (Cosentyx-NVR)

Ankylosing Spondylitis

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- a) have axial symptoms* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR

- b) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for a maximum adult dose of 150 mg at 0, 1, 2, and 3 weeks followed by monthly maintenance dosing of 150 mg starting at week 4.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: maximum of 12 months.

Requests for renewal must include information showing the beneficial effects of the treatment, specifically:

- a) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
- b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Hidradenitis Suppurative

For the treatment of patients with active moderate to severe hidradenitis suppurativa (HS) who have not responded to conventional therapy and who meet all of the following criteria:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics

Initial renewal criteria:

- Requests for renewal should provide objective evidence of a treatment response, defined as at least a 50% reduction in abscess and inflammatory nodule count with no increase in abscess or draining fistula count relative to baseline at week 12.

Subsequent renewal criteria:

- Requests for renewal should provide objective evidence of the preservation of treatment effect (i.e. the current abscess and inflammatory nodule count and draining fistula count should be compared to the count prior to initiating treatment with secukinumab).

Claim Notes:

- Approvals will be for 300mg given at weeks 0, 1, 2, 3, and 4, followed by monthly maintenance dosing. Based on clinical response, a maintenance dose of 300 mg every 2 weeks can be considered.
- Must be prescribed by a dermatologist or physician with experience in the treatment of HS.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months.
- Renewal Approval: 1 year

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Plaque Psoriasis

For the treatment of patients 6 years of age or older with chronic moderate to severe plaque psoriasis who meet all of the following:

- Psoriasis Area Severity Index (PASI) greater than 10 and Dermatology Life Quality Index (DLQI) greater than 10, OR major involvement of visible areas, scalp, genitals, or nails;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A $>75\%$ reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score; or
- A $>50\%$ reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure 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 to treatments. The nature of intolerance(s) must be clearly documented.
- For patients aged 6 to 16, a Children's Dermatology Life Quality Index (CDLQI) greater than 7 will be considered.
- For pediatric patients an adequate trial of a weight-based appropriate dose of methotrexate will be considered.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.

Claim notes:

- Approvals will be for a maximum adult dose of 300 mg at 0, 1, 2, 3, and 4 weeks followed by monthly maintenance dosing, up to 12 weeks. If response criteria are met at 12 weeks, approval will be continued to a maximum dose of 300 mg.
- For pediatric patients weighing less than 50kg, approvals will be for a maximum of 75mg given at weeks 0, 1, 2, 3 and 4, then monthly.
- Initial Approval: 12 weeks.
- Renewal Approval: 1 year.
- Concurrent use of biologics not approved.

Requests must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis

- 1) For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; and
 - Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of 150mg at weeks 0, 1, 2 and 3 followed by monthly maintenance dosing of 150mg starting at week 4. For patients who are anti-TNF α inadequate responders and continue to have active psoriatic arthritis, consider using the 300 mg dose. For psoriatic arthritis patients with coexistent moderate to severe plaque psoriasis, use the dosing and administration recommendations for plaque psoriasis (i.e. 300 mg at weeks 0, 1, 2, and 3, followed by monthly maintenance dosing starting at week 4).
- Initial Approval 16 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Seebri Breezhaler – see Glycopyrronium Bromide

Selexipag, tablet, 200mcg, 400mcg, 600mcg, 800mcg, 1000mcg, 1200mcg, 1400mcg, 1600mcg (Uptravi-ACT)

For the long-term treatment of idiopathic pulmonary arterial hypertension (PAH), heritable PAH, PAH associated with connective tissue disorders, and PAH associated with congenital heart disease, in adult patients with World Health Organization (WHO) functional class (FC) II to III to delay disease progression, if the following clinical criterion and conditions are met:

- Inadequate control with a first and second-line PAH therapy
- Prescribed by a clinician with experience in the diagnosis and treatment of PAH

NOTE:

Combination therapy with prostacyclin or prostacyclin analogs therapies will not be covered

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Selinexor, tablet, 20mg (Xpovio-FTI)

In combination with bortezomib and dexamethasone for the treatment of adult patients with multiple myeloma and who have received at least one prior therapy.

Clinical Notes:

1. Prior treatment with bortezomib/proteasome inhibitor is permitted if all the following criteria are met:
 - Best response achieved with bortezomib/proteasome inhibitor was at least a partial response.
 - Bortezomib/proteasome inhibitor not discontinued for grade 3 or higher toxicity
 - Bortezomib/proteasome inhibitor treatment-free interval has been at least six months.
2. Treatment should continue until disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Selpercatinib, capsule, 40mg, 80mg (Retevmo-LIL)

Medullary Thyroid Cancer

For the treatment of patients 12 years and older with unresectable locally advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who have progressed on, are intolerant to, or have a contraindication to first-line therapy.

Clinical Notes:

- Discontinuation for unacceptable toxicity or loss of clinical benefit.
- Patients should have a good performance status.
- Monotherapy only.
- Confirm RET mutation prior to initiating therapy.
- Patients with prior progression on a RET inhibitor are ineligible.

Differentiated Thyroid Carcinoma (DTC)

For the treatment of adult patients with locally advanced or metastatic RET fusion-positive differentiated thyroid carcinoma (DTC) not amenable to surgery or radioactive iodine therapy, following prior treatment with lenvatinib.

Clinical Notes:

- Discontinuation for unacceptable toxicity or loss of clinical benefit.
- Patients should have a good performance status.
- Monotherapy only.
- Confirm RET mutation prior to initiating therapy.
- Patients with prior progression on a RET inhibitor are ineligible.

Non-Small Cell Lung Cancer

For the treatment of adult patients with metastatic RET fusion-positive non-small cell lung cancer (NSCLC) as first-line treatment or after prior systemic therapy.

Clinical Notes:

- Discontinuation for unacceptable toxicity or loss of clinical benefit.
- Patients should have a good performance status.
- Monotherapy only.
- Confirm RET mutation prior to initiating therapy.
- Patients with prior progression on a RET inhibitor are ineligible.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Selumetinib, capsule, 10mg, 25mg (Koselugo-ALX)

For pediatric patients aged 2 to 18 years with neurofibromatosis type 1 (NF1) with symptomatic, inoperable plexiform neurofibromas (PNs).

Initial renewal:

- The physician must document the beneficial clinical effect when requesting continuation of reimbursement.
- Patients on therapy should be monitored for response (e.g., a reduction in pain, improved function, reduction in tumour volume and/or size, disease stabilization) using clinical judgment and/or standard imaging.

Second and subsequent renewal criteria (at 18 months after initiation and thereafter):

- The patient does not have disease worsening or progression (e.g., worsening of motor function or pain).

Claim Notes:

- The patient must be under the care of either a neurooncologist or a pediatrician with expertise in neurooncology.
- Initial approval: 18 months
- Renewal Approval: 12 months

The Special Authorization form is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Semaglutide, tablet, 3mg, 7mg, 14mg (Rybelsus-NNO)

For the treatment of type 2 diabetes in combination with metformin and a sulfonylurea, when diet and exercise plus dual therapy with metformin and a sulfonylurea do not achieve adequate glycemic control.

The request for coverage must be made using the Semaglutide Special Authorization Request Form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Semaglutide, pen injector, 0.25-0.5mg, 1mg (Ozempic-NNO)

For the treatment of type 2 diabetes in combination with metformin and a sulfonylurea, when diet and exercise plus dual therapy with metformin and a sulfonylurea do not achieve adequate glycemic control.

Claim Note:

- Approvals will be for a maximum of 1 prefilled pen every 4 weeks.

The request for coverage must be made using the Semaglutide Special Authorization Request Form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Serc - see Betahistine

Serevent - see Salmeterol

Serevent Diskus - see Salmeterol

Sevelamer carbonate, tablet, 800mg (Accel-Sevelamer)

For the treatment of hyperphosphatemia (>1.8 mmol/L) in patients with end stage renal disease (eGFR <15 mL/min) who have:

- Inadequate control of phosphate levels on a calcium based phosphate binder, or
- Hypercalcemia (corrected for albumin), or
- Calciphylaxis (calcific arteriolopathy)

NOTE

Initial Approval for 6 months, renewed at 1 year intervals with demonstration of clinically meaningful improvement of phosphate levels (lab values must be provided).

Sevelamer hcl, tablet, 800mg (Renagel-GZY)

For the treatment of hyperphosphatemia (>1.8 mmol/L) in patients with end stage renal disease (eGFR<15mL/min) who have:

- Inadequate control of phosphate levels on a calcium based phosphate binder, or
- Hypercalcemia (corrected for albumin), or
- Calciphylaxis (calcific arteriolopathy)

NOTE

Initial Approval for 6 months, renewed at 1 year intervals with demonstration of clinically meaningful improvement of phosphate levels (lab values must be provided).

Sildenafil, tablet, 20mg (Revatio-PFI and generics)

For the treatment of patients with World Health Organization (WHO) functional class III idiopathic pulmonary arterial hypertension (IPAH) who do not demonstrate vasoreactivity on testing or who do demonstrate vasoreactivity on testing but fail a trial of calcium channel blockers.

For the treatment of patients with World Health Organization (WHO) functional class III pulmonary arterial hypertension (PAH) associated with connective tissue diseases who do not respond to conventional therapy.

Diagnosis of PAH should be confirmed by cardiac catheterization.

Coverage must be requested and medications prescribed by a Pulmonary Arterial Hypertension (PAH) specialist.

Claim Note:

The maximum dose of sildenafil that will be reimbursed is 20mg three times daily.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Siliq – see Brodalumab

Simlandi - see Adalimumab

Simponi – see Golimumab

Siponimod, tablet, 0.25mg, 2mg (Mayzent-NVR)

Initiation Criteria:

For the treatment of patients with active secondary progressive multiple sclerosis, who meet all the following criteria:

- a history of relapsing-remitting multiple sclerosis (RRMS)

- an Expanded Disability Status Scale (EDSS) score of 3.0 to 6.5
- documented EDSS progression during the two years prior to initiating treatment with siponimod (≥ 1 point if EDSS < 6.0; ≥ 0.5 points if EDSS ≥ 6.0 at screening).

Renewal Criteria:

- Patients who do NOT exhibit evidence of disease progression since the previous assessment. Disease progression is defined as:
 - an increase in the EDSS score of greater than or equal to 1 point if the EDSS score was 3.0 to 5.0 at siponimod initiation
OR
 - an increase of greater than or equal to 0.5 points if the EDSS score was 5.5 to 6.5 at siponimod initiation

Patients who do NOT exhibit one of the following:

- progression to an EDSS score of equal to or greater than 7.0 at any time during siponimod treatment
- confirmed worsening of at least 20% on the timed 25-foot walk (T25W) since initiating siponimod treatment

Clinical Notes:

- Patients should be assessed for a response to siponimod every six months.

Claim Notes:

- The patient is under the care of a neurologist with experience in the diagnosis and management of multiple sclerosis.
- Siponimod should not be used in combination with other disease-modifying treatments (DMTs) used to treat multiple sclerosis.
- Approval Period: 1 year

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Sitagliptin, tablet, 25mg, 50mg, 100mg (Januvia-MSD and generics)

For the treatment of patients with type 2 diabetes when added to metformin for patients who have inadequate glycemic control on metformin.

Clinical Notes:

For patients who cannot take metformin due to contraindications or intolerances, details must be provided.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Sitagliptin & Metformin Hydrochloride, tablet, 50mg/500mg, 50mg/850mg, 50mg/1000mg (Janumet-MSD and generics)

For the treatment of type 2 diabetes for patients who are already stabilized on therapy with sitagliptin and metformin, to replace the individual components of sitagliptin and metformin.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Sitagliptin & Metformin Hydrochloride, extended release tablet, 50mg/500mg, 50mg/1000mg, 100mg/1000mg (Janumet XR-MSD and generics)

For the treatment of type 2 diabetes for patients who are already stabilized on therapy with sitagliptin and metformin, to replace the individual components of sitagliptin and metformin.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Skyrizi – see Risankizumab

Sodium Cromoglycate, capsule, 100mg (Nalcrom-AVN)

For the treatment of patients who experience severe reactions to foods which cannot be avoided.

Sofosbuvir, tablet, 400mg (Sovaldi-GIL)

For treatment-naïve or treatment-experienced adult patients with chronic hepatitis C virus (HCV) who meet the following criteria:

	Approval Period
Genotype 2 • Without cirrhosis • With compensated cirrhosis	12 weeks in combination with ribavirin (RBV)
Genotype 3 • Without cirrhosis • With compensated cirrhosis	24 weeks in combination with RBV

Clinical Notes:

1. Genotype must be provided.
2. Compensated cirrhosis is defined as a Child-Turcotte-Pugh (CTP) score of 5 to 6 (Class A) and decompensated cirrhosis as a CTP score of 7 or above (Class B or C).

Claim Note:

- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating a patient with hepatitis C infection)

Sofosbuvir & Ledipasvir, tablet, 400mg & 90mg (Harvoni-GIL)

For treatment-naïve or treatment-experienced adult patients with chronic hepatitis C virus (HCV) who meet the following criteria:

	Approval Period
Genotype 1 • Treatment naïve without cirrhosis, who have pre-treatment HCV RNA level < 6 million IU/mL and mono-HCV infected only	8 or 12 weeks
Genotype 1 • Treatment-naïve without cirrhosis, who have pretreatment HCV RNA level ≥ 6 million IU/mL • Treatment-naïve with compensated cirrhosis • Treatment-naïve with advanced liver fibrosis (Fibrosis stage F3-F4) • Treatment-experienced without cirrhosis • HCV/HIV co-infected without cirrhosis or with compensated cirrhosis • Liver transplant recipients without cirrhosis or with compensated cirrhosis.	12 weeks
Genotype 1 • Treatment-experienced with compensated cirrhosis • Decompensated cirrhosis	24 weeks

Clinical Notes:

1. Genotype must be provided
2. Compensated cirrhosis is defined as a Child-Turcotte-Pugh (CTP) score of 5 to 6 (Class A) and decompensated cirrhosis as a CTP score of 7 or above (Class B or C).

Claim Note:

- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating a patient with hepatitis C infection).

Sofosbuvir & Velpatasvir, tablet, 400mg & 100mg (Epclusa-GIL)

For treatment-naïve or treatment-experienced adult patients with chronic hepatitis C virus (HCV) who meet the following criteria:

	Approval Period
Genotypes 1,2,3,4,5,6 or mixed genotypes • Patients with compensated cirrhosis • Patients without cirrhosis	12 weeks
Genotypes 1,2,3,4,5,6 or mixed genotypes • Patients with decompensated cirrhosis	24 weeks

Clinical Note:

- Compensated cirrhosis is defined as a Child-Turcotte-Pugh (CTP) score of 5 to 6 (Class A) and decompensated cirrhosis as a CTP score of 7 or above (Class B or C).

Claim Note:

- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating a patient with hepatitis C infection).

Sofosbuvir & Velpatasvir & Voxilaprevir, tablet, 400mg & 100mg & 100mg (Vosevi-GIL)

For treatment-experienced adult patients with chronic hepatitis C virus (HCV) who meet the following criteria:

	Approval Period
Genotypes 1,2,3,4,5,6 or mixed genotypes • Patients with compensated cirrhosis • Patients without cirrhosis	12 weeks

Clinical Note:

- Compensated cirrhosis is defined as a Child-Turcotte-Pugh (CTP) score of 5 to 6 (Class A).

Claim Note:

- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating a patient with hepatitis C infection).

Somatrogen, prefilled pen, 24 mg/1.2 ml, 60 mg/1.2 ml (Ngenla-PFI)

For the long-term treatment of pediatric patients who have growth failure due to an inadequate secretion of endogenous growth hormone (growth hormone deficiency [GHD]) only if the following conditions are met:

Initiation Criteria:

Pre-pubertal children who are at least 3 years of age, and who are diagnosed with either isolated GHD, or growth hormone insufficiency as part of multiple pituitary hormone deficiency.

Discontinuation Criteria:

Treatment with somatrogen must be discontinued upon the occurrence of any of the following:

1. Height velocity is less than 2 cm per year and bone age is more than 16 years in boys and 14 years in girls
2. Closure of the epiphyseal growth plates

Clinical Notes:

1. Patient height and weight must be provided with all requests.
2. Confirmation there is no evidence of epiphyseal growth plate closure and a copy of the bone age report must be provided with all requests.
3. Bone age assessments may be based on the Greulich Pyle Atlas, Tanner-Whitehouse, or other appropriate methods of assessment.

Claim Notes:

- Must be prescribed by, or in consultation with, an endocrinologist.
- Approvals will be for a maximum of 0.66 mg/kg weekly.
- Approval Period: 1 year

Sorafenib, tablet, 200mg (Nexavar-BAY)

- For use as a single agent second line treatment in patients with documented evidence of histologically confirmed advanced or metastatic clear cell renal cell carcinoma, considered to be intermediate or low risk (according to Memorial Sloan-Kettering (MSKCC) prognostic score, see below), have an ECOG performance status of 0 or 1 and progressed after prior cytokine therapy (or intolerance) within the previous 8 months. In any one patient all of the following conditions must be met:
- Sorafenib may be a second line option only after cytokine therapy.
- Sorafenib may not be used after another tyrosine kinase inhibitor (i.e. Sunitinib) as sequential therapy.
In the event of severe toxicity within the first 8 weeks of therapy, a switch to another tyrosine kinase inhibitor (i.e. Sunitinib) may be allowed.
- For use in patients with Child-Pugh Class A advanced hepatocellular carcinoma, who have progressed on trans-arterial chemoembolization (TACE) or are not suitable for the TACE

procedure and have an ECOG performance status of 0 to 2. Renewal of coverage requires no further progression of the patient's disease as evidenced by radiological or scan results. Copies of the results must accompany the Special Authorization.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Sovaldi – see Sofosbuvir

Spinraza – see Nusinersen

Spiriva - see Tiotropium

Spiriva Respimat – see Tiotropium

Sporanox - see Itraconazole

Sprycel - see Dasatinib

Stalevo – see Carbidopa & Levodopa & Entacapone

Steqeyma– see Ustekinumab

Stiripentol, capsules, powder for inhalation, 250mg, 500mg (Diacomit-BIO)

For use in combination with clobazam and valproate as adjunctive therapy of refractory generalized tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy (Dravet syndrome), whose seizures are not adequately controlled with clobazam and valproate alone.

The patient must be under the care of a neurologist or a pediatrician.

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Stivarga – see Regorafenib

Sucroferric oxyhydroxide, chewable tablet, 500mg (Velphoro-VFM)

For the treatment of hyperphosphatemia (>1.8 mmol/L) in patients with end stage renal disease (eGFR<15mL/min) who have:

- Inadequate control of phosphate levels on a calcium based phosphate binder, or

- Hypercalcemia (corrected for albumin), or
- Calciphylaxis (calcific arteriopathy)

Clinical Notes:

- Initial Approval for 6 months, renewed at 1 year intervals with demonstration of clinically meaningful improvement of phosphate levels (lab values must be provided).

Sumatriptan, nasal spray, 5mg, 20mg; injection 6mg/0.5mL (Imitrex DF-GSK and generics)

For the treatment of migraine headaches where other standard therapies, such as oral analgesics have failed **AND** the patient has not responded to Zolmitriptan or Rizatriptan.

Coverage for the injectable form will only be considered if the tablet and nasal dosage forms are not appropriate.

Coverage is limited to 6 sprays or 6 syringes per 30 day period. Anyone requiring more than 6 doses per 30 day period should be considered for migraine prophylaxis therapy if they are not already receiving such therapy.

Sunitinib, capsule, 12.5mg, 25mg, 50mg (Sutent-PFI and generic)

- For use as a single agent first line treatment in patients with documented evidence of histologically confirmed advanced or metastatic clear cell renal cell carcinoma who have an ECOG performance status of 0 or 1. In any one patient all of the following conditions must be met:
 - Sunitinib may be a first line option.
 - Sunitinib may not be used after another tyrosine kinase inhibitor (i.e. Sorafenib) as sequential therapy.

In the event of severe toxicity within the first 8 weeks of therapy, a switch to another tyrosine kinase inhibitor (i.e. Sorafenib) may be allowed.

- For use as a single agent for the treatment of advanced gastrointestinal stromal tumor (GIST) patients after failure of Imatinib due to intolerance or resistance.
- For the treatment of patients with progressive, unresectable, locally advanced or metastatic, well or moderately differentiated pancreatic neuroendocrine tumours.

Clinical Notes:

1. Patients must have a good performance status.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Sutent - see Sunitinib

Symbicort Turbuhaler - see Formoterol & Budesonide

Tacrolimus, topical ointment, 0.1% (Protopic-AST)

For intermittent use in adults with moderate to severe atopic dermatitis who have failed or are intolerant to a site appropriate strength of corticosteroid therapy (i.e. low potency on face versus intermediate to high potency for trunk and extremities).

Tacrolimus, topical ointment, 0.03% (Protopic-AST)

For use in children greater than 2 years of age with refractory atopic dermatitis for a period of up to 12 months.

Tafamidis, tablet, 61mg (Vyndamax-PFI)

Tafamidis meglumine, capsule, 20mg (Vyndaqel-PFI)

For the treatment of cardiomyopathy in adult patients with documented hereditary or wildtype transthyretin-mediated amyloidosis (ATTR) who meet all of the following criteria:

- New York Heart Association (NYHA) class I to III heart failure.
- At least one prior hospitalization for heart failure or clinical evidence of heart failure that required treatment with a diuretic.
- Has not previously undergone a heart or liver transplant.
- Does not have an implanted cardiac mechanical assist device (CMAD).

Discontinuation Criteria:

The patient has:

- NYHA class IV heart failure, or
- received an implanted CMAD, or
- received a heart or liver transplant.

Clinical Notes :

1. Wild-type ATTR-cardiomyopathy (CM) consists of all of the following:
 - absence of a variant transthyretin (TTR) genotype
 - evidence of cardiac involvement by echocardiography with end-diastolic interventricular septal wall thickness greater than 12mm
 - positive findings on technetium-99m pyrophosphate (Tc-99m-PYP) scintigraphy with single-photon emission computerized tomography (SPECT) scanning OR presence of amyloid deposits in biopsy tissue (fat aspirate,

salivary gland, median nerve connection tissue sheath, or cardiac tissue); and TTR precursor protein identification by immunohistochemistry, scintigraphy, or mass spectrometer

2. Hereditary ATTR-CM consists of all of the following:
- presence of a variant TTR genotype associated with CM and presenting with a CM phenotype
 - evidence of cardiac involvement by echocardiography with end-diastolic interventricular septal wall thickness greater than 12mm
 - positive findings on technetium-99m pyrophosphate (Tc-99m-PYP) scintigraphy with single-photon emission computerized tomography (SPECT) scanning OR presence of amyloid deposits in biopsy tissue (fat aspirate, salivary gland, median nerve connective tissue sheath, or cardiac tissue)

Claim Notes:

- The patient must be under the care of a physician with experience in the diagnosis and treatment of ATTR-CM.
- Combination therapy with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat ATTR-CM will not be reimbursed.
- Initial Approval Period: 9 months.
- Renewal Approval Period: 1 year.

Patients must also apply for coverage by the High Cost Drug Program. The patient application is available from the Drug Program Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Tafinlar – see Dabrafenib

Tagrisso – see Osimertinib

Takhzyro – see Lanadelumab

Taltz – see Ixekizumab

Tasigna – see Nilotinib

Tazarotene/Halobetasol propionate, lotion, 0.01%/0.045% (Duobrii – BLO)

Patients must have a clinical diagnosis of moderate to severe plaque psoriasis and an inadequate response to a topical high-potency corticosteroid.

Tecfidera – see Multiple Sclerosis Agents

Tecta - see Proton Pump Inhibitors

Temodal – see Temozolomide

Temozolomide, capsule, 5mg, 20mg, 100mg, 140mg, 250mg (Temodal–MSD and generics)

For the treatment of brain tumors (Malignant glioma)

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Testim – see Testosterone

Testosterone, transdermal gel, 25mg/2.5gm packet, 50mg/5gm packet (AndroGel-BGP); 50mg/5gm tube (Testim-PAL)

For the treatment of congenital and acquired primary or secondary hypogonadism in males with a specific diagnosis of;

Primary - Cryptorchidism, Klinefelter's, orchiectomy, and other established causes.

Secondary - Pituitary-hypothalamic injury due to tumors, trauma, radiation. Testosterone deficiency should be clearly demonstrated by clinical features and confirmed by two separate biochemical tests before initiating any testosterone therapy. Limited to 5 g/day gel.

Older males with non-specific symptoms of fatigue, malaise or depression who have low testosterone (T) levels do not satisfy these criteria.

Testosterone Undecanoate, capsule, 40mg (Generics)

For patients with a documented deficiency in whom treatment with depo-testosterone products have been unsuccessful, intolerable or are medically contraindicated.

Tezepelumab, prefilled pen, prefilled syringe, 210mg/1.91mL (Tezspire-AZE)

For the treatment of severe asthma in patients 12 years and older who are inadequately controlled with high-dose inhaled corticosteroids (ICS), and one or more additional asthma controller(s) (e.g., long-acting beta-agonist), and have experienced 2 or more clinically significant asthma exacerbations in the past 12 months.

Initial Discontinuation Criteria:

- Baseline asthma control questionnaire score has not improved at 12 months since initiation of treatment, or
- No decrease in the daily maintenance OCS dose in the first 12 months of treatment, or

- The number of clinically significant asthma exacerbations has increased within the previous 12 months.

Subsequent Discontinuation Criteria:

- Asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
- The reduction in the daily maintenance dose of OCS achieved after the first 12 months of treatment is not maintained or improved subsequently, or
- The number of clinically significant asthma exacerbations has increased within the previous 12 months.

Clinical Notes:

- A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be provided.
- A baseline and annual number of clinically significant asthma exacerbations must be provided.
- High dose ICS is defined as ≥ 500 mcg of fluticasone propionate or equivalent daily dose.
- A significant clinical exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized.

Claim Notes:

- Must be prescribed by a respirologist, clinical immunologist, allergist or internist experienced in the treatment of severe asthma.
- Combined use of tezepelumab with other biologics used to treat asthma will not be reimbursed.
- Approvals will be for a maximum of 210mg subcutaneous injection every 4 weeks.
- Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Tezspire – see Tezepelumab

Tildrakizumab, prefilled syringe, 100mg/mL (Ilumya-SUN)

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of $>10\%$ and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND

- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score ; or
- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum of 100mg at week 0, week 4, and every 12 weeks thereafter. If response criteria is met at 16 weeks, approvals will be continued to a maximum dose of 100mg every 12 weeks up to one year.
- Initial Approval: 16 weeks.
- Renewal Approval: 1 year.
- Concurrent use of biologics not approved.

Requests must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Thyrogen - see Thyrotropin

Thyrotropin, injection, 0.9mg.mL (Thyrogen-GZY)

For use as a single agent in patients who have documented evidence of thyroid cancer, who have undergone appropriate surgical and/or medical management, and require on-going evaluation to monitor for recurrence and metastatic disease. This includes:

- a) Primary use in patients with inability to raise an endogenous TSH level (≥ 25 mu/L) with thyroid hormone withdrawal.

- b) Primary use in cases of documented morbidity in patients for whom severe hypothyroidism could be life threatening, such as unstable angina, recent myocardial infarction, class III to IV congestive heart failure, or uncontrolled psychiatric illness.
- c) Secondary use in patients with previous thyroid hormone withdrawal resulting in a documented life-threatening event.

(This criteria is for patients of the Catastrophic Drug Program, only)

- d) As a single agent for the preparation of radioiodine remnant ablation in patients with papillary or follicular thyroid cancer who have undergone thyroidectomy as treatment for thyroid cancer. Thyrotropin may be used in new patients or patients with previously incomplete remnant ablation or who have a recurrence of thyroid cancer and require therapeutic remnant ablation.

Ticagrelor, tablet, 90mg (Brilinta – AZE and generic)

To be taken in combination with ASA 75mg -150mg daily^a for patients with acute coronary syndrome (i.e. ST elevation myocardial infarction (STEMI), non-ST elevation myocardial infarction (NSTEMI), or unstable angina (UA), as follows:

STEMI^{bc}

- STEMI patients undergoing primary PCI

NSTEMI or Unstable Angina^{bc}

- Presence of high risk features irrespective of intent to perform revascularization:
 - High GRACE risk score (>140)
 - High TIMI risk score (5-7)
 - Second ACS within 12 months
 - Complex or extensive coronary artery disease e.g. diffuse three vessel disease
 - Definite documented cerebrovascular or peripheral vascular disease
 - Previous CABG

OR

- Undergoing PCI + high risk angiographic anatomy^d

Notes:

- a) Co-administration of ticagrelor with high maintenance dose ASA (>150mg daily) is not recommended.
- b) In the PLATO study more patients on ticagrelor experienced non CABG related major bleeding than patients on clopidogrel, however, there was no difference between the rate of overall major bleeding, between patients treated with ticagrelor and those treated with clopidogrel. As with all other antiplatelet

treatments the benefit/risk ratio of antithrombotic effect vs. bleeding complications should be evaluated.

- c) Ticagrelor is contraindicated in patients with active pathological bleeding, in those with a history of intracranial hemorrhage and moderate to severe hepatic impairment.
- d) High risk angiographic anatomy is defined as any of the following: left main stenting, high risk bifurcation stenting (i.e., two-stent techniques), long stents ≥ 38 mm or overlapping stents, small stents ≤ 2.5 mm in patients with diabetes.

Approval will be for a maximum of 12 months.

Ticlopidine HCL, tablet, 250mg (Generics)

- For the secondary prevention of the ischemic stroke or transient ischemic attack (TIA) in patients with a documented severe allergy to ASA (manifested by anaphylactic reaction, asthma, or nasal polyps) or who experience a recurrent thrombotic event (stroke, symptoms of TIA) while taking ASA; or
- For the prevention of thrombosis in patients post intra coronary stent implantation for a period of up to six months.

GI intolerance to ASA is not considered a criterion for coverage of Ticlopidine, although severe cases (e.g. gastric ulceration or bleeds) may be considered.

Tinzaparin – see Low Molecular Weight Heparins

Tiotropium - see Chronic Obstructive Pulmonary Disease

Tipranavir, capsule, 250mg (Aptivus-BOE)

For the treatment of adult patients with HIV-1 infection who are treatment experienced, have demonstrated failure to multiple protease inhibitors and in whom no other protease inhibitor is a treatment option.

Tizanidine HCl, tablet 4mg (Generic)

For the second- line treatment for those individuals with spasticity resulting from traumatic brain injury, multiple sclerosis, spinal cord injury or cerebral vascular accident and are intolerant to or have had ineffective results from Baclofen and/or benzodiazepines.

Tocilizumab, IV Vial, 80mg/4l, 200mg/10mL, 400mg/20mL; prefilled syringe, 162mg/0.9mL; auto-injector, 162mg/0.9mL (Actemra-HLR; Tyenue-FKB)

Patients with existing PEI Pharmacare coverage for Actemra® will need to switch to a biosimilar version before July 31, 2026, or by the renewal date of their current special Authorization, whichever is earlier, to maintain coverage through PEI Pharmacare.

Giant Cell Arteritis

For the treatment of adult patients with new onset or relapsed giant cell arteritis (GCA) in combination with glucocorticoids (at initiation of therapy, or with relapse).

Initial coverage will be for 16 weeks.

- Reassessment should occur between 12 weeks and 16 weeks of therapy to determine response.

Renewal requests:

- Confirmation of response to treatment (i.e absence of flares AND normalization of C-reactive protein (CRP) to <1mg/dL)

Clinical Note:

- Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) greater or equal to 30 mm/hr attributable to GCA.

Claim Note:

- Must be prescribed by, or in consultation with, a rheumatologist or other physician experienced in the treatment of GCA.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Subcutaneous injection: Approvals will be for 162 mg every week
- Duration of therapy will be limited to 52 weeks per treatment course

Authorization may be granted following any new episode of the disease, according to the treatment terms and conditions previously mentioned for the initial episode.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Juvenile Idiopathic Arthritis

For the treatment of active systemic juvenile idiopathic arthritis (sJIA), in patients 2 years of age or older, who have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs) and systemic corticosteroids (with or without methotrexate) due to intolerance or lack of efficacy.

- Must be prescribed by, or in consultation with, a pediatric rheumatologist.
- Coverage will be approved for an IV dose of 12 mg/kg for patients weighing less than 30kg or 8 mg/kg for patients weighing greater than or equal to 30kg to a maximum of 800mg, administered every two weeks.
- Initial Approval Period: 16 weeks.
- Renewal Approval: Long term. Continued coverage will be dependent on a positive patient response as determined by a pediatric rheumatologist.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Polyarticular Juvenile Idiopathic Arthritis

For patients who have had an inadequate response to one or more disease modifying antirheumatic drugs (DMARDs).

- Must be prescribed by, or in consultation with, a pediatric rheumatologist.
- Coverage will be approved for an IV dose of 10 mg/kg for patients weighing less than 30kg or 8 mg/kg for patients weighing greater than or equal to 30kg to a maximum of 800mg, administered every four weeks.
- Initial Approval Period: 16 weeks.
- Renewal Approval: Long term. Continued coverage will be dependent on a positive patient response as determined by a pediatric rheumatologist.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

- Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks AND
- Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

IV formulation: approvals for adults is 4mg/kg/dose every four weeks, with a maximum maintenance dose escalation up to 8mg/kg, to a maximum of 800mg per infusion.

SC formulation: approvals for adults is 162mg every other week for patients less than 100kg, with a maximum maintenance dose escalation to weekly dosing permitted. Patients equal to or greater than 100kg will be approved for 162mg every week, with no dose escalation permitted

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate

must be considered.

- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: Long term. Confirmation of continued response is required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Tofacitinib, tablet, 5mg, 10mg (Xeljanz-PFI and generics); extended release tablet, 11mg (Xeljanz XR-PFI and generic)

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks
AND

Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks

NOTE:

Must be prescribed by a rheumatologist.

Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ulcerative Colitis

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4 , and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone ≥ 40 mg daily for two weeks or IV equivalent for one week) OR
- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:

- a decrease in the partial Mayo score ≥ 2 from baseline, and
- a decrease in the rectal bleeding subscore ≥ 1 .

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo > 6) do not require a trial of 5-ASA

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval is for a maximum dose of 10 mg twice daily for 16 weeks.
- Renewal of coverage will require reassessment of the patient and submission of a new Ulcerative Colitis Special Authorization form.
- Renewal: 1 year at a maximum dose of 10 mg twice daily

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs

office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Topamax – see Topiramate

Topiramate, 15mg, 25mg, sprinkle capsule (Topamax-JAN)

For patients who require topiramate, cannot take the tablet form, and require sprinkle capsules for proper administration

Tucatinib, tablet, 50mg 150mg (Tukysa-PFI)

In combination with trastuzumab and capecitabine for the treatment of patients with locally advanced unresectable or metastatic HER2-positive breast cancer who have received prior treatment with trastuzumab, pertuzumab and a HER2-targeted antibody-drug conjugate (e.g., trastuzumab emtansine or trastuzumab deruxtecan), where at least one was given in the advanced or metastatic setting.

Clinical Notes:

1. Patients should have a good performance status.
2. Treatment should be discontinued upon disease progression, unacceptable toxicity, or if both trastuzumab and capecitabine are discontinued.

* Claims that exceed the maximum claim amount of \$9999.99 must be divided as separate transactions, using DIN first and PDIN* second.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Tukysa – see Tucatinib

Toujeo Solostar– see insulin Glargine

Toujeo Doublestar – see insulin Glargine

Tracleer - see Bosentan

Trajenta – see Linagliptin

Trametinib, tablet, 0.5mg, 2mg (Mekinist-NVR)

Adjuvant Melanoma

In combination with dabrafenib for the adjuvant treatment of patients with cutaneous melanoma who meet all of the following criteria:

- Stage IIIA (limited to lymph node metastases of greater than 1 mm) to stage IIID disease (AJCC 8th edition)
- BRAF V600-mutation positive
- Completely resected disease including in-transit metastases

Clinical Notes:

1. Patients must have a good performance status.
2. Treatment should continue until disease recurrence, unacceptable toxicity, or up to a maximum of 12 months.

Claim Notes:

1. Requests will be considered for patients with regional lymph nodes with micrometastases after sentinel lymph node biopsy.
2. Requests will not be considered for patients who received adjuvant immunotherapy for greater than three months. Patients may switch to BRAF targeted therapy within the first three months of initiating immunotherapy to complete a total of 12 months of adjuvant treatment.
3. Approval Period: up to 12 months

Metastatic Melanoma

For the treatment of patients with BRAF V600 mutation-positive unresectable or metastatic melanoma when used alone or in combination with dabrafenib.

Clinical Notes:

1. Patients must have a good performance status.
2. If brain metastases are present, patients should be asymptomatic or have stable symptoms.
3. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Trelegy Ellipta – see Fluticasone & Umeclidinium & Vilanterol

Tremfya – see Guselkumab

Tretinoin, capsule, 10mg (Vesanoid - ROC and generic)

Open benefit if written by an oncologist upon notification to Pharmacare.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Triamcinolone Hexacetonide, ampule, 20mg/mL (Trispan-MED)

For the treatment of Juvenile Idiopathic Arthritis.

Trientine, capsule, 250mg (Waymade-Trientine-WMD & Mar-Trientine-MAR)

For the treatment of Wilson's disease in patients who have experienced intolerance or have a contraindication to d-penicillamine.

Clinical Notes:

- Intolerance is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

1. Treatment must be initiated by clinicians experienced in the management of Wilson's disease for adult patients 18 years of age or older.
2. Treatment must be initiated and renewed by clinicians experienced in the management of Wilson's disease for patients less than 18 years of age.

Trifluridone & Tipiracil, tablet, 15mg & 6.14mg, 20mg & 8.19mg (Lonsurf-TAI)**Metastatic Gastric Cancer Or Adenocarcinoma Of The Gastroesophageal Junction**

For the treatment of adult patients with metastatic gastric cancer or adenocarcinoma of the gastroesophageal junction who meet the following criteria:

- Previously treated with at least two prior lines of chemotherapy including a fluoropyrimidine, a platinum, and either a taxane or irinotecan and if appropriate, with HER2-targeted therapy.
- Patients should have a good performance status.

Clinical notes:

- Trifluridine/tipiracil should be used in combination with best supportive care
- Treatment should be discontinued upon disease progression or unacceptable toxicity
- Requests will be considered for patients who have an intolerance or contraindication to platinum-based therapy

Unresectable or Metastatic Colorectal Cancer

In combination with bevacizumab for the treatment of adult patients with unresectable or metastatic colorectal cancer who:

- Have previously been treated with, or are not candidates for, available therapies including fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapies, anti-VEGF biological agents, and, if RAS wild-type, anti-EGFR agents; and
- Have disease progression or demonstrated intolerance to a maximum of 2 prior chemotherapy regimens for the treatment of unresectable or metastatic colorectal cancer.

Clinical Notes:

- Patients should have a good performance status.
- Treatment should continue until disease progression or unacceptable toxicity.
- No active CNS metastases (eligible if treated/stable).
- Patients with small bowel or appendiceal adenocarcinoma are eligible.
- Patients who were unable to receive bevacizumab in a prior line of therapy due to a contraindication will be eligible.
- Patients who have received adjuvant/neoadjuvant chemotherapy and had recurrence during or within 6 months of completion can count the adjuvant/neoadjuvant therapy as 1 of the maximum of 2 required prior chemotherapy regimens. Regimens which contain only targeted therapy or immunotherapy will not be considered as chemotherapy regimens.
- If bevacizumab is discontinued due to intolerance or contraindication, trifluridine-tipiracil can be continued at the discretion of the physician.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Triheptanoin, oral liquid, 8.3kcal/mL (Dojolvi-UGX)

For the treatment of adult and pediatric patients with an acute life-threatening long-chain fatty acid oxidation disorder (LC-FAOD) who meet the following criteria:

- patients with a confirmed diagnosis of LC-FAOD and acute life-threatening events who require alternative therapy to conventional even-chain medium-chain triglyceride (MCT) supplementation, OR
- patients without a confirmed diagnosis of LC-FAOD presenting with acute life-threatening events consistent with LC-FAOD who require alternative therapy to conventional even-chain MCT supplementation.

Claim Notes:

1. Triheptanoin should only be prescribed by clinicians experienced in the management of LC-FAOD.
2. Approval: 1 year. Confirmation of continued response required.

* Claims that exceed the maximum claim amount of \$9999.99 must be divided as separate transactions, using DIN first and PDIN* second.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Trikafta – see Elexacaftor & Tezacaftor & Ivacaftor & Ivacaftor

Trileptal - see Oxcarbazepine

Trispan – see Triamcinolone Hexacetonide

Trosec - see Trospium

Trospium, tablet, 20mg (Trosec-SNV)

For the treatment of over-active bladder (not stress incontinence) after a reasonable trial (e.g. 3 months) of immediate release oxybutynin, solifenacin, or tolterodine is not tolerated.

Truxima – see Rituximab

Turdoze Genuair – see Acridinium Bromide

Tyenne - see Tocilizumab

Tysabri – see Natalizumab

Ultibro Breezhaler – see Indacaterol & Glycopyrronium

Ultomiris – see Ravulizumab

Upadacitinib, extended release tablet, 15 mg, 30 mg, 45 mg (Rinvoq-ABV)

Ankylosing Spondylitis (15mg Tab)

For the treatment of patients with moderate to severe ankylosing spondylitis (Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:

- a) have axial symptoms and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation or in whom NSAIDs are contraindicated OR

- b) have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months observation and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.

*Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease, do not require a trial of NSAIDs alone.

Claim Notes:

- Approvals will be for a maximum dosage of 15mg once daily
- Combined use with biologic DMARDs or other JAK inhibitor treatments for active AS will not be reimbursed
- Initial Approval: 6 months
- Renewal Approval: Maximum of 12 months.
- Requests for renewal must include information showing the beneficial effects of the treatment, specifically:
 - a) a decrease of at least two points on the BASDAI scale, compared with pretreatment score OR
 - b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients must also apply for coverage through the High Cost Drug Program. The patient application is available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Atopic Dermatitis (15mg & 30mg Tab)

For the treatment of moderate to severe atopic dermatitis (AD) in patients 12 years of age and older who meet all of the following criteria:

Patients must have had an adequate trial (with a documented refractory disease), or were intolerant (with documented intolerance), or are ineligible for each of the following therapies:

- maximally tolerated medical topical therapies for AD combined with phototherapy (where available), and;
- maximally tolerated medical topical therapies for AD combined with at least 1 of the 4 systemic immunomodulators (methotrexate, cyclosporine, mycophenolate mofetil, or azathioprine).

AND

Baseline Physician Global Assessment score of 3 or greater and Eczema Area and Severity Index (EASI) of 7.1 or greater.

Renewal criteria:

- Requests for renewal must provide proof of beneficial clinical effect defined as a 75% or greater improvement from baseline in the Eczema Area and Severity Index (EASI-75) score six months after treatment initiation.
- Proof of maintenance of EASI-75 response from baseline must be provided for subsequent authorizations.

Clinical Note:

- Not to be used in combination with phototherapy or any immunomodulatory drugs (including biologics) or a Janus kinase inhibitor treatment for moderate-to-severe AD.

Claim Notes:

- The patient must be under the care of a dermatologist, allergist, clinical immunologist, or pediatrician who has expertise in the management of moderate to severe AD.
- Approvals will be for a maximum of 30 mg daily.
- Initial Approval Period: 6 months.
- Renewal Approval Period: 1 year.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Crohn's Disease (15mg, 30mg & 45mg Tab)

For the treatment of patients with moderate to severe Crohn's disease who have active disease and are refractory, intolerant or have contraindications to:

- Prednisone 40mg (or equivalent) daily for ≥ 2 weeks, AND
- Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
- Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
- Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:

- Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
- Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients who have an aggressive/severe disease course (e.g. extensive disease, a

modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.

Claim notes:

- Approvals will be for a maximum of 45mg daily for 12 weeks, followed by a maximum of 30mg daily.
- Initial Approval Period: 16 weeks
- Renewal Approval: 1 year. Maximum approved dose is 30 mg daily. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD or other JAK inhibitor treatment for CD will not be reimbursed.

The request for coverage must be made by a gastroenterologist using the Crohn's Disease Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Psoriatic Arthritis (15mg Tab)

For the treatment of predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs at a maximum tolerated dose for a minimum of two weeks each.

For the treatment of predominantly peripheral psoriatic arthritis who are refractory or intolerant or have contraindications to:

- Sequential use of at least two NSAIDs at a maximum tolerated dose for a minimum of two weeks each; and
- Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; and
- Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.

- Combined use with other biologic drugs will not be reimbursed.
- Approvals will be for a maximum of 15 mg daily.
- Initial Approval 16 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms> .

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Rheumatoid Arthritis (15mg Tab)

For the treatment of moderately to severely active rheumatoid arthritis, alone or in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant or have contraindications to:

- Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age), for a minimum of 12 weeks AND
- Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
- 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. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use with other biologic drugs or janus kinase inhibitors will not be reimbursed.
- Approvals will be for a maximum of 15 mg daily.

- Initial Approval: 6 months
- Renewal Approval: 1 year. Confirmation of continued response is required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ulcerative Colitis (15mg, 30mg & 45mg Tab)

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4 , and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone ≥ 40 mg daily for two weeks or IV equivalent for one week) OR
- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo > 6) do not require a trial of 5-ASA

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Approvals will be for a maximum of 45 mg daily for 8 weeks followed by a maximum of 30 mg daily. Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:
 - a decrease in the partial Mayo score ≥ 2 from baseline, and a decrease in the rectal bleeding subscore ≥ 1 .
- Initial Approval: 12 weeks
- Renewal Approval: 1 year. Maximum approved dose is 30 mg daily
- Combined use of more than one biologic DMARD or JAK inhibitor for UC will not be reimbursed.

The request for coverage must be made by a gastroenterologist using the

Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Uptravi – see Selexipag

Urispas - see Flavoxate

Ustekinumab, syringe, 45mg/0.5mL, 90mg/mL (Jamteki-JPC; Steqeyma-VTX, Wezlana-AMG); vial, 45mg/0.5mL (Wezlana-AMG); vial, 130mg/26mL (Steqeyma-VTX)

Plaque Psoriasis

For patients with severe, debilitating chronic plaque psoriasis who meet all of the following:

- Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals;
- Failure to, contraindication to or intolerant of methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 12 weeks or cyclosporine for a minimum of 6 weeks; AND
- Failure to, intolerant of or unable to access phototherapy.

Continued coverage is dependent on evidence of improvement, specifically:

- A >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score; or
- A >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or
- Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

Clinical Note:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Failure is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Treatment should be discontinued if a response has not been demonstrated after 16 weeks.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim notes:

- Approvals will be for a maximum adult dose of up to 90 mg at 0, 4, and 16 weeks. If response criteria is met at 16 weeks, approval will be continued to a maximum dose of up to 90 mg every 12 weeks up to one year.
- Initial Approval: 16 weeks.
- Renewal Approval: Long term. Confirmation of continued response is required.
- Concurrent use of biologics not approved.

Requests must be made by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ustekinumab, syringe, 45mg/0.5mL, 90mg/mL (Jamteki-JPC; Steqeyma-VTX, Wezlana-AMG); vial, 45mg/0.5mL (Wezlana-AMG); vial, 130mg/26mL (Steqeyma-VTX)

Psoriatic Arthritis

- 1) For the treatment of patients with predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.
- 2) For the treatment of predominantly peripheral psoriatic arthritis who are refractory, intolerant or have contraindications to:
 - Sequential use of at least two NSAIDs for a minimum of two weeks each; AND
 - Methotrexate (oral or parenteral) at a dose of $\geq 20\text{mg}$ weekly ($\geq 15\text{mg}$ if patient is ≥ 65 years of age) for a minimum of 8 weeks; AND
 - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be 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 to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Concurrent use of biologics not approved.

- Initial Approval: 6 months.
- Approvals will be for a maximum of 45mg subcutaneously at Weeks 0 and 4, and maintenance dosing of 45mg subcutaneously every 12 weeks. For patients >100kg, doses of 90mg may be considered.
- Renewal Approval: Long term. Confirmation of continued response required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ustekinumab, vial, 45mg/0.5mL; syringe, 45mg/0.5mL, 90mg/mL (Steqeyma-VTX, Wezlana I.V.-AMG); vial, 130mg/26mL (Steqeyma-VTX, Wezlana I.V.-AMG)

Crohn's Disease

For the treatment of patients with moderate to severe Crohn's disease who have active disease and are refractory, intolerant or have contraindications to:

- Prednisone 40mg (or equivalent) daily for ≥ 2 weeks, AND
- Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
- Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
- Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:

- Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
- Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients who have an aggressive/severe disease course (e.g. extensive disease, a modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.

- Combined use with other biologic drugs or janus kinase (JAK) inhibitors will not be reimbursed.
- Initial reimbursement will be for a single intravenous dose of up to 520mg at Week 0 and a subcutaneous dose of 90mg at Week 8 and 16. Subsequent reimbursement for maintenance dosing is 90mg subcutaneously every 8 weeks.
- Initial Approval: 16 weeks
- Renewal Approval: Long term. Confirmation of continued response is required.

The request for coverage must be made by a gastroenterologist using the Crohn's Disease Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ulcerative Colitis

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone ≥ 40mg daily for two weeks or IV equivalent for one week) OR
- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo > 6) do not require a trial of 5-ASA

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial reimbursement will be for a single intravenous dose of up to 520mg at Week 0 and a subcutaneous dose of 90mg at Week 8 and 16. Subsequent reimbursement for maintenance dosing is 90mg subcutaneously every 8 weeks.

- Initial Approval: 16 weeks
- Renewal Approval: Long term. Confirmation of continued response is required.

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Vabysmo – see Faricimab

Valcyte - see Valganciclovir

Valganciclovir, tablet, 450mg (Valcyte-CAG and generics)

- For the treatment of cytomegalovirus (CMV) retinitis in patients with AIDS.
- For the prevention of cytomegalovirus (CMV) disease in solid organ transplant patients at risk (where either the donor or the recipient is CMV +).

Valganciclovir, oral suspension, 50mg/mL (Valcyte-XPI)

Requests for oral suspension will be considered for patients when oral tablets are not an option, for the following indications:

- For the treatment of cytomegalovirus (CMV) retinitis in patients with AIDS.
- For the prevention of cytomegalovirus (CMV) disease in solid organ transplant patients at risk (where either the donor or the recipient is CMV +).

Vandetanib, tablet, 100mg, 300mg (Caprelsa-GZY)

For the treatment of symptomatic and/or progressive medullary thyroid cancer (MTC) in patients with unresectable locally advanced or metastatic disease.

Treatment should be for patients with a good performance status and should continue until disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Vascepa – see Icosapent ethyl

Vedolizumab, prefilled pen, prefilled syringe (108 mg/0.68 mL), vial, 300mg (Entyvio-TAK)

Crohn's Disease

For the treatment of patients with moderate to severe Crohn's disease who have active disease and are refractory, intolerant or have contraindications to:

- Prednisone 40mg (or equivalent) daily for ≥ 2 weeks, AND
- Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
- Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
- Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:

- Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
- Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients who have an aggressive/severe disease course (e.g. extensive disease, a modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.

Claim notes:

- Intravenous infusion: Initial Approval for adults is for induction doses of 300mg at weeks 0, 2, and 6.
- Subcutaneous injection: Approvals will be for a maximum of 108 mg every two weeks following at least two intravenous infusions of vedolizumab. Renewal of coverage will require reassessment of the patient and submission of a new Crohn's Disease Special Authorization form. Continued coverage may be approved at a dose not exceeding 300mg every 8 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a gastroenterologist using the Crohn's Disease Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Ulcerative Colitis

For the treatment of adult patients with moderately to severely active ulcerative colitis

who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:

- Refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks AND prednisone ≥ 40mg daily for two weeks or IV equivalent for one week) OR
- Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Intravenous infusion: Initial Approval is for induction doses of 300mg at weeks 0, 2, and 6, then 300 mg every eight weeks.
- Subcutaneous injection: Approvals will be for a maximum of 108 mg every two weeks following at least two intravenous infusions of vedolizumab. Renewal of coverage will require reassessment of the patient and submission of a new Ulcerative Colitis Special Authorization form.
- Continued coverage will be approved at a dose not exceeding 300mg every 8 weeks.

Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:

- a decrease in the partial Mayo score ≥ 2 from baseline, and
 - a decrease in the rectal bleeding subscore ≥ 1.
-
- Combined use of more than one biologic DMARD will not be reimbursed.

Clinical Notes:

- 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. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease (partial Mayo > 6) do not require a trial of 5-ASA

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at <http://www.princeedwardisland.ca/pharmacareforms>

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Velaglucerase alfa, vial, 400 unit (VPRIV-SHR)

For patients with Gaucher disease type 1 (GD1) who meet established clinical criteria.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Velphoro – see Sucroferric oxyhydroxide

Vemurafenib, tablet, 240mg (Zelboraf-HLR)

As a first line, single agent for the treatment of BRAF V600 mutation positive unresectable or metastatic melanoma in patients with an ECOG performance status (PS) of 0 or 1. For BRAF V600 mutation positive patients who have progressed after first line treatment prior to vemurafenib availability, funding or vemurafenib as a second line agent may be considered.

OR

For use in combination with cobimetinib, for the treatment of patients with previously untreated BRAF V600 mutation-positive unresectable stage III or IV melanoma who have a good performance status. Treatment should continue until unacceptable toxicity or disease progression. If brain metastases are present, patients should be asymptomatic or have stable symptoms.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Venclexta – see Venetoclax

Venetoclax, tablet, starter pack, 10mg, 50mg 100mg (Venclexta-ABV)

1. Monotherapy:
 - As monotherapy in patients with chronic lymphocytic leukemia (CLL) who have received at least one prior therapy and who have failed a B-cell receptor inhibitor (BCRi).
 - Patients should have good performance status and treatment should be continued until disease progression or unacceptable toxicity.
2. Combination therapy:
 - As combination therapy with rituximab for the treatment of adult patients with chronic lymphocytic leukemia (CLL) who have received at least one prior therapy, irrespective of their 17p deletion status.
 - Patients should be continued until disease progression or unacceptable toxicity up

to a maximum of two years, whichever comes first.

Clinical Notes:

- Patients currently receiving and responding to venetoclax monotherapy, but who have not achieved an adequate response are eligible to have rituximab added to venetoclax. The funded duration of venetoclax therapy from the point rituximab addition will be up to a maximum of 2 years.
- Patients may be re-treated with venetoclax plus rituximab if they responded to and completed two years of therapy with at least 12 months of progression-free interval.
- Patients with relapsed CLL will be eligible for sequencing venetoclax + rituximab and ibrutinib in second or third line settings, for either intolerance or disease progression, providing patients have not received prior treatment with either option and meet all other funding criteria.

3. Combination therapy:

- In combination with obinutuzumab for the treatment of adult patients with previously untreated chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) who are fludarabine ineligible.

Clinical Notes:

- Treatment should be given for a total of 12 months (six 28-day cycles in combination with obinutuzumab, followed by six months of monotherapy), or until disease progression or unacceptable toxicity, whichever occurs first.
- Retreatment with a venetoclax based regimen is funded if relapse is greater than 12 months from completion of venetoclax in combination with obinutuzumab.
- Either ibrutinib or acalabrutinib is funded as a subsequent treatment option, provided all other funding criteria are met.

4. Combination therapy:

- In combination with azacitidine for the treatment of patients with newly diagnosed acute myeloid leukemia (AML) who are 75 years of age or older, or who have comorbidities that preclude the use of intensive induction chemotherapy.

Clinical Notes:

- Treatment should continue until disease progression or unacceptable toxicity.
- All newly diagnosed AML patients who are ineligible for induction chemotherapy are eligible regardless of cytogenetic risk.
- On a time-limited need, patients who are currently receiving azacitidine for newly diagnosed AML may have venetoclax added to their treatment provided there is no disease progression and patient otherwise meets criteria.

Claim Notes:

- Patients who have been previously treated with a hypomethylating agent or chemotherapy for the treatment of myelodysplastic syndromes (MDS) are not eligible for treatment with venetoclax in combination with azacitidine.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Verkazia – see Cyclosporine

Verzenio – see Abemaciclib

Vesanoid – see Tretinoin

Vigabatrin, tablet, 500mg (Sabril-LUD)

- Vigabatrin is an alternative treatment option for patients who have had an inadequate response or intolerance to other antiepileptic drug combinations
- A restricted benefit status is appropriate due to the risk of ophthalmological adverse effects associated with vigabatrin

Vigamox – see Moxifloxacin

Vismodegib, capsule, 150mg (Erivedge-HLR)

For the treatment of locally advanced BCC (including basal cell nevus syndrome i.e. Gorlin syndrome who are 18 years of age and older) in patients who are inappropriate for surgery and radiotherapy based on a discussion/evaluation with other members of the multi-disciplinary team OR
As a single agent for the treatment of measurable metastatic basal cell carcinoma (BCC)

Clinical Note:

1. Patients must have an ECOG performance status of ≤ 2

Note: Vismodegib (Erivedge) is only available through a controlled distribution program called the Erivedge Pregnancy Prevention Program (EPPP). Under this program, only prescribers and pharmacies registered with the program are able to prescribe and dispense the product, respectively. In addition, Vismodegib can only be dispensed to patients who are registered and meet all the conditions of the EPPP.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Vitrakvi – see Larotrectinib

Vocabria – see Cabotegravir

Volibris – see Ambrisentan

Voriconazole, tablet, 50mg, 200mg (Vfend-PFI and generics)

Candidemia: For the treatment of culture proven invasive candidiasis with documented resistance to fluconazole.

Aspergillosis, invasive: For the management of invasive aspergillosis. Initial requests will be approved for a maximum of 3 months.

Must be prescribed in consultation with a specialist in infectious diseases or medical microbiology.

Vosevi – see Sofosbuvir & Velpatasvir & Voxilaprevir

Votrient – see Pazopanib

VPRIV – see Velaglucerase Alfa

Vraylar – see Cariprazine

Vyalev – see Foslevodapa & Foscarbidopa

Vyepti – see Eptinezumab

Vyndaqel – see Tafamidis meglumine

Vyndamax – see Tafamidis

Vyvanse – see Lisdexamfetamine

Wezlana – see Ustekinumab

Wyost – see Denosumab

Xalkori – see Crizotinib

Xeljanz – see Tofacitinib

Xeljanz XR – see Tofacitinib

Xolair – see Omalizumab

Xospata – see Gilteritinib

Xpovio – see Selinexor

Xtandi – see Enzalutamide

Yuflyma - see Adalimumab

Zanubrutinib, capsule, 80mg (Brukinsa-BIG)

Chronic Lymphocytic Leukemia

1. As monotherapy for adult patients with previously untreated chronic lymphocytic leukemia (CLL) / small lymphocytic lymphoma (SLL) for whom fludarabine-based treatment is inappropriate due to high-risk cytogenetic markers (i.e., del17p, TP53 mutation, or unmutated IGHV).
2. As monotherapy for the treatment of adult patients with relapsed or refractory CLL / SLL who have received at least one prior systemic therapy.

Clinical Notes:

1. Patients must have a good performance status and no evidence of prolymphocytic leukemia or Richter's transformation.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Requests will not be considered for patients who experience disease progression on a Bruton's tyrosine kinase (BTK) inhibitor or idelalisib.
- Approval Period: 1 year.

Relapsed Or Refractory Waldenström Macroglobulinemia

For the treatment of adult patients with relapsed or refractory Waldenström macroglobulinemia who have received at least one prior therapy and have not experienced disease progression on a Bruton's tyrosine kinase inhibitor.

Clinical Notes:

1. Patients must meet at least one criterion for treatment as per IWWM consensus panel.
2. Patients must have a good performance status and no evidence of disease transformation.
3. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Prescriptions written by PEI oncologists do not require written Special Authorization.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at <http://www.princeedwardisland.ca/pharmacareforms>.

Zaxine – see Rifaximin

Zejula – see Niraparib

Zelboraf – see Venurafenib

Zeposia – see Ozanimod

Ziextenzo – see Pegfilgrastim

Ziprasidone hydrochloride. Capsule, 20mg, 40mg, 60mg, 80mg (Zeldox-PFI and generic)

For the treatment of schizophrenia and schizoaffective disorders in patients who have a contraindication to a trial of at least TWO less expensive antipsychotic agents because of intolerance or lack of response.

Zithromax - see Azithromycin

Zofran - see Ondansetron

Zydelig – see Idelalisib

Zykadia – see Ceritinib

Zymar – see Gatifloxacin

Zytiga – see Abiraterone

Zyvoxam - see Linezolid

APPENDIX B

Links to Drug Program Forms

Special Authorization Forms

[Ankylosing Spondylitis Special Authorization Form](#)

[Crohn's Disease Special Authorization Form](#)

[DPP-4/SGLT2 Inhibitors](#)

[Enfuvirtide Special Authorization Form](#)

[Nintedanib / Pirfenidone Special Authorization Form](#)

[Paxlovid Special Authorization Form](#)

[Plaque Psoriasis Special Authorization Form](#)

[Psoriatic Arthritis Special Authorization Form](#)

[Retinal Disease Treatment Special Authorization Form](#)

[Rheumatoid Arthritis Special Authorization Form](#)

[Semaglutide Special Authorization Request Form](#)

[Standard Special Authorization Form](#)

[Ulcerative Colitis Special Authorization Form](#)

Program Application Forms

[Catastrophic Drug Program Application Form](#)

[Glucose Sensor Program](#)

[Diabetes Drug Program Application](#)

[Erythropoietin Program Approval Form](#)

[Family Health Benefits Drug Program - Application Form](#)

[High Cost Drug Program - Application Form](#)

[Home Oxygen Program - Application Form](#)

[Insulin Pump Program](#)

[Ostomy Supplies Program Application Form](#)

[Ostomy Supplies Program Registration Form for Health Care Providers](#)

APPENDIX C List of Manufacturer Abbreviations

AAA	AA Pharmaceuticals Inc.
ABB	Abbott Laboratories Ltd.
ABC	Abbott Diabetes Care
ABV	Abbvie Corporation
ACC	Accel Pharma
ACH	Accord Healthcare
ACS	Acerus Pharmaceuticals Corp.
ALC	Alcon Canada Inc.
ALH	Altius Healthcare
ALL	Allergan Inc.
ALY	Amylyx Pharmaceuticals
ALX	Alexion Pharma
AMB	Ambicare Pharmaceuticals In.
AMD	Amdipharm Limited
AMG	Amgen Canada Inc.
ANA	Analog Pharma
ANB	ANB Canada
ANG	Angita Pharma.
APX	Apotex Inc.
ARO	Auro Pharma Inc
ARN	Accelera Pharma Canada Inc.
APM	Amphastar Pharmaceuticals
ASN	Aspen Pharma Trading Ltd.
AST	Astellas Pharma Canada, Inc.
AVI	Avir Pharma Inc.
ATL	Laboratoire Atlas
ATN	Atnahs Pharma UK Ltd.
AVN	Sanofi-Aventis
AZE	AstraZeneca Canada Inc.
BAX	Baxter Corporation
BAY	Bayer Inc.
BCP	BioCryst Pharma
BDD	Bayer Healthcare, Diabetes Care Division
BIG	Biogen Idec Canada Inc.
BGP	BGP Pharma Ulc.
BIG	Beigene (Canada) ULC
BIN	Bionime Corporation
BLO	Bausch & Lomb Inc.
BMS	Bristol-Myers Squibb Canada
BOE	Boehringer Ingelheim (Canada) Ltd.
BOX	Biocodex S.A.
BSL	Bausch Health, Canada Inc.
CDC	Church & Dwight Canada Corp.
CEL	Celgene Inc.
CIP	Cipher Pharmaceuticals
CLT	Celltrion Healthcare Ltd.
COV	Covis Pharma Canada Ltd.
DUI	Duchesnay Inc.
D&C	D&C Mobility Solutions Inc.
EIS	Eisai Limited
ELV	Elvium Life Sciences
END	Endomedical

ERF	Erfa Canada Inc.
EPM	Essential Pharma
ETH	Ethypharm Inc.
FEI	Ferring Inc.
FKB	Fresenius Kabi Canada
FRP	Formative Pharma Inc.
FTI	Forus Therapeutics
GAC	Galderma Canada Inc.
GIL	Gilead Sciences, Inc.
GMD	GenMed, Division of Pfizer Canada
GMP	Generic Medical Partners
GSK	GlaxoSmithKline Inc.
GLM	Glenmark Generic
GZY	Sanofi Genzyme
ICL	Indivior Canada Ltd.
HLR	Hoffmann-La Roche Limited
HOS	Hospira Healthcare Corporation
JAC	Jacobus Pharmaceutical Company Inc.
JAN	Janssen Inc..
JJM	Johnson & Johnson - Merck Consumer Pharmaceuticals of Canada
JPC	Jamp Pharma
KNI	Knight Therapeutics Inc.
KYE	Kye Pharmaceuticals
LBI	Leadiant Biosciences Inc.
LEO	Leo Pharma Inc.
LIL	Eli Lilly Canada Inc.
LTH	Labtician Thea
LSN	Life Scan Canada Ltd.
LUD	Lundbeck Canada Inc.
LUP	Lupin Pharma
MRA	MantraPharma
MAR	Marcan Pharmaceuticals Inc.
MCL	McNeil Consumer Healthcare
MDN	MDA Inc.
MDU	Medunik Canada
MSR	Medisure Canada Inc.
MDA	3M Pharmaceuticals
MDP	Deciphera Pharmaceuticals
MFI	Medical Futures Inc.
MNT	Mint Pharmaceuticals
MJS	Mead Johnson Canada, Division of Bristol-Myers Squibb Canada Inc.
MRS	Merus Labs
MSD	Merck Frosst Canada Ltd.
MTP	Methapharm Inc.
MYL	Mylan Pharmaceuticals
NAT	Natco Pharma
NRA	Nora Pharma Inc.
NNO	Novo Nordisk Canada Inc.
NVR	Novartis Pharmaceuticals Canada Inc.
ODN	Odan Laboratories Ltd.
OMG	Omega Laboratories Ltd.
ORG	Organon Canada
OTS	Otsuka Canada Pharmaceuticals

PAL	Paladin Labs Inc.
PEN	Pendopharm, Division of Pharmascience Inc.
PFI	Pfizer Canada ULC
PSL	Pharma Stullin
PFR	Purdue Pharma
PGA	Proctor & Gamble Inc.
PMS	Pharmascience Inc.
PRZ	Pharmaris Canada
RAN	Ranbaxy Pharmaceuticals Canada Inc.
RCH	Dr. Reddy's Laboratory
RIV	Laboratoire Riva Inc.
ROC	Roche Diagnostics
ROG	Rougier Pharma Inc., Division of Ratiopharm Inc.
ROS	Ross Laboratories, Division of Abbott Laboratories Ltd.
RRD	Recordati Rare Diseases Canada Inc.
SDZ	Sandoz Canada Inc.
SEV	Servier Canada Inc.
SHR	Shire Biochem Inc.
SIV	Sivem Pharmaceutical
SLP	Searchlight Pharma Inc.
SNE	Smith & Nephew Inc.
SNS	Sanis Health Inc.
SRO	Serono Canada Inc.
STE	Sterimax Inc.
STM	Steri-Med Pharma Inc.
STR	Strides Pharma.
SNV	Sunovion Pharmaceuticals Canada
TAK	Takeda Canada Inc.
TAR	Taro Pharmaceuticals Inc.
TAV	Tanvex BioPharma USA
TPG	Tillotts Pharma
TRT	TerSera Therapeutics
TEV	Teva Canada Ltd.
TLG	Teligent
TRI	Trividia Health
UCB	UCB Canada Inc.
UGX	Ultragenyx Pharmaceutical
UJC	Upjohn Canada ULC
UNK	Unknown
VAL	Valeant Canada Limited
VII	VIIV Healthcare ULC
WES	WellSpring Pharmaceutical Canada
XPI	Xediton Pharmaceuticals Inc.

Appendix D Approved Vendors List *(listed in alphabetical order)*

Revised May 20,2025

Insulet Canada Insulin Pumps and Supplies

Insulin Pumps		
Device Name	Model Number	Description
Omnipod 5 Automated Insulin Delivery (AID) System Starter Kit, Locked Controller with Omnipod 5 App	SKT-CAN1-M001-G-MM	
Omnipod Insulin Management System Starter Kit (ENGLISH)	SKT-CAT45E	• 1 Personal Diabetes Manager • 1 USB Cable • 1 User guide • 1 Carrying care • 1 Software CD • 1 Choice of PDM gel skin cover (7 colors available)
Omnipod Insulin Management System Starter Kit (FRENCH)	SKT-CAT45F	
Omnipod DASH® Insulin Management System – Personal Diabetes Manager (PDM) Starter Kit [Bilingual]	SKT-CAN-D001-MM	
Pump Supplies		
Device Name	Model Number	Description
Omnipod 5 Automated Insulin Delivery (AID) System PODS	POD-OMNI-I1-6729	Box of 10 Pods.
Omnipod Insulin management System (POD)	POD-ZXR425	Internal insulin reservoir and pumping mechanism Small and lightweight • Strong adhesive • Stores personalized settings • Built-in insertion components • Durable, waterproof exterior • Customizable reminders

Medtronic of Canada Insulin Pumps and Supplies

Device Name	Model Number	Description
MiniMed 630G-Insulin Pump	MMT-1754K	Pump 3.0 reservoir capacity • Black
MiniMed 670G-Insulin Pump	MMT-1762KCN*	Pump 3.0 reservoir capacity • Black
MiniMed 770G-Insulin Pump	MMT- 1891 CN	Pump 3.0 reservoir capacity • Black
MiniMed 780G- Insulin Pump	MMT- 1895 CN	Pump 3.0 reservoir capacity • Black
Reservoir for 5 series MiniMed® Paradigm® Pump (1.8 mls reservoir)	MMT-326A	1.8 mls reservoir for use in 5 series Paradigm Insulin Pump (10 reservoirs /box)
Reservoir for 7 Series MiniMed®	MMT-332A	3.0 mls reservoir for use in 7

Paradigm® Pump (3.0mls reservoir)		series Paradigm Insulin Pump only (10 reservoirs /box)
Medtronic Extended Reservoir 3.0 ML	MMT-342	3.0 mls reservoirs (10 reservoirs per box)
Quick –Serter	MMT-305QS600	Insertion device for Quickset infusion sets
Device Name	Model Number	Description
Medtronic Extended wear infusion set 6MM – box of 3 sets	MMT-431AH	6mm cannula with 60cm (23") tubing. 3 infusion sets per box. Up to 7 day wear time
Medtronic Extended wear infusion set 9MM – box of 3 sets	MMT-441AH	9mm cannula with 60cm (23") tubing. 3 infusion sets per box. Up to 7 day wear time
Medtronic Extended wear infusion set 9MM – box of 3 sets	MMT-442AH	9mm cannula with 80cm (32") tubing. 3 infusion sets per box. Up to 7 day wear time
Medtronic Extended infusion set 6MM – box of 1 set	MMT-431AJ	6mm cannula with 60cm (23") tubing. 1 infusion set per box. Up to 7 day wear time
Medtronic Extended infusion set 9MM – box of 1 set	MMT-441AJ	9mm cannula with 60cm (23") tubing. 1 infusion set per box. Up to 7 day wear time
Medtronic Extended infusion set 9MM – box of 1 set	MMT-442AJ	9mm cannula with 80cm (32") tubing. 1 infusion set per box. Up to 7 day wear time
MiniMed Mio 30 infusion set	MMT 905A600	13mm cannula infusion set with 60cm (23 ") tubing GRAY (10 per box)
	MMT 906A600	13mm cannula infusion set with 110cm (43 ") tubing GRAY (10 per box)
Quickset® Infusion Sets • 6mm or 9mm cannula	MMT-394A600	6 mm teflon cannula infusion set with 45cm (18") tubing (10 cannula and 10 tubing / box)
Quickset® Infusion Sets(cont'd) • 6mm or 9mm cannula	MMT-399A600	6 mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)
Quickset® Infusion Sets • 6mm or 9mm cannula Quickset® Infusion Sets(cont'd) • 6mm or 9mm cannula	MMT-394A600	6 mm teflon cannula infusion set with 45cm (18") tubing (10 cannula and 10 tubing / box)
	MMT-399A600	6 mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)
	MMT-387A600	6 mm teflon cannula infusion set with 80cm (32") tubing (10 cannula and 10 tubing / box)
	MMT-398A600	6 mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
	MMT-397A600	9 mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)

	MMT-386A600	9 mm teflon cannula infusion set with 80cm (32") tubing (10 cannula and 10 tubing / box)
	MMT-396A600	9 mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
Device Name	Model Number	Description
MiniMed Mio Advance Infusion Sets <i>P cap connectors</i> - Compatible with Medtronic insulin pumps only <i>Leur Lock connectors</i>- Compatible with Non-Medtronic durable insulin pumps only	MMT-242600	6mm cannula infusion set with Length - 23 " tubing, P-cap connector, (10 cannula and 10 tubing / box) Color- Clear
	MMT-243A600	9mm cannula infusion set with Length - 23 " tubing, P-cap connector, (10 cannula and 10 tubing / box) Color- Clear
	MMT-244A600	9mm cannula infusion set with Length - 43 " tubing, P-cap connector, (10 cannula and 10 tubing / box) Color- Clear
	MMT-247600	6mm cannula infusion set with Length - 23 " tubing, Luer lock connector, (10 cannula and 10 tubing / box) Color- Clear
	MMT-248600	9mm cannula infusion set with Length - 43 " tubing, Luer lock connector, (10 cannula and 10 tubing / box) Color- Clear
mio™ Infusion Sets - All in one infusion set and insertion device 6mm or 9mm cannula	MMT-921A600	6 mm teflon cannula infusion set with 45cm (18") tubing PINK (10 cannula and 10 tubing / box)
	MMT-941A600	6 mm teflon cannula infusion set with 45cm (18") tubing BLUE (10 cannula and 10 tubing / box)
	MMT-923A600	6 mm teflon cannula infusion set with 60cm (23") tubing PINK (10 cannula and 10 tubing / box)
	MMT-943A600	6 mm teflon cannula infusion set with 60cm (23") tubing BLUE (10 cannula and 10 tubing / box)
	MMT-965A600	6 mm teflon cannula infusion set with 80cm (32") tubing CLEAR (10 cannula and 10 tubing / box)
	MMT-975A600	9 mm teflon cannula infusion set with 80cm (32") tubing CLEAR (10 cannula and 10 tubing / box)
Mio 30™	MMT-905A600	13 mm cannula infusion set with 60cm (23") tubing GRAY 10/Box
	MMT-906A600	13 mm cannula infusion set with 110cm (43") tubing GRAY 10/Box

Silhouette® Infusion Sets 13mm or 17mm cannula	MMT-371	Silhouette 43" Full Set 10/Box
	MMT-373	Silhouette 23" Full Set 10/Box
	MMT-368A600	13 mm teflon cannula infusion set with 45cm (18") tubing (10 cannula and 10 tubing / box)
	MMT-381A600	13 mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)
	MMT-383A600	13 mm teflon cannula infusion set with 80cm (32") tubing (10 cannula and 10 tubing / box)
	MMT-382A600	13 mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
	MMT-378A600	17 mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)
	MMT-384A600	17 mm teflon cannula infusion set with 80cm (32") tubing (10 cannula and 10 tubing / box)
	MMT-377A600	17 mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
	MMT- 369600	Silhouette Cannula only, 13 mm 10 cannulas / box
	MMT- 370600	Silhouette Cannula only, 17 mm 10 cannulas / box
Sure-T Infusion Sets Needle infusion set (90° angle of insertion)	MMT-862A	6mm <u>needle</u> infusion set with 45cm (18") tubing (10 needles & 10 tubing / box)
	MMT-864A	6mm <u>needle</u> infusion set with 60cm (23") tubing (10 needles & 10 tubing / box)
	MMT-866A	6mm <u>needle</u> infusion set with 80cm (32") tubing (10 needles & 10 tubing / box)
	MMT-874A	8mm <u>needle</u> infusion set with 60cm (23") tubing (10 needles & 10 tubing / box)
Additional supplies – Skin Preparation and Skin Tape		
Skin Prep Wipes	HMS-59420425	Skin Prep Adhesive wipes (box of 50)
Skin Tact Wipes	HMS-180	Skin Tact Wipes (50 / box)
Tape Dressing	MMT-134A	Polyskin Tape Dressing (100 / box)
Adhesive patch	MMT-172	Acutek Non-Sterile Sof-set Adhesive Patch (50/box)
Transparent dressing	MMT-174	IV 3000 1-Hand with Strips and Label (100 / box)
Transparent dressing	HMS-175	IV 3000 Adhesive patch Large (50/box)

Transparent dressing	HMS-66800786	IV 3000 Adhesive tape 1/3" x 2 3/4" " transparent dressing (box of 30)
Adhesive remover wipes	403120	Universal Adhesive Remover Wipes (50 / box)

Tandem Diabetes Care Canada Insulin Pumps and Supplies

Insulin Pumps		
Device Name	Model Number	Description
t:slim X2 insulin pump with Control-IQ technology v7.4	1005611	Insulin Pump with 5 year warranty
t:slim X2 insulin pump with Basal-IQ technology v6.4	1006419	Insulin Pump with 5 year warranty
Accessory Kit Included with Pump Purchase (based on pump model)	For version 7.4 1005583 EN 1005585 FR For version 6.4 1006816 EN 1006730 FR	Accessory Kit includes - t:slim™ USB Cable (6ft.) - t:slim Wall Power USB Adapter - t:slim Car Power USB Adapter - Cartridge Removal Tool - Pump Screen Protector - t:case™ Pump Case, Black - User Guide and Instructions (EN or FR)
Pump Supplies		
Device Name	Model Number	Description / Units or Measure per box
t:slim Cartridge (300 units)	1002541	300 units (3mls) cartridge for insulin, 10 cartridges per box
AutoSoft 90 infusion sets	1002817	6mm cannula infusion set with 23" (60cm) tubing, grey (10 cannula and tubing/box)
	1002818	6mm cannula infusion set with 43" (110cm) tubing, grey (10 cannula and tubing/box)
	1002819	9mm cannula infusion set with 23" (60cm) tubing, grey (10 cannula and tubing/box)
	1002820	9mm cannula infusion set with 43" (110cm) tubing, grey (10 cannula and tubing/box)
	1002821	6mm cannula infusion set with 23" (60cm) tubing, pink (10 cannula and tubing/box)
	1002822	9mm cannula infusion set with 23" (60cm) tubing, pink (10 cannula and tubing/box)
	1002823	6mm cannula infusion set with 23"

		(60cm) tubing, blue (10 cannula and tubing/box)
	1002824	9mm cannula infusion set with 23" (60cm) tubing, blue (10 cannula and tubing/box)
Pump Supplies (cont'd)		
Device Name	Model Number	Description / Units or Measure per box
AutoSoft 30 infusion sets	1002825	13mm cannula infusion set with 23" (60cm) tubing (10 cannula and tubing/box)
	1002826	13mm cannula infusion set with 23" (110cm) tubing (10 cannula and tubing/box)
VariSoft infusion sets	1002827	13mm cannula infusion set with 23" (60cm) tubing (10 cannula and tubing/box)
	1002828	13mm cannula infusion set with 32" (80cm) tubing (10 cannula and tubing/box)
	1002830	17mm cannula infusion set with 23" (60cm) tubing (10 cannula and tubing/box)
	1002832	17mm cannula infusion set with 43" (110cm) tubing (10 cannula and tubing/box)
TruSteel infusion sets	1002833	6mm needle infusion set with 23" (60cm) tubing (10 needles and tubing/box)
	1002834	6mm needle infusion set with 32" (80cm) tubing (10 needles and tubing/box)
	1002835	8mm needle infusion set, 23" (60cm) tubing (10 needles and tubing/box)
	1002836	8mm needle infusion set, 32" (80cm) tubing (10 needles and tubing/box)
Skin preparation		
Product Name	Model Number	Description / Units or Measure per box
3M Tegaderm Transparent Dressing	RP-1624W	100 dressings per box
Smith & Nephew Skin Prep wipes	MMT-173	50 wipes per box

Appendix E Eligible Ostomy Supplies List

This list details eligible categories, and examples of products within each category. This list may not be exhaustive of all examples within each category.

Skin wafers & Pouches

Hollister

- Ceraplus
- New Image
- Premier
- Karaya
- Pouchkins
- Hollihesive

Coloplast

- Sensura Mio
- Sensura
- Assura
- Easiflex

Convatec

- Natura
- Esteem synergy
- Esteem
- Activelife
- Little Ones
- Salts
- Confidence
- Harmony

Adhesive removers

- Brava
- Wipeaway
- AllKare
- Niltac
- Adapt
- Universal

Skin barrier wipes

- Peri-prep sensitive
- Brava
- AllKare
- Silesse
- Restore

Stoma powders, pastes and barrier rings

- Adapt
- Karaya

- Stomahesive
- Eakin Cohesive
- Stomapaste
- Secuplast
- Brava

Ostomy belts

- Ostomy appliance belt
- Adjustable ostomy belt
- Brava
- Adapt

Appendix F Eligible Diabetes Glucose Sensor Supplies

Sensor (pseudoDIN)	Wear time per sensor	Maximum Annual # of device	Packaged	Annual maximum # of dispenses	Quantity/Day Supply	Maximum Reimbursable Price
Medtronic Guardian Sensor (3) (97799158)	7 days	55 sensors	5 per box	11 boxes per year	5 sensors every 35 days	79.80 per sensor
Medtronic Guardian Sensor (4) (97798971)	7 days	55 sensors	5 per box	11 boxes per year	5 sensors every 35 days	79.80 per sensor
Dexcom G6 (97799136)	10 days	39 sensors	3 per box	13 boxes per year	3 sensors every 30 days	99.67 per sensor
Dexcom G7 (97798972)	10 days	39 sensors	1 per box	39 boxes per year	3 sensors every 30 days	75.00 per sensor
Libre 2 (97799075)	14 days	26 sensors	1 per box	26 boxes per year	2 sensors every 28 days	90.00 per sensor
Libre 3 Plus (97798966)	15 days	24 sensors	1 per box	24 boxes per year	2 sensors every 30 days	97.50 per sensor
Medtronic Guardian Link transmitter for Minimed 670G (97799154)	365 days	1 transmitter	1 per box	1 per year	1 transmitter every 365 days	800 per transmitter
Medtronic Guardian Link transmitter for Minimed 770G (97799071)	365 days	1 transmitter	1 per box	1 per year	1 transmitter every 365 days	800 per transmitter
Medtronic Guardian 4 transmitter for Minimed 780G (97798969)	365 days	1 transmitter	1 per box	1 per year	1 transmitter every 365 days	800 per transmitter
Medtronic Guardian Connect transmitter (97799152)	365 days	1 transmitter	1 per box	1 per year	1 transmitter every 365 days	599 per transmitter
Dexcom G6 Transmitter (97799135)	90 days	4 transmitters	1 per box	4 per year	1 transmitter every 90 days	29 per transmitter

Optional readers (for Libre) and receivers (for Dexcom) should be acquired by the patients directly through the manufacturer's Customer Care Line.

For patients who do not have a compatible smart phone, a G7 receiver may be dispensed through the Diabetes Glucose Sensor Program at no cost to the patient utilizing DIN 97798973. The pharmacy must call the Glucose Sensor Program Administrative Officer at 1-833-335-0538 to have the receiver added to the patients profile if one is needed.

Household Income Range	Co-payment per dispense period of benefit*
\$0 to \$20,000	\$0.00
\$20,001 to \$40,000	\$10.00
\$41,001 to \$50,000	\$20.00
\$50,001 to \$100,000	\$60.00
\$100,001 or greater	\$80.00

*co-payment adjustments for those with third-party insurance based on the *Drug Cost Assistance Regulations*