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.

Published by the authority of the Minister of Health and Wellness, Province of Prince Edward Island for the exclusive use of PEI Pharmacare

Updated: December 2025

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

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.
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.
Tuberculosis (TB) Drug Program (X)	Persons diagnosed with tuberculosis or who have been in close contact with a person diagnosed with tuberculosis,	Approved antibiotics	No fee.

Program (Formulary Code)	Beneficiaries	Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)	Fee
	and who have registered with the program through the Chief Health Officer.		
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: Canada's Drug Agency | CDA-AMC

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: The pCODR Expert Review Committee (pERC) | CDA-AMC

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
    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)

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 ones 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**
02367335	SANDOZ-LATANOPROST	SDZ	**FGNQSW**
02373041	MYLAN-LATANOPROST	MYL	**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		M	High Cost Drug Program
A	HIV Drug Program	N	Nursing Home/Institutional
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

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	MCL	**NW**
02380617	JAMP-PYRANTEL PAMOATE	JPC	**NW**
02535467	RIVA-PYRANTEL PAMOATE	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	SDZ	**CFGNQSW**
02502372	TOBRAMYCIN SULFATE	STE	**CFGNQSW**
02533103	TOBRAMYCIN	JPC	**CFGNQSW**

08:12.04 ANTIBIOTICS ANTIFUNGALS

FLUCONAZOLE

50MG TABLET

02236978	TEVA-FLUCONAZOLE	TEV	**AFGNQSW**
02237370	APO-FLUCONAZOLE	APX	**AFGNQSW**
02245292	MYLAN-FLUCONAZOLE	MYL	**AFGNQSW**
02245643	PMS-FLUCONAZOLE	PMS	**AFGNQSW**
02281260	ACT-FLUCONAZOLE	TEV	**AFGNQSW**
02517396	FLUCONAZOLE	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	ODN	**FNQSVW**
02432773	AURO-CEFIXIME	ARO	**FGNQSVW**

100MG/5ML ORAL SUSPENSION

00868965	SUPRAX	ODN	**FNQSW**
02468689	AURO-CEFIXIME	ARO	**FGNQSW**

CEFPROZIL

250MG TABLET

02293528	TARO-CEFPROZIL	TAR	**FGNQSW**

500MG TABLET

02293536	TARO-CEFPROZIL	TAR	**FGNQSW**
02347253	AURO-CEFPROZIL	ARO	**FGNQSW**

25MG/ML ORAL SUSPENSION

02329204	TARO-CEFPROZIL	TAR	**FGNQSW**
02347261	AURO-CEFPROZIL	ARO	**FGNQSW**

50MG/ML ORAL SUSPENSION

02293579	TARO-CEFPROZIL	TAR	**FGNQSW**
02347288	AURO-CEFPROZIL	ARO	**FGNQSW**

CEFTRIAXONE

1.0G/VIAL INTRAMUSCULAR INJECTION

02287633	CEFTRIAXONE FOR SODIUM	TEV	**NQ**
02292270	CEFTRIAXONE	SDZ	**NQ**
02325616	CEFTRIAXONE SODIUM	STE	**NQ**

CEFUROXIME AXETIL

250MG TABLET

02244393	APO-CEFUROXIME	APX	**CFGNQSW**
02344823	AURO-CEFUROXIME	ARO	**CFGNQSW**
02547198	JAMP-CEFUROXIME	JPC	**CFGNQSW**

500MG TABLET

02244394	APO-CEFUROXIME	APX	**CFGNQSW**
02344831	AURO-CEFUROXIME	ARO	**CFGNQSW**
02547201	JAMP-CEFUROXIME	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**
02471140	LUPIN-CEPHALEXIN	LUP	**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**
02471159	LUPIN-CEPHALEXIN	LUP	**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

250MG TABLET

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

SEE APPENDIX A FOR SA CRITERIA

600MG TABLET

02261642	PMS-AZITHROMYCIN (SA)	PMS	**ACFGNQSWX**

20MG/ML ORAL SUSPENSION

02332388	SANDOZ-AZITHROMYCIN	SDZ	**ACFGNQSWX**
02482363	AURO-AZITHROMYCIN	ARO	**ACFGNQSWX**

40MG/ML ORAL SUSPENSION

02332396	SANDOZ-AZITHROMYCIN	SDZ	**ACFGNQSWX**
02482371	AURO-AZITHROMYCIN	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-DOXYCYLINE	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**
02399245	SANDOZ-VORICONAZOLE (SA)	SDZ	**FGNQSW**
02525771	JAMP-VORICONAZOLE (SA)	JPC	**FGNQSW**

200MG TABLET

02256479	VFEND (SA)	PFI	**FNQSW**
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	APX	**AFGNQSW**
02242784	MYLAN-ACYCLOVIR	MYL	**AFGNQSW**
02285959	TEVA-ACYCLOVIR	TEV	**AFGNQSW**
02524708	MINT-ACYCLOVIR	MNT	**AFGNQSW**

400MG TABLET

02207648	APO-ACYCLOVIR	APX	**AFGNQSW**
02242463	MYLAN-ACYCLOVIR	MYL	**AFGNQSW**
02285967	TEVA-ACYCLOVIR	TEV	**AFGNQSW**
02524716	MINT-ACYCLOVIR	MNT	**AFGNQSW**

800MG TABLET

02207656	APO-ACYCLOVIR	APX	**AFGNQSW**
02242464	MYLAN-ACYCLOVIR	MYL	**AFGNQSW**
02285975	TEVA-ACYCLOVIR	TEV	**AFGNQSW**
02524724	MINT-ACYCLOVIR	MNT	**AFGNQSW**

FAMCICLOVIR

125MG TABLET

02229110	FAMVIR	ATN	**AFNQSW**
02292025	APO-FAMCICLOVIR	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)

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**
02544954	JAMP-NITROFURANTOIN BID	JPC	**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

250MG TABLET

02371065	ZYTIGA	JAN	**NMQW**
02477114	REDDY-ABIRATERONE	RCH	**NMQW**
02486393	SANDOZ-ABIRATERONE	SDZ	**NMQW**
02491397	APO-ABIRATERONE	APX	**NMQW**
02492601	PMS-ABIRATERONE	PMS	**NMQW**
02494132	NAT-ABIRATERONE	NAT	**NMQW**
02502305	JAMP-ABIRATERONE	JPC	**NMQW**
02503980	MAR-ABIRATERONE	MAR	**NMQW**
02540452	PRZ-ABIRATERONE	PRZ	**NMQW**

500MG TABLET

02457113	ZYTIGA	JAN	**NMQW**
02491400	APO-ABIRATERONE	APX	**NMQW**
02501503	PMS-ABIRATERONE	PMS	**NMQW**
02503999	MAR-ABIRATERONE	MAR	**NMQW**
02521644	SANDOZ-ABIRATERONE	SDZ	**NMQW**
02525380	ABIRATERONE	JPC	**NMQW**
02529629	JAMP ABIRATERONE	JPC	**NMQW**
02533251	REDDY-ABIRATERONE	RCH	**NMQW**
02540460	PRZ-ABIRATERONE	PRZ	**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**
02560038	REDDY-BOSUTINIB (SA)	RCH	**NMQW**

500MG TABLET

02419157	BOSULIF (SA)	PFI	**NMQW**
02560046	REDDY-BOSUTINIB (SA)	RCH	**NMQW**

BRIGATINIB

SEE APPENDIX A FOR SA CRITERIA

30MG TABLET

02479206	ALUNBRIG (SA)	TAK	**NMQW**
00904758	ALUNBRIG (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

90MG TABLET

02479214	ALUNBRIG (SA)	TAK	**NMQW**
00904759	ALUNBRIG (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

180MG TABLET

02479222	ALUNBRIG (SA)	TAK	**NMQW**
00904760	ALUNBRIG (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

90MG (7) & 180MG (21) INITIATION PACK

02479230	ALUNBRIG (SA)	TAK	**NMQW**
00904761	ALUNBRIG (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

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**
02558971	FULVESTRANT (SA)	STE	**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)	PFI	**NMQW**
00900025	LORBRENA (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

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	TEV	**FGNQSW**
02415275	MERCAPTOPURINE	STE	**FGNQSW**

METHOTREXATE

2.5MG TABLET

02170698	PMS-METHOTREXATE	PMS	**FGNQSW**
02182963	APO-METHOTREXATE	APX	**FGNQSW**
02509067	ACH-METHOTREXATE	ACH	**FGNQSW**
02524023	AURO-METHOTREXATE	ARO	**FGNQSW**
02534916	M-METHOTREXATE	MRA	**FGNQSW**

10MG TABLET

02182750	METHOTREXATE	PFI	**FNQSW**
02553740	JAMP-METHOTREXATE	JPC	**FGNQSW**

7.5MG & 0.3ML PREFILLED SYRINGE

02422166	METHOTREXATE	PMS	**FGNQSW**

10MG & 0.2ML PREFILLED SYRINGE

02454831	METOJECT	MED	**FNQSW**
02539608	PMS-METHOTREXATE	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)	NVR	**NMQW**
00904390	RYDAPT (SA)		**NMQW**

*use when drug cost in excess of CPHA maximum

NILOTINIB

SEE APPENDIX A FOR SA CRITERIA

150MG CAPSULE

02368250	TASIGNA (SA)	NVR	**NMQW**
02550881	APO-NILOTINIB (SA)	APX	**NMQW**
02556634	REDDY-NILOTINIB (SA)	RCH	**NMQW**

200MG CAPSULE

02315874	TASIGNA (SA)	NVR	**NMQW**
02550903	APO-NILOTINIB (SA)	APX	**NMQW**
02556642	REDDY-NILOTINIB (SA)	RCH	**NMQW**

NIRAPARIB

SEE APPENDIX A FOR SA CRITERIA

100MG CAPSULE

02489783	ZEJULA (SA)	GSK	**NMQW**
00904719	ZEJULA (SA)*		**NMQW**

100MG TABLET

02530031	ZEJULA (SA)	GSK	**NMQW**
00904985	ZEJULA (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

NIRAPARIB & ABIRATERONE ACETATE

SEE APPENDIX A FOR SA CRITERIA

50MG & 500MG TABLET

02538555	AKEEGA (SA)	JAN	**NMQW**

100MG & 500MG TABLET

02538563	AKEEGA (SA)	JAN	**NMQW**

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**
02552957	EUGIA-PAZOPANIB (SA)	EUP	**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**
02552892	NAT-SUNITINIB (SA)	NAT	**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**
02552906	NAT-SUNITINIB (SA)	NAT	**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**
02539284	NAT-SUNITINIB (SA)	NAT	**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**

160MG TABLET

02554267	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 CRITERA
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	BOE	**CFNQSW**
02542587	JAMP-IPRATROPIUM HFA	JPC	**CFGNQSW**

0.25MG/ML INHALATION SOLUTION (20ML)

02126222	AA-IPRAVENT	AAA	**CFGNQSW**
02231136	PMS-IPRATROPIUM	PMS	**CFGNQSW**

0.0125% INHALATION SOLUTION NEBULE (2ML)

02231135	PMS-IPRATROPIUM	PMS	**FGNQSW**

0.025% INHALATION SOLUTION NEBULE (2ML)

02216221	TEVA-IPRATROPIUM	TEV	**FGNQSW**
02231245	PMS-IPRATROPIUM	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	TEV	**FGNQSW**
02483394	IPRATROPIUM-SALBUTAMOL	MDN	**FGNQSW**

IPRATROPIUM BROMIDE & SALBUTAMOL SULPHATE
20MCG-100MCG/ACTUATION MIST INHALER

02419106	COMBIVENT RESPIMAT	BOE	**FNQSW**

PINAVERIUM BROMIDE

50MG TABLET

01950592	DICETEL	BGP	**FNQSW**
02469677	PINAVERIUM	AAA	**FGNQSW**

100MG TABLET

02230684	DICETEL	BGP	**FNQSW**
02469685	PINAVERIUM	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)	BOE	**FNQSW**
02537850	LUPIN-TIOTROPIUM (SA)	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)	GSK	**FNQSW**
02494507	PMS-FLUTICASONE/SALMETEROL (SA)	PMS	**FGNQSW**
02495597	WIXELA INHUB (SA)	MYL	**FGNQSW**

50MCG & 250MCG/DOSE INHALER POWDER DISK

02240836	ADVAIR DISKUS (SA)	GSK	**FNQSW**
02494515	PMS-FLUTICASONE/SALMETEROL (SA)	PMS	**FGNQSW**
02495600	WIXELA INHUB (SA)	MYL	**FGNQSW**

50MCG & 500MCG/DOSE INHALER POWDER DISK

02240837	ADVAIR DISKUS (SA)	GSK	**FNQSW**
02494523	PMS-FLUTICASONE/SALMETEROL (SA)	PMS	**FGNQSW**
02495619	WIXELA INHUB (SA)	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	SDZ	**FGNQSW**
02315866	APO-ALFUZOSIN	APX	**FGNQSW**
02443201	AURO-ALFUZOSIN	ARO	**FGNQSW**
02447576	ALFUZOSIN	SIV	**FGNQSW**
02519844	ALFUZOSIN	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**
02544482	JAMP-BACLOFEN	JPC	**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**
02544490	JAMP-BACLOFEN	JPC	**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**

1MG SPRAY

80054636	NIC-HIT	**Z**

2MG SPRAY

80060452	NIC-HIT	**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	BMS	**FNQSW**
02484994	TEVA-APIXABAN	TEV	**FGNQSW**
02486806	AURO-APIXABAN	ARO	**FGNQSW**
02487381	APO-APIXABAN	APX	**FGNQSW**
02487713	ACH-APIXABAN	ACH	**FGNQSW**
02489228	SANDOZ-APIXABAN	SDZ	**FGNQSW**
02492369	MAR-APIXABAN	MAR	**FGNQSW**
02492814	NAT-APIXABAN	NAT	**FGNQSW**
02495430	MINT-APIXABAN	MNT	**FGNQSW**
02510464	TARO-APIXABAN	TAR	**FGNQSW**
02528924	JAMP-APIXABAN	JPC	**FGNQSW**
02529009	M-APIXABAN	MRA	**FGNQSW**
02530708	APIXABAN	SIV	**FGNQSW**
02548879	APIXABAN	SNS	**FGNQSW**

5MG TABLET

02397714	ELIQUIS	BMS	**FNQSW**
02485001	TEVA-APIXABAN	TEV	**FGNQSW**
02486814	AURO-APIXABAN	ARO	**FGNQSW**
02487403	APO-APIXABAN	APX	**FGNQSW**
02487721	ACH-APIXABAN	ACH	**FGNQSW**
02489236	SANDOZ-APIXABAN	SDZ	**FGNQSW**
02492377	MAR-APIXABAN	MAR	**FGNQSW**
02492822	NAT-APIXABAN	NAT	**FGNQSW**
02495449	MINT-APIXABAN	MNT	**FGNQSW**
02510472	TARO-APIXABAN	TAR	**FGNQSW**
02528932	JAMP-APIXABAN	JPC	**FGNQSW**
02529017	M-APIXABAN	MRA	**FGNQSW**
02530716	APIXABAN	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 CRITERA (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**

⑤ENOXAPARIN

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 (TRANSPLANT DRUG PROGRAM DOES NOT REQUIRE AN SA REQUEST)

300 MCG/0.5ML PREFILLED SYRINGE

02441489	GRASTOFIL (SA)	APX	**NMQTW**
02485575	NIVESTYM (SA)	PFI	**NMQTW**
02520990	NYPOZI (SA)	TAV	**NMQTW**

300 MCG/ML VIAL

02485591	NIVESTYM (SA)	PFI	**NMQTW**

480 MCG/0.8ML PREFILLED SYRINGE

02454548	GRASTOFIL (SA)	APX	**NMQTW**
02485583	NIVESTYM (SA)	PFI	**NMQTW**
02521008	NYPOZI (SA)	TAV	**NMQTW**

480 MCG/1.6ML VIAL

02485656	NIVESTYM (SA)	PFI	**NMQTW**

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)	CEL	**NMQW**
00904729	REBLOZYL (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

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**

⑤AMIODARONE

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**

⑤AMLODIPINE 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**

⑤ATENOLOL

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**

⑤ATENOLOL & CHLORTHALIDONE

50 MG & 25MG TABLET

02248763	AA-ATENIDONE	AAA	**FGNQSW**

100MG & 25MG TABLET

02248764	AA-ATENIDONE	AAA	**FGNQSW**

⑤BISOPROLOL

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**

02554399	AURO-DIGOXIN	ARO	**FGNQSW**

0.125MG TABLET

02335719	PMS-DIGOXIN	PMS	**FGNQSW**
02498510	JAMP-DIGOXIN	JPC	**FGNQSW**
02554402	AURO-DIGOXIN	ARO	**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	TIAXAC XC	BSL	**FNQSW**
02429349	TEVA-DILTIAZEM XC	TEV	**FGNQSW**

360MG EXTENDED RELEASE TABLET

02256770	TIAXAC XC	BSL	**FNQSW**
02429357	TEVA-DILTIAZEM XC	TEV	**FGNQSW**

120MG CONTROLLED DELIVERY CAPSULE

02230997	APO-DILTIAZ CD	APX	**FGNQSW**
02242538	TEVA-DILTAZEM 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**

⑤PROPRANOLOL

10MG TABLET

00496480	TEVA-PROPRANOLOL	TEV	**FGNQSW**

20MG TABLET

00740675	TEVA-PROPRANOLOL	TEV	**FGNQSW**
02550814	PRZ-PROPRANOLOL	PRZ	**FGNQSW**

40MG TABLET

00496499	TEVA-PROPRANOLOL	TEV	**FGNQSW**
02550822	PRZ-PROPRANOLOL	PRZ	**FGNQSW**

80MG TABLET

00496502	TEVA-PROPRANOLOL	TEV	**FGNQSW**
02550830	PRZ-PROPRANOLOL	PRZ	**FGNQSW**

PROPRANOLOL ORAL SOLUTION

SEE APPENDIX A FOR SA CRITERIA

3.75MG/ML ORAL SOLUTION

02457857	HEMANGIOL (SA)	PFB	**FQW**

⑤SOTALOL 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	AA-VERAP	AAA	**FGNQSW**
02237921	MYLAN-VERAPAMIL	MYL	**FGNQSW**

120MG TABLET

00782491	AA-VERAP	AAA	**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**

⑤CHOLESTYRAMINE

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**

⑤COLESEVELAM

625MG TABLET

02373955	LODALIS	BSL	**FNQSW**
02494051	APO-COLESEVELAM	APX	**FGNQSW**

3.75G PACKET

02432463	LODALIS	BSL	**FNQSW**

⑤EVOLOCUMAB

SEE APPENDIX A FOR SA CRITERIA

140MG/ML PEN INJECTOR

02446057	REPATHA (SA)	AMG	**FNQSW**

⑤EZETIMIBE

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**

INCLISIRAN

SEE APPENDIX A FOR SA CRITERIA

284MG/1.5ML PRE-FILLED SYRINGE

02518376	LEQVIO (SA)	NVR	**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-SIMVISTATIN	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	PERINDORPIL 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**

⑤METHYLDOPA

125MG TABLET

00360252	METHYLDOPA	AAA	**FGNQSW**

250MG TABLET

00360260	METHYLDOPA	AAA	**FGNQSW**

500MG TABLET

00426830	METHYLDOPA	AAA	**FGNQSW**

24:12.00 MISCELLANEOUS VASODILATING AGENTS

AMBRISENTAN

SEE APPENDIX A FOR SA CRITERIA

5MG TABLET

02307065	VOLIBRIS (SA)	GSK	**NMQW**
02475375	APO-AMBRISENTAN (SA)	APX	**NMQW**
02521938	JAMP-AMBRISENTAN (SA)	JPC	**NMQW**

10MG TABLET

02307073	VOLIBRIS (SA)	GSK	**NMQW**
02475383	APO-AMBRISENTAN (SA)	APX	**NMQW**
02521946	JAMP-AMBRISENTAN (SA)	JPC	**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 VIAL

02230845	FLOLAN (SA)	GSK	**NMQW**

1.5MG VIAL

02230848	FLOLAN (SA)	GSK	**NMQW**

EPOPROSTENOL SODIUM (ARGININE)

SEE APPENDIX A FOR SA CRITERIA

0.5MG VIAL

02397447	CARIPUL (SA)	JAN	**NMQW**

1.5MG VIAL

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	LXO	**FNQSW**

NITROGLYCERIN

NOTES:

884. 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).

⑤NITROGLYCERIN 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**

⑤ENALAPRIL 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**

⑤ENALAPRIL & 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**
02550202	PMSC-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	**FNGQSW**
02421305	MINT-RAMIPRIL	MNT	**FGNQSW**
02469065	PHARMA-RAMIPRIL	PMS	**FGNQSW**
02477572	AG-RAMIPRIL	ANG	**FGNQSW**
02486172	NRA-RAMIPRIL	NRA	**FGNQSW**
02550210	PMSC-RAMIPRIL	PMS	**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**
02550229	PMSC-RAMIPRIL	PMS	**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**
02550237	PMSC-RAMIPRIL	PMS	**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**

⑤CANDESARTAN 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**

⑤EPROSARTAN 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**

⑤TELMISARTAN & AMLODIPINE

40MG & 5MG TABLET

02371022	TWYNSTA	BOE	**FNQSW**

40MG & 10MG TABLET

02371030	TWYNSTA	BOE	**FNQSW**

80MG & 5MG TABLET

02371049	TWYNSTA	BOE	**FNQSW**

80MG & 10MG TABLET

02371057	TWYNSTA	BOE	**FNQSW**

⑤TELMISARTAN & 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**

⑤VALSARTAN

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**

⑤VALSARTAN & 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**

⑤NALTREXONE 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)

⑤PHENOBARBITAL

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	NVR	**FNQSW**
02261839	SANDOZ-CARBAMAZEPINE CR	SDZ	**FGNQSW**

400MG CONTROLLED RELEASE TABLET

00755583	TEGRETOL CR	NVR	**FNQSW**
02261847	SANDOZ-CARBAMAZEPINE CR	SDZ	**FGNQSW**

SEE APPENDIX A FOR SA CRITERIA

100MG/5ML SUSPENSION

02194333	TEGRETOL (SA)	NVR	**FNQSW**
02367394	TARO-CARBAMAZEPINE (SA)	TAR	**FGNQSW**

CENOBAMATE

SEE APPENDIX A FOR SA CRITERIA

12.5MG (14) & 25MG (14) TABLET

02538776	XCOPRI TITRATION PACK 1	KNI	**FNQSW**

50MG (14) & 100MG (14) TABLET

02538784	XCOPRI TITRATION PACK 2	KNI	**FNQSW**

150MG (14) & 200MG (14) TABLET

02538792	XCOPRI TITRATION PACK 3	KNI	**FNQSW**

12.5MG TABLET

02538652	XCOPRI (SA)	KNI	**FNQSW**

25MG TABLET

02538660	XCOPRI (SA)	KNI	**FNQSW**

50MG TABLET

02538725	XCOPRI (SA)	KNI	**FNQSW**

100MG TABLET

02538733	XCOPRI (SA)	KNI	**FNQSW**

150MG TABLET

02538741	XCOPRI (SA)	KNI	**FNQSW**

200MG TABLET

02538768	XCOPRI (SA)	KNI	**FNQSW**

CLOBAZAM

Eligible for a 90 day supply

10MG TABLET

02238334	TEVA-CLOBAZAM	TEV	**FGNQSW**
02244638	APO-CLOBAZAM	APX	**FGNQSW**

⑤DIVALPROEX SODIUM

125MG ENTERIC COATED TABLET

00596418	EPIVAL	BGP	**FNQSW**
02239698	APO-DIVALPROEX	APX	**FGNQSW**
02458926	MYLAN-DIVALPROEX	MYL	**FGNQSW**

250MG ENTERIC COATED TABLET

00596426	EPIVAL	BGP	**FNQSW**
02239699	APO-DIVALPROEX	APX	**FGNQSW**
02458934	MYLAN-DIVALPROEX	MYL	**FGNQSW**

500MG ENTERIC COATED TABLET

00596434	EPIVAL	BGP	**FNQSW**
02239700	APO-DIVALPROEX	APX	**FGNQSW**
02459019	MYLAN-DIVALPROEX	MYL	**FGNQSW**

ESLICARBAZEPINE ACETATE

SEE APPENDIX A FOR SA CRITERIA

200MG TABLET

02426862	APTIOM (SA)	SNV	**FNQSW**
02527421	AURO-ESLICARBAZEPINE (SA)	ARO	**FGNQSW**
02537931	APO-ESLICARBAZEPINE (SA)	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-LEVERTIRACETAM	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	**FNGQSW**
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**

⑤VALPROATE 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**
02313405	JAMP-CITALOPRAM	JPC	**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**
02313413	JAMP-CITALOPRAM	JPC	**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**
02559080	MAR-DOXEPIN	MAR	**FGNQSW**

25MG CAPSULE

00024333	SINEQUAN	AAA	**FNQSW**
02559099	MAR-DOXEPIN	MAR	**FGNQSW**

50MG CAPSULE

00024341	SINEQUAN	AAA	**FNQSW**
02559102	MAR-DOXEPIN	MAR	**FGNQSW**

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**
02554909	NATCO-ESCITALPRAM	NAT	**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**
02554933	NATCO-ESCITALOPRAM	NAT	**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**

TRANYLCYPROMINE 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)

⑤ARIPIPRAZOLE

2MG TABLET

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

5MG TABLET

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

10MG TABLET

02322390	ABILIFY	OTS	**FNQSW**
02460041	AURO-ARIPIPRAZOLE	ARO	**FGNQSW**
02466651	PMS-ARIPIPRAZOLE	PMS	**FGNQSW**
02471108	APO-ARIPIPRAZOLE	APX	**FGNQSW**
02473674	SANDOZ-ARIPIPRAZOLE	SDZ	**FGNQSW**
02483572	MINT-ARIPIPRAZOLE	MNT	**FGNQSW**
02506726	ARIPIPRAZOLE	SNS	**FGNQSW**
02534347	ARIPIPRAZOLE	SIV	**FGNQSW**

15MG TABLET

02322404	ABILIFY	OTS	**FNQSW**
02460068	AURO-ARIPIPRAZOLE	ARO	**FGNQSW**

02466678	PMS-ARIPIPRAZOLE	PMS	**FGNQSW**
02471116	APO-ARIPIPRAZOLE	APX	**FGNQSW**
02473682	SANDOZ-ARIPIPRAZOLE	SDZ	**FGNQSW**
02483580	MINT-ARIPIPRAZOLE	MNT	**FGNQSW**
02506734	ARIPIPRAZOLE	SNS	**FGNQSW**
02534355	ARIPIPRAZOLE	SIV	**FGNQSW**

20MG TABLET

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

30MG TABLET

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

BREXPIPRAZOLE

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

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-OLANZPAINE 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-RISPERIODONE	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-RISPERIODONE	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-RISPERIODONE	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-RISPERIODONE	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-RISPERIODONE	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**

⑤TRIFLUOPERAZINE

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**

⑤DEXTROAMPHETAMINE 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**

⑤LISDEXAMFETAMINE

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**

⑤METHYLPHENIDATE 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-LORAZEPM	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**
02549298	JAMP-ZOPICLONE	JPC	**FNQW**

884.1 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**
02549301	JAMP-ZOPICLONE	JPC	**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

ATOGEPANT

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**

ELETRIPTAN

20MG TABLET

02382091	TEVA-ELETRIPTAN	TEV	**FGNQSW**
02479451	AURO-ELETRIPTAN	ARO	**FGNQSW**
02518015	APO-ELETRIPTAN	APX	**FGNQSW**

40MG TABLET

02382105	TEVA-ELETRIPTAN	TEV	**FGNQSW**
02479478	AURO-ELETRIPTAN	ARO	**FGNQSW**
02518023	APO-ELETRIPTAN	APX	**FGNQSW**

Note: Coverage is limited to 6 tablets per 30 day period

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-RIZATRIPAN 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

⑤BENZTROPINE 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

⑤ACAMPROSATE

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**

⑤ATOMOXETINE

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	WES	**NW**
80033602	JAMP-K EFFERVESCENT	JPC	**NW**

SODIUM CHLORIDE

0.9% INJECTION SOLUTION (10ML)

00037796	SODIUM CHLORIDE	PFI	**NQ**
02304341	SODIUM CHLORIDE	TLG	**NQ**

0.9% IRRIGATION SOLUTION (1000ML)

00786160	SODIUM CHLORIDE	BAX	**CNQW**

STERILE WATER

INJECTION SOLUTION (10ML)

02142546	STERILE WATER FOR INJECTION	PFI	**CNQ**
02299186	STERILE WATER FOR INJECTION	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	PEN	**FGNQSW**
02026961	KAYEXALATE	AVN	**FNQSW**
02473941	ODAN-SODIUM POLYSTYRENE SULFONATE	ODN	**FGNQSW**
02497557	JAMP-SODIUM POLYSTYRENE SULFONATE	JPC	**FGNQSW**

15G/60ML ORAL POWDER

00769541	SOLYSTAT	PEN	**FGNQSW**
02473968	ODAN-SODIUM POLYSTYRENE SULFONATE	ODN	**FGNQSW**

SUCROFERRIC OXYHYDROXIDE

SEE APPENDIX A FOR SA CRITERIA

500MG CHEWABLE TABLET

02471574	VELPHORO (SA)	VFM	**FNQSW**

40:20.00 CALORIC AGENTS

TRIHEPTANOIN
SEE APPENDIX A FOR SA CRITERIA
8.3KCAL/ML

02512556	DOJOLVI (SA)	UGX	**NMQW**
00900021	DOJOLVI (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

40:28.00 DIURETICS

⑤CHLORTHALIDONE
50MG TABLET

00360279	APO-CHLORTHALIDONE	APX	**FGNQSW**
02523817	JAMP-CHLORTHALIDONE	JPC	**FGNQSW**

ETHACRYNIC ACID
25MG TABLET

02258528	EDECRIN	BLO	**FNQSW**

⑤FUROSEMIDE
20MG TABLET

00337730	TEVA-FUROSEMIDE	TEV	**FGNQSW**
00396788	APO-FUROSEMIDE	APX	**FGNQSW**
02351420	FUROSEMIDE	SNS	**FGNQSW**
02466759	MINT-FUROSEMIDE	MNT	**FGNQSW**

40MG TABLET

00337749	TEVA-FUROSEMIDE	TEV	**FGNQSW**
00362166	APO-FUROSEMIDE	APX	**FGNQSW**
02351439	FUROSEMIDE	SNS	**FGNQSW**
02466767	MINT-FUROSEMIDE	MNT	**FGNQSW**

80MG TABLET

00707570	APO-FUROSEMIDE	APX	**FGNQSW**
00765953	TEVA-FUROSEMIDE	TEV	**FGNQSW**
02351447	FUROSEMIDE	SNS	**FGNQSW**
02466775	MINT-FUROSEMIDE	MNT	**FGNQSW**

10MG/ML ORAL SOLUTION

02224720	LASIX	AVN	**FNQSW**

10MG/ML INJECTION

02382539	FUROSEMIDE (2ML AMP)	SDZ	**NQ**
02527502	FUROSEMIDE (2ML VIAL)	JPC	**NQ**

10MG/ML INJECTION

00527033	FUROSEMIDE (2ML VIAL)	SDZ	**NQ**

⑤HYDROCHLOROTHIAZIDE

12.5MG TABLET

02327856	APO-HYDRO	APX	**FGNQSW**
02425947	MINT-HYDROCHLOROTHIAZIDE	MNT	**FGNQSW**

25MG TABLET

00021474	TEVA-HYDROCHLOROTHIAZIDE	TEV	**FGNQSW**
00326844	APO-HYDRO 25	APX	**FGNQSW**
02247386	PMS-HYDROCHLOROTHIAZIDE	PMS	**FGNQSW**
02360594	HYDROCHLOROTHIAZIDE	SNS	**FGNQSW**
02426196	MINT-HYDROCHLOROTHIAZIDE	MNT	**FGNQSW**

50MG TABLET

00021482	TEVA-HYDROCHLOROTHIAZIDE	TEV	**FGNQSW**
00312800	APO-HYDRO 50	APX	**FGNQSW**
02247387	PMS-HYDROCHLOROTHIAZIDE	PMS	**FGNQSW**
02360608	HYDROCLOROTHIAZIDE	SNS	**FGNQSW**

⑤INDAPAMIDE HEMIHYDRATE

1.25MG TABLET

02240067	MYLAN-INDAPAMIDE	MYL	**FGNQSW**
02245246	APO-INDAPAMIDE	APX	**FGNQSW**

2.5MG TABLET

02153483	MYLAN-INDAPAMIDE	MYL	**FGNQSW**
02223678	APO-INDAPAMIDE	APX	**FGNQSW**

⑤METOLAZONE

2.5MG TABLET

00888400	ZAROXOLYN	AVN	**FNQSW**

40:28.10 DIURETICS (POTASSIUM SPARING)

⑤AMILORIDE HCL & HYDROCHLOROTHIAZIDE

5MG & 50MG TABLET

00784400	AA-AMILZIDE	AAA	**FGNQSW**

⑤SPIRONOLACTONE

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**

⑤SPIRONOLACTONE & HYDROCHLOROTHIAZIDE

25MG & 25MG TABLET

00613231	TEVA-SPIRONOLACTONE/HCTZ	TEV	**FGNQSW**

50MG & 50MG TABLET

00657182	TEVA-SPIRONOLACTONE/HCTZ	TEV	**FGNQSW**

⑤TRIAMTERENE & 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)	SHR	**NMQW**
00904378	VPRIV (SA)*		**NMQW**
00904379	VPRIV (SA)*		**NMQW**
00904380	VPRIV (SA)*		**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

ELEXACAFTOR & TEZACAFTOR & IVACAFTOR & IVACAFTOR
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**

IVACAFTOR
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)	PMS	**FGNQSW**
02463105	ODAN-BENZYDAMINE (SA)	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

884.1 MG/ML OPHTHALMIC SOLUTION

02324997	LUMIGAN	ALL	**FNQSW**

BRIMONIDINE TARTRATE

0.15% OPHTHALMIC SOLUTION

02248151	ALPHAGAN P	ALL	**FNQSW**
02301334	BRIMONIDINE P	AAA	**FGNQSW**

0.2% OPHTHALMIC SOLUTION

02236876	ALPHAGAN	ALL	**FNQSW**
02260077	APO-BRIMONIDINE	APX	**FGNQSW**
02305429	SANDOZ BRIMONIDINE	SDZ	**FGNQSW**
02449226	JAMP-BRIMONIDINE	JPC	**FGNQSW**
02507811	MED-BRIMONIDINE	GMP	**FGNQSW**
02515377	BRIMONIDINE TARTRATE	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**
02367335	SANDOZ-LATANOPROST	SDZ	**FGNQSW**
02373041	MYLAN-LATANOPROST	MYL	**FGNQSW**
02426935	MED-LATANOPROST	GMP	**FGNQSW**
02453355	JAMP-LATANOPROST	JPC	**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**
02554194	AFLIVU (SA)	APX	**FNMSQW**
02535858	YESAFILI (SA)	BIL	**FNMSQW**

2MG/0.05ML PRE-FILLED SYRINGE

02554178	AFLIVU (SA)	APX	**FNMSQW**
02558238	YESAFILI (SA)	BIL	**FNMSQW**

APRACLONIDINE 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	**FNMSQW**
02542250	RANOPTO (SA)	TEV	**FNMSQW**

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	TEV	**FGNQSW**
02212005	APO-LOPERAMIDE	APX	**FGNQSW**
02228351	PMS-LOPERAMIDE	PMS	**FGNQSW**

0.2MG/ML ORAL SOLUTION

02016095	PMS-LOPERAMIDE HCL	PMS	**FGNQSW**

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-SENNA	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 & 40,000USP U CAPSULE

00263818	COTAZYM	MSD	**CFNQSW**

10,800 & 45,000 & 42,000USP U CAPSULE (ENTERIC COATED PARTICLES)

00502790	COTAZYM ECS 8	MSD	**CFNQSW**

25,000 & 100,000 & 100,000USP U CAPSULE (ENTERIC COATED PARTICLES)

00821373	COTAZYM ECS 20	MSD	**CFNQSW**

10,440 & 57,100 & 56,400USP U TABLET

02230019	VIOKACE	ARN	**CFNQSW**

20,880 & 112,500 & 113,400USP 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

02100622	SULCRATE	ALL	**FNQSW**
02045702	TEVA-SUCRALFATE	TEV	**FGNQSW**
02125250	APO-SUCRALFATE	APX	**FGNQSW**

200MG/ML ORAL SUSPENSION

02103567	SULCRATE PLUS	AVN	**FNQSW**

56:28.36 PROTON PUMP INHIBITORS

LANSOPRAZOLE

SEE APPENDIX A FOR SA CRITERIA

15MG DELAYED RELEASE CAPSULE

02165503	PREVACID (SA)	ABB	**FNQSW**
02280515	TEVA-LANSOPRAZOLE (SA)	TEV	**FGNQSW**
02293811	APO-LANSOPRAZOLE (SA)	APX	**FGNQSW**
02353830	MYLAN-LANSOPRAZOLE (SA)	MYL	**FGNQSW**
02357682	LANSOPRAZOLE (SA)	SNS	**FGNQSW**
02385643	SANDOZ-LANSOPRAZOLE (SA)	SDZ	**FGNQSW**
02385767	LANSOPRAZOLE DR (SA)	SIV	**FGNQSW**
02395258	PMS-LANSOPRAZOLE (SA)	PMS	**FGNQSW**
02402610	TARO-LANSOPRAZOLE (SA)	SUN	**FGNQSW**
02433001	LANSOPRAZOLE (SA)	PMS	**FGNQSW**

30MG DELAYED RELEASE CAPSULE

02165511	PREVACID (SA)	ABB	**FNQSW**
02280523	TEVA-LANSOPRAZOLE (SA)	TEV	**FGNQSW**
02293838	APO-LANSOPRAZOLE (SA)	APX	**FGNQSW**

02353849	MYLAN-LANSOPRAZOLE (SA)	MYL	**FGNQSW**
02357690	LANSOPRAZOLE (SA)	SNS	**FGNQSW**
02385651	SANDOZ-LANSOPRAZOLE (SA)	SDZ	**FGNQSW**
02395266	PMS-LANSOPRAZOLE (SA)	PMS	**FGNQSW**
02402629	TARO-LANSOPRAZOLE (SA)	SUN	**FGNQSW**
02410389	LANSOPRAZOLE (SA)	SIV	**FGNQSW**
02433028	LANSOPRAZOLE (SA)	PMS	**FGNQSW**

SEE APPENDIX A FOR SA CRITERIA

15MG DELAYED RELEASE TABLET

02249464	PREVACID FASTAB (SA)	ABB	**FNQSW**

30MG DELAYED RELEASE TABLET

02249472	PREVACID FASTAB (SA)	ABB	**FNQSW**

LANSOPRAZOLE & CLARITHROMYCIN & AMOXICILLIN

SEE APPENDIX A FOR SA CRITERIA

30MG & 500MG & 500MG 7-DAY PACKAGE

02470780	AA-LANSOPRAZOLE-AMOXICILLIN-CLARITHROMYCIN	AAA	**FGNQSW**

OMEPRAZOLE

SEE PROTON PUMP INHIBITORS IN APPENDIX A FOR SA CRITERIA **FOR DOSAGES GREATER THAN 20MG PER DAY.**

10MG CAPSULE

02295407	TEVA-OMEPRAZOLE	TEV	**FGNQSW**
02296438	SANDOZ-OMEPRAZOLE	SDZ	**FGNQSW**

20MG CAPSULE

00846503	LOSEC	XPI	**FNQSW**
02245058	APO-OMEPRAZOLE	APX	**FGNQSW**
02296446	SANDOZ-OMEPRAZOLE	SDZ	**FGNQSW**
02348691	OMEPRAZOLE	SNS	**FGNQSW**
02411857	OMEPRAZOLE-20	SIV	**FGNQSW**

20MG DELAYED RELEASE TABLET

02295415	TEVA-OMEPRAZOLE	TEV	**FGNQSW**
02416549	OMEPRAZOLE MAGNESIUM	ACH	**FGNQSW**
02420198	JAMP-OMEPRAZOLE	JPC	**FGNQSW**
02439549	NAT-OMEPRAZOLE	NAT	**FGNQSW**
02501880	NRA-OMEPRAZOLE MAGNESIUM	NRA	**FGNQSW**
02504294	OMEPRAZOLE MAGNESIUM	SNS	**FGNQSW**

PANTOPRAZOLE MAGNESIUM

SEE PROTON PUMP INHIBITORS IN APPENDIX A FOR SA CRITERIA **FOR DOSAGES GREATER THAN 40 MG/DAY**

40MG ENTERIC TABLET

02267233	TECTA	TAK	**FNQSW**
02408570	MYLAN-PANTOPRAZOLE T	MYL	**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	JAN	**FNQSW**
02314185	SANDOZ-RABEPRAZOLE	SDZ	**FGNQSW**
02356538	RABEPRAZOLE	SNS	**FGNQSW**
02385457	RABEPRAZOLE	SIV	**FGNQSW**
02415291	JAMP-RABEPRAZOLE	JPC	**FGNQSW**

56:32.00 MISCELLANEOUS G.I. DRUGS

DOMPERIDONE MALEATE

10MG TABLET

01912070	TEVA-DOMPERIDONE	TEV	**FGNQSW**
02103613	APO-DOMPERIDONE	APX	**FGNQSW**
02238341	DOMPERIDONE	SIV	**FGNQSW**
02268078	RAN-DOMPERIDONE	RAN	**FGNQSW**
02350440	DOMPERIDONE	SNS	**FGNQSW**
02369206	JAMP-DOMPERIDONE	JPC	**FGNQSW**
02403870	MAR-DOMPERIDONE	MAR	**FGNQSW**
02462834	PRZ-DOMPERIDONE	PRZ	**FGNQSW**

METOCLOPRAMIDE HCL

5MG TABLET

02230431	PMS-METOCLOPRAMIDE	PMS	**FGNQSW**
02517795	MAR-METOCLOPRAMIDE	MAR	**FGNQSW**
02548747	PRZ-METOCLOPRAMIDE	PRZ	**FGNQSW**

10MG TABLET

02548755	PRZ-METOCLOPRAMIDE	PRZ	**FGNQSW**

1MG/ML ORAL SOLUTION

02230433	PMS-METOCLOPRAMIDE	PMS	**FGNQSW**

5MG/ML INJECTION SOLUTION (2ML)

02185431	METOCLOPRAMIDE HCL	SDZ	**NQ**
02243563	METOCLOPRAMIDE	OMG	**NQ**
02537397	METOCLOPRAMIDE HCL	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.	PMS	**FGNQSW**
02064472	SALAZOPYRIN	PFI	**FNQSW**

500MG TABLET

00598461	PMS-SULFASALAZINE	PMS	**FGNQSW**
02064480	SALAZOPYRIN	PFI	**FNQSW**

TRIMEBUTINE MALEATE

100MG TABLET

02245663	APO-TRIMEBUTINE	APX	**FGNQSW**
02538202	MINT-TRIMEBUTINE	MNT	**FGNQSW**

200MG TABLET

02245664	APO-TRIMEBUTINE	APX	**FGNQSW**
02538210	MINT-TRIMEBUTINE	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	ALL	**FNQSW**
02524481	MEZERA	AVI	**FNQSW**

1000MG ENTERIC COATED TABLET

02545012	MEZERA	AVI	**FNQSW**

500MG EXTENDED RELEASE TABLET

02099683	PENTASA	FEI	**FNQSW**

800MG DELAYED RELEASE TABLET

02465752	OCTASA	PEN	**FNQSW**

1600MG DELAYED RELEASE TABLET
02529610 OCTASA PEN **FNQSW**

1.2GM DELAYED RELEASE TABLET
02297558 MEZAVANT SHI **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 APT **FNQSW**
02153564 PENTASA 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**

OLSALAZINE SODIUM
250MG CAPSULE
02063808 DIPENTUM ATN **FNQSW**

56:44.00 IMMUNOMODULATOR AGENTS

ETRASIMOD
SEE APPENDIX A FOR SA CRITERIA

2MG TABLET

02544903	VELSIPITY (SA)	PFI	**NMQW**

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	**CFGNQSW**

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	**FGNQSW**

200MCG/DOSE INHALATION AEROSOL

02285614	ALVESCO	COV	**FGNQSW**

CORTISONE ACETATE

25MG TABLET

00280437	CORTISONE	BSL	**CFNQSW**

DEXAMETHASONE

0.5MG TABLET

01964976	PMS-DEXAMETHASONE	PMS	**CFGNQSW**
02261081	APO-DEXAMETHASONE	APX	**CFGNQSW**

0.75MG TABLET

01964968	PMS-DEXAMETHASONE	PMS	**FGNQSW**

2MG TABLET

02279363	PMS-DEXAMETHASONE	PMS	**FGNQSW**

4MG TABLET

01964070	PMS-DEXAMETHASONE	PMS	**CFGNQSW**
02250055	APO-DEXAMETHASONE	APX	**CFGNQSW**

DEXAMETHASONE 21 PHOSPHATE

4MG/ML INJECTION SOLUTION (5ML)

00664227	DEXAMETHASONE	SDZ	**FGNQSW**
01977547	DEXAMETHASONE	STE	**FGNQSW**

FLUDROCORTISONE ACETATE

0.1MG TABLET

02086026	FLORINEF	PAL	**FNQSW**
02552248	JAMP-FLUDROCORTISONE	JPC	**FGNQSW**

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	GSK	**CFNQSW**
02503115	PMS-FLUTICASONE HFA	PMS	**CFGNQSW**
02528428	APO-FLUTICASONE HFA	APX	**CFGNQSW**

125MCG/DOSE INHALATION AEROSOL HYDROFLUOROALKANE (HFA)

02244292	FLOVENT HFA	GSK	**CFNQSW**
02503123	PMS-FLUTICASONE HFA	PMS	**CFGNQSW**
02526557	APO-FLUTICASONE HFA	APX	**CFGNQSW**

250MCG/DOSE INHALATION AEROSOL HYDROFLUOROALKANE (HFA)

02244293	FLOVENT HFA	GSK	**CFNQSW**
02503131	PMS-FLUTICASONE HFA	PMS	**CFGNQSW**
02510987	APO-FLUTICASONE HFA	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	PFI	**CFNQSW**
02524465	AURO-HYDROCORTISONE	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	**FGNQSW**

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	PFI	**FQW**
02496003	TARO-TESTOSTERONE	TAR	**FQW**

TESTOSTERONE UNDECANOATE

SEE APPENDIX A FOR SA CRITERIA

40MG CAPSULE

02322498	PMS-TESTOSTERONE (SA)	PMS	**FNQSW**
02421186	TARO-TESTOSTERONE (SA)	TAR	**FNQSW**

68:12.00 CONTRACEPTIVES

ESTRADIOL & ETONOGESTREL

2MG & 11.4MG VAGINAL INSERT

02253186	NUVARING	MSD	**National**
02520028	HALOETTE	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	MSD	**National**
02317192	APRI 21	TEV	**National**
02396491	FREYA 21	MYL	**National**
02410249	MIRVALA 21	APX	**National**

0.03MG & 0.15MG TABLET (28 DAY)

02042479	MARVELON	MSD	**National**
02317206	APRI 28	TEV	**National**

02396610	FREYA 28	MYL	**National**
02410257	MIRVALA 28	APX	**National**

ETHINYL ESTRADIOL & DROSPIRENONE

3MG & 0.02MG TABLET

02321157	YAZ	BAY	**National**
02415380	MYA	APX	**National**
02462060	DROSPIRENONE-ETHINYL ESTRADIOL	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	STR	**DNQW**
02494078	MAR-ACARBOSE	MAR	**DNQW**

100MG TABLET

02494086	MAR-ACARBOSE	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**

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

25MG TABLET

02388839	JANUVIA	MSD	**DNQW**
02503840	PMS-SITAGLIPTIN	PMS	**DNQW**
02504049	SANDOZ-SITAGLIPTIN	SDZ	**DNQW**
02508656	APO-SITAGLIPTIN MALATE	APX	**DNQW**
02512475	ACH-SITAGLIPTIN	ACH	**DNQW**
02522705	TEVA-SITAGLIPTIN MALATE	TEV	**DNQW**
02529033	SITAGLIPTIN	SIV	**DNQW**
02529866	AURO-SITAGLIPTIN HCL	ARO	**DNQW**
02531631	TARO-SITAGLIPTIN FUMERATE	TAR	**DNQW**
02534134	JAMP SITAGLIPTIN	JPC	**DNQW**
02548550	SITAGLIPTIN	SNS	**DNQW**

50MG TABLET

02388847	JANUVIA	MSD	**DNQW**
02503859	PMS-SITAGLIPTIN	PMS	**DNQW**
02504057	SANDOZ-SITAGLIPTIN	SDZ	**DNQW**
02508664	APO-SITAGLIPTIN MALATE	APX	**DNQW**
02512483	ACH-SITAGLIPTIN	ACH	**DNQW**
02522713	TEVA-SITAGLIPTIN MALATE	TEV	**DNQW**

02529041	SITAGLIPTIN	SIV	**DNQW**
02529874	AURO-SITAGLIPTIN HCL	ARO	**DNQW**
02531658	TARO-SITAGLIPTIN FUMERATE	TAR	**DNQW**
02534142	JAMP SITAGLIPTIN	JPC	**DNQW**
02548569	SITAGLIPTIN	SNS	**DNQW**

100MG TABLET

02303922	JANUVIA	MSD	**DNQW**
02503867	PMS-SITAGLIPTIN	PMS	**DNQW**
02504065	SANDOZ-SITAGLIPTIN	SDZ	**DNQW**
02508672	APO-SITAGLIPTIN MALATE	APX	**DNQW**
02512491	ACH-SITAGLIPTIN	ACH	**DNQW**
02522721	TEVA-SITAGLIPTIN MALATE	TEV	**DNQW**
02529068	SITAGLIPTIN	SIV	**DNQW**
02529882	AURO-SITAGLIPTIN HCL	ARO	**DNQW**
02531666	TARO-SITAGLIPTIN FUMERATE	TAR	**DNQW**
02534150	JAMP SITAGLIPTIN	JPC	**DNQW**
02548577	SITAGLIPTIN	SNS	**DNQW**

⑤SITAGLIPTIN & METFORMIN HYDROCHLORIDE

50MG/500MG TABLET

02333856	JANUMET	MSD	**DNQW**
02503956	SANDOZ SITAGLIPTIN-METFORMIN	SDZ	**DNQW**
02509415	APO-SITAGLIPTIN-METFORMIN	APX	**DNQW**
02520494	TEVA-SITAGLIPTIN-METFORMIN	TEV	**DNQW**
02529157	SITAGLIPTIN-METFORMIN	SIV	**DNQW**
02540118	REDDY-SITAGLIPTIN-METFORMIN	RCH	**DNQW**
02547805	AURO-SITAGLIPTIN-METFORMIN	ARO	**DNQW**
02556189	JAMP-SITAGLIPTIN-METFORMIN HCL	JPC	**DNQW**

50MG/850MG TABLET

02503964	SANDOZ SITAGLIPTIN-METFORMIN	SDZ	**DNQW**
02509423	APO-SITAGLIPTIN-METFORMIN	APX	**DNQW**
02520508	TEVA-SITAGLIPIN-METFORMIN	TEV	**DNQW**
02529165	SITAGLIPTIN-METFORMIN	SIV	**DNQW**
02540126	REDDY-SITAGLIPTIN-METFORMIN	RCH	**DNQW**
02547813	AURO-SITAGLIPTIN-METFORMIN	ARO	**DNQW**
02556197	JAMP-SITAGLIPTIN-METFORMIN HCL	JPC	**DNQW**

50MG/1000MG TABLET

02333872	JANUMET	MSD	**DNQW**
02503972	SANDOZ SITAGLIPTIN-METFORMIN	SDZ	**DNQW**
02509431	APO-SITAGLIPTIN-METFORMIN	APX	**DNQW**
02520516	TEVA-SITAGLIPIN-METFORMIN	TEV	**DNQW**
02529173	SITAGLIPTIN-METFORMIN	SIV	**DNQW**
02540134	REDDY-SITAGLIPTIN-METFORMIN	RCH	**DNQW**

02547821	AURO-SITAGLIPTIN-METFORMIN	ARO	**DNQW**
02556200	JAMP-SITAGLIPTIN-METFORMIN HCL	JPC	**DNQW**

50MG/500MG EXTENDED RELEASE TABLET

02416786	JANUMET XR	MSD	**DNQW**
02506270	APO-SITAGLIPTIN-METFORMIN XR	APX	**DNQW**
02529106	SANDOZ SITAGLIPTIN-METFORMN XR	SDZ	**DNQW**

50MG/1000MG EXTENDED RELEASE TABLET

02416794	JANUMET XR	MSD	**DNQW**
02506289	APO-SITAGLIPTIN-METFORMIN XR	APX	**DNQW**
02529114	SANDOZ SITAGLIPTIN-METFORMN XR	SDZ	**DNQW**

100MG/1000MG EXTENDED RELEASE TABLET

02416808	JANUMET XR	MSD	**DNQW**
02506297	APO-SITAGLIPTIN-METFORMIN XR	APX	**DNQW**
02529122	SANDOZ SITAGLIPTIN-METFORMN XR	SDZ	**DNQW**

68:20.06 ANTIDIABETIC DRUGS (INCRETIN MIMETICS)

⑤SEMAGLUTIDE

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

⑤SEE 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	DEMOSPRESSIN (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 MINIQUICK	PFI	**Y**

0.8 MG/0.25 ML

02401770	GENOTROPIN MINIQUICK	PFI	**Y**

1 MG/0.25 ML

02401789	GENOTROPIN MINIQUICK	PFI	**Y**

1.2 MG/0.25 ML

02401797	GENOTROPIN MINIQUICK	PFI	**Y**

1.4 MG/0.25 ML

02401800	GENOTROPIN MINIQUICK	PFI	**Y**

1.6 MG/0.25 ML

02401819	GENOTROPIN MINIQUICK	PFI	**Y**

1.8 MG/0.25 ML

02401827	GENOTROPIN MINIQUICK	PFI	**Y**

2 MG/0.25 ML

02401835	GENOTROPIN MINIQUICK	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**
02244726	AA-MEDROXY	AAA	**FGNQSW**

5MG TABLET

00030937	PROVERA	PFI	**FNQSW**
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**

LIOTHYRONINE

5MCG TABLET

02494337	TEVA-LIOTHYRONINE	TEV	**FGNQSW**
02549999	AURO-LIOTHYRONINE	ARO	**FGNQSW**

25MCG TABLET

02494345	TEVA-LIOTHYRONINE	TEV	**FGNQSW**
02550008	AURO-LIOTHYRONINE	ARO	**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	LEO	**FNQSW**
02528096	TARO-FUSIDIC ACID	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	TAR	**N**
02237227	POLYSPORIN	JJM	**N**
02357569	JAMPOLYCIN	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	**FNSQW**

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	**FNSQW**

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	**NSW**

TERBINAFINE HCL

1% TOPICAL CREAM

02031094	LAMISIL	NVR	**FNSQW**

1% TOPICAL SPRAY

02238703	LAMISIL	NVR	**FNSQW**

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
Hydrocortison 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

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

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-HYDROCORITSONE	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	ACCUTANE	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 ACCUTANE 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 CRITIERA
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**

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**

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

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	SDZ	**NW**
01987003	CYANOCOBALAMIN	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	AAA	**FGNQW**
02366061	JAMP-FOLIC ACID	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 CRITIERA

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 CRITIERA

3MG NASAL SPRAY

02492415	BAQSIMI (*)	APM	**DNQW**

*Regular benefit up to two devices per 12 months. Additional units require patient meets SA criteria

INTERFERON BETA-1A

SEE APPENDIX A FOR SA CRITERIA

30MCG PREFILLED SYRINGE, 30MCG PEN WITH AUTO-INJECTOR

02269201	AVONEX PS (SA)	BIG	**NMQW**

22MCG SYRINGE

02237319	REBIF (SA)	SRO	**NMQW**

44MCG SYRINGE

02237320	REBIF (SA)	SRO	**NMQW**

66MCG/1.5ML PRE-FILLED CARTRIDGE

02318253	REBIF MULTIDOSE (SA)	SRO	**NMQW**

132MCG/1.5ML PRE-FILLED CARTRIDGE

02318261	REBIF MULTIDOSE (SA)	SRO	**NMQW**

INTERFERON BETA-1B

SEE APPENDIX A FOR SA CRITERIA

0.3MG INJECTION POWDER

02169649	BETASERON (SA)	BAY	**NMQW**

LANADELUMAB

SEE APPENDIX A FOR SA CRITERIA

300MG/2ML VIAL

02480948	TAKHZYRO (SA)	TAK	**NMQW**
00904577	TAKHZYRO (SA)*		**NMQW**
00904578	TAKHZYRO (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

300MG/2ML PREFILLED SYRINGE

02505614	TAKHZYRO (SA)	TAK	**NMQW**
00904638	TAKHZYRO (SA)*		**NMQW**
00904639	TAKHZYRO (SA)*		**NMQW**

*use when drug cost in excess of CPHA maximum

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	AVN	**FNQSW**
02256495	APO-LEFLUNOMIDE	APX	**FGNQSW**
02261251	TEVA-LEFLUNOMIDE	TEV	**FGNQSW**
02283964	SANDOZ-LEFLUOMIDE	SDZ	**FGNQSW**
02351668	LEFLUNOMIDE	SNS	**FGNQSW**
02543575	LEFLUNOMIDE	SIV	**FGNQSW**
02551918	MAR-LEFLUNOMIDE	MAR	**FGNQSW**

20MG TABLET

02241889	ARAVA	AVN	**FNQSW**

02256509	APO-LEFLUNOMIDE	APX	**FGNQSW**
02261278	TEVA-LEFLUNOMIDE	TEV	**FGNQSW**
02283972	SANDOZ -EFLUOMIDE	SDZ	**FGNQSW**
02351676	LEFLUNOMIDE	SNS	**FGNQSW**
02543583	LEFLUNOMIDE	SIV	**FGNQSW**
02551926	MAR-LEFLUNOMIDE	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**

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

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	SDZ	**FNQSW**
02422433	ZOLEDRONIC ACID	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

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 — UCB **NMQW**

02331675 CIMZIA (SA)

200MG/ML AUTO-INJECTOR KIT — UCB **NMQW**

02465574 CIMZIA (SA)

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**
02551691	SANDOZ-TOFACITINIB (SA)	SDZ	**NMQW**

10MG TABLET

02480786	XELJANZ (SA)	PFI	**NMQW**
02511312	TARO-TOFACITINIB (SA)	TAR	**NMQW**
02530015	AURO-TOFACITINIB (SA)	ARO	**NMQW**
02551705	SANDOZ-TOFACITINIB (SA)	SDZ	**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	**FNQSTW**
02320630	SANDOZ-MYCOPHENOLATE	SDZ	**FGNQSTW**
02352559	APO-MYCOPHENOLATE	APX	**FGNQSTW**
02364883	TEVA-MYCOPHENOLATE	TEV	**FGNQSTW**
02383780	MYCOPHENOLATE MOFETIL	ACH	**FGNQSTW**
02386399	JAMP-MYCOPHENOLATE	JPC	**FGNQSTW**
02457369	MYCOPHENOLATE MOFETIL	SNS	**FGNQSTW**

500MG TABLET

02237484	CELLCEPT	HLR	**FNQSTW**
02313855	SANDOZ-MYCOPHENOLATE	SDZ	**FGNQSTW**
02352567	APO-MYCOPHENOLATE	APX	**FGNQSTW**
02348675	TEVA-MYCOPHENOLATE	TEV	**FGNQSTW**
02378574	MYCOPHENOLATE MOFETIL	ACH	**FGNQSTW**

02380382	JAMP-MYCOPHENOLATE	JPC	**FGNQSTW**
02457377	MYCOPHENOLATE MOFETIL	SNS	**FGNQSTW**

MYCOPHENOLATE SODIUM

180MG ENTERIC-COATED TABLET

02264560	MYFORTIC	NVR	**FNQSTW**
02372738	APO-MYCOPHENOLIC ACID	APX	**FGNQSTW**
02511673	MAR-MYCOPHENOLIC ACID	MAR	**FGNQSTW**
02518538	JAMP-MYCOPHENOLIC ACID	JPC	**FGNQSTW**

360MG ENTERIC-COATED TABLET

02264579	MYFORTIC	NVR	**FNQSTW**
02372746	APO-MYCOPHENOLIC ACID	APX	**FGNQSTW**
02511681	MAR-MYCOPHENOLIC ACID	MAR	**FGNQSTW**
02518511	JAMP-MYCOPHENOLIC ACID	JPC	**FGNQSTW**

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	ENVARSUS PA	END	**T**

1MG EXTENDED RELEASE TABLET

02485885	ENVARSUS PA	END	**T**

4MG EXTENDED RELEASE TABLET

02485893	ENVARSUS PA	END	**T**

92:92 OTHER MISCELLANEOUS AGENTS

CYSTEAMINE BITARTRATE
SEE APPENDIX A FOR SA CRITERIA
25MG CAPSULE

02464705	PROCYSBI (SA)	AMG	**MNQW**

75MG CAPSULE

02464713	PROCYSBI (SA)	AMG	**MNQW**
00904354	PROCYSBI (SA)*		**MNQW**

*use when drug cost in excess of CPHA maximum

SAPROPTERIN
SEE APPENDIX A FOR SA CRITERIA
100MG POWDER FOR ORAL SOLUTION

02534533	REDDY-SAPROPTERIN (SA)	RCH	**MNQW**
96599937	SAPROPTERIN (SA)*		**MNQW**

500MG POWDER FOR ORAL SOLUTION

02535610	REDDY-SAPROPTERIN (SA)	RCH	**MNQW**
96599936	SAPROPTERIN (SA)*		**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**
90109268	PHARYNGITIS WITH SWAB POSITIVE	**PHARMACY PLUS**
90109816	PHARYNGITIS WITH SWAB NEGATIVE	**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
- Pharmacists

- 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 Specialities (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 **PEI Pharmacare Forms | Government of Prince Edward Island**

- 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 **PEI Pharmacare Forms | Government of Prince Edward Island**

- 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-naive patients, a single loading dose of up to 1000mg, then 125mg sc injection should be give 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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Acamprosate, delayed release, tablet, 333mg (Campral-MYL)f

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/0.4mg 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 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 (not required for treatment of Fistulizing Crohn's Disease),
  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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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.
- 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Aflibercept, vial, 2mg/0.5mL (Eylea-BAY; Aflivu-APX; Yesafili-BIL); pre-filled syringe (Aflivu-APX; Yesafili-BIL)

For aflibercept-naïve patients whose aflibercept therapy is initiated after November 18, 2025, the aflibercept biosimilar (Aflivu or Yesafili) will be the product approved. Patients with existing PEI Pharmacare coverage for Eylea will need to switch to a currently listed biosimilar version before May 31, 2026, or by the renewal date of their current special

authorization, whichever is earlier, to maintain coverage through PEI Pharmacare.

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. <u>Retinal vein occlusion (RVO)</u>

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 PEI Pharmacare Forms | Government of Prince Edward Island

Agalsidase alfa – see Replagal

Agalsidase beta – see Fabrazyme

Agrylin - see Anagrelide

Ajovy – see Fremanezumab

Akeega – see Niraparib & Abiraterone Acetate

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 PEI Pharmacare Forms | Government of Prince Edward Island

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-Cless 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.

4. For patients who cannot take a statin due to an intolerance or contraindication, details must be provided (i.e. confirmed rhabdomyolysis, active liver disease, unexplained persistent elevations of serum transaminases exceeding three times the upper limit of normal).

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Amlodipine, oral solution, 1mg/mL (Generic)

- For patients who require administration though 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 metastases[1].
   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 PEI Pharmacare Forms | Government of Prince Edward Island

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 > 1500mg/m²
- Patients who receive carboplatin-based regimens with AUC ≥ 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 cabozantanib 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 cabozantanib or axitimib 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Azithromycin, tablet, 600mg (Generic)

For the prevention of disseminated Mycobacterium avium complex (MAC) disease in patients with advanced HIV infections.

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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/μL 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/μL 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 [PEI Pharmacare Forms | Government of Prince Edward Island]

Benzydamine HCl, oral rinse, 0.15% (Generic)

For oncology patients only.

Berotralstat 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 berotralstat compared to the number of attacks observed before initiating treatment with berotralstat; 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 berotralstat.

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 berotralstat, 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 Brolucizumab

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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Bosulif – see Bosutinib

Bosutinib, tablet, 100mg, 500mg (Bosulif-PFI and generic)

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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. <u>Neovascular Age-Related Macular Degeneration</u>

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. <u>Diabetic Macular Edema (DME)</u>

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 [PEI Pharmacare Forms | Government of Prince Edward Island]

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

Brukinsa – 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (not amenable to curative surgery or radiation therapy) or metastatic renal cell carcinoma when used as:

- First-line therapy in combination with nivolumab
- Second-line monotherapy following disease progression on:
  - vascular endothelial growth factor receptor (VEGFR) tyrosine kinase inhibitor (TKI) (i.e., sunitinib or pazopanib); or
  - pembrolizumab in combination with either axitinib or lenvatinib
- Third-line monotherapy following disease progression on:
  - first-line VEGFR TKI (i.e., sunitinib or pazopanib) and second-line nivolumab monotherapy; or
  - first-line nivolumab in combination with ipilimumab and second-line VEGFR TKI (i.e., sunitinib or pazopanib)

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:

- Patients who experience disease progression during or within 6 months of completing pembrolizumab in the adjuvant setting are not eligible for cabozantinib in combination with nivolumab for advanced RCC.
- Requests for cabozantinib will not be considered for patients who experience disease progression on 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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

Cenobamate, tablet, starter kit, 12.5mg, 25mg, 50mg, 100mg, 150mg, 200mg (Xcopri-KNI)

For the adjunctive treatment of refractory partial-onset seizures (POS) in patients who are currently receiving two or more antiepileptic drugs and have had an inadequate response or intolerance to at least three other antiepileptic drugs.

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 PEI Pharmacare Forms | Government of Prince Edward Island

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:

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 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:
    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 PEI Pharmacare Forms | Government of Prince Edward Island

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

PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 Dyhydrate, 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 Fumerate, 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, (Inspiolto 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) Salmeterol (Serevent)	Aclidinium (Tudorza Genuair) Glycopyrronium Bromide (Seebri) Tiotropium (Spiriva and generics) 18mcg; (Spiriva Respimat) 2.5mcg Umeclidinium Bromide (Incruse Ellipta)

All requests must include a numerical spirometry report. Reports from any date are acceptable. Requests submitted without a spirometry report will not be considered.

For any one agent listed in Table 1:
For the treatment of chronic obstructive pulmonary disease (COPD) as defined by spirometry[i] 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 FEV_1 <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)
Aclidinium Bromide & Formoterol Fumarate Dihydrate (Duaklir Genuair) Indacaterol/Glycopyrronium (Ultibro Breezhaler) Tiotropium/Olodaterol (Inspiolto 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 spirometry[i], 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 spirometry[i]
  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 spirometry[i], 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:

(i) COPD is defined by spirometry as a post bronchodilator FEV_1/FVC ratio of < 0.70. **All requests must include a numerical spirometry report. Reports from any date are acceptable. Requests submitted without a spirometry report will not be considered**.

(ii) 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 bitartrate, capsule, 25mg, 75mg (Procysbi-AMG)

For the treatment of infantile nephropathic cystinosis with documented cystinosin (lysosomal cystine transporter) gene mutation.

Claim Note:

- Must be prescribed by, or in consultation with, a prescriber with experience in the diagnosis and management of cystinosis.

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 cystinosin (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 PEI Pharmacare Forms | Government of Prince Edward Island

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 $CHADS_2$ 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 8thedition)
- 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 metastases[1].

- 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.

[1]High 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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)

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 (≥ 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 Aclidinium 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)

<u>Atopic Dermatitis</u>

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 ≥ 0.15×10^9/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 ≥ 0.15×10^9/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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 30kg: 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Enerzair Breezhaler – see Indacaterol & Glycopyrronium & Mometasone

Enfuvirtide, injection kit, 90mg/mL (Fuzeon-HLR)

For patients:

a) Who have a CD4 count greater than 100 cells/mm^3; **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 Enfurvirtide 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 PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 metastases[1].
    - 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.

[1]High 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≤ 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 PEI Pharmacare Forms | Government of Prince Edward Island

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

[PEI Pharmacare Forms | Government of Prince Edward Island]

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 PEI Pharmacare Forms | Government of Prince Edward Island

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:

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 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

Etrasimod, tablet, 2mg (Velsipity-PFI)

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 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 etrasimod with a biologic DMARD, JAK inhibitor or sphingosine 1-phosphate modulator will not be reimbursed.
- Approvals will be for a maximum dose of 2 mg daily.
- Initial Approval: 12 weeks

- Renewal Approval: 1 year

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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.
4. For patients who cannot take a statin due to an intolerance or contraindication, details must be provided (i.e. confirmed rhabdomyolysis, active liver disease, unexplained persistent elevations of serum transaminases exceeding three times the upper limit of normal).

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)

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

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

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.

Claim Notes:
- Approvals will be for a maximum of 1 vial/syringe per eye 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 malignant or chronic non-malignant pain in adult patients who were previously receiving continuous long-acting opioid administration, or who are unable to take oral therapy.

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 m^2 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 m^2 ; 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 Epoprostentol

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 Fumerate, 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

PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ▪ NS3/4A inhibitor treatment-naïve and treatment experienced with regimens	▪ 16 weeks

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.

Glucagen – 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

Hadlima - see Adalimumab

Harvoni – see Sofosbuvir & Ledipasvir

Hemangiol – 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Imbruvica – see Ibrutinib

Imitrex - see Sumatriptan

Inclisiran, pre-filled syringe, 284mg/1.5mL (Leqvio-NVR)

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:

- LDL-C levels must be provided.
- 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.
- For patients who cannot take a statin due to an intolerance or contraindication, details must be provided (i.e. confirmed rhabdomyolysis, active liver disease, unexplained persistent elevations of serum transaminases exceeding three times the upper limit of normal).
- For patients who cannot take ezetimibe due to an intolerance or contraindication, details must be provided.

Claim Notes:

- Initial approval: 6 months
- Renewal approval: 1 year
- Maximum dose approved: 284 mg initially, at 3 months, then every 6 months thereafter Inclisiran and PCSK9 inhibitors will not be insured in combination.

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-beta$_2$-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 (Atectura 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (not required for treatment of Fistulizing Crohn's Disease),
  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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≤ 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 then 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 FEV_1 of at least 5% when compared to the FEV_1 test conducted prior to the commencement of therapy. FEV_1 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 FEV_1 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

[1]Please 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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

Ixifi – see Infliximab

Jakavi – see Ruxolitinib

Jamteki – see Ustekinumab

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 PEI Pharmacare Forms | Government of Prince Edward Island

Lancora – see Ivabradine

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.

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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.

Hepatocelular 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Levemir – see Insulin Detemir

Levetiracetam, oral solution, 100mg/mL (Generic)

- For patients who require administration though 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Linezolid, tablet, 600mg (Generics)

(a) For the treatment of proven VRE (Vancomycin-Resistant Entercoccus) 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).

Claim Notes:
- The maximum dose reimbursed is 60mg daily.
- Pediatric patients 12 and under will not require written Special Authorization.

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥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 ≥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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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) ≥ 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 ≤ 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 PEI Pharmacare Forms | Government of Prince Edward Island

Mavenclad – see Cladribine

Maviret – see Glecaprevir & Pibrentasvir

Mayzent – see Siponimod

Mecasermin, 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/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/μL 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/μL 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
PEI Pharmacare Forms | Government of Prince Edward Island

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 Notes:

- The maximum dose reimbursed is 80 mg daily.
- Pediatric patients 12 and under will not require written Special Authorization.

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 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 ≥ 2 from baseline, and
    - a decrease in the rectal bleeding subscore ≥ 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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 course[1] (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 PEI Pharmacare Forms | Government of Prince Edward Island

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 Somatrogon

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (nindetanib) 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 ≥ 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 ≥ 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 (nindetanib) 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Niraparib & Abiraterone Acetate, tablet, 50mg & 500mg, 100mg & 500mg (Akeega-JAN)

In combination with prednisone for the first-line treatment of adult patients with deleterious or suspected deleterious germline and/or somatic BRCA-mutated metastatic castration-resistant prostate cancer (mCRPC) in whom chemotherapy is not clinically indicated.

Clinical Notes:

- Patients should have a good performance status.
- Treatment should continue until disease progression or unacceptable toxicity.
- Eligible patients must have a confirmed germline and/or somatic BRCA1 or BRCA2 gene alteration prior to starting treatment.
- Patients should not have received prior treatment with a poly - (ADP ribose)

polymerase (PARP) inhibitor, or with androgen-receptor-axis-targeted (ARAT) therapy (e.g., apalutamide, darolutamide, enzalutamide).

- Patients should not have received prior treatment with abiraterone, or are within 4 months of initiating abiraterone in the mCRPC setting with no disease progression.

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 PEI Pharmacare Forms | Government of Prince Edward Island

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/1.73m^2)

- 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

1) Patient is not currently requiring permanent invasive ventilation*, AND
2) 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 less than 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Ofev – see Nintedanib

Olaparib, tablet, 100 mg, 150 mg (Lynparza- AZE)

First-Line Metastatic Castrate-Resistant Prostate Cancer

In combination with abiraterone and prednisone for the first-line treatment of adult patients with deleterious or suspected deleterious germline and/or somatic BRCA-mutated metastatic castration-resistant prostate cancer (mCRPC) in whom chemotherapy is not clinically indicated.

Clinical Notes:

- Patients should have a good performance status.
- Treatment should continue until disease progression or unacceptable toxicity.
- Eligible patients must have a confirmed germline and/or somatic BRCA1 or BRCA2 gene alteration prior to starting treatment.
- Patients should not have received prior treatment with a poly - (ADP ribose) polymerase (PARP) inhibitor, or with androgen-receptor-axis-targeted (ARAT) therapy (e.g., apalutamide, darolutamide, enzalutamide).
- Patients should not have received prior treatment with abiraterone or are within 4 months of initiating abiraterone in the mCRPC setting with no disease progression.

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.

[1]Patients 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 ≤ 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 [PEI Pharmacare Forms | Government of Prince Edward Island]

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:

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 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 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 ≥ 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 (nindetanib) 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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.

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Pulmozyme – see Dornase Alfa

Pradaxa – see Dabigatran

Praluent – see Alirocumab

Prevacid - see Lansoprazole

Prevacid FasTab – see Lansoprazole

Prevymis – see Letermovir

Procysbi – see Cysteamine bitartrate

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.

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)

For ranibizumab-naïve patients whose ranibizumab therapy is initiated after November 18, 2025, the ranibizumab biosimilar (Byooviz or Ranopto) will be the product approved. Patients with existing PEI Pharmacare coverage for Lucentis will need to switch to a currently listed biosimilar version before May 31, 2026, or by the renewal date of their current special authorization, whichever is earlier, to maintain coverage through PEI Pharmacare.

1. **<u>Neovascular Age-Related Macular Degeneration</u>**

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. <u>Diabetic Macular Edema (DME)</u>

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. <u>Retinal Vein Occlusion (RVO)</u>

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 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/1.73m^2, 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 x 10^9/L, platelet count below 20 x 10^9/L, reticulocytes below 25 x 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 ≥ 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 × 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 < 60mL/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 ≥ 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 < 30mL/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 ≥ 25% decline from patient baseline or thrombocytopenia (platelet count < 150,000 × 10^9/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

PEI Pharmacare Forms | Government of Prince Edward Island

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.

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Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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* 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 ≤ 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (not required for treatment of Fistulizing Crohn's Disease),
  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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 rheumatoid arthritis, vasculitis, or other autoimmune disease.

Claim Notes:

- Must be prescribed by a specialist.
- Initial Approval: 6 months.
- Renewal Approval: Long term. Confirmation of continued response is required.
- 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥ 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)

<u>Acute Graft-Versus-Host Disease</u>

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 x 10^9/L and white blood cell count > 10 x 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 x 10^9/L, platelet count < 100 x 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 x 10^9/L, white blood cell count < 10 x 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 PEI Pharmacare Forms | Government of Prince Edward Island

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) ≥ 150pg/mL or N-terminal prohormone B-type natriuretic peptide (NTproBNP) ≥ 600 pg/mL.

Clinical Notes:

1. A plasma BNP ≥ 100 pg/mL or NT-proBNP ≥ 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 umol/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 umol/L to 360 umol/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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 treatments[1] for NMOSD, OR
  - because the patient cannot tolerate other preventive treatments[1] 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.

[1]Other 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
PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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-TNFα 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

Serc - see Betahistine

Serevent - see Salmeterol

Serevent Diskus - see Salmeterol

Sevelamer carbonate, tablet, 800mg (Accel-Sevelamer)

For the treatment of hyperphosphetemia (>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).

Sevelamer hcl, tablet, 800mg (Renagel-GZY)

For the treatment of hyperphosphetemia (>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 [PEI Pharmacare Forms | Government of Prince Edward Island]

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 PEI Pharmacare Forms | Government of Prince Edward Island

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).

Somatrogon, 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 is 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 somatrogon 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 PEI Pharmacare Forms | Government of Prince Edward Island

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, poweder 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 arteriolopathy)

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)

a) 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.

b) 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.

c) 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 PEI Pharmacare Forms | Government of Prince Edward Island

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-99mm 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-99mm 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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, orichidectomy, 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 ris/k 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; Tyenne-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.

<u>Giant Cell Arteritis</u>

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 8thedition)
- 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Trikafta – see Elexacaftor & Tezacaftor & Ivacaftor & Ivacaftor

Trileptal - see Oxcarbazepine

Trispan – see Triamcinolone Hexacetonide

Trospium, tablet, 20mg (Generics)

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 Aclidinium 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
PEI Pharmacare Forms | Government of Prince Edward Island

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
PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (not required for treatment of Fistulizing Crohn's Disease),
  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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 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.
- 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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 ≥ 20mg weekly (≥15mg 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
PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at
PEI Pharmacare Forms | Government of Prince Edward Island

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 (not required for treatment of Fistulizing Crohn's Disease),
  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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

Vabysmo – see Faricimab

Valcyte - see Valganciclovir

Valganciclovir, tablet, 450mg (Valcyte-CAG and generics)

a) For the treatment of cytomegalovirus (CMV) retinitis in patients with AIDS.
b) 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:

a) For the treatment of cytomegalovirus (CMV) retinitis in patients with AIDS.
b) 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 (not required for treatment of Fistulizing Crohn's Disease),
  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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Patients requesting coverage through the High Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

Velsipity – see Etrasimod

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 PEI Pharmacare Forms | Government of Prince Edward Island

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 and 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 PEI Pharmacare Forms | Government of Prince Edward Island

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 PEI Pharmacare Forms | Government of Prince Edward Island

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

Xcopri – see Cenobamate

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, tablet, 160mg (Brukinsa-BIG)

<u>Chronic Lymphocytic Leukemia</u>

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 Waldenstrom 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 PEI Pharmacare Forms | Government of Prince Edward Island

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.

Zofran - see Ondansetron

Zydelig – see Idelalisib

Zykadia – see Ceritinib

Zymar – see Gatifloxacin

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 Coroporation
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

EPM	Essential Pharma
ERF	Erfa Canada Inc.
ETH	Ethypharm Inc.
EUP	Eugia Pharma
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
LXO	Laboratoire X.O
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 Labortory
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® Paradigm ® Pump (3.0mls reservoir)	MMT-332A	3.0 mls reservoir for use in 7 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 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)
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 • *P cap connectors* - Compatible with Medtronic insulin pumps only • *Leur Lock connectors*- 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 ¾ " 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*