Health PEI

P.E.I. Pharmacare Formulary
Inquiries should be directed to:

<table>
<thead>
<tr>
<th>PEI Pharmacare</th>
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<tr>
<td>Health PEI</td>
</tr>
<tr>
<td>P.O. Box 2000, 20 Fitzroy St.</td>
</tr>
<tr>
<td>Charlottetown, PEI</td>
</tr>
<tr>
<td>C1A 7N8</td>
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Telephone inquiries should be directed to:

<table>
<thead>
<tr>
<th>Inquiries</th>
<th>Phone Numbers</th>
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<tbody>
<tr>
<td>Client Eligibility</td>
<td>1-902-368-4947 Charlottetown</td>
</tr>
<tr>
<td>Prescriber Eligibility</td>
<td>1-877-577-3737 Toll Free in PEI</td>
</tr>
<tr>
<td>Medication Eligibility</td>
<td>1-902-368-4905 Fax</td>
</tr>
<tr>
<td>Pharmacy Eligibility</td>
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<td>Pharmacist Eligibility</td>
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<td>Claim Inquiries</td>
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<td>Special Authorization Drug Status</td>
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<td>Formulary Inquiries</td>
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<tr>
<td>Pharmacy Information Program (PhIP) Inquiries</td>
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<tr>
<td>and Technical Support Help Desk</td>
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<tr>
<td>PEI Insulin Pump Program</td>
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<tr>
<td>Montague Health Center</td>
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</tr>
<tr>
<td>407 MacIntyre Avenue</td>
<td></td>
</tr>
<tr>
<td>Montague, PE C0A 1R0</td>
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Published by the authority of the Minister of Health and Wellness, Province of Prince Edward Island for the exclusive use of PEI Pharmacare

Updated: May 2021
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
- Nursing Home Drug Program
- Nutrition Services Program
- Opioid Replacement Therapy Program
- Phenylketonuria (PKU) Program
- Smoking Cessation Drug Program
- Seniors Drug Program
- Sexually Transmitted Diseases 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 Health PEI website at – www.healthpei.ca/formulary
### PRINCE EDWARD ISLAND DRUG PROGRAMS

<table>
<thead>
<tr>
<th>Program (Formulary Code)</th>
<th>Beneficiaries</th>
<th>Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td><strong>Programs Delivered Through Community Retail Pharmacies</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Children-In-Care Program (W)</strong></td>
<td>Persons in temporary or permanent custody of the Director of Child Welfare</td>
<td>All prescription medications. Non-prescription medications approved under the Financial Assistance Program</td>
<td>No fee.</td>
</tr>
<tr>
<td><strong>Generic Drug Program (G)</strong></td>
<td>Persons less than 65 years of age with no private drug insurance</td>
<td>Approved generic prescription medications.</td>
<td>Maximum of $19.95 per prescription.</td>
</tr>
<tr>
<td><strong>Diabetes Drug Program (D)</strong></td>
<td>Persons eligible for PEI Medicare, diagnosed with diabetes, and registered with the program.</td>
<td>Approved insulin products</td>
<td>$10.00 per 10 mL vial of insulin. $20.00 per box of insulin cartridges.</td>
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<tr>
<td></td>
<td></td>
<td>Approved oral diabetes medications</td>
<td>$11.00 per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approved urine testing materials (Diastix and Ketostix – no prescription required)</td>
<td>$11.00 per prescription</td>
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<tr>
<td></td>
<td></td>
<td>Blood Glucose test strips. Patients must have used insulin within 150 days (no prescription required).</td>
<td>$11 per dispense. Maximum of 100 strips per 25 days.</td>
</tr>
<tr>
<td><strong>Financial Assistance Drug Program (W)</strong></td>
<td>Persons eligible under the Social Assistance Act and Regulations.</td>
<td>Approved prescription and non-prescription medications.</td>
<td>No fee.</td>
</tr>
<tr>
<td><strong>Family Health Benefit Drug Program</strong></td>
<td>Families (parents, guardians, and children under 25</td>
<td>Approved prescription medications.</td>
<td>The pharmacy professional fee for each prescription</td>
</tr>
<tr>
<td>Program (Formulary Code)</td>
<td>Beneficiaries</td>
<td>Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)</td>
<td>Fee</td>
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<tr>
<td>(F)</td>
<td>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.</td>
<td>obtained.</td>
<td></td>
</tr>
<tr>
<td>High-Cost Drug Program (M)</td>
<td>Persons eligible for PEI Medicare and approved for coverage for one or more of the medications included in the program. Patients must apply for coverage on an annual basis and provide income information to the program.</td>
<td>Approved high-cost medications.</td>
<td>An income-based portion of the medication cost plus the pharmacy professional fee for each prescription obtained.</td>
</tr>
<tr>
<td>Nursing Home Drug Program (N)</td>
<td>Residents in private nursing homes eligible for coverage under the Social Assistance Act.</td>
<td>Approved prescription and non-prescription medications.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Opioid Replacement Therapy Drug Program (L)</td>
<td>Persons eligible for PEI Medicare and assessed by a clinical team through Health PEI and determined to require treatment for an opioid use disorder and registered in a program of opioid</td>
<td>Approved prescription medications.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Program (Formulary Code)</td>
<td>Beneficiaries</td>
<td>Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)</td>
<td>Fee</td>
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<tr>
<td>Smoking Cessation Drug Program (Z)</td>
<td>Persons eligible for PEI Medicare and having received smoking cessation counselling through Primary Care. For more information please visit <a href="http://www.princeedwardisland.ca/quitsmoking">www.princeedwardisland.ca/quitsmoking</a></td>
<td>12 weeks of approved prescription or non-prescription medications.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Seniors Drug Program (S)</td>
<td>Persons eligible for PEI Medicare and 65 years of age or older. Eligibility is effective upon a person becoming 65 years of age.</td>
<td>Approved prescription medications.</td>
<td>First $8.25 of the medication cost plus the first $7.69 of the pharmacy dispensing fee for each prescription obtained.</td>
</tr>
<tr>
<td>Catastrophic Drug Program (Q)</td>
<td>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.</td>
<td>Out of pocket costs for eligible drug expenses</td>
<td>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.</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases (STD) Program (V)</td>
<td>Persons diagnosed with a sexually transmitted disease or identified contacts of a person diagnosed with a</td>
<td>Approved antibiotics</td>
<td>No fee.</td>
</tr>
<tr>
<td>Program (Formulary Code)</td>
<td>Beneficiaries</td>
<td>Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)</td>
<td>Fee</td>
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<tr>
<td>HIV Drug Program (A)</td>
<td>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.</td>
<td>Approved antiretroviral agents and adjunctive therapies.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Community Mental Health Drug Program (B)</td>
<td>Approved long-term psychiatric patients living in the community.</td>
<td>Approved long-acting injectable antipsychotic medications provided through out-patient psychiatric programs.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Cystic Fibrosis Drug Program (C)</td>
<td>Persons eligible for PEI Medicare, diagnosed with cystic fibrosis, and who are registered with the program.</td>
<td>Approved prescription and non-prescription medications.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Growth Hormone Drug Program (Y)</td>
<td>Children eligible for PEI Medicare, with a proven growth hormone deficiency or Turners Syndrome, and who are registered with the program.</td>
<td>Approved growth hormone supplements.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Hepatitis Drug Program (H)</td>
<td>Persons diagnosed with hepatitis</td>
<td>Approved prescription medications.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Persons who have been in close contact</td>
<td>Hepatitis A vaccine</td>
<td>No fee.</td>
<td></td>
</tr>
<tr>
<td>Program (Formulary Code)</td>
<td>Beneficiaries</td>
<td>Benefits (Note: A prescription is required for all benefits unless otherwise indicated.)</td>
<td>Fee</td>
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<td>with a person diagnosed with hepatitis or are at risk of infection.</td>
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<td></td>
<td>Hepatitis B vaccine</td>
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<td></td>
<td></td>
<td>Hepatitis A &amp; B vaccine</td>
<td></td>
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<tr>
<td>Institutional Pharmacy Program (N)</td>
<td>Residents in government manors.</td>
<td>Approved prescription and non-prescription medications.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Nutrition Services Program (O)</td>
<td>High-risk pregnant women diagnosed with a nutritional deficiency.</td>
<td>Approved vitamin and mineral supplement provided through Community Nutritionists.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Phenylketonuria (PKU) Program (P)</td>
<td>Persons eligible for PEI Medicare, diagnosed with phenylketonuria, and who are registered with the program.</td>
<td>Special low protein formula. Up to $3600 annually for low protein food items.</td>
<td>No fee.</td>
</tr>
<tr>
<td>Transplant Drugs Program (T)</td>
<td>Persons eligible for PEI Medicare, who received a bone marrow or solid organ transplant, and are registered with the program.</td>
<td>Approved immunosuppressant medications</td>
<td>No fee.</td>
</tr>
<tr>
<td>Tuberculosis (TB) Drug Program (X)</td>
<td>Persons diagnosed with tuberculosis or who have been in close contact with a person diagnosed with tuberculosis, and who have registered with the program through the Chief Health Officer.</td>
<td>Approved antibiotics</td>
<td>No fee.</td>
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<thead>
<tr>
<th>Programs Delivered Through Hospitals</th>
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<tbody>
<tr>
<td>Erythropoietin Program (E)</td>
<td>Persons eligible for PEI Medicare, have been diagnosed with chronic renal failure</td>
</tr>
<tr>
<td>Program (Formulary Code)</td>
<td>Beneficiaries</td>
</tr>
<tr>
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<tr>
<td></td>
<td>or are receiving kidney dialysis.</td>
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## PEI Insulin Pump Program

<table>
<thead>
<tr>
<th>Program</th>
<th>Beneficiaries</th>
<th>Benefits</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td>Programs Delivered Through Approved Vendors (who have entered into an agreement with Health PEI) <strong>See Appendix D For Approved Vendors</strong></td>
<td></td>
<td>An income-based program. Funding through the program varies depending on household income and private health insurance coverage.</td>
<td></td>
</tr>
<tr>
<td>Insulin Pump Program</td>
<td>Children / Youth up to the age of 25 years living with type 1 diabetes who meet eligibility requirements</td>
<td>Insulin pump and pump supplies from the approved vendors list <em>(see appendix D)</em>&lt;br&gt;The following list details the supplies that are eligible for coverage under the PEI Insulin Pump Program:&lt;br&gt;  - Insulin pump (one pump every 5 years)&lt;br&gt;  - Infusion sets (maximum of 140 sets per year)&lt;br&gt;  - Reservoirs (maximum of 140 per year)&lt;br&gt;  - Site inserts (maximum of one replacement device per year)&lt;br&gt;  - Skin adhesive wipes (maximum of 150 per year)&lt;br&gt;  - Sterile transparent dressings (maximum of 200 per year)</td>
<td>An income-based program. Funding through the program varies depending on household income and private health insurance coverage.</td>
</tr>
</tbody>
</table>

*www.healthpei.ca/insulin-pump*
## PEI Ostomy Supplies Program

<table>
<thead>
<tr>
<th>Program</th>
<th>Beneficiaries</th>
<th>Benefits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs Delivered Through Ostomy Supply Vendors</td>
<td>See Appendix E for Eligible Supplies</td>
<td>Ostomy supplies (see appendix E for examples)</td>
<td>An income-based program.</td>
</tr>
<tr>
<td>Ostomy Supplies Program</td>
<td>Persons eligible for PEI Medicare, with permanent abdominal ostomies who meet</td>
<td>Coverage is in the form of reimbursement, and will be based on the client's household income. Coverage is not retroactive. Clients must be enrolled in the Ostomy Supplies Program at the time of ostomy supply purchase to be eligible for reimbursement.</td>
<td>Funding through the program varies depending on household income and private health insurance coverage</td>
</tr>
<tr>
<td></td>
<td>requirements <a href="#">Ostomy Supplies Program</a></td>
<td>The following list details the categories that are eligible for coverage under the PEI Ostomy Supplies Program:</td>
<td>Ostomy Supplies Program</td>
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<tr>
<td></td>
<td></td>
<td>• Skin wafers</td>
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<td></td>
<td></td>
<td>• Ostomy pouches</td>
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<td></td>
<td></td>
<td>• Adhesive removers</td>
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<td></td>
<td></td>
<td>• Skin barrier wipes</td>
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<td></td>
<td></td>
<td>• Stoma powders, pastes, and barrier rings</td>
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<td></td>
<td></td>
<td>• Ostomy belts <a href="#">Appendix E</a></td>
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</table>
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), 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](#).
National Common Drug Review
PEI is a participant in the national Common Drug Review (CDR) process. The CDR 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 Canadian Expert Drug Advisory Committee (CEDAC).

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

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

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

Atlantic Common Drug Review
PEI is a participant in the Atlantic Common Drug Review (ACDR). The ACDR provides the provincial drug benefit programs in New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island with a systematic review of the best available clinical evidence, and a formulary listing recommendation made by the Atlantic Expert Advisory Committee (AEAC), for drugs that do not fall under the mandate of CDR 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
Health PEI
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 Common Drug Review (CDR) 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
The final formulary listing decision is made by the Provincial Drugs and Therapeutics committee (PD&T). Final drug formulary listing is based on the expert advisory committees’ recommendation and other factors such as drug plan mandates, jurisdictional priorities, budget impact, and resources. Drug formulary listing decisions for PEI Pharmacare are announced in a Bulletin which is posted on the PEI Pharmacare webpage.
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.


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. Canadian Agency for Drugs and Technologies in Health (CADTH)

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. Canadian Agency for Drugs and Technologies in Health (CADTH)


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, High-Cost Drugs, Institutional Pharmacy, Nursing Home, Seniors, and Transplant Drugs 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.

Unless special authorization is granted, clients 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.

In cases where a patient experiences problems with a specific brand of medication (e.g. a documented allergy) and has tried all other eligible generic products, a prescriber may apply to PEI Pharmacare for exemption from the cost of the higher cost brand by submitting a completed Special Authorization Request form.
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, Department of Veterans Affairs, Non-Insured Health Benefits, 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
  - 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 and appliances, and medical supplies, including first aid supplies and syringes.
PRESCRIPTION QUANTITIES
Based on the negotiated Pharmacy Services Contract between the Province and the PEI Pharmacists’ Association and due to possible wastage as well as the potential danger of storing large quantities of potent drugs in the home, all PEI Pharmacare programs have limits on the maximum days supply of drugs that will be paid for at one time. These limits are:

<table>
<thead>
<tr>
<th>Program</th>
<th>Maximum Allowable Days Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home Drug Program</td>
<td>35</td>
</tr>
<tr>
<td>Institutional Pharmacy Program (Gov’t Manors)</td>
<td>35</td>
</tr>
<tr>
<td>HIV Drug Program</td>
<td>60</td>
</tr>
<tr>
<td>Catastrophic Drug Program</td>
<td>30 - regular drugs, 90 - maintenance drugs</td>
</tr>
<tr>
<td></td>
<td>30 - drugs under SA coverage</td>
</tr>
<tr>
<td></td>
<td><em>Note: Prescriptions introducing a new medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</em></td>
</tr>
<tr>
<td>Children-In-Care Program</td>
<td>30 - regular drugs, 90 - maintenance drugs</td>
</tr>
<tr>
<td></td>
<td><em>Note: Prescriptions introducing a new medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</em></td>
</tr>
<tr>
<td>Community Mental Health Drug Program</td>
<td>not applicable</td>
</tr>
<tr>
<td>Cystic Fibrosis Drug Program</td>
<td>60</td>
</tr>
<tr>
<td>Diabetes Drug Program</td>
<td>25 – test strips, 30 – insulin, 90 - oral medications</td>
</tr>
<tr>
<td></td>
<td>30 - drugs under SA coverage</td>
</tr>
<tr>
<td></td>
<td><em>Note: Prescriptions introducing a new medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</em></td>
</tr>
<tr>
<td>Erythropoietin Program</td>
<td>not applicable</td>
</tr>
<tr>
<td>Family Health Benefit Drug Program</td>
<td>30 - regular drugs, 90 - maintenance drugs</td>
</tr>
<tr>
<td></td>
<td>30 - drugs under SA coverage</td>
</tr>
<tr>
<td></td>
<td><em>Note: Prescriptions introducing a new medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</em></td>
</tr>
<tr>
<td>Financial Assistance Drug Program</td>
<td>30 - regular drugs, 90 - maintenance drugs</td>
</tr>
<tr>
<td></td>
<td>30 - drugs under SA coverage</td>
</tr>
<tr>
<td></td>
<td><em>Note: Prescriptions introducing a new medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</em></td>
</tr>
<tr>
<td>Generic Drug Program</td>
<td>90 - regular drugs, 90 - maintenance drugs</td>
</tr>
<tr>
<td></td>
<td>30 - drugs under SA coverage</td>
</tr>
<tr>
<td></td>
<td><em>Note: Prescriptions introducing a new medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</em></td>
</tr>
<tr>
<td>Program</td>
<td>Maximum Allowable Days Supply</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</td>
</tr>
<tr>
<td>Growth Hormone Drug Program</td>
<td>30</td>
</tr>
<tr>
<td>Hepatitis Drug Program</td>
<td>30</td>
</tr>
<tr>
<td>High-Cost Drug Program</td>
<td>30, unless otherwise specified in criteria for drug(s).</td>
</tr>
<tr>
<td>Nutrition Services Program</td>
<td>not applicable</td>
</tr>
<tr>
<td>Opioid Replacement Therapy Program</td>
<td>not applicable</td>
</tr>
<tr>
<td>Phenylketonuria Program</td>
<td>60</td>
</tr>
<tr>
<td>Seniors Drug Program</td>
<td>30 - regular drugs, 90 - maintenance drugs 30 - drugs under SA coverage</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Prescriptions introducing a new medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills.</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases Program</td>
<td>not applicable</td>
</tr>
<tr>
<td>Smoking Cessation Drug Program</td>
<td>28 days – OTC Drugs ; 28 days – Prescription drugs</td>
</tr>
<tr>
<td>Transplant Drugs Program</td>
<td>60</td>
</tr>
<tr>
<td>Tuberculosis Drug Program</td>
<td>60</td>
</tr>
</tbody>
</table>

Maintenance drugs under the Children-In-Care, Family Health Benefit, Financial Assistance, and Seniors Programs include:

a. Antilipemic agents, including statins, fibrates, and bile acid sequestrants.

b. Oral nonsteroidal anti-inflammatory agents (NSAIDS), as well as Acetaminophen 325 mg & 500mg tablets.

c. Gastrointestinal agents, including digestants, histamine H2 antagonists, prostaglandins, protectants, and proton pump inhibitors.

d. Cardiovascular Drugs, including beta blockers, calcium channel blockers, ACE inhibitors, angiotensin receptor blockers. Nitroglycerin transdermal patches are not included.

e. Antihypertensives, including beta blockers, calcium channel blockers, ACE inhibitors, angiotensin receptor blockers.

f. Anticonvulsants

g. Anti-Coagulants
h. Diuretics

i. Estrogens/Progestogens, including oral contraceptives and products for the prevention of menopause symptoms.

j. Tamsulosin for use in benign prostatic hyperplasia (BPH).

k. Thyroid preparations

l. Other therapeutic classifications or specific drugs which may be listed following negotiations with the P.E.I. Pharmacists’ Association.

Maintenance drugs are identified in the formulary by an asterix (*) preceding the non-proprietary or generic name.

STANDARDIZATION OF PACKAGE SIZES
In order 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.

<table>
<thead>
<tr>
<th>FORM</th>
<th>QUANTITY</th>
<th>FORM</th>
<th>QUANTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosols</td>
<td>Per dose</td>
<td>Nasal sprays</td>
<td>Per dose</td>
</tr>
<tr>
<td>Capsules</td>
<td>Per capsule</td>
<td>Nebules</td>
<td>Per ml</td>
</tr>
<tr>
<td>Creams</td>
<td>Per gram</td>
<td>Ointments</td>
<td>Per gram</td>
</tr>
<tr>
<td>Enemas</td>
<td>Per gm/per ml</td>
<td>Oral Contraceptives</td>
<td>Per tablet</td>
</tr>
<tr>
<td>Gels</td>
<td>Per gram</td>
<td>Patches</td>
<td>Per patch</td>
</tr>
<tr>
<td>Inhalers</td>
<td>Per dose</td>
<td>Powders</td>
<td>Per gram</td>
</tr>
<tr>
<td>Insulins (vials, pens, cartridges)</td>
<td>Per ml</td>
<td>Powder injectables</td>
<td>Per vial</td>
</tr>
<tr>
<td>Kits</td>
<td>Per kit</td>
<td>Suppositories</td>
<td>Per supp</td>
</tr>
<tr>
<td>Liquids Injectables</td>
<td>Per vial/syr</td>
<td>Tablets</td>
<td>Per tablet</td>
</tr>
<tr>
<td>Liquids</td>
<td>Per ml</td>
<td>Test Strips</td>
<td>Per strip</td>
</tr>
</tbody>
</table>
**LEGEND**

**08:12.16 ANTIBIOTICS PENICILLINS**

**AMOXICILLIN**

250MG CAPSULE

<table>
<thead>
<tr>
<th>Code</th>
<th>Brand Name</th>
<th>Code</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>00406724</td>
<td>NOVAMOXIN</td>
<td>00628115</td>
<td>APO-AMOXI</td>
</tr>
<tr>
<td>02352710</td>
<td>AMOXICILLIN</td>
<td>02388073</td>
<td>AURO-AMOXICILLIN</td>
</tr>
<tr>
<td>02433060</td>
<td>JAMP-AMOXICILLIN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CEFPROZIL**

SEE APPENDIX A FOR SA CRITERIA

250MG TABLET

<table>
<thead>
<tr>
<th>Code</th>
<th>Brand Name</th>
<th>Code</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>02293528</td>
<td>RAN-CEFPROZIL (SA)</td>
<td>02302179</td>
<td>SANDOZ-CEFPROZIL (SA)</td>
</tr>
</tbody>
</table>

**LATANOPROST**

50UG/ML OPHTHALMIC SOLUTION

<table>
<thead>
<tr>
<th>Code</th>
<th>Brand Name</th>
<th>Code</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>02231493</td>
<td>XALATAN</td>
<td>02254786</td>
<td>TEVA-LATANOPROST</td>
</tr>
<tr>
<td>02296527</td>
<td>APO-LATANOPROST</td>
<td>02317125</td>
<td>PMS-LANANOPROST</td>
</tr>
<tr>
<td>02367335</td>
<td>SANDOZ-LATANOPROST</td>
<td>02373041</td>
<td>GD-LATANOPROST</td>
</tr>
<tr>
<td>02426935</td>
<td>MED-LATANOPROST</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The provincial drug programs will only pay for one 2.5 mL bottle of Latanoprost per client every 30 days. Clients are responsible for the entire prescription cost of any Latanoprost required beyond this.
**Legend Key:**

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>HIV Drug Program</td>
</tr>
<tr>
<td>B</td>
<td>Community Mental Health Drug Program</td>
</tr>
<tr>
<td>C</td>
<td>Cystic Fibrosis Drug Program</td>
</tr>
<tr>
<td>D</td>
<td>Diabetes Drug Program</td>
</tr>
<tr>
<td>E</td>
<td>Erythropoietin Program</td>
</tr>
<tr>
<td>F</td>
<td>Family Health Benefit Drug Program</td>
</tr>
<tr>
<td>G</td>
<td>Generic Drug Program</td>
</tr>
<tr>
<td>H</td>
<td>Hepatitis Drug Program</td>
</tr>
<tr>
<td>L</td>
<td>Opioid Replacement Therapy Program</td>
</tr>
<tr>
<td>M</td>
<td>High-Cost Drug Program</td>
</tr>
<tr>
<td>N</td>
<td>Nursing Home/Institutional Program</td>
</tr>
<tr>
<td>O</td>
<td>Nutrition Services Program</td>
</tr>
<tr>
<td>P</td>
<td>Phenylketonuria (PKU) Program</td>
</tr>
<tr>
<td>Q</td>
<td>Catastrophic Drug Program</td>
</tr>
<tr>
<td>S</td>
<td>Seniors Drug Program</td>
</tr>
<tr>
<td>T</td>
<td>Transplant Drug Program</td>
</tr>
<tr>
<td>V</td>
<td>Sexually Transmitted Diseases (STD) Program</td>
</tr>
<tr>
<td>W</td>
<td>Financial Assistance Program / Children-In-Care Program</td>
</tr>
<tr>
<td>X</td>
<td>Tuberculosis (TB) Drug Program</td>
</tr>
<tr>
<td>Y</td>
<td>Growth Hormone Program</td>
</tr>
<tr>
<td>Z</td>
<td>Smoking Cessation Drug Program</td>
</tr>
</tbody>
</table>

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

DIPHENHYDRAMINE HCL
25MG CAPSULE
00757683  PDP-DIPHENHYDRAMINE PEN NW
50MG CAPSULE
00757691  PDP-DIPHENHYDRAMINE PEN NW

12.5MG/5ML ELIXIR
02019736  BENADRYL MCL 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
PYRANTEL PAMOATE
125MG TABLET
01944363 COMBANTRIN MCL 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
02420287 JAMP-TOBRAMYCIN JPC CFGNQSW

08:12.04 ANTIBIOTICS ANTIFUNGALS

FLUCONAZOLE
SEE APPENDIX A FOR SA CRITERIA (HIV PROGRAM DOES NOT REQUIRE AN SA REQUEST)
50MG TABLET
02236978 TEVA-FLUCONAZOLE (SA) TEV AFGNQSW
02237370 APO-FLUCONAZOLE (SA) APX AFGNQSW
02245292 MYLAN-FLUCONAZOLE (SA) MYL AFGNQSW
02245643 PMS-FLUCONAZOLE (SA) PMS AFGNQSW
02281260 ACT-FLUCONAZOLE (SA) ATV AFGNQSW

100MG TABLET
02236979 TEV-FLUCONAZOLE (SA) TEV AFGNQSW
02237371 APO-FLUCONAZOLE (SA) APX AFGNQSW
02245293 MYLAN-FLUCONAZOLE (SA) MYL AFGNQSW
02245644 PMS-FLUCONAZOLE (SA) PMS AFGNQSW
02281279 ACT-FLUCONAZOLE (SA) ATV AFGNQSW

150MG TABLET
02141442 DIFLUCAN ONE (SA) PFI AFGNQSW
02241895 APO-FLUCONAZOLE (SA) APX AFGNQSW
ITRACONAZOLE
SEE APPENDIX A FOR SA CRITERIA
100MG CAPSULE
02047454  SPORANOX (SA)  JAN  FNQSW
02462559  MINT-ITRACONAZOLE (SA)  MNT  FGNQSW

KETOCONAZOLE
SEE APPENDIX A FOR SA CRITERIA (HIV PROGRAM DOES NOT REQUIRE AN SA REQUEST)
200MG TABLET
02231061  TEVA-KETOCONAZOLE (SA)  TEV  AFGNQSW
02237235  APO-KETOCONAZOLE (SA)  APX  AFGNQSW

08:12.06  ANTIBIOTICS CEPHALOSPORINS

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

CEFIXIME
400MG TABLET
00868981  SUPRAX  ODN  FNQSVW
02432773  AURO-CEFIXIME  ARO  FGNQSVW

CEFPROZIL
SEE APPENDIX A FOR SA CRITERIA
250MG TABLET
02293528  RAN-CEFPROZIL (SA)  RAN  FGNQSW
02302179  SANDOZ-CEFPROZIL (SA)  SDZ  FGNQSW

500MG TABLET
02293536  RAN-CEFPROZIL (SA)  RAN  FGNQSW
02302187  SANDOZ-CEFPROZIL (SA)  SDZ  FGNQSW
02347253  AURO-CEFPROZIL (SA)  ARO  FGNQSW

25MG/ML ORAL SUSPENSION
02329204  RAN-CEFPROZIL (SA)  RAN  FGNQSW

50MG/ML ORAL SUSPENSION
02293579 RAN-CEFPROZIL (SA) RAN FGNQSW

CEFTRIAXONE
1.0G/VIAL INTRAMUSCULAR INJECTION
02287633 CEFTRIAXONE FOR SODIUM TEV NQ
02292270 CEFTRIAXONE SDZ NQ
02292874 CEFTRIAXONE PFI NQ
02325616 CEFTRIAXONE SODIUM STE NQ

CEFUROXIME AXETIL
250MG TABLET
02212277 CEFTIN GSK CFNQSW
02244393 APO-CEFUROXIME APX CFGNQSW
02344823 AURO-CEFUROXIME ARO CFGNQSW

500MG TABLET
02212285 CEFTIN GSK CFNQSW
02244394 APO-CEFUROXIME APX CFGNQSW
02344831 AURO-CEFUROXIME ARO CFGNQSW

25MG/ML ORAL SUSPENSION
02212307 CEFTIN GSK CFNQSW

CEPHALEXIN MONOHYDRATE
250MG CAPSULE
00342084 TEVA-CEPHALEXIN TEV FGNQSW

500MG CAPSULE
00342114 TEVA-CEPHALEXIN TEV FGNQSW

250MG TABLET
00583413 TEVA-CEPHALEXIN TEV CFGNQSW
00768723 APO-CEPHALEX APX CFGNQSW
02470578 AURO-CEPHALEXIN ARO CFGNQSW

500MG TABLET
00583421 TEVA-CEPHALEXIN TEV CFGNQSW
00768715 APO-CEPHALEX APX CFGNQSW
02470586 AURO-CEPHALEXIN ARO CFGNQSW
02495651 CEPHALEXIN SIV CFGNQSW

25MG/ML ORAL SUSPENSION
00342106 TEVA-CEPHALEXIN TEV CFGNQSW

50MG/ML ORAL SUSPENSION
08:12.07 MONOBACTAMS

AZTREONAM
SEE APPENDIX A FOR SA CRITERIA
75MG/ML INHALATION VIAL
02329840 CAYSTON (SA) GIL MQ

08:12.12 ANTIBIOTICS ERYTHROMYCINS

AZITHROMYCIN
SEE APPENDIX A. FOR SA CRITERIA (HIV, CYSTIC FIBROSIS, SEXUALLY TRANSMITTED DISEASES AND TUBERCULOSIS DO NOT REQUIRE A SA REQUEST)
250MG TABLET
02212021 ZITHROMAX (SA) PFI ACFNQSWVX
02261634 PMS-AZITHROMYCIN (SA) PMS ACFGNQSWVX
02265826 SANDOZ AZITHROMYCIN (SA) SDZ ACFGNQSWVX
02267845 TEVA-AZITHROMYCIN (SA) TEV ACFGNQSWVX
02330881 AZITHROMYCIN (SA) SNS ACFGNQSWVX
02415542 APO-AZITHROMYCIN Z (SA) APX ACFGNQSWVX
02442434 AZITHROMYCIN (SA) SIV ACFGNQSWVX
02452308 JAMP-AZITHROMYCIN (SA) JPC ACFGNQSWVX
02452324 MAR-AZITHROMYCIN (SA) MAR ACFGNQSWVX
02479680 NRA-AZITHROMYCIN (SA) NRA ACFGNQSWVX
02480700 AG-AZITHROMYCIN (SA) AGP ACFGNQSWVX

600MG TABLET
02261642 PMS-AZITHROMYCIN (SA) PMS ACFGNQSWVX

20MG/ML ORAL SUSPENSION
02223716 ZITHROMAX (SA) PFI ACFNQSWVX
02274566 GD-AZITHROMYCIN (SA) GMD ACFGNQSWVX
02332388 SANDOZ-AZITHROMYCIN (SA) SDZ ACFGNQSWVX
02482363 AURO-AZITHROMYCIN (SA) ARO ACFGNQSWVX

40MG/ML ORAL SUSPENSION
02223724 ZITHROMAX (SA) PFI ACFNQSWVX
02274574 GD-AZITHROMYCIN (SA) GMD ACFGNQSWVX
02332396 Sandoz-Azithromycin (SA) SDZ ACFGNQSWX
02482371 Aurol-Azithromycin (SA) ARO ACFGNQSWX

CLARITHROMYCIN
250MG TABLET
01984853 Biaxin BGP AFCNQSWX
02247573 PMS-Clarithromycin PMS ACFGNQSWX
02248804 Teva-Clarithromycin TEV ACFGNQSWX
02266539 Sandoz Clarithromycin SDZ ACFGNQSWX
02274744 APO-Clarithromycin APX ACFGNQSWX
02361426 Ran-Clarithromycin RAN ACFGNQSWX
02442469 Clarithromycin SIV ACFGNQSWX
02466120 Clarithromycin SNS ACFGNQSWX

500MG TABLET
02126710 Biaxin BGP ACFGNQSWX
02247574 PMS-Clarithromycin PMS ACFGNQSWX
02248805 Teva-Clarithromycin TEV ACFGNQSWX
02266547 Sandoz Clarithromycin SDZ ACFGNQSWX
02274752 APO-Clarithromycin APX ACFGNQSWX
02361434 Ran-Clarithromycin RAN ACFGNQSWX
02442485 Clarithromycin SIV ACFGNQSWX

500MG EXTENDED-RELEASE TABLET
02403196 Act-Clarithromycin XL ATV CFGNQSW
02413345 APO-Clarithromycin XL APX CFGNQSW

25MG/ML ORAL SUSPENSION
02146908 Biaxin BGP CFNQSWX
02390442 Taro-Clarithromycin TAR CFGNQSWX
02408988 Clarithromycin SNS CFGNQSWX

50MG/ML ORAL SUSPENSION
02244641 Biaxin BGP CFNQSWX
02390450 Taro-Clarithromycin TAR CFGNQSWX
02408996 Clarithromycin SNS CFGNQSWX

ERYTHROMYCIN BASE
333MG CAPSULE (ENTERIC COATED PELLETS)
00873454 Eryc PFI CFNQSW

250MG TABLET
00682020 Erythro-Base AAA CFGNQSVW

FIDAXOMICIN
| 200MG TABLET | 02387174 | DIFICID(SA) | MSD | FNQSW |
| 08:12.16 ANTIBIOTICS PENICILLINS |
| AMOXICILLIN |
| 250MG CAPSULE |
| 00406724 | NOVAMOXIN | TEV | CFGNQSW |
| 00628115 | APO-AMOXI | APX | CFGNQSW |
| 02352710 | AMOXICILLIN | SNS | CFGNQSW |
| 02388073 | AURO-AMOXICILLIN | ARO | CFGNQSW |
| 02401495 | AMOXICILLIN | SIV | CFGNQSW |
| 02433060 | JAMP-AMOXICILLIN | JPC | CFGNQSW |
| 500MG CAPSULE |
| 00406716 | NOVAMOXIN | TEV | CFGNQSVW |
| 00628123 | APO-AMOXI | APX | CFGNQSVW |
| 02352729 | AMOXICILLIN | SNS | CFGNQSVW |
| 02388081 | AURO-AMOXICILLIN | ARO | CFGNQSVW |
| 02401509 | AMOXICILLIN | SIV | CFGNQSVW |
| 02433079 | JAMP-AMOXICILLIN | JPC | CFGNQSVW |
| 02477726 | AG-AMOXICILLIN | ANG | CFGNQSVW |
| 25MG/ML ORAL SUSPENSION |
| 00452149 | NOVAMOXIN | TEV | CFGNQSW |
| 00628131 | APO-AMOXI | APX | CFGNQSW |
| 01934171 | NOVAMOXIN | TEV | 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 |
| AMOXICILLIN & CLAVULANIC ACID |
| 250MG & 125MG TABLET |
| 02243350 | APO-AMOXI CLAV | APX | CFGNQSW |
| 500MG & 125MG TABLET |
| 01916858 | CLAVULIN | GSK | CFNQSW |

SEE APPENDIX A FOR SA CRITERIA
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<th>Code</th>
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<td>GSK CFNQSW</td>
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<tr>
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<td>PEN VK</td>
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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

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<td>ATV CFGNQSWX</td>
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<td>PMS-CIPROFLOXACIN (SA)</td>
<td>PMS CFGNQSWX</td>
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<td>SPT CFGNQSWX</td>
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<td>JAMP-CIPROFLOXACIN (SA)</td>
<td>JPC CFGNQSWX</td>
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500MG TABLET

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750MG TABLET

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100MG/ML ORAL SUSPENSION
02237514 CIPRO (SA) BAY FNQSW

SEE APPENDIX A FOR SA CRITERIA (CYSTIC FIBROSIS, NURSING HOME, AND TUBERCULOSIS PROGRAMS DO NOT REQUIRE AN SA REQUEST)
100MG EXTENDED RELEASE TABLET
02251787 CIPRO XL (SA) BAY FNQSW

LEVOFLOXACIN
SEE APPENDIX A FOR SA CRITERIA (CYSTIC FIBROSIS AND NURSING HOME PROGRAMS DO NOT REQUIRE AN SA REQUEST)
250MG TABLET
02248262 TEVA-LEVOFLOXACIN (SA) TEV CFGNQSW
02284707 APO-LEVOFLOX (SA) APX CFGNQSW
02298635 SANDOZ-LEVOFLOXACIN (SA) SDZ CFGNQSW
02315424 ACT-LEVOFLOXACIN (SA) ATV CFGNQSW

500MG TABLET
02248263 TEVA-LEVOFLOXACIN (SA) TEV CFGNQSW
02284715 APO-LEVOFLOX (SA) APX CFGNQSW
02298643 SANDOZ-LEVOFLOXACIN (SA) SDZ CFGNQSW
02315432 ACT-LEVOFLOXACIN (SA) ATV CFGNQSW

MOXIFLOXACIN HCL
SEE APPENDIX A FOR SA CRITERIA (CYSTIC FIBROSIS PROGRAM DOES NOT REQUIRE AN SA REQUEST)
400MG TABLET
02242965 AVELOX (SA) BAY FNQSW
02375702 TEVA-MOXIFLOXACIN (SA) TEV FGNQSW
02383381 SANDOZ-MOXIFLOXACIN (SA) SDZ FGNQSW
02404923 APO-MOXIFLOXACIN (SA) APX FGNQSW
02432242 AURO-MOXIFLOXACIN (SA) ARO FGNQSW
02443929 JAMP-MOXIFLOXACIN (SA) JPC FGNQSW
02447053 MAR-MOXIFLOXACIN (SA) MAR FGNQSW
02447061 JAMP-MOXIFLOXACIN (SA) JPC FGNQSW
02478137 AG-MOXIFLOXACIN (SA) ANG FGNQSW

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
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

100 MG TABLET
00860751 DOXYCIN RIV FGQSWV
00874256 APO-DOXY APX FGQSWV
02158574 TEVA-DOXYCYCLINE TEV FGQSWV
02351242 DOXYCYCLINE SNS FGQSWV

MINOCYCLINE HCL
50MG CAPSULE
02084090 MINOCYCLINE AAA FGQW
02108143 TEVA-MINOCYCLINE TEV FGQW

100 MG CAPSULE
02084104 MINOCYCLINE AAA FGQW
02108151 TEVA-MINOCYCLINE TEV FGQW

TETRACYCLINE
250MG CAPSULE
00580929 TETRACYCLINE AAA CFGNQSW

8:12.28 ANTIBIOTICS OTHER ANTIBIOTICS
CLINDAMYCIN HCL
150MG CAPSULE
00030570   DALACIN C      PFI   CFNQSW
02241709   TEVA-CLINDAMYCIN  TEV   CFGNQSW
02245232   APO-CLINDAMYCIN  APX   CFGNQSW
02436906   AURO-CLINDAMYCIN ARO   CFGNQSW
02483734   JAMP-CLINDAMYCIN JPC   CFGNQSW
02493748   NRA-CLINDAMYCIN  NRA   CFGNQSW

300MG CAPSULE
02182866   DALACIN C      PFI   CFNQSW
02241710   TEVA-CLINDAMYCIN  TEV   CFGNQSW
02245233   APO-CLINDAMYCIN  APX   CFGNQSW
02436914   AURO-CLINDAMYCIN ARO   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

RIFAXIMIN
SEE APPENDIX A FOR SA CRITERIA
550MG TABLET
02410702   ZAXINE (SA)      LUP   FNQSW

VANCOMYCIN HCL
125MG CAPSULE
00800430   VANCOCIN      MRS   FNQSW
02407744   VANCOMYCIN     JPC   FGNQSW

08:14.00 ANTIFUNGALS

NYSTATIN
100,000U/ML ORAL SUSPENSION
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**TERBINAFINE**

*SEE APPENDIX A* FOR SA CRITERIA

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**VORICONAZOLE**

*SEE APPENDIX A* FOR SA CRITERIA

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**08:16.00 ANTITUBERCULOSIS AGENTS**

**ETHAMBUTOL**

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**ISONIAZID**

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**PYRAZINAMIDE**

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PEI Pharmacare Formulary .................................................................Page - 38 -
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**8:16.92 MISCELLANEOUS ANTIMYCOBACTERIALS**

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**8:18.00 ANTIVIRALS**

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800MG TABLET

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### FAMCICLOVIR

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### VALACYCLOVIR

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### VALGANCICLOVIR

**SEE APPENDIX A FOR SA CRITERIA**

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PEI Pharmacare Formulary .................................................................Page - 40 -
8:18.04 ADAMANTANES

AMANTADINE HCL
10MG/ML SYRUP
02022826 PDP-AMANTADINE PEN FGNQSW

100MG CAPSULE
01990403 PDP-AMANTADINE PEN FGNQSW

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

ENFUVIRTIDE
SEE APPENDIX A FOR SA CRITERIA
90MG/ML INJECTION KIT
02247725 FUZEON (SA) HLR A

MARAVIROX
150MG TABLET
02299844 CELSENTRI VII A

300MG TABLET
02299852 CELSENTRI VII A

08:18.08.08 ANTIRETROVIRAL AGENTS (PROTEASE INHIBITORS)

ATAZANAVIR
150MG CAPSULE
02248610 REYATAZ BMS A
02443791 TEVA-ATAZANAVIR TEV A
02456877 MYLAN-ATAZANAVIR MYL A

200MG CAPSULE
02248611 REYATAZ BMS A
02443813 TEVA-ATAZANAVIR TEV A
02456885 MYLAN-ATAZANAVIR MYL A

300MG CAPSULE

PEI Pharmacare Formulary ..........................................................Page - 41 -
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**DARUNAVIR**

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**ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE**

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**LOPINAVIR & RITONAVIR**

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100MG FILM COATED TABLET
02357593 NORVIR ABV A

SAQUINAVIR
200MG CAPSULE
02216965 INVIRASE HLR A

500MG TABLET
02279320 INVIRASE HLR 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
02478579 BIKTARVY GIL 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)

EFAVIRENZ
50MG CAPSULE
02239886  SUSTIVA  BMS  A

200MG CAPSULE
02239888  SUSTIVA  BMS  A

600MG TABLET
02246045  SUSTIVA  BMS  A
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
02238748  VIRAMUNE  BOE  A
02318601  AURO-NEVIRAPINE  ARO  A
02387727  MYLAN-NEVIRAPINE  MYL  A
02405776  JAMP-NEVIRAPINE  JPC  A

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

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**ABACAVIR & LAMIVUDINE**

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<td>APX A</td>
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<td>MYL A</td>
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<td>ARO A</td>
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**ABACAVIR & LAMIVUDINE & ZIDOVUDINE**

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**DIDANOSINE**

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**EFAVIRENZ & EMTRICITABINE & TENOFOVIR**

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<td>02478404 AURO-EFAVIRENZ-EMTRICITABINE-TENOFOVIR</td>
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<td>02484676 SANDOZ-EFAVIRENZ-EMTRICITABINE-TENOFOV</td>
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**LAMIVUDINE**

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<td>02239193 HEPTOVIR</td>
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<td>02393239 APO-LAMIVUDINE HBV</td>
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<td>02192683 3TC</td>
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<td>02369052 APO-LAMIVUDINE</td>
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<td>02507110 JAMP-LAMIVUDINE</td>
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<td>02247825 3TC</td>
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<td>02369060 APO-LAMIVUDINE</td>
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<td>02507129 JAMP-LAMIVUDINE</td>
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**LAMIVUDINE & ZIDOVUDINE**

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<td>02387247 TEVA-LAMIVUDINE/ZIDOVUDINE</td>
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**STAVUDINE**

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<td>02216116</td>
<td>ZERIT BMS A</td>
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<td><strong>300MG TABLET</strong></td>
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<td>02247128</td>
<td>VIREAD GIL AH</td>
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<td>02403889</td>
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<td>02451980</td>
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<td>02452634</td>
<td>MYLAN-TENOFOVIR PMS AH</td>
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<td>02460173</td>
<td>AURO-TENOFOVIR ARO AH</td>
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<td>02472511</td>
<td>NAT-TENOFOVIR NAT AH</td>
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<td>02479087</td>
<td>JAMP-TENOFOVIR JPC AH</td>
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<td><strong>TENOFOVIR &amp; EMTRICITABINE</strong></td>
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<td><strong>300MG &amp; 200MG TABLET</strong></td>
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<td>02274906</td>
<td>TRUVADA GIL A</td>
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<td>02399059</td>
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<td>02443902</td>
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<td>02452006</td>
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<td>02461110</td>
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<td>02487012</td>
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<td>02496356</td>
<td>AG-EMTRICITABINE-TENOFOVIR ANG A</td>
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<td><strong>ZIDOVUDINE (AZT)</strong></td>
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<td>01946323</td>
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**08:18.32  NUCLEOSIDES AND NUCLEOTIDES**

**ENTECAVIR**

SEE APPENDIX A FOR SA CRITERIA

**0.5MG TABLET**

| 02282224 | BARACLUD (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 |
### 08:18.40 HCV PROTEASE INHIBITORS

**GLECAPREVIR & PIBRENTASVIR**  
100MG & 40MG TABLET  
02467550 MAVIRET ABV H

**RIBAVIRIN**  
200MG TABLET  
02436396 MODERIBA ABV H

400MG TABLET  
02436418 MODERIBA ABV H

### 08:30.08 ANTIMALARIALS

**CHLOROQUINE PHOSPHATE**  
250MG TABLET  
00021261 TEVA-CHLOROQUINE TEV FNQSW

**HYDROXYCHLOROQUINE Sulfate**  
200MG TABLET  
02017709 PLAQUENIL AVN FNQSW  
02246691 APO-HYDROXYQUINE APX FNQSW  
02424991 MINT-HYDROXYCHLOROQUINE MNT FNQSW  
02491427 JAMP-HYDROXYCHLOROQUINE Sulfate JPC FNQSW

### 08:30.92 MISCELLANEOUS ANTIPROTOZOALS

**METRONIDAZOLE**  
250MG TABLET  
00545066 METRONIDAZOLE AAA CFGNQSW
08:36.00  URINARY ANTI INFECTIVES

FOSFOMYCIN

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

3G SACHET
02240335  MONUROL (SA)  PAL  FNQSW
02473801  JAMP-FOSFOMYCIN (SA)  JPC  FGNQSW

NITROFURANTOIN

50MG CAPSULE (MACROCRYSTALS)
02231015  TEVA-FURANTOIN  TEV  FGNQSW

100MG CAPSULE (MACROCRYSTALS)
02231016  TEVA-FURANTOIN  TEV  FGNQSW

50MG TABLET
00319511  NITROFURANTOIN  AAA  FGNQSW

100MG TABLET
00312738  NITROFURANTOIN  AAA  FGNQSW

NITROFURANTOIN MONOHYDRATE/MACROCRYSTALS

100MG CAPSULE
02063662  MACROBID  ALL  FNQSW
02455676  PMS-NITROFURANTOIN  PMS  FGNQSW

TRIMETHOPRIM

100MG TABLET
02243116  TRIMETHOPRIM  AAA  FGNQSW

200MG TABLET
02243117  TRIMETHOPRIM  AAA  FGNQSW

10:00.00  ANTINEOPLASTIC AGENTS

ABIRATERONE ACETATE

SEE APPENDIX A FOR SA CRITERIA

250MG TABLET
02371065  ZYTIGA (SA)  JAN  MQ
<table>
<thead>
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<th>Company</th>
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<td>02477114</td>
<td>REDDY-ABIRATERONE (SA)</td>
<td>RCH MQ</td>
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<td>02486393</td>
<td>SANDOZ-ABIRATERONE (SA)</td>
<td>SDZ MQ</td>
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<td>02491397</td>
<td>APO-ABIRATERONE (SA)</td>
<td>APX MQ</td>
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<td>02492601</td>
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<td>02494132</td>
<td>NAT-ABIRATERONE (SA)</td>
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<td>02502305</td>
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<td>02503980</td>
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### 500MG TABLET

<table>
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<td>JAN MQ</td>
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<td>02491400</td>
<td>APO-ABIRATERONE (SA)</td>
<td>APX MQ</td>
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<td>02501503</td>
<td>PMS-ABIRATERONE (SA)</td>
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<td>02503999</td>
<td>MAR-ABIRATERONE (SA)</td>
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### AFATINIB

**See Appendix A** for SA criteria

### 20MG TABLET

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<th>Company</th>
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### 30MG TABLET

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### 40MG TABLET

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<tr>
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### ANASTROZOLE

**1MG TABLET**

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<td>SANDOZ-ANASTROZOLE</td>
<td>SDZ FGNQSW</td>
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<td>JAMP-ANASTROZOLE</td>
<td>JPC FGNQSW</td>
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<td>ACH-ANASTROZOLE</td>
<td>ACH FGNQSW</td>
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<td>TARO-ANASTROZOLE</td>
<td>TAR FGNQSW</td>
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<td>ATV FGNQSW</td>
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### AXITINIB

**See Appendix A** for SA criteria

**1MG TABLET**

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<td>BUSULFAN</td>
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**BOSUTINIB**

SEE APPENDIX A FOR SA CRITERIA

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<tbody>
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<td>100MG TABLET</td>
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<td>500MG TABLET</td>
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<td>500MG TABLET</td>
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<td>PFI MQ</td>
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<td>MYLERAN</td>
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**CAPECITABINE**

150MG TABLET

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<td>150MG TABLET</td>
<td>02238453</td>
<td>HLR FNQSW</td>
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<tr>
<td>ACH-CAPECITABINE</td>
<td>150MG TABLET</td>
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<td>HLR FNQSW</td>
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<td>TARO-CAPECITABINE</td>
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<td>HLR FNQSW</td>
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500MG TABLET

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<tr>
<td>ACH-CAPECITABINE</td>
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<td>TARO-CAPECITABINE</td>
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**CHLORAMBUICIL**

2MG TABLET

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<td>ASN FNQSW</td>
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<tr>
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<td>2MG TABLET</td>
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<td>ASN FNQSW</td>
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<tr>
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<td>ASN FNQSW</td>
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<tr>
<td>TARO-CAPECITABINE</td>
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### IMATINIB

**SEE APPENDIX A** FOR SA CRITERIA

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### LENALIDOMIDE

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### LETROZOLE

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02358514  APO-LETROZOLE  APX  FGNSQSW
02372282  RAN-LETROZOLE  RAN  FGNSQSW
02373009  JAMP-LETROZOLE  JPC  FGNSQSW
02373424  MAR-LETROZOLE  MAR  FGNSQSW
02421585  NAT-LETROZOLE  NAT  FGNSQSW
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LEUPROLIDE ACETATE
3.75MG/ML DEPOT INJECTION
00884502  LUPRON DEPOT  ABV  FQWY

7.5MG/ML DEPOT INJECTION
00836273  LUPRON DEPOT  ABV  FNQSWY
02248239  ELIGARD  AVN  FNQSWY

11.25MG DEPOT INJECTION
02239834  LUPRON DEPOT  ABV  FNQSW

22.5MG/ML DEPOT INJECTION
02230248  LUPRON DEPOT  ABV  FNQSW
02248240  ELIGARD  AVN  FNQSW

45MG DEPOT INJECTION
02268892  ELIGARD  AVN  FNQSW

MEDROXYPROGESTERONE ACETATE
100MG TABLET
02267640  APO-MEDROXY  APX  FGNSQSW

MEGESTROL ACETATE
SEE APENDIX A FOR SA CRITERIA (HIV PROGRAM DOES NOT REQUIRE AN SA REQUEST)
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02195917  MEGESTROL (SA)  AAA  AFNSQSW

160MG TABLET
02195925  MEGESTROL (SA)  AAA  FGNSQSW

MELPHALAN
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00004715  ALKERAN  ASN  FNQSW
**MERCAPTOPURINE**

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<td>10MG &amp; 1ML PREFILLED SYRINGE</td>
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PEI Pharmacare Formulary .................................................................Page - 57 -
25MG/ML INJECTION SOLUTION
02099705 METHOTREXATE SODIUM TEV FGNQSW
02182955 METHOTREXATE/PF PFI FNQSW
02417626 METHOTREXATE MYL FGNQSW
02419173 JAMP-METHOTREXATE JPC FGNQSW

MIDOSTAURIN
**SEE APPENDIX A FOR SA CRITERIA**
25MG CAPSULE
02466236 RYDAPT (SA) NVR MQ

NILOTINIB
**SEE APPENDIX A FOR SA CRITERIA**
150MG CAPSULE
02368250 TASIGNA (SA) NVR MQ

200MG CAPSULE
02315874 TASIGNA (SA) NVR MQ

NILUTAMIDE
**SEE APPENDIX A FOR SA CRITERIA**
50 MG TABLET
02221861 ANANDRON (SA) CHE FNQSW

OSIMERTINIB
**SEE APPENDIX A FOR SA CRITERIA**
40MG TABLET
02456214 TAGRISSO (SA) AZE MQ

80MG TABLET
02456222 TAGRISSO (SA) AZE MQ

PALBOCICLIB
**SEE APPENDIX A FOR SA CRITERIA**
75MG TABLET
02493535 IBRANCE (SA) PFI MQ

100MG TABLET
02493543 IBRANCE (SA) PFI MQ

125MG TABLET
02493551 IBRANCE (SA) PFI MQ

PAZOPANIB
**SEE APPENDIX A FOR SA CRITERIA**
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25 MG CAPSULE
02280809 SUTENT (SA) PFI MQ

50 MG CAPSULE
02280817 SUTENT (SA) PFI MQ

TAMOXIFEN CITRATE
10MG TABLET
00812404 APO-TAMOX APX FGNNQSW
00851965 TEVA-TAMOXIFEN TEV FGNNQSW

20MG TABLET
00812390 APO-TAMOX APX FGNNQSW
00851973 TEVA-TAMOXIFEN TEV FGNNQSW
02048485 NOLVADEX D AZE FGNNQSW

TEMOZOLOMIDE
SEE APPENDIX A FOR HIGH-COST DRUG PROGRAM CRITERIA
5MG CAPSULE
02241093 TEMODAL MSD FMNQSW
02441160 ACT-TEMOZOLOMIDE ATV FGMNQSW
02443473 TARO-TEMOZOLOMIDE TAR FGMNQSW

20MG CAPSULE
02241094 TEMODAL MSD FMNQSW
02395274 ACT-TEMOZOLOMIDE ATV FGMNQSW
02443481 TARO-TEMOZOLOMIDE TAR FGMNQSW

100MG CAPSULE
02241095 TEMODAL MSD FMNQSW
02395282 ACT-TEMOZOLOMIDE ATV FGMNQSW
02443511 TARO-TEMOZOLOMIDE TAR FGMNQSW

140MG CAPSULE
02312794 TEMODAL MSD FMNQSW
02395290 ACT-TEMOZOLOMIDE ATV FGMNQSW
02443538 TARO-TEMOZOLOMIDE TAR FGMNQSW

250MG CAPSULE
02241096 TEMODAL MSD FMNQSW
02395312 ACT-TEMOZOLOMIDE ATV FGMNQSW
02443554 TARO-TEMOZOLOMIDE TAR FGMNQSW
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<td>TRELSTAR</td>
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<td><strong>BETHANECHOL CHLORIDE</strong></td>
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<td>10MG TABLET</td>
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<td>DUVOID</td>
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### DONEPEZIL

SEE CHOLINESTERASE INHIBITORS IN APPENDIX A FOR SA CRITERIA

SEE APPENDIX A FOR SA CRITERIA

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<th>Strength</th>
<th>Brand Name</th>
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<td>50MG TABLET</td>
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<td>JAMP-DONEPEZIL (SA)</td>
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| 10MG TABLET | ARICEPT (SA) | PFI |
|            | PMS-DONEPEZIL (SA) | PMS |
|            | SANDOZ-DONEPEZIL (SA) | SDZ |
|            | TEVA-DONEPEZIL (SA) | TEV |
|            | APO-DONEPEZIL (SA) | APX |
|            | RAN-DONEPEZIL (SA) | RAN |
|            | AURO-DONEPEZIL (SA) | ARO |
|            | MAR-DONEPEZIL (SA) | MAR |
|            | DONEPEZIL (SA) | SIV |
|            | JAMP-DONEPEZIL (SA) | JPC |
|            | MINT-DONEPEZIL (SA) | MNT |
|            | JAMP-DONEPEZIL (SA) | JPC |
|            | DONEPEZIL (SA) | SIV |
|            | DONEPEZIL (SA) | SNS |
|            | SEPTA-DONEPEZIL (SA) | SPT |
|            | NAT-DONEPEZIL (SA) | NAT |

### GALANTAMINE

SEE CHOLINESTERASE INHIBITORS IN APPENDIX A FOR SA CRITERIA
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<td>02339439  MYLAN-GALANTAMINE (SA)</td>
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<td>02420821  MAR-GALANTAMINE ER (SA)</td>
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<td>02425157  AURO-GALANTAMINE ER (SA)</td>
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<td>02398389  PMS-GALANTAMINE ER (SA)</td>
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<td>02420848  MAR-GALANTAMINE ER (SA)</td>
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<td>02425165  AURO-GALANTAMINE ER (SA)</td>
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<td>02420856  MAR-GALANTAMINE ER (SA)</td>
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<td>5MG TABLET</td>
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<td>02216345  SALAGEN (SA)</td>
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<td>02496119  ACCEL-PILOCARPINE (SA)</td>
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<td>00869961  MESTINON</td>
<td>VAL  FNQSW</td>
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<td>02495643  RIVA-PYRIDOSTIGMINE</td>
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<p>| RIVASTIGMINE                      |                  |                  |
| SEE CHOLINESTERASE INHIBITORS FOR SA CRITERIA|
|SEE APPENDIX A FOR SA CRITERIA    |                  |                  |
| 1.5MG CAPSULE                     |                  |                  |
| 02242115  EXELON (SA)             | NVR  FNQSW       |
| 02306034  PMS-RIVASTIGMINE (SA)   | PMS  FGNQSW      |</p>
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<td>GMP FGNQSW</td>
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### 4.5MG CAPSULE

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<td>MED-RIVASTIGMINE (SA)</td>
<td>GMP FGNQSW</td>
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<tr>
<td>02485389</td>
<td>JAMP-RIVASTIGMINE (SA)</td>
<td>JPC FGNQSW</td>
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### 6MG CAPSULE

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<tr>
<td>02242118</td>
<td>EXELON (SA)</td>
<td>NVR FNQSW</td>
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<tr>
<td>02324601</td>
<td>SANDOZ-RIVASTIGMINE (SA)</td>
<td>SDZ FGNQSW</td>
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<tr>
<td>02336758</td>
<td>APO-RIVASTIGMINE (SA)</td>
<td>APX FGNQSW</td>
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<td>02485397</td>
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### 12:08.08 ANTIMUSCARINICS/ANTISPASMODICS

**ACLIDINIUM BROMIDE**

**SEE APPENDIX A** FOR SA CRITERIA

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>02409720</td>
<td>TUDORZA GENUAIR (SA)</td>
<td>AZE FNQSW</td>
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**ACLIDINIUM BROMIDE & FORMOTEROL FUMARATE DIHYDRATE**

**SEE APPENDIX A** FOR SA CRITERIA

<table>
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**ATROPINE SULFATE**

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<tr>
<td>02409720</td>
<td>TUDORZA GENUAIR (SA)</td>
<td>AZE FNQSW</td>
</tr>
</tbody>
</table>

0.6MG/ML INJECTION SOLUTION (1ML)
00392693 ATROPINE SULFATE SDZ N

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 BOE FNQSW

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

IPRATROPIUM BROMIDE
200UG/DOSE INHALER AEROSOL (200 DOSE)
02247686 ATROVENT HFA BOE CFNQSW

0.25MG/ML INHALATION SOLUTION (20ML)
02126886 APO-IPRAVENT APX 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
02163705 ATROVENT NASAL SPRAY BOE CFNQSW
02239627 PMS-IPRATROPIUM PMS CFGNQSW

IPRATROPIUM & SALBUTAMOL
1.0MG & 0.2MG PER ML INHALATION SOLUTION NEBULE (2.5ML)
02231675   COMBIVENT       BOE   FNQSW
02272695   TEVA-COMBO STERINEBS   TEV   FGNQSW
02483394   IPRATROPIUM-SALBUTAMOL   MDN   FGNQSW

IPRATROPIUM BROMIDE & SALBUTAMOL SULPHATE
20MCG-100MCG/ACTUATION
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/INHALATION POWDER CAPSULE
02246793   SPIRIVA (SA)       BOE   FNQSW

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

TIOTROPIUM/OLODATEROL
SEE APPENDIX A FOR SA CRITERIA
02441888   INSPIOLTO RESPIMAT (SA)       BOE   FNQSW

UNMECLIDINIUM BROMIDE
SEE APPENDIX A FOR SA CRITERIA
62.5MCG BLISTER WITH INHALATION DEVICE
02423596   INCRUSE ELLIPTA (SA)       GKS   FNQSW

UMECLIDINIUM BROMIDE &VILANTEROL TRIFENATATE
SEE APPENDIX A FOR SA CRITERIA
62.5MCG/25MCG BLISTER
02418401   ANORO ELLIPTA (SA)       GSK   FNQSW

PEI Pharmacare Formulary ..............................................................Page - 66 -
12:12.00 SYMPATHOMIMETIC (ADRENERGIC) AGENTS

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

SEE APPENDIX A FOR SA CRITERIA
0.15MG PER DOSE AUTO-INJECTOR
00578657 EPIPEN JR. (*) PFI FQW

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

*quantity limit of two (2) injections per fiscal year. The prescriber can submit a request for consideration should beneficiaries require more than two (2) injections per fiscal year.

FLUTICASONE FUROATE/VILAN TEROL
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
12UG/DOSE AEROSOL POWDER CAPSULE
02230898 FORADIL (SA) NVR FNQSW

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 & BUD ESONIDE
SEE APPENDIX A FOR SA CRITERIA
6UG & 100UG PER DOSE INHALER POWDER
02245385 SYMBICORT TURBUHALER (SA) AZE FNQSW

6UG & 200UG PER DOSE INHALER POWDER
INDACATEROL
SEE APPENDIX A FOR SA CRITERIA
75MCG INHALATION POWDER CAPSULE
02376938 ONBREZ (SA) NVR FNQSW

MIDODRINE HCL
SEE APPENDIX A FOR SA CRITERIA
2.5MG TABLET
02278677 APO-MIDODRINE (SA) APX FGNQSW
02473984 MAR-MIDODRINE (SA) MAR FGNQSW

5MG TABLET
02278685 APO-MIDODRINE (SA) APX FGNQSW
02473992 MAR-MIDODRINE (SA) MAR FGNQSW

MOMETASONE FURUATE/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

ORCIPRENALINE SULFATE
2MG/ML SYRUP
02236783 ORCIPRENALINE AAA FGNQSW

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
50UG/DOSE INHALED POWDER DISK (60)
02231129   SEREVENT DISKUS (SA)   GSK  FNQSW

SALMETEROL & FLUTICASONE
SEE APPENDIX A FOR SA CRITERIA
25UG & 125UG/DOSE INHALER AEROSOL
02245126   ADVAIR (SA)   GSK  FNQSW

25UG & 250UG/DOSE INHALER AEROSOL
02245127   ADVAIR (SA)   GSK  FNQSW

50UG & 100UG/DOSE INHALER POWDER DISK
02240835   ADVAIR DISKUS (SA)   GSK  FNQSW
02494507   PMS-FLUTICASONE/SALMETEROL (SA)   PMS  FGNQSW
02495597   WIXELA INHUB (SA)   MYL  FGNQSW

50UG & 250UG/DOSE INHALER POWDER DISK
02240836   ADVAIR DISKUS (SA)   GSK  FNQSW
02494515   PMS-FLUTICASONE/SALMETEROL (SA)   PMS  FGNQSW
02495600   WIXELA INHUB (SA)   MYL  FGNQSW

50UG & 500UG/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**

*SEE APPENDIX A FOR SA CRITERIA*

4MG/ML NASAL SPRAY

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<th>Manufacturer</th>
<th>Code</th>
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<td>02228947</td>
<td>MIGRANAL (SA)</td>
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Note: Coverage is limited to 6 bottles per 30 day period.

### 12:20.00 SKELETAL MUSCLE RELAXANTS

**BACLOFEN**

10MG TABLET

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<td>02088398</td>
<td>MYLAN BACLOFEN</td>
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<td>FGNSW</td>
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<tr>
<td>02139332</td>
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<td>02287021</td>
<td>BACLOFEN</td>
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20MG TABLET

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<td>RATIO-BACLOFEN</td>
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**CYCLOBENZAPRINE HCL**

*SEE APPENDIX A FOR SA CRITERIA*

10MG TABLET

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**DANTROLENE SODIUM**

25MG CAPSULE

PEI Pharmacare Formulary ..............................................................Page - 70 -
01997602    DANTRIUM    PAL    FNQSW

METHOCARBAMOL
500MG TABLET
01930990    ROBAXIN    PFI    NW

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    ROBAXISCAL C-1/4    PFI    FQW

400MG & 325MG & 32.4MG CAPLET
01934791    ROBAXISCAL C-1/2    PFI    FQW

TIZANIDINE HCL
SEE APPENDIX A FOR SA CRITERIA
4MG TABLET
02259893    TIZANIDINE (SA)    AAA    FGNQSW

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

BUPROPION
150 MG SUSTAINED RELEASE TABLET
02238441    ZYBAN    VAL    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
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<td>NICOTINE BITARTRATE</td>
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PEI Pharmacare Formulary
20:04.04 IRON PREPARATIONS

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

Ferrous Sulfate
30MG (6MG IRON)/ML SYRUP
00792675 PMS-FERROUS SULFATE PMS CNW

75MG (15MG IRON)/ML ORAL DROPS
02232202 PEDIAFER SDZ W

300MG (60MG IRON) TABLET
00031100 JAMP-FERROUS SULFATE JPC CNOW

20:12.04 ANTI COAGULANTS

ApiXaban
SEE APPENDIX A FOR SA CRITERIA
2.5MG TABLET
02377233 ELIQUIS (SA) BMS FNQSW

5MG TABLET
02397714 ELIQUIS (SA) BMS FNQSW

Dabigatran
SEE APPENDIX A FOR SA CRITERIA
110MG CAPSULE
02312441 PRADAXA (SA) BOE FNQSW

150MG CAPSULE
02358808 PRADAXA (SA) BOE FNQSW
02468913 APO-DABIGATRAN (SA) APX FNQSW

Dalteparin
SEE APPENDIX A FOR SA CRITERA (NURSING HOME PROGRAM DOES NOT REQUIRE AN SA REQUEST)
PRE-FILLED SYRINGE 2,500 UNITS/0.2ML
02132621  FRAGMIN (SA)  PFI  FNQSW

PRE-FILLED SYRINGE 5,000 UNITS/0.2ML
02132648  FRAGMIN (SA)  PFI  FNQSW

PRE-FILLED SYRINGE 7500 UNITS/0.3ML
02352648  FRAGMIN (SA)  PFI  FNQSW

PRE-FILLED SYRINGE 10,000 UNITS/0.4ML
02352656  FRAGMIN (SA)  PFI  FNQSW

PRE-FILLED SYRINGE 12,500 UNITS/0.5ML
02352664  FRAGMIN (SA)  PFI  FNQSW

PRE-FILLED SYRINGE 15,000 UNITS/0.6ML
02352672  FRAGMIN (SA)  PFI  FNQSW

PRE-FILLED SYRINGE 18,000 UNITS/0.72ML
02352680  FRAGMIN (SA)  PFI  FNQSW

AMP 10,000 UNITS/ML (1ML)
02132664  FRAGMIN (SA)  PFI  FNQSW

MULTIDOSE VIAL 25,000 UNITS/ML (3.8ML)
02231171  FRAGMIN (SA)  PFI  FNQSW

EDOXABAN

SEE APPENDIX A FOR SA CRITERIA
15MG TABLET
02458640  LIXIANA (SA)  SER  FNQSW

30MG TABLET
02458659  LIXIANA (SA)  SER  FNQSW

60MG TABLET
02458667  LIXIANA (SA)  SER  FNQSW

ENOXAPARIN

SEE APPENDIX A FOR SA CRITERA (NURSING HOME PROGRAM DOES NOT REQUIRE AN SA REQUEST)

PRE-FILLED SYRINGE 30MG/0.3ML
02012472  LOVENOX (SA)  AVN  FNQSW
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*WARFARIN*

1MG TABLET
01918311 COUMADIN BMS FNQSW
02242680 TARO-WARFARIN TAR FGNQSW
02242924 APO-WARFARIN APX FGNQSW

2MG TABLET
01918338 COUMADIN BMS FNQSW
02242681 TARO-WARFARIN TAR FGNQSW
02242925 APO-WARFARIN APX FGNQSW

2.5MG TABLET
01918346 COUMADIN BMS FNQSW
02242682 TARO-WARFARIN TAR FGNQSW
02242926 APO-WARFARIN APX FGNQSW

3MG TABLET
02240205 COUMADIN BMS FNQSW
02242683 TARO-WARFARIN TAR FGNQSW
02245618 APO-WARFARIN APX FGNQSW

4MG TABLET
02007959 COUMADIN BMS FNQSW
02242684 TARO-WARFARIN TAR FGNQSW
02242927 APO-WARFARIN APX FGNQSW

5MG TABLET
01918354 COUMADIN BMS FNQSW
02242685 TARO-WARFARIN TAR FGNQSW
02242928 APO-WARFARIN APX FGNQSW

6MG TABLET
02240206 COUMADIN BMS FNQSW

10MG TABLET
01918362 COUMADIN BMS FNQSW
02242687 TARO-WARFARIN TAR FGNQSW
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PRASUGREL  
SEE APPENDIX A FOR SA CRITERIA  
10MG TABLET  
02349124 EFFIENT (SA) LIL FNQSW

TICAGRELOR  
SEE APPENDIX A FOR SA CRITERIA  
90MG TABLET  
02368544 BRILINTA (SA) AZE FNQSW

TICLOPIDINE HCL  
SEE APPENDIX A FOR SA CRITERIA  
250MG TABLET  
02237701 TICLOPIDINE (SA) AAA FGQSW

20:16.00 HEMATOPOIETIC AGENTS

DARBEPOETIN ALFA  
SEE APPENDIX A FOR SA CRITERIA  
10UG/ML PRE-FILLED SYRINGE  
02392313 ARANESP (SA) AMG E

20UG/ML PRE-FILLED SYRINGE  
02392321 ARANESP (SA) AMG E

30UG/ML PRE-FILLED SYRINGE  
02392348 ARANESP (SA) AMG E

40UG/ML PRE-FILLED SYRINGE  
02391740 ARANESP (SA) AMG E

50UG/ML PRE-FILLED SYRINGE  
02391759 ARANESP (SA) AMG E

60UG/ML PRE-FILLED SYRINGE  
02392356 ARANESP (SA) AMG E

80UG/ML PRE-FILLED SYRINGE  
02391767 ARANESP (SA) AMG E

100UG/ML PRE-FILLED SYRINGE  
02391775 ARANESP (SA) AMG E

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<th>Strength</th>
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<th>Product Name</th>
<th>Formulation</th>
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**EPOETIN ALFA**

*See Appendix A for SA Criteria*

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**FILGRASTIM**

*See Appendix A for SA Criteria*

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*See Appendix A for SA Criteria*

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**HEMORRHEOLOGIC AGENTS**

**PENTOXIFYLLINE**

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PEI Pharmacare Formulary ..........................................................Page - 79 -
# 24:00.00 CARDIAC DRUGS

## *ACEBUTOLOL HCL*

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0.05MG/ML ELIXIR
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02335700  TOLOXIN  PEN  FNQSW

0.125MG TABLET
02335719  TOLOXIN  PEN  FNQSW

0.25MG TABLET
02335727  TOLOXIN  PEN  FNQSW

0.25 MG/ML INJECTION SOLUTION
02048264  DIGOXIN  SDZ  NQ

*DILTIAZEM*

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02245918  SANDOZ-DILTIAZEM T  SDZ  FGNQSW
02271605  TEVA-DILTIAZEM ER  TEV  FGNQSW
02370441  ACT-DILTIAZEM  ATV  FGNQSW
02465353  MAR-DILTIAZEM T  MAR  FGNQSW
02495376  JAMP-DILTIAZEM T  JPC  FGNQSW

180MG EXTENDED RELEASE CAPSULE
02231151  TIAZAC  VAL  FNQSW
02245919  SANDOZ-DILTIAZEM T  SDZ  FGNQSW
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02465361  MAR-DILTIAZEM T  MAR  FGNQSW
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**IVABRADINE**

*SEE APPENDIX A FOR SA CRITERIA*

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PEI Pharmacare Formulary .................................................................Page - 87 -
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**MEXILETINE HCL**

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## ANTILIPEMIC DRUGS

### *ATORVASTATIN CALCIUM*

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02392941  MYLAN-ATORVASTATIN MYL  FGNQSW
02399385  PMS-ATORVASTATIN   PMS  FGNQSW
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02411369  ATORVASTATIN       SIV  FGNQSW
02417944  REDDY-ATORVASTATIN RCH  FGNQSW
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02457768  ACH-ATORVASTATIN   ACH  FGNQSW
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40MG TABLET
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02324962  SANDOZ-ATORVASTATIN SDZ  FGNQSW
02391074  JAMP-ATORVASTATIN  JPC  FGNQSW
02392968  MYLAN-ATORVASTATIN MYL  FGNQSW
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02411377  ATORVASTATIN       SIV  FGNQSW
02417952  REDDY-ATORVASTATIN RCH  FGNQSW
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02478161  AG-ATORVASTATIN    ANG  FGNQSW
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02477173 PMS-ATORVASTATIN PMS FGNQSW
02478188 AG-ATORVASTATIN ANG FGNQSW

*CHOLESTERYRAMINE*
REGULAR - 4G/POUCH X 30 POUCHES - 120G/PK ORAL POWDER (POUCHES)
02210320 OLESTYR PMS FGNQSW
* price per gram for cholesteryramine powder pouches

LIGHT - 4G/POUCH X 30 POUCHES- 120G/PK
00890960 OLESTYR PMS FGNQSW
02455609 CHOLESTERYRAMINE-ODAN ODN FGNQSW
02478595 JAMP-CHOLESTERYRAMINE JPC FGNQSW

COLESEVELAM
625MG TABLET
02373955 LODALIS VAL FNQSW
02494051 APO-COLESEVELAM APX FGNQSW

3.75G PACKET
02432463 LODALIS VAL FNQSW

EZETIMIBE
SEE APPENDIX A FOR SA CRITERIA
10MG TABLET
02247521 EZETROL (SA) MSD FNQSW
02354101 TEVA-EZETIMIBE (SA) TEV FGNQSW
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02416778 SANDOZ-EZETIMIBE (SA) SDZ FGNQSW
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02422662 MAR-EZETIMIBE (SA) MAR FGNQSW
02423235 JAMP-EZETIMIBE (SA) JPC FGNQSW
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02427826 APO-EZETIMIBE (SA) APX FGNQSW
02429659 EZETIMIBE (SA) SIV FGNQSW
02431300 EZETIMIBE (SA) SNS FGNQSW
02460750 GLN-EZETIMIBE (SA) GLM FGNQSW
02469286 AURO-EZETIMIBE (SA) ARO FGNQSW
02475898 AG-EZETIMIBE (SA) AGP FGNQSW

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02481669  NRA-EZETIMIBE (SA)  NRA  FGNQSW

**FENOFIBRATE**

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02246859  APO-FENO-SUPER  APX  FGNQSW
02288044  SANDOZ-FENOFIBRATE S  SDZ  FGNQSW

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02241602  LIPIDIL SUPRA  BGP  FNQSW
02246860  APO-FENO-SUPRA  APX  FGNQSW
02288052  SANDOZ-FENOFIBRATE S  SDZ  FGNQSW

200MG CAPSULE
02239864  AA-FENO-MICRO  AAA  FGNQSW

**FLUVASTATIN SODIUM**

20MG CAPSULE
02299224  TEVA-FLUVASTATIN  TEV  FGNQSW

40MG CAPSULE
02299232  TEVA-FLUVASTATIN  TEV  FGNQSW

**GEMFIBROZIL**

300MG CAPSULE
02241704  TEVA-GEMFIBROZIL  TEV  FGNQSW

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02142074  TEVA-GEMFIBROZIL  TEV  FGNQSW

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02353237  LOVASTATIN  SNS  FGNQSW

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**24:08.16 CENTRAL ALPHA AGONISTS**
**CLONIDINE HCL**

- **0.025MG TABLET**
  - 02304163 TEVA-CLONIDINE TEV FGNQSW

- **0.1MG TABLET**
  - 02046121 TEVA-CLONIDINE TEV FGNQSW
  - 02462192 MINT-CLONIDINE MNT FGNQSW

- **0.2MG TABLET**
  - 02046148 TEVA-CLONIDINE TEV FGNQSW
  - 02462206 MINT-CLONIDINE MNT FGNQSW

**METHYLDOPA**

- **125MG TABLET**
  - 00360252 METHYLDOPA AAA FGNQSW

- **250MG TABLET**
  - 00360260 METHYLDOPA AAA FGNQSW

- **500MG TABLET**
  - 00426830 METHYLDOPA AAA FGNQSW

---

**24:12.00 MISCELLANEOUS VASODILATING AGENTS**

**AMBRISENTAN**

**SEE APPENDIX A** FOR SA CRITERIA

- **5MG TABLET**
  - 02307065 VOLIBRIS (SA) GSK MQ
  - 02475375 APO-AMBRISENTAN (SA) APX MQ

- **10MG TABLET**
  - 02307073 VOLIBRIS (SA) GSK MQ
  - 02475383 APO-AMBRISENTAN (SA) APX MQ

**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
  - 02374757 ACT-BETAHISTINE (SA) ATV FGNQSW
  - 02449153 AURO-BETAHISTINE (SA) ARO FGNQSW
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**EPOPROSTENOL SODIUM (GLYCINE)**

*SEE APPENDIX A FOR SA CRITERIA*

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**EPOPROSTENOL SODIUM (ARGININE)**

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**ISOSORBIDE DINITRATE**

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PEI Pharmacare Formulary ..............................................................Page - 102 -
*ISOSORBIDE MONONITRATE

60MG TABLET
02126559 IMDUR AST FNQSW
02272830 APO-ISMM APX FGNQSW
02301288 PMS-ISMN PMS FGNQSW

NITROGLYCERIN

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

0.2MG/HR TRANSDERMAL PATCH
01911910 NITRO-DUR 0.2 RCH FNQSW
02407442 MYLAN-NITRO PATCH MYL FGNQSW

0.2MG/HR TRANSDERMAL PATCH
02162806 MINITRAN 0.2 VAL FQSW
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
02163527 MINITRAN 0.4 VAL FQSW
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
02163535 MINITRAN 0.6 VAL 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

0.3MG SUBLINGUAL TABLET
00037613 NITROSTAT UJC NQW
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**RIOCIGUAT**

*SEE APPENDIX A FOR SA CRITERIA*

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**SELEXIPAG**

*SEE APPENDIX A FOR SA CRITERIA*

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### 24:28.08 DIHYDROPYRIDINES (CALCIUM CHANNEL BLOCKERS)

### *FELODIPINE*

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10MG SUSTAINED RELEASE TABLET

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5MG & 12.5MG TABLET

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**ENALAPRIL MALEATE**

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02291908   ACT-ENALAPRIL  ATV  FGNQSW
02299976   SANODZ-ENALAPRIL  SDZ  FGNQSW
02300060   MYLAN-ENALAPRIL  MYL  FGNQSW
02352265   RAN-ENALAPRIL  RAN  FGNQSW
02400685   ENALAPRIL    SNS  FGNQSW
02442981   ENALAPRIL    SIV  FGNQSW
02444798   MAR-ENALAPRIL  MAR  FGNQSW
02474816   JAMP-ENALAPRIL  JPC  FGNQSW

*ENALAPRIL & HYDROCHLOROTHIAZIDE
5MG & 12.5MG TABLET
02352923   ENALAPRIL MALEATE/HCTZ  AAA  FGNQSW

10MG & 25MG TABLET
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02331004   JAMP-FOSINOPRIL  JPC  FGNQSW
02294524   RAN-FOSINOPRIL  RAN  FGNQSW
02459388   FOSINOPRIL    SNS  FGNQSW

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02294532   RAN-FOSINOPRIL  RAN  FGNQSW
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*LISINOPRIL
5MG TABLET
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**TRANDOLAPRIL**

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### 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

**Candesartan Cilexetil**

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**32MG TABLET**

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*CANDESARTAN CILEXETIL & HYDROCHLOROTHIAZIDE*

**16MG & 12.5MG TABLET**

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**OLMESARTAN & HYDROCHLOROTHIAZIDE**

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**SACUBITRIL & VALSARTAN**

SEE APPENDIX A FOR SA CRITERIA

**24MG & 26MG TABLET**

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**TELMISARTAN**

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**160MG & 25MG TABLET**

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**28:08.04 NONSTEROIDAL ANTI INFLAMMATORY AGENTS**

***ACETYLSALICYLIC ACID***

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PEI Pharmacare Formulary .............................................................Page - 123 -
### CELECOXIB

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<td>02445670</td>
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<tr>
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<td>NRA-CELECOXIB</td>
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**200MG CAPSULE**

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<thead>
<tr>
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<th>Brand</th>
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<tbody>
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<td>02239942</td>
<td>CELEBREX</td>
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<td>02355450</td>
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<td>02412500</td>
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<td>02418940</td>
<td>APO-CELECOXIB</td>
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<td>02420066</td>
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<td>MAR</td>
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<td>02420163</td>
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### DICLOFENAC SODIUM

**25MG ENTERIC COATED TABLET**

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Brand</th>
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<tbody>
<tr>
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<td>TEVA-DICLOFENAC EC</td>
<td>TEV</td>
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<tr>
<td>00839175</td>
<td>APO-DICLO</td>
<td>APX</td>
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<td>02302616</td>
<td>PMS-DICLOFENAC</td>
<td>PMS</td>
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**50MG ENTERIC COATED TABLET**

<table>
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<th>Code</th>
<th>Name</th>
<th>Brand</th>
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<tbody>
<tr>
<td>00808547</td>
<td>TEVA DIFENAC</td>
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<tr>
<td>00839183</td>
<td>APO-DICLO</td>
<td>APX</td>
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<tr>
<td>02261960</td>
<td>SANDOZ-DICLOFENAC</td>
<td>SDZ</td>
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<tr>
<td>02302624</td>
<td>PMS-DICLOFENAC</td>
<td>PMS</td>
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<tr>
<td>02352397</td>
<td>DICLOFENAC EC</td>
<td>SNS</td>
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</table>
### 75mg Sustained Release Tablet

<table>
<thead>
<tr>
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<th>Brand</th>
<th>Manufacturer</th>
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<tbody>
<tr>
<td>02158582</td>
<td>TEVA Difenac SR</td>
<td>TEV FGNQSW</td>
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<tr>
<td>02162814</td>
<td>APO-Diclo SR</td>
<td>APX FGNQSW</td>
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<td>02231504</td>
<td>PMS-Diclofenac SR</td>
<td>PMS FGNQSW</td>
</tr>
<tr>
<td>02261901</td>
<td>Sandoz-Diclofenac</td>
<td>SDZ FGNQSW</td>
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### 100mg Sustained Release Tablet

<table>
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<th>Brand</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>02091194</td>
<td>APO-Diclo SR</td>
<td>APX FGNQSW</td>
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<td>02231505</td>
<td>PMS-Diclofenac SR</td>
<td>PMS FGNQSW</td>
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<tr>
<td>02261944</td>
<td>Sandoz-Diclofenac</td>
<td>SDZ FGNQSW</td>
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</tbody>
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### 50mg Suppository

<table>
<thead>
<tr>
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<th>Manufacturer</th>
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<tbody>
<tr>
<td>00632724</td>
<td>Voltaren</td>
<td>NVR FNGQSW</td>
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<tr>
<td>02231506</td>
<td>PMS-Diclofenac</td>
<td>PMS FGNQSW</td>
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<tr>
<td>02261928</td>
<td>Sandoz-Diclofenac</td>
<td>SDZ FGNQSW</td>
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</table>

Note: Suppository formulation limited to a maximum one-month supply of medication.

### Diclofenac & Misoprostol

#### 50mg/200mg Tablet

<table>
<thead>
<tr>
<th>Code</th>
<th>Brand</th>
<th>Manufacturer</th>
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</thead>
<tbody>
<tr>
<td>01917056</td>
<td>Arthrotec</td>
<td>PFI FNGQSW</td>
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<tr>
<td>02341689</td>
<td>GD-Diclofenac/Misoprostol</td>
<td>GMD FGNQSW</td>
</tr>
<tr>
<td>02413469</td>
<td>PMS-Diclofenac/Misoprostol</td>
<td>PMS FGNQSW</td>
</tr>
</tbody>
</table>

#### 75mg/200mg Tablet

<table>
<thead>
<tr>
<th>Code</th>
<th>Brand</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>02229837</td>
<td>Arthrotec</td>
<td>PFI FNGQSW</td>
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<tr>
<td>02341697</td>
<td>GD-Diclofenac/Misoprostol</td>
<td>GMD FGNQSW</td>
</tr>
<tr>
<td>02413477</td>
<td>PMS-Diclofenac/Misoprostol</td>
<td>PMS FGNQSW</td>
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</tbody>
</table>

### *Flurbiprofen*

#### 50mg Tablet

<table>
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<th>Brand</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>01912046</td>
<td>Flurbiprofen</td>
<td>AAA FGNQSW</td>
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#### 100mg Tablet

<table>
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<tr>
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<th>Manufacturer</th>
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</thead>
<tbody>
<tr>
<td>01912038</td>
<td>Flurbiprofen</td>
<td>AAA FGNQSW</td>
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<tr>
<td>02100517</td>
<td>Teva-Flurbiprofen</td>
<td>TEV FGNQSW</td>
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</table>

### *Ibuprofen*

#### 300mg Tablet

<table>
<thead>
<tr>
<th>Code</th>
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<th>Manufacturer</th>
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<tbody>
<tr>
<td>00999986</td>
<td>Ibuprofen (DIN for billing purposes only)</td>
<td>NW</td>
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</table>
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

50MG RECTAL SUPPOSITORY
02231799  SANDOZ-INDOMETHACIN  SDZ  FGNQSW

100MG RECTAL SUPPOSITORY
02231800  SANDOZ-INDOMETHACIN  SDZ  FGNQSW
Note: Suppository formulation limited to a maximum one-month supply of medication.

*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

100MG RECTAL SUPPOSITORY
02015951  PMS-KETOPROFEN  PMS  FGNQSW
Note: Suppository formulation limited to a maximum one-month supply of medication.

*MEFENAMIC ACID
250MG CAPSULE
00155225  PONSTAN  AAA  FQW

*MELOXICAM
7.5MG TABLET
02242785  MOBICOX  BOE  FNQSW
02248267  PMS-MELOXICAM  PMS  FGNQSW

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02248973  APO-MELOXICAM          APX  FGNQSW
02250012  ACT-MELOXICAM          ATV  FGNQSW
02258315  TEVA-MELOXICAM         TEV  FGNQSW
02353148  MELOXICAM              SNS  FGNQSW
02390884  AURO-MELOXICAM         ARO  FGNQSW

15MG TABLET
02242786  MOBICOX                BOE  FNQSW
02248268  PMS-MELOXICAM          PMS  FGNQSW
02248974  APO-MELOXICAM          APX  FGNQSW
02250020  ACT-MELOXICAM          ATV  FGNQSW
02258323  TEVA-MELOXICAM         TEV  FGNQSW
02353156  MELOXICAM              SNS  FGNQSW
02390892  AURO-MELOXICAM         ARO  FGNQSW

NABUMETONE
SEE APPENDIX A FOR CRITERIA
500MG TABLET
02238639  NABUMETONE (SA)        AAA  FGNQSW

*NAPROXEN
125MG TABLET
00522678  APO-NAPROXEN           APX  FGNQSW

250MG TABLET
00522651  APO-NAPROXEN           APX  FGNQSW
00565350  TEVA-NAPROX            TEV  FGNQSW
02350750  NAPROXEN               SNS  FGNQSW

375MG TABLET
00600806  APO-NAPROXEN           APX  FGNQSW
00627097  TEVA NAPROX            TEV  FGNQSW
02350769  NAPROXEN               SNS  FGNQSW

500MG TABLET
00589861  TEVA-NAPROX            TEV  FGNQSW
00592277  APO-NAPROXEN           APX  FGNQSW
02350777  NAPROXEN               SNS  FGNQSW

250MG ENTERIC COATED TABLET
02243312  TEVA-NAPROXEN EC       TEV  FGNQSW
02350785  NAPROXEN EC            SNS  FGNQSW

375MG ENTERIC COATED TABLET
02162415  NAPROSYN-E             MTP  FNQSW
<table>
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<th>Brand</th>
<th>Formulation</th>
</tr>
</thead>
<tbody>
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<td>02246700</td>
<td>APO-NAPROXEN EC</td>
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<td>FGNQSW</td>
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<td>02350793</td>
<td>NAPROXEN EC</td>
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<td>FGNQSW</td>
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**500MG ENTERIC COATED TABLET**

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<td>MTP</td>
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<td>FGNQSW</td>
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<td>02246701</td>
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<td>FGNQSW</td>
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<td>02350807</td>
<td>NAPROXEN EC</td>
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<td>FGNQSW</td>
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**750MG SUSTAINED RELEASE TABLET**

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<td>NAPROSYN SR</td>
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**500MG RECTAL SUPPOSITORY**

<table>
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<th>Formulation</th>
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<tbody>
<tr>
<td>02017237</td>
<td>PMS-NAPROXEN</td>
<td>PMS</td>
<td>FGNQSW</td>
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</table>

Note: Suppository formulation limited to a maximum one-month supply of medication.

**PIROXICAM**

**10MG CAPSULE**

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<th>Brand</th>
<th>Formulation</th>
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<tbody>
<tr>
<td>00695718</td>
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**20MG CAPSULE**

<table>
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<th>Formulation</th>
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<tbody>
<tr>
<td>00695696</td>
<td>TEVA-PIROXICAM</td>
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<td>FGNQSW</td>
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**SULINDAC**

**150MG TABLET**

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<th>Formulation</th>
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<tbody>
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<td>00745588</td>
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<td>TEV</td>
<td>FGNQSW</td>
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**200MG TABLET**

<table>
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<tr>
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<th>Brand</th>
<th>Formulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>00745596</td>
<td>TEVA-SULINDAC</td>
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<td>FGNQSW</td>
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**TIAPROFENIC ACID**

**200MG TABLET**

<table>
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<tr>
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<th>Brand</th>
<th>Formulation</th>
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</thead>
<tbody>
<tr>
<td>02179679</td>
<td>TEVA-TIAPROFENIC ACID</td>
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</table>

**300MG TABLET**

<table>
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<th>Formulation</th>
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**28:08.08  OPIATE AGONISTS (NARCOTIC ANALGESICS)**

**ACETAMINOPHEN & CODEINE**

300MG & 60MG TABLET
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<tr>
<td>00293504</td>
<td>ATASOL</td>
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<td>00653241</td>
<td>TEVA-LENOLTEC NO.2</td>
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<tr>
<td>00653276</td>
<td>TEVA-LENOLTEC NO.3</td>
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<tr>
<td>00593435</td>
<td>TEVA-CODINE</td>
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<td>00593451</td>
<td>TEVA-CODINE</td>
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<tr>
<td>02230302</td>
<td>CODEINE CONTIN (SA)</td>
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<tr>
<td>02163748</td>
<td>CODEINE CONTIN (SA)</td>
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<td>02163780</td>
<td>CODEINE CONTIN (SA)</td>
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<td>02163799</td>
<td>CODEINE CONTIN (SA)</td>
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<td>TEVA-FENTANYL (SA)</td>
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<td>02341379</td>
<td>PMS-FENTANYL MTX (SA)</td>
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<tr>
<td>02282941</td>
<td>TEVA-FENTANYL (SA)</td>
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<tr>
<td>02327120</td>
<td>SANDOZ-FENTANYL (SA)</td>
</tr>
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<td>02330113</td>
<td>RAN-FENTANYL MTX (SA)</td>
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<tr>
<td>02341387</td>
<td>PMS- FENTANYL MTX (SA)</td>
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<td></td>
<td>SEE APPENDIX A FOR SA CRITERIA</td>
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</table>

**ACETAMINOPHEN COMPOUND WITH CODEINE**

**15MG CODEINE TABLET**

- Code 00621463: TEVA-LENOLTEC NO.4
- Code 00293504: ATASOL
- Code 00653241: TEVA-LENOLTEC NO.2

**30MG CODEINE TABLET**

- Code 00653276: TEVA-LENOLTEC NO.3

**CODEINE**

**15MG TABLET**

- Code 00593435: TEVA-CODINE

**30MG TABLET**

- Code 00593451: TEVA-CODINE

**SEE APPENDIX A FOR SA CRITERIA**

**50MG CONTROLLED RELEASE TABLET**

- Code 02230302: CODEINE CONTIN (SA)

**100MG CONTROLLED RELEASE TABLET**

- Code 02163748: CODEINE CONTIN (SA)

**150MG CONTROLLED RELEASE TABLET**

- Code 02163780: CODEINE CONTIN (SA)

**200MG CONTROLLED RELEASE TABLET**

- Code 02163799: CODEINE CONTIN (SA)

**FENTANYL**

**SEE APPENDIX A FOR SA CRITERIA**

**12UG/HR TRANSDERMAL PATCH**

- Code 02311925: TEVA-FENTANYL (SA)
- Code 02327112: SANDOZ-FENTANYL (SA)
- Code 02330105: RAN-FENTANYL MTX(SA)
- Code 02341379: PMS-FENTANYL MTX (SA)

**25UG/HR TRANSDERMAL PATCH**

- Code 02282941: TEVA-FENTANYL (SA)
- Code 02327120: SANDOZ-FENTANYL (SA)
- Code 02330113: RAN-FENTANYL MTX (SA)
- Code 02341387: PMS- FENTANYL MTX (SA)

**37UG/HR TRANSDERMAL PATCH**
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<th>Brand</th>
<th>Formulation</th>
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</thead>
<tbody>
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<td>SANDOZ-FENTANYL (SA)</td>
<td>SDZ FNQSW</td>
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<td><strong>50UG/HR TRANSDERMAL PATCH</strong></td>
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<td>02282968</td>
<td>TEVA-FENTANYL (SA)</td>
<td>TEV FNQSW</td>
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<td>SANDOZ-FENTANYL (SA)</td>
<td>SDZ FNQSW</td>
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<tr>
<td>02330121</td>
<td>RAN-FENTANYL MTX (SA)</td>
<td>RBX FNQSW</td>
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<tr>
<td>02341395</td>
<td>PMS- FENTANYL MTX (SA)</td>
<td>PMS FNQSW</td>
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<td>02282976</td>
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<td>TEV FNQSW</td>
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<td>3MG</td>
<td>Suppository</td>
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<tr>
<td>2MG/ML</td>
<td>Injection Solution (1ML)</td>
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SEE APPENDIX A FOR SA CRITERIA. **NOTE:** SA NOT REQUIRED FOR NURSING HOME PROGRAM.

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<th>Code</th>
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<td>Injection Solution (1ML, 5ML, AND 50ML)</td>
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<td><strong>SEE APPENDIX A FOR SA CRITERIA</strong></td>
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Tablets Only - For the management of severe chronic or malignant pain as an alternative to other opiates

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<td>02244290</td>
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<td>200MG SUSTAINED RELEASE TABLET</td>
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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  RATIO-OXYCODAN  RPH  FQSW

**28:08.12 OPIATE PARTIAL AGONISTS**

**BUPRENORPHINE & NALOXONE**

2MG/0.5MG TABLET
02295695  SUBOXONE  ICL  FLNQSW
02424851  PMS-BUPRENORPHINE/NALOXONE  PMS  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
### 28:12.04 ANTICONVULSANTS (BARBITURATES)

**Phenobarbital**

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<td>00178799</td>
<td>Phenobarb</td>
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<td>30mg tablet</td>
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<td>60mg tablet</td>
<td>00178810</td>
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<td>100mg tablet</td>
<td>00178829</td>
<td>Phenobarb</td>
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<tr>
<td>5mg/ml elixir</td>
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**Primidone**

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### 28:12.08 ANTICONVULSANTS (BENZODIAZEPINES)

**Clonazepam**

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<td>0.5mg tablet</td>
<td>00382825</td>
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02048701  PMS-CLONAZEPAM  PMS  FNQSW
02177889  APO-CLONAZEPAM  APX  FNQSW
02207818  PMS-CLONAZEPAM-R  PMS  FNQSW
02239024  TEVA-CLONAZEPAM  TEV  FNQSW

1MG TABLET
02048728  PMS-CLONAZEPAM  PMS  FNQSW

2MG TABLET
00382841  RIVOTRIL  HLR  FNQSW
02048736  PMS-CLONAZEPAM  PMS  FNQSW
02177897  APO-CLONAZEPAM  APX  FNQSW
02442051  CLONAZEPAM  SIV  FNQSW

LORAZEPAM
4MG/ML INJECTION SOLUTION
02243278  LORAZEPAM  SDZ  NQ

28:12.12 ANTICONVULSANTS (HYDANTOINS)

*PHENYTOIN
50MG TABLET
00023698  DILANTIN  UJC  FGNQSW

30MG CAPSULE
00022772  DILANTIN  UJC  FGNQSW

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

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

50MG/ML INJECTION SOLUTION
00780626  PHENYTOIN SODIUM  SDZ  NQ
### 28:12.20 ANTICONVULSANTS (SUCCINIMIDES)

**ETHOSUXIMIDE**

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### 28:12.92 ANTICONVULSANTS (MISCELLANEOUS)

**BRIVARACETAM**

*See Appendix A for SA criteria*

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**CARBAMAZEPINE**

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<td>TAR FGQW</td>
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OXCARBAZEPINE
SEE APPENDIX A FOR SA CRITERIA
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300MG TABLET
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PERAMpanel
SEE APPENDIX A FOR SA CRITERIA
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4MG TABLET
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6MG TABLET
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### PREGABALIN

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**SEE APPENDIX A** FOR SA CRITERIA

**15MG SPINKLE CAPSULE**

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**25MG SPINKLE CAPSULE**

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**VALPROATE SODIUM**

**50MG/ML SYRUP**

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**VALPROIC ACID**

**250MG CAPSULE**

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**VIGABATRIN**

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### 28:16.04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

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**FLUOXETINE**

**SEE APPENDIX A FOR SA CRITERIA**

**20MG/5ML ORAL SOLUTION**

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### 28:16.08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTICS)

#### ARIPIPRAZOLE

**SEE APPENDIX A FOR SA CRITERIA**

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**SEE APPENDIX A FOR SA CRITERIA**

**300MG INJECTION**

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400MG INJECTION
02420872 ABILIFY MAINTENA (SA) OTS FNQSW

ASENAPINE
SEE APPENDIX A FOR SA CRITERIA
5MG SUBLINGUAL TABLET
02374803 SAPHRIS (SA) LUD Q

10MG SUBLINGUAL TABLET
02374811 SAPHRIS (SA) LUD Q

BREXIPIPRAZOLE
SEE APPENDIX A FOR SA CRITERIA
0.25MG TABLET
02461749 REXULTI (SA) OTS FNQSW

0.5MG TABLET
02461757 REXULTI (SA) OTS FNQSW

1MG TABLET
02461765 REXULTI (SA) OTS FNQSW

2MG TABLET
02461773 REXULTI (SA) OTS FNQSW

3MG TABLET
02461781 REXULTI (SA) OTS FNQSW

4MG TABLET
02461803 REXULTI (SA) OTS FNQSW

CHLORPROMAZINE
25MG TABLET
00232823 TEVA-CHLORPROMAZINE TEV FGNQSW

50MG TABLET
00232807 TEVA-CHLORPROMAZINE TEV FGNQSW

100MG TABLET
00232831 TEVA-CHLORPROMAZINE TEV FGNQSW

CLOZAPINE
SEE APPENDIX A FOR SA CRITERIA
25MG TABLET
00894737 CLOZARIL (SA) NVR FNQSW
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

**FLUPENTHIXOL DIHYDROCHLORIDE**

0.5MG TABLET
02156008  FLUANXOL  LUD  FNQSW

3MG TABLET
02156016  FLUANXOL  LUD  FNQSW

**FLUPHENAZINE HCL**

1MG TABLET
00405345  FLUPHENAZINE  AAA  FGNQSW

2MG TABLET
00410632  FLUPHENAZINE  AAA  FGNQSW

5MG TABLET
00405361  FLUPHENAZINE  AAA  FGNQSW
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SEE APPENDIX A FOR SA CRITERIA

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**SEE APPENDIX A FOR SA CRITERIA**

### 0.5MG ORALLY DISINTEGRATING TABLET
<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Brand</th>
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<tbody>
<tr>
<td>02413485</td>
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### 1MG ORALLY DISINTEGRATING TABLET
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### 1 MG/Ml ORAL SOLUTION
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<td>02236950</td>
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<td>02280396</td>
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**SEE APPENDIX A FOR SA CRITERIA**

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PEI Pharmacare Formulary .................................................................Page - 172 -
<table>
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<tr>
<th>Dose</th>
<th>Code</th>
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**28:20.00 RESPIRATORY AND CEREBRAL STIMULANTS**

**DEXTROAMPHETAMINE/AMPHETAMINE**

**5MG CAPSULE**

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**10MG CAPSULE**

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**15MG CAPSULE**

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**20MG CAPSULE**

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**25MG CAPSULE**

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<tr>
<td>10MG CAPSULE</td>
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<tr>
<td>02439603  VYVANSE (SA)</td>
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### 30mg Controlled Release Capsule

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### 40mg Controlled Release Capsule

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### 50mg Controlled Release Capsule

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### 60mg Controlled Release Capsule

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### 80mg Controlled Release Capsule

<table>
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<tbody>
<tr>
<td>02277212</td>
<td>Biphentin (SA)</td>
<td>ELV FQW</td>
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### Modafinil

**See Appendix A** for SA criteria.

### 100mg Tablet

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<th>Brand</th>
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<td>02239665</td>
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<td>TEV FNQSW</td>
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<tr>
<td>02285398</td>
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<td>APX FGQSW</td>
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<td>02420260</td>
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<td>TEV FGQSW</td>
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<td>MAR FGQSW</td>
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<tr>
<td>02503727</td>
<td>Jamp-Modafinil (SA)</td>
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### 28:24.08 Anxiolytics, Sedatives, Hypnotics (Benzodiazepines)

### Alprazolam

#### 0.25mg Tablet

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#### 0.5mg Tablet

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<td>JPC FNQSW</td>
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<tr>
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<td></td>
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<table>
<thead>
<tr>
<th>OXAZEPAM</th>
<th>30MG TABLET</th>
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</table>
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

BUSPIRONE
10MG TABLET
02211076 APO-BUSPIRONE APX FGNQSW
02230942 PMS-BUSPIRONE PMS FGNQSW
02231492 TEVA-BUSPIRONE TEV FGNQSW
02500213 AURO-BUSPIRONE ARO FGNQSW

CHLORAL HYDRATE
100MG/ML SYRUP
02247621 CHLORAL HYDRATE ODAN ODN FNQSW

HYDROXYZINE HCL
10MG CAPSULE
00646059 HYDROXYZINE AAA FGNQSW

25MG CAPSULE
00646024 HYDROXYZINE AAA FGNQSW

50MG CAPSULE
00646016 HYDROXYZINE AAA FGNQSW

2MG/ML SYRUP
00024694 ATARAX ERF FNQSW
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<td>02243426</td>
<td>PMS-ZOPICLONE PMS FNQW</td>
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<td>APO-ZOPICLONE APX FNQW</td>
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<td>02246534</td>
<td>RATIO-ZOPICLONE RPH FNQW</td>
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<td>02257572</td>
<td>SANDOZ-ZOPICLONE SDZ FNQW</td>
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<tr>
<td>02267918</td>
<td>RAN-ZOPICLONE RAN FNQW</td>
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<tr>
<td>02344122</td>
<td>ZOPICLONE SNS FNQW</td>
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<td>02385821</td>
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<td>02386771</td>
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<td>SEPTA-ZOPICLONE SPT FNQW</td>
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<td>02218313</td>
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**28:28.00 ANTIMANIC AGENTS**

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### 28:32.00 MISCELLANEOUS ANTIMIGRAINE AGENTS

**ALMOTRIPTAN**

12.5MG TABLET

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<td>APO-ALMOTRIPTAN</td>
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Note: Coverage is limited to 6 tablets per 30 day period.

**NARATRIPTAN HCL**

SEE APPENDIX A FOR SA CRITERIA

1MG TABLET

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2.5MG TABLET

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<td>GSK</td>
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Note: Coverage is limited to 6 tablets per 30 day period.

**PIZOTYLINE**

1MG TABLET

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**RIZATRIPTAN**

PEI Pharmacare Formulary ........................................................................Page - 182 -
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Note: Coverage is limited to 6 tablets per 30 day period.

### SUMATRIPTAN

#### 50MG TABLET

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**SEE APPENDIX A FOR SA CRITERIA**

#### 6MG/0.5ML INJECTION SOLUTION

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**SEE APPENDIX A FOR SA CRITERIA**

#### 5MG NASAL SPRAY

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#### 20MG NASAL SPRAY

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Note: Coverage is limited to 6 tablets or 6 sprays or 6 syringes per 30 day period.

### ZOLMITRIPTAN

#### 2.5MG TABLET

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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

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

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

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### LEVODOPA & CARBIDOPA

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

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### PRAMIPEXOLE DIHYDROCHLORIDE

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**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
02068087 TEVA-SELEGILINE TEV FGNQSW
02230641 SELEGILINE AAA FGNQSW

**28:36.08 ANTICHOLINERGIC AGENTS**

**BENZTROPINE MESYLATE**

1MG TABLET
00706531 PDP-BENZTROPINE PEN FGNQSW

1MG/ML INJECTION SOLUTION (2ML)
02238903 BENZTROPINE OMEGA OMG NQ

**PROCYCLIDINE HCL**

5MG TABLET
00587354 PDP-PROCYCLIDINE PEN FGNQSW

**TRIHEXYPHENIDYL HCL**

2MG TABLET
00545058 TRIHEXYPHENIDYL AAA FGNQSW

5MG TABLET
00545074 TRIHEXYPHENIDYL AAA FGNQSW

**28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS**
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### 36:26.00 DIABETES MELLITUS
NOTE: THE DRUG IDENTIFICATION NUMBERS LISTED IN THIS SECTION ARE FOR BILLING PURPOSES ONLY.

#### BLOOD GLUCOSE TEST STRIP

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### URINE GLUCOSE TEST STRIP

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### 36:60.00 THYROID FUNCTION

**THYROTROPIN ALFA**

*See Appendix A for SA CRITERIA*

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### 36:84.00 TUBERCULOSIS

**TUBERCULIN PURIFIED PROTEIN DERIVATIVE**

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### 40:08.00 ALKALINIZING AGENTS

**SODIUM BICARBONATE**

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50MMOL INJECTION SOLUTION (50ML SYRINGE)  
00261998  SODIUM BICARBONATE INJECTION  

**40:12.00 REPLACEMENT AGENTS**

**CALCIUM CARBONATE**

250MG TABLET  
00999910  CALCIUM CARBONATE  
Note: The Drug Identification Number listed is for billing purposes only.

500MG TABLET  
00999919  CALCIUM CARBONATE  
Note: The Drug Identification Number listed is for billing purposes only.

**DEXTROSE**

50% INJECTION SOLUTION (50ML SYRINGE)  
00037974  DEXTROSE 50%  

**MAGNESIUM GLUCOHEPTONATE**

100MG/ML ORAL SOLUTION  
00026697  ROUGIER-MAGNESIUM  

**POTASSIUM CHLORIDE**

8MMOL EXTENDED RELEASE TABLET  
80013005  JAMP-K 8  

8MMOL EXTENDED RELEASE CAPSULE  
80062704  JAMP-POTASSIUM CHLORIDE ER  

2MMOL/ML INJECTION SOLUTION (10ML)  
00037869  POTASSIUM CHLORIDE  

**POTASSIUM CITRATE**

25MMOL EFFERVESCENT TABLET  
02085992  K-LYTE  

**SODIUM CHLORIDE**

0.9% INJECTION SOLUTION (10ML)  
00037796  SODIUM CHLORIDE  
02304341  SODIUM CHLORIDE  

0.9% IRRIGATION SOLUTION (1000ML)  
00786160  SODIUM CHLORIDE
STERILE WATER
INJECTION SOLUTION (10ML)
02142546  STERILE WATER FOR INJECTION  PFI  CNQ
02299186  STERILE WATER FOR INJECTION  TLG  CNQ

40:18.00  POTASSIUM-REMOVING RESINS

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

40:28.00  DIURETICS

*CHLORTHALIDONE
50MG TABLET
00360279  CHLORTHALIDONE  AAA  FGNQSW

*FUROSEMIDE
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
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*METOLAZONE
2.5MG TABLET
00888400 ZAROXOLYN AVN FNQSW

40:28.10 DIURETICS (POTASSIUM SPARING)

*AMILORIDE HCL & HYDROCHLOROTHIAZIDE
5MG & 50MG TABLET
00784400 AA-AMILZIDE AAA FNQSW

*SPIRONOLACTONE
25MG TABLET
00028606 ALDACTONE PFI FNQSW
00613215 TEVA-SPIRONOLACTONE TEV FGNQSW
02488140 MINT-SPIRONOLACTONE MNT FGNQSW
100MG TABLET
00285455 ALDACTONE PFI FNQSW
00613223 TEVA-SPIRONOLACTONE TEV FGNQSW
02488159 MINT-SPIRONOLACTONE MNT FGNQSW

*SPIRONOLACTONE & HYDROCHLOROTHIAZIDE
25MG & 25MG TABLET
00613231 TEVA-SPIRONOLACTONE/HCTZ TEV FGNQSW

50MG & 50MG TABLET
00657182 TEVA-SPIRONOLACTONE/HCTZ TEV FGNQSW

*TRIAMTERENE & HYDROCHLOROTHIAZIDE
50MG & 25MG TABLET
00441775 APO-TRIAZIDE APX FGNQSW
00532657 TEVA-TRIAMTERENE/HCTZ TEV FGNQSW

44:00.00 ENZYMES

DORNASE ALFA
SEE APPENDIX A FOR SA CRITERIA
1MG/ML INHALATION SOLUTION
02046733 PULMOZYME (SA) HLR MQ
VELAGLUCERASE ALFA
SEE APPENDIX A FOR SA CRITERIA
400 UNIT VIAL
02357119 VPRIV (SA) SHR MQ

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

48:10.20 INTERLEUKIN ANTAGONISTS

BENRALIZUMAB
SEE APPENDIX A FOR SA CRITERIA
30MG/ML SYRINGE
02473232 FASENRA (SA) AZN MQ

30MG/ML AUTOINJECTOR
02496135 FASENRA (SA) AZN MQ

MEPOLIZUMAB
SEE APPENDIX A FOR SA CRITERIA
100MG VIAL
02449781 NUCALA (SA) GSK MQ

100MG/ML AUTOINJECTOR
02492989 NUCALA (SA) GSK MQ
100MG/ML SYRINGE
02492997 NUCALA (SA) GSK MQ

48:14.12 CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR POTENTIATORS

IVACAFTOR
SEE APPENDIX A FOR SA CRITERIA
150MG TABLET
02397412 KALYDECO (SA) VTX MQ
00903963 KALYDECO (SA)* MQ
00903964 KALYDECO (SA)* MQ
*use when drug cost in excess of CPHA maximum

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

48:24.00 MUCOLYTIC AGENTS

ACETYLICYSTEINE
20% SOLUTION (30 ML)
02243098 ACETYLICYSTEINE SOLUTION SDZ FGNQSW

48:92.00 RESPIRATORY AGENTS, MISCELLANEOUS
OMALIZUMAB
SEE APPENDIX A FOR SA CRITERIA
150MG VIAL
02260565 XOLAIR (SA) NVR MQ

52:02.00 ANTIALLERGIC AGENTS

KETOTIFEN
0.025% OPHTHALMIC DROPS
02242324 ZADITOR LTH FNQSW

OLOPATADINE
0.1% OPHTHALMIC DROPS
02233143 PATANOL NVR FNQSW
02305054 APO-OLOPATADINE APX FGQSW
02358913 SANDOZ-OLOPATADINE SDZ FGQSW
02422727 MINT-OLOPATADINE MNT FGQSW
02458411 JAMP-OLOPATADINE JPC FGQSW

OLOPATADINE
0.2% OPHTHALMIC DROPS
02362171 PATADAY NVR FNQSW
02402823 APO-OLOPATADINE APX FGQSW
02420171 SANDOZ-OLOPATADINE SDZ FGQSW

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 FGQSW
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

GATIFLOXACIN
SEE APPENDIX A FOR SA CRITERIA
0.3% OPHTHALMIC DROPS
02257270 ZYMAR (SA) ALL FGNQSW
02327260 APO-GATIFLOXACIN (SA) APX FGNQSW

MOXIFLOXACIN
SEE APPENDIX A FOR SA CRITERIA
0.5% OPHTHALMIC DROPS
02252260 VIGAMOX (SA) ALC FNQSW
02404656 ACT-MOXIFLOXACIN (SA) ATV FGNQSW
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

OFLOXACIN
SEE APPENDIX A FOR SA CRITERIA
0.3% OPHTHALMIC SOLUTION
02143291 OCUFLOX (SA) ALL FGNQSW

POLYMYXIN B & BACITRACIN
10,000U & 500U/G OPHTHALMIC OINTMENT
02239157 POLYSPORIN JJM NW

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   PERICHLOR (SA)   PMS  N

52:08.00 ANTI INFLAMMATORY AGENTS

BECLOMETHASONE DIPROPIONATE
50UG/DOSE AQUEOUS NASAL SPRAY
02172712   MYLAN-BECLO AQ.   MYL  FNQSW
02238796   APO-BECLOMETHASONE   APX  FGNQSW

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

FLUNISOLIDE
0.025% NASAL SPRAY
02239288  APO-FLUNISOLIDE APX  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
50UG/DOSE AQUEOUS NASAL SPRAY
02294745  APO-FLUTICASONE APX  FGNQSW
02296071  RATIO-FLUTICASONE RPH  FGNQSW

KETOROLAC TROMETHAMINE
0.5% OPHTHALMIC SOLUTION
01968300  ACULAR ALL  FNQSW
02245821  KETOROLAC AAA  FGNQSW

MOMETASONE
50UG/DOSE NASAL SPRAY
02238465  NASONEX MSD  FNQSW
02403587  APO-MOMETASONE APX  FGNQSW
02449811  SANDOZ-MOMETASONE SDZ  FGNQSW
02475863  TEVA-MOMETASONE TEV  FGNQSW

PREDNISOLONE ACETATE
0.12% OPHTHALMIC SUSPENSION
00299405  PRED MILD ALL  FNQSW

1% OPHTHALMIC SUSPENSION
00301175  PRED FORTE ALL  FNQSW
00700401  RATIO-PREDNISOLONE RPH  FGNQSW
01916203  SANDOZ-PREDNISOLONE SDZ  FGNQSW

TRIAMCINOLONE
55UG/DOSE NASAL SPRAY
02213834  NASACORT AQ AVN  FNQSW
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 & 50UG & 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  FNQSW

BRINZOLAMIDE
02238873  AZOPT  ALC  FNQSW

DORZOLAMIDE HCL
2% OPHTHALMIC SOLUTION
02216205  TRUSOPT  ELV  FNQSW
02316307  SANDOZ-DORZOLAMIDE  SDZ  FNQSW
02453347  JAMP-DORZOLAMIDE  JPC  FNQSW

METHAZOLAMIDE
50MG TABLET
02245882  METHAZOLAMIDE  AAA  FNQSW
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 VASOCONSTRUCTORS

XYLOMETAZOLINE
0.1% NASAL SPRAY
00653330 OTRIVIN NVR N
01939998 DECONGESTANT NASAL SPRAY ROG N

52:40.00 ALPHA AND BETA ADRENERGIC AGENTS AND PROSTAGLANDIN ANALOGS

BETAXOLOL HCL
0.25% OPHTHALMIC SUSPENSION
01908448 BETOPTIC S ALC FNQSW

BIMATOPROST
0.1 MG/ML OPHTHALMIC SOLUTION
<table>
<thead>
<tr>
<th>Code</th>
<th>Product Name</th>
<th>Type</th>
<th>Brand(s)</th>
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<tbody>
<tr>
<td>02324997</td>
<td>Lumigan</td>
<td>Ophthalmic Solution</td>
<td>All</td>
</tr>
<tr>
<td>02248151</td>
<td>Alphagan P</td>
<td>Ophthalmic Solution</td>
<td>All</td>
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<tr>
<td>02301334</td>
<td>Brimonidine P</td>
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<td>AAA</td>
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<td>Alphagan</td>
<td>Ophthalmic Solution</td>
<td>All</td>
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<tr>
<td>02246284</td>
<td>Pms-Brimonidine</td>
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<td>02260077</td>
<td>APO-Brimonidine</td>
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<tr>
<td>02305429</td>
<td>Sandoz Brimonidine</td>
<td>Ophthalmic Solution</td>
<td>SDZ</td>
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<tr>
<td></td>
<td>Brimonidine Tartrate</td>
<td></td>
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<td></td>
<td>0.15% Ophthalmic Solution</td>
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<tr>
<td>02248347</td>
<td>Combigan</td>
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<td></td>
<td>Brimonidine &amp; Timolol</td>
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<tr>
<td></td>
<td>0.2% &amp; 0.5% Ophthalmic Solution</td>
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<td>02435411</td>
<td>Simbrinza</td>
<td>Ophthalmic Suspension</td>
<td>ALC</td>
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<td>Brinzolamide &amp; Brimonidine</td>
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<td>1% &amp; 0.2% Ophthalmic Suspension</td>
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<tr>
<td>02331624</td>
<td>Azarga</td>
<td>Ophthalmic Suspension</td>
<td>ALC</td>
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<td>Dorzolamide &amp; Timolol</td>
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<td>2% &amp; 0.5% Ophthalmic Solution</td>
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<tr>
<td>02317125</td>
<td>Pms-Latanoprost</td>
<td>Ophthalmic Solution</td>
<td>Pms</td>
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<tr>
<td>02367335</td>
<td>Sandoz-Latanoprost</td>
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<td>SDZ</td>
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<td>Ophthalmic Solution</td>
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<td>Jamp-Latanoprost</td>
<td>Ophthalmic Solution</td>
<td>JPC</td>
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<tr>
<td>02489570</td>
<td>Latanoprost</td>
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<td>Latanoprost 50ug/ml</td>
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<tr>
<td>02231493</td>
<td>Xalatan</td>
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<td>02296527</td>
<td>APO-Latanoprost</td>
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<td>Pms</td>
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<td>02367335</td>
<td>Sandoz-Latanoprost</td>
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<td>Gmp</td>
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<td>02489570</td>
<td>Latanoprost</td>
<td>Ophthalmic Solution</td>
<td>TLG</td>
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<td><strong>LATANOPROST &amp; TIMOLOL</strong></td>
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<tr>
<td>50MCG &amp; 5MG PER ML OPHTHALMIC SOLUTION</td>
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<tr>
<td>02246619 XALACOM</td>
<td>UJC FNQSW</td>
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<td>02373068 GD-LATANOPROST/TIMOLOL</td>
<td>UJC FGNQSW</td>
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<td>02436256 ACT-LATANOPROST/TIMOLOL</td>
<td>ATV FGNQSW</td>
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<td>02453770 JAMP-LATANOPROST/TIMOLOL</td>
<td>JPC FGNQSW</td>
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<td>02454505 MED-LATANOPROST/TIMOLOL</td>
<td>MED FGNQSW</td>
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<td>02489368 LATANOPROST/TIMOLOL</td>
<td>TLG FGNQSW</td>
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<thead>
<tr>
<th><strong>LATANOPROSTENE BUNOD</strong></th>
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<tbody>
<tr>
<td>0.024% OPHTHALMIC SOLUTION</td>
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<tr>
<td>02484218 VYZULTA</td>
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<tr>
<th><strong>LEVOBUNOLOL HCL</strong></th>
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<tbody>
<tr>
<td>0.5% OPHTHALMIC SOLUTION</td>
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<td>00637661 BETAGAN</td>
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<tbody>
<tr>
<td>0.25% OPHTHALMIC SOLUTION</td>
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<tr>
<td>02166712 SANDOZ-TIMOLOL</td>
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<th><strong>TIMOLOL MALEATE</strong></th>
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<tr>
<td>0.5% OPHTHALMIC SOLUTION</td>
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<tr>
<td>00451207 TIMOPTIC</td>
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<td>00755834 APO-TIMOP</td>
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<td>02166720 SANDOZ-TIMOLOL MALEATE</td>
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<td>02447800 JAMP-TIMOLOL</td>
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<thead>
<tr>
<th><strong>TIMOLOL MALEATE</strong></th>
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<tbody>
<tr>
<td>0.25% GEL FORMING SOLUTION</td>
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<tr>
<td>02242275 TIMOLOL MALEATE-EX</td>
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<table>
<thead>
<tr>
<th><strong>TIMOLOL MALEATE</strong></th>
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<tbody>
<tr>
<td>0.5% GEL FORMING SOLUTION</td>
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<td>02171899 TIMOPTIC-XE</td>
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<td>02242276 TIMOLOL MALEATE-EX</td>
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<table>
<thead>
<tr>
<th><strong>TRAVOPROST</strong></th>
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<tbody>
<tr>
<td>0.004% OPHTHALMIC SOLUTION</td>
</tr>
<tr>
<td>02318008 TRAVATAN Z</td>
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<tr>
<td>02413167 SANDOZ-TRAVOPROST</td>
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<tr>
<td>02415739 APO-TRAVOPROST Z</td>
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<tr>
<th><strong>TRAVOPROST &amp; TIMOLOL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.004% &amp; 0.5% OPHTHALMIC SOLUTION</td>
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<tr>
<td>02278251 DUOTRAV</td>
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<tr>
<td>02415305 APO-TRAVOPROST-TIMOLOL</td>
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</table>
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 MQ

APRACLONIDINE HCL
0.5% OPHTHALMIC SOLUTION
02076306 IOPIDINE NVR FNQSW

ARTIFICIAL TEARS
0.5% OPHTHALMIC SOLUTION
00000809 ISOPTO TEARS ALC NW

1% OPHTHALMIC SOLUTION
00000817 ISOPTO TEARS ALC NW

5% OPHTHALMIC OINTMENT
00750816 MURO-128 BLO NW

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 MQ

0.5MG/0.5ML PREFILLED SYRINGE
CROMOLYN SODIUM
2% OPHTALMIC SOLUTION
02009277 CROMOLYN PEN FNSW
02230621 OPTICROM ALL FNSW

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

MAGNESIUM HYDROXIDE & ALUMINIUM HYDROXIDE & SIMETHICONE
200MG & 200MG & 25MG TABLET
00116882 DIOVOL PLUS CDC NW

56:08.00 ANTI-DIARRHEA AGENTS

DIPHENOXYLATE HCL/ATROPINE SULFATE
SEE APPENDIX A FOR SA CRITERIA
2.5MG/0.025MG TABLET
00036323 LOMOTIL (SA) PFI FNQSW

LOPERAMIDE
2MG CAPLET
02132591 TEVA-LOPERAMIDE TEV FNQSW
02183862 IMODIUM MCL FNQSW
02212005 APO-LOPERAMIDE APX FNQSW
02228351 PMS-LOPERAMIDE PMS FNQSW
56:10.00 ANTIFLATULENTS

SIMETHICONE
80MG TABLET
00292990 OVL 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 BOE NW
02273411 ODAN-BISACODYL ODN NW

10MG RECTAL SUPPOSITORY
00003875 DULCOLAX BOE NW
02361450 JAMP-BISACODYL JPC 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) RPH NW
02295881 JAMP-LACTULOSE (SA) JPC NW
LACTULOSE (SA) 02412268    SNS NW
PMS-LACTULOSE-PHARMA (SA) 02469391    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 02374137    EMOLAX JPC NW

PSYLLIUM MUCILLOID
ORAL POWDER 02174782    METAMUCIL SUGAR FREE PGA NW
02174812    METAMUCIL PGA NW

SENNOSIDES A&B
8.6MG TABLET 00026158    SENOKOT PFR NW
00896411    PMS-SENNOSIDES PMS 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
SEE APPENDIX A FOR SA CRITERIA
250MG TABLET
02238984    URSO (SA) ALL FNQSW
02273497    PMS-URSODIOL C (SA) PMS FGNSW
02426900    URSODIOL (SA) GLM FGNSW
02472392    JAMP-URSODIOL (SA) JPC FGNSW

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500MG TABLET
02245894    URSO DS (SA)         ALL      FNQSW
02273500    PMS-URSODIOL C (SA) PMS      FGNQSW
02426919    URSODIOL (SA)      GLM      FGNQSW
02472406    JAMP-URSODIOL (SA) JPC      FGNQSW

56:16.00 DIGESTANTS

LIPASE & PROTEASE & AMYLASE
5,000 & 320 & 5,100 UNIT GRANULES
02445158    CREON MINIMICROSPHERES MICRO  BGP  CFNQSW

6,000 & 19,000 & 30,000 UNIT CAPSULE
02415194    CREON 6 MINIMICROSPHERES       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

*PANCRELIPASE EQUIVALENT TO LIPASE & PROTEASE & AMYLASE
10,000 & 35,000 & 40,000 USP U CAPSULE
00263818    COTAZYM                  MSD  CFNQSW

10,800 & 45,000 & 42,000 USP U CAPSULE (ENTERIC COATED PARTICLES)
00502790    COTAZYM ECS 8            MSD  CFNQSW

25,000 & 100,000 & 100,000 USP U CAPSULE (ENTERIC COATED PARTICLES)
00821373    COTAZYM ECS 20           MSD  CFNQSW

10,440 & 57,100 & 56,400 USP U TABLET
02230019    VIOKACE                   NES  CFNQSW

20,880 & 112,500 & 113,400 USP U TABLET
02241933    VIOKACE                   NES  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)**
  - 00013579 GRAVOL CDC NW
  - 00392537 DIMENHYDRINATE IM 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

### Nabilone

[See Appendix A](#) for SA Criteria

- **0.5mg Capsule**
  - 02256193 CESAMET (SA) VAL FNQSW
  - 02380900 PMS-NABILONE (SA) PMS FNQSW
  - 02384884 TEVA-NABILONE (SA) TEV FNQSW
  - 02393581 ACT-NABILONE (SA) ATV FNQSW
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**NETUPITANT & PALONOSETRON HCL**

*See Appendix A for SA criteria*

**ONDANSETRON**

*See Appendix A for SA criteria*

**ONDANSETRON HCL**

*See Appendix A for SA criteria*
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### 56:28.12 HISTAMINE H2 ANTAGONISTS

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### 56:28:28 Prostaglandins

#### *Misoprostol*

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56:28.32 PROTECTANTS

*SUCRALFATE
1G TABLET
02045702 TEVA-SUCRALFATE TEV FGNQSW
02100622 SULCRATE ALL FNQSW
02125250 APO-SUCRALFATE APX FGNQSW

200MG/ML ORAL SUSPENSION
02103567 SULCRATE PLUS AVN FNQSW

56:28.36 PROTON PUMP INHIBITORS

LANSOPRAZOLE
SEE PROTON PUMP INHIBITORS IN 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 RAN-LANSOPRAZOLE (SA) RAN 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 RAN-LANSOPRAZOLE (SA) RAN FGNQSW
02410389 LANSOPRAZOLE (SA) SIV FGNQSW
02433028 LANSOPRAZOLE (SA) PMS FGNQSW

15MG DELAYED RELEASE TABLET
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PEI Pharmacare Formulary ......................................................................Page - 216 -
**GREATER THAN ONE UNIT/DAY**

**20MG ENTERIC TABLET**

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**RABEPRAZOLE SODIUM**

*See Proton Pump Inhibitors in Appendix A for SA criteria for dosages.*

**GREATER THAN 20 MG/DAY**

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### 56:32.00 MISCELLANEOUS G.I. DRUGS

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02171929 TEVA-5 ASA TEV FNQSW

500MG ENTERIC COATED TABLET
02112787 SALOFALK ALL FNQSW

500MG DELAYED RELEASE TABLET
02099683 PENTASA FEI FNQSW

1G EXTENDED RELEASE TABLET
02399466 PENTASA FEI FNQSW

500MG RECTAL SUPPOSITORY
02112760 SALOFALK APT FNQSW

1G RECTAL SUPPOSITORY
02242146 SALOFALK APT FNQSW
02153564 PENTASA FEI 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
HYDROCORTISONE
100MG/60ML ENEMA (60ML)
02112736 CORTENEMA ALL FNQSW

OLSAMZINE SODIUM
250MG CAPSULE
02063808 DIPENTUM ATN FNQSW

64:00.00 HEAVY METAL ANTAGONISTS

DEFERASIROX
SEE APPENDIX A FOR SA CRITERIA
125MG DISPERSIBLE TABLETS
02287420 EXJADE (SA) NVR Q
02407957 TEVA-DEFERASIROX (SA) TEV Q
02461544 APO-DEFERASIROX (SA) APX Q
02463520 TARO-DEFERASIROX (SA) TAR Q
02464454 SANDOZ-DEFERASIROX (SA) SDZ Q

250MG DISPERSIBLE TABLETS
02287439 EXJADE (SA) NVR Q
02407965 TEVA-DEFERASIROX (SA) TEV Q
02461552 APO-DEFERASIROX (SA) APX Q
02463539 TARO-DEFERASIROX (SA) TAR Q
02464462 SANDOZ-DEFERASIROX (SA) SDZ Q

500MG DISPERSIBLE TABLETS
02287447 EXJADE (SA) NVR Q
02461560 APO-DEFERASIROX (SA) APX Q
02463547 TARO-DEFERASIROX (SA) TAR Q
02464470 SANDOZ-DEFERASIROX (SA) SDZ Q

PENICILLAMINE
250MG CAPSULE
00016055 CUPRIMINE VAL FNQSW
68:04.00 CORTICOSTEROIDS

BECLOMETHASONE DIPROPIONATE
50UG/INHALER
02242029 QVAR VAL FNQSW
100UG/INHALER
02242030 QVAR VAL FNQSW

BUDESONIDE
100UG/DOSE INHALER POWDER (200 DOSE)
00852074 PULMICORT TURBUHALER AZE FQW
200UG/DOSE INHALER POWDER (200 DOSE)
00851752 PULMICORT TURBUHALER AZE CFNQSW
400UG/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 CFQW
02465949 TEVA-BUDESONIDE (SA) TEV CFGQW

0.25MG/ML INHALATION SOLUTION (2ML)
01978918 PULMICORT NEBUAMP (SA) AZE CFNQW

0.5MG/ML INHALATION SOLUTION (2ML)
01978926 PULMICORT NEBUAMP (SA) AZE CFNQW
02465957 TEVA-BUDESONIDE (SA) TEV CFGNQW

3MG DELAYED AND EXTENDED RELEASE CAPSULE
SEE APPENDIX A FOR SA CRITERIA
02229293 ENTOCORT (SA) TPG FNQSW

CICLESONIDE
100UG/DOSE INHALATION AEROSOL
02285606 ALVESCO COV FGNQSW
200UG/DOSE INHALATION AEROSOL
02285614 ALVESCO COV FGNQSW
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<th>Drug Name</th>
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<td>25mg Tablet</td>
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<td>Cortisone</td>
<td>Val</td>
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<td>Dexamethasone</td>
<td>0.5mg Tablet</td>
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<td>02261081</td>
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<td>APX</td>
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<td>2mg Tablet</td>
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<td>4mg Tablet</td>
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<td>02250055</td>
<td>APO-Dexamethasone</td>
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<td>4mg/ml Injection Solution</td>
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<td>SDZ</td>
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<td>STE</td>
<td>FGNQSW</td>
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<td>Florinef</td>
<td>PAL</td>
<td>FNQSW</td>
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<td>Fluticasone Furoate</td>
<td>100mcg Powder For Inhalation</td>
<td>02446561</td>
<td>Arnuity Ellipta</td>
<td>GSK</td>
<td>FNQSW</td>
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<td>02446588</td>
<td>Arnuity Ellipta</td>
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<td>Fluticasone Propionate</td>
<td>50mcg/Doze Inhalation Aerosol</td>
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<td>Flovent HFA</td>
<td>GSK</td>
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<td>Flovent HFA</td>
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<td>Code</td>
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<td>APO-FLUTICASONE HFA</td>
<td>APX</td>
<td>CFG</td>
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<td>GSK</td>
<td>FNQS</td>
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<td>02237245</td>
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<tr>
<td>250UG/DOSE</td>
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<td>FLOVENT DISKUS</td>
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<td>HYDROCORTISONE</td>
<td>10MG TABLET</td>
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<td>00030910</td>
<td>CORTEF</td>
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<td>CF N</td>
<td>QSW</td>
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<td>250MG INJECTION POWDER</td>
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<td>SOLU-CORTEF</td>
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<td>METHYLPRIDNISOLONE</td>
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<td>METHYLPRIDNISOLONE ACETATE</td>
<td>40MG/ML INJECTION SUSPENSION (1ML)</td>
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<td>METHYLPRIDNISOLONE ACETATE</td>
<td>40MG/ML INJECTION SUSPENSION (2ML)</td>
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<td>80MG/ML INJECTION SUSPENSION (1ML)</td>
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<td>FNQS</td>
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<tr>
<td>MOMETASONE FUROATE</td>
<td>200MCG DRY POWDER INHALER</td>
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<td>02243595</td>
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<td>CFN</td>
<td>QSW</td>
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<td>MOMETASONE FUROATE</td>
<td>400MCG DRY POWDER INHALER</td>
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<td>02243596</td>
<td>ASMANEX</td>
<td>MSD</td>
<td>CFN</td>
<td>QSW</td>
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</table>
PREDNISOLONE SODIUM PHOSPHATE
1MG/ML ORAL LIQUID
02230619 PEDIAPRED AVN CFNQSW
02245532 PMS-PREDNISOLONE PMS CFGNQSW

PREDNISONE
1MG TABLET
00271373 WINPRED AAA CFNQSW

5MG TABLET
00021695 TEVA-PREDNISONE TEV CFGNQSW
00312770 APO-PREDNISONE APX CFGNQSW

50MG TABLET
00232378 TEVA-PREDNISONE TEV CFGNQSW
00550957 APO-PREDNISONE APX CFGNQSW

TRIAMCINOLONE ACETONIDE
10MG/ML VIAL
01999761 KENALOG-10 BMS FNQSW

40MG/ML VIAL
01999869 KENALOG-40 BMS FNQSW
01977563 TRIAMCINOLONE ACETONIDE STE FNQSW

68:08.00 ANDROGENS

DANAZOL
50MG CAPSULE
02018144 CYCLOMEN AVN FQW

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 FGNQSW
### 50MG/5GM TRANSDERMAL GEL

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Manufacturer</th>
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<tbody>
<tr>
<td>02245346</td>
<td>ANDROGEL (SA)</td>
<td>BGP FNQSW</td>
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<td>02463806</td>
<td>TARO-TESTOSTERONE (SA)</td>
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### 50MG/5GM TRANSDERMAL GEL

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<td>02280248</td>
<td>TESTIM (SA)</td>
<td>PAL FNQSW</td>
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### TESTOSTERONE CYPIONATE

**100MG/ML VIAL**

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<td>00030783</td>
<td>DEPO-TESTOSTERONE</td>
<td>PFI FQW</td>
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<td>02496003</td>
<td>TARO-TESTOSTERONE</td>
<td>TAR FQW</td>
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### TESTOSTERONE ENANTHATE

**200MG/ML OILY INJECTION SOLUTION**

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<td>00029246</td>
<td>DELATESTRYL</td>
<td>VAL FQW</td>
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### TESTOSTERONE UNDECANOATE

**SEE APPENDIX A FOR SA CRITERIA**

**40MG CAPSULE**

<table>
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<tbody>
<tr>
<td>02322498</td>
<td>PMS-TESTOSTERONE (SA)</td>
<td>PMS FGNQSW</td>
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<tr>
<td>02421186</td>
<td>TARO-TESTOSTERONE (SA)</td>
<td>TAR FGNQSW</td>
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### 68:12.00 CONTRACEPTIVES

#### ESTRADIOL & ETONOGESTREL

**2 MG & 11.4MG VAGINAL INSERT**

<table>
<thead>
<tr>
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<tr>
<td>02253186</td>
<td>NUVARING</td>
<td>MSD FQW</td>
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#### *ETHINYL ESTRADIOL & DESOGESTREL*

**0.025MG & 0.10MG TABLET (21 DAY)**

<table>
<thead>
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<th>Code</th>
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<tr>
<td>02272903</td>
<td>LINESSA</td>
<td>ASN FQW</td>
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**0.025MG & 0.10MG TABLET (28 DAY)**

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<tbody>
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<td>02257238</td>
<td>LINESSA</td>
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**0.03MG & 0.15MG TABLET (21 DAY)**

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<td>02042487</td>
<td>MARVELON</td>
<td>MSD FQW</td>
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<td>02317192</td>
<td>APRI 21</td>
<td>TEV FGQW</td>
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<td>02396491</td>
<td>FREYA 21</td>
<td>MYL FGQW</td>
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<tr>
<td>02410249</td>
<td>MIRVALA 21</td>
<td>APX FGQW</td>
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<td>Strength</td>
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<td>Manufacturer</td>
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<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td>0.03MG &amp; 0.15MG Tablet</td>
<td>MARVELON</td>
<td>MSD</td>
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<tr>
<td>0.03MG &amp; 0.15MG Tablet</td>
<td>APRI 28</td>
<td>TEV</td>
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<td>0.03MG &amp; 0.15MG Tablet</td>
<td>FREYA 21</td>
<td>MYL</td>
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<td>0.03MG &amp; 0.15MG Tablet</td>
<td>MIRVALA 28</td>
<td>APX</td>
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*ETHINYL ESTRADIOL & DROSPIRENONE*

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<th>Pack Size</th>
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<td>3.0MG &amp; 0.03MG Tablets</td>
<td>YASMIN 21</td>
<td>BAY</td>
<td>FQW</td>
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<td>3.0MG &amp; 0.03MG Tablets</td>
<td>ZAMINE 21</td>
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*ETHINYL ESTRADIOL & L-NORGESTREL*

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<tr>
<td>0.2MG &amp; 0.1MG Tablet</td>
<td>ALESSE</td>
<td>PFI</td>
<td>FQW</td>
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<td>0.2MG &amp; 0.1MG Tablet</td>
<td>AVIANE 21</td>
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<td>FGQW</td>
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<tr>
<td>0.2MG &amp; 0.1MG Tablet</td>
<td>ALYSENA</td>
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<td>0.03MG &amp; 0.05MG (6); 0.04MG &amp; 0.075MG (5); 0.03MG &amp; 0.125MG (10) Tablet</td>
<td>TRIQUILAR</td>
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<td>FQW</td>
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<th>Brand Name</th>
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<td>TRIQUILAR</td>
<td>BAY</td>
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*ETHINYL ESTRADIOL & NORETHINDRONE*

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<td>0.035MG &amp; 0.5MG Tablet</td>
<td>PORTIA</td>
<td>TEV</td>
<td>FGQW</td>
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<tr>
<td>0.035MG &amp; 0.5MG Tablet</td>
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<td>APX</td>
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<td>FQW</td>
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<td>0.035MG &amp; 0.5MG Tablet</td>
<td>PORTIA</td>
<td>TEV</td>
<td>FGQW</td>
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<td>0.035MG &amp; 0.5MG Tablet</td>
<td>OVIMA</td>
<td>APX</td>
<td>FGQW</td>
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<td>0.035MG &amp; 0.5MG (7); 0.035MG &amp; 1.0MG (7); 0.035MG &amp; 0.5MG (7) TABLET (21 DAY)</td>
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<tr>
<td>02187108</td>
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<td>BREVICON 1/35</td>
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<td>02197502</td>
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*ETHINYL ESTRADIOL & NORETHINDRONE ACETATE*

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<td>00297143</td>
<td>LOESTRIN 1.5/30</td>
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<td>00353027</td>
<td>LOESTRIN 1.5/30</td>
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*ETHINYL ESTRADIOL & NORGESTIMATE*

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<td>TRI-CYCLEN LO</td>
<td>0.025MG &amp; 0.180MG (7); 0.025MG &amp; 0.215MG (7); 0.025MG &amp; 0.250MG (7) TABLET (21 DAY)</td>
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<tr>
<td>02401967</td>
<td>TRICIRA LO</td>
<td>0.025MG &amp; 0.180MG (7); 0.025MG &amp; 0.215MG (7); 0.025MG &amp; 0.250MG (7); INERT TABLETS (7) TABLET (28 DAY)</td>
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PEI Pharmacare Formulary .........................................................Page - 227 -
<table>
<thead>
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<tr>
<td>02486296</td>
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<td>GLM</td>
<td>FGQW</td>
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0.035MG & 0.180MG (7); 0.035MG & 0.215MG (7); 0.035MG & 0.250MG (7); TABLET

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0.035MG & 0.25MG TABLET (21 DAY)

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0.035MG & 0.25MG TABLET (28 DAY)

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**LEVONORGESTROL**

1.5MG TABLET

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13.5MG INTRAUTERINE DEVICE

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<td>02408295</td>
<td>JAYDESS</td>
<td>BAY</td>
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19.5MG INTRAUTERINE SYSTEM

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<tr>
<td>02459523</td>
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52MG INTRAUTERINE SYSTEM

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**NORETHINDRONE**

0.35MG TABLET (28 DAY)

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<td>JAN</td>
<td>FQW</td>
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<tr>
<td>02410303</td>
<td>MOVISSE</td>
<td>MYL</td>
<td>FGQW</td>
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<td>LUP</td>
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**68:16.00 ESTROGENS**

**CONJUGATED ESTROGENS**

0.3MG TABLET

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<td>PFI</td>
<td>FNQSW</td>
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PEI Pharmacare Formulary .......................................................Page - 228 -
<table>
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<th>Brand Name</th>
<th>Unit of Measure</th>
<th>追溯码</th>
<th>制造商</th>
<th>批号</th>
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<td>PREMARIN</td>
<td>PFI</td>
<td>FNQSW</td>
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<tr>
<td>1.25MG TABLET</td>
<td></td>
<td>PREMARIN</td>
<td>PFI</td>
<td>FNQSW</td>
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<tr>
<td>0.625MG/G VAGINAL CREAM</td>
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<td>PREMARIN</td>
<td>PFI</td>
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**Estradiol**

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<th>Unit of Measure</th>
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<tr>
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<td>LUP</td>
<td>FGKNQSW</td>
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<td>1MG TABLET</td>
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<td>ACS</td>
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<td>FGKNQSW</td>
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<td>LUPIN-ESTRADIOL</td>
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<td>LUP</td>
<td>FGKNQSW</td>
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**See Appendix A for SA Criteria**

<table>
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<th>Unit of Measure</th>
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<tr>
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<td>SDZ</td>
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<td>FNQSW</td>
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<td>SANDOZ-ESTRADIOL DERM (SA)</td>
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**Estradiol & Norethirone Acetate**

**See Appendix A for SA Criteria**

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<th>Brand Name</th>
<th>Unit of Measure</th>
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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)

*ACARBOSE
50MG TABLET
02190885 GLUCOBAY BAY DNQW
0243780 ACARBOSE STR DNQW
02494078 MAR-ACARBOSE MAR DNQW

100MG TABLET
02190893 GLUCOBAY BAY DNQW
02493799 ACARBOSE STR DNQW
02494086 MAR-ACARBOSE MAR DNQW

CANAGLIFLOZIN
SEE APPENDIX A FOR SA CRITERIA
100MG TABLET
02425483 INVOKANA (SA) JAN DNQW

300MG TABLET
02425491 INVOKANA (SA) JAN DNQW

DAPAGLIFLOZIN
SEE APPENDIX A FOR SA CRITERIA
5MG TABLET
02435462 FORXIGA (SA) AZE DNQW

10MG TABLET
DAPAGLIFLOZIN & METFORMIN HYDROCHLORIDE
See Appendix A for SA criteria
5MG/850MG TABLET
02449935 XIGDUO (SA) AZE DNQW

5MG/1000MG TABLET
02449943 XIGDUO (SA) AZE DNQW

EMPAGLIFLOZIN
See Appendix A for SA criteria
10MG TABLET
02443937 JARDIANCE (SA) BOE DNQW

25MG TABLET
02443945 JARDIANCE (SA) BOE DNQW

EMPAGLIFLOZIN & METFORMIN HCL
See Appendix A for SA criteria
5MG & 500MG TABLET
02456575 SYNJARDY (SA) BOE DNQW

5MG & 850MG TABLET
02456583 SYNDARDY (SA) BOE DNQW

5MG & 1000MG TABLET
02456591 SYNDARDY (SA) BOE DNQW

12.5MG & 500MG TABLET
02456605 SYNJARDY (SA) BOE DNQW

12.5MG & 850MG TABLET
02456613 SYNJARDY (SA) BOE DNQW

12.5MG & 1000MG TABLET
02456621 SYNJARDY (SA) BOE DNQW

*GLICLAZIDE
30MG MODIFIED RELEASE TABLET
02242987 DIAMICRON MR SEV DNQW
02297795 APO-GLICLAZIDE MR APX DNQW
02423286 MINT-GLICLAZIDE MR MNT DNQW
02438658 MYLAN-GLICLAZIDE MR MYL DNQW
02461323 SANDOZ-GLICLAZIDE MR SDZ DNQW
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<td>BOE DNQW</td>
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**LINAGLIPTIN**

*See Appendix A for SA Criteria*

**5MG TABLET**

02370921 | TRAJENTA (SA) | BOE DNQW |
**LINAGLIPTIN & METFORMIN HYDROCHLORIDE**

SEE APPENDIX A FOR SA CRITERIA

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**METFORMIN**

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<td>02167786 APO-METFORMIN</td>
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<td>02223562 PMS-METFORMIN</td>
<td>PMS DNQW</td>
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<tr>
<td>02242974 RATIO-METFORMIN</td>
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**PIOGLITAZONE HCL**

SEE APPENDIX A FOR SA CRITERIA
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**SAXAGLIPTIN**

[SEE APPENDIX A](#) FOR SA CRITERIA

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**SAXAGLIPTIN & METFORMIN HYDROCHLORIDE**

[SEE APPENDIX A](#) FOR SA CRITERIA

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<td>50MG/500MG TABLET</td>
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68:20.08  ANTIDIABETIC DRUGS (INSULINS-HUMAN BIOSYNTHETIC)

INSULIN (DEGLUDEC)
100MG UNIT/ML PREFILLED PEN
02467879   TRESIBA FLEXTOUCH      NNO  DNQW

200MG UNIT/ML PREFILLED PEN
02467887   TRESIBA FLEXTOUCH      NNO  DNQW

INSULIN (DETEMIR)
SEE APPENDIX A FOR SA CRITERIA
100 UNIT/ML CARTRIDGE
02271842   LEVEMIR (SA)           NNO  DNQW

100 UNIT/ML PREFILLED PEN
02412829   LEVEMIR FLEXTOUCH (SA) NNO  DNQW

INSULIN (GLARGINE)
100 UNIT/ML CARTRIDGE
02444844   BASAGLAR               LIL  DNQW

100 UNIT/ML PREFILLED PEN (60 UNIT)
02444852   BASAGLAR KWIKPEN       LIL  DNQW

100 UNIT/ML PREFILLED PEN (80 UNIT)
02461528   BASAGLAR               LIL  DNQW

SEE APPENDIX A FOR SA CRITERIA
100 UNIT/ML VIAL
02245689   LANTUS (SA)            AVN  DNQW

100 UNIT/ML CARTRIDGE
02251930   LANTUS (SA)            AVN  DNQW

100 UNIT/ML PREFILLED PEN
02294338   LANTUS SOLOSTAR (SA)   AVN  DNQW

SEE APPENDIX A FOR SA CRITERIA
300 UNIT/ML PREFILLED PEN
02441829   TOUJEO (SA)            AVN  DNQW

INSULIN (GLULISINE)
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<td>02377209</td>
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100U/ML INJECTION SUSPENSION 30%/70% (CARTRIDGE)
01959212 HUMULIN 30/70 CARTRIDGE LIL DNQW
02025248 NOVOLIN GE 30/70 PENFILL NNO DNQW

100U/ML INJECTION SUSPENSION 40%/60% (CARTRIDGE)
02024314 NOVOLIN GE 40/60 PENFILL NNO DNQW

100U/ML INJECTION SUSPENSION 50%/50% (CARTRIDGE)
02024322 NOVOLIN GE 50/50 PENFILL NNO DNQW

INSULIN (REGULAR) LISPRO
100U/ML INJECTION SOLUTION (10ML)
02229704 HUMALOG LIL DNQW

INSULIN (REGULAR/PROTAMINE) LISPRO
100U/ML INJECTION SUSPENSION 25%/75% (CARTRIDGE)
02240294 HUMALOG MIX 25 CARTRIDGE LIL DNQW

68:28.00 PITUITARY AGENTS

DESMOPRESSIN
SEE APPENDIX A FOR SA CRITERIA
10U/DOSE INTRANASAL SOLUTION
00402516 DDAVP RHINYLE (SA) FEI FNQSW

10U/DOSE INTRANASAL SOLUTION (SPRAY PUMP)
02242465 DEMOSPRESSIN (SA) AAA FGQSW

0.1MG TABLET
00824305 DDAVP (SA) FEI FNQSW
02284030 DESMOPRESSIN (SA) AAA FGQSW

0.2MG TABLET
00824143 DDAVP (SA) FEI FNQSW
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<td>00745626</td>
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6MG INJECTION (CARTRIDGE)
02243077    HUMATROPE CARTRIDGE LIL Y

12MG INJECTION (CARTRIDGE)
02243078    HUMATROPE CARTRIDGE LIL Y

24MG INJECTION (CARTRIDGE)
02243079    HUMATROPE CARTRIDGE LIL Y

SOMATROPIN
5MG/1.5ML CARTRIDGE
02325063    OMNITROPE SDZ Y

10MG/1.5ML CARTRIDGE
02325071    OMNITROPE SDZ Y

15MG/1.5ML CARTRIDGE
02459647    OMNITROPE SDZ Y

SOMATROPIN
5MG/1.5ML PREFILLED PEN
02334852    NORDITROPIN NORDIFLEX NNO Y

10MG/1.5ML PREFILLED PEN
02334860    NORDITROPIN NORDIFLEX NNO Y

15MG/1.5ML PREFILLED PEN
02334879    NORDITROPIN NORDIFLEX NNO Y

SOMATROPIN
5MG/2ML PEN INJECTOR
02399091    NUTROPIN AQ HLR Y

10MG/2ML PEN INJECTOR
02376393    NUTROPIN AQ HLR Y

20MG/2ML PEN INJECTOR
02399083    NUTROPIN AQ HLR Y

SOMATROPIN
6MG CARTRIDGE
02350122    SAIZEN EMD Y

12MG CARTRIDGE
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<th>Code</th>
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<td>02350130</td>
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### 68:32.00 PROGESTOGENS

#### DIENOGEST

**See Appendix A** for SA Criteria

**2MG TABLET**

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<td>ASPEN-DIENOGEST</td>
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<td>02498189</td>
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#### *MEDROXYPROGESTERONE ACETATE*

**2.5MG TABLET**

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<th>Code</th>
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<th>Progesterone Type</th>
<th>Company</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>00708917</td>
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<td>FNQSW</td>
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<tr>
<td>02221284</td>
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<td>FGQSW</td>
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<td>02244726</td>
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**5MG TABLET**

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**10MG TABLET**

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#### MEDROXYPROGESTERONE ACETATE

**150MG/ML INJECTION SUSPENSION (1ML)**

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### 68:36.04 THYROID AGENTS

#### *LEVOTHYROXINE SODIUM*

**25 MCG TABLET**

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**50 MCG TABLET**

PEI Pharmacare Formulary ..............................................................Page - 241 -
<table>
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<td>02172100</td>
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<td>02213214</td>
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**68:36.08 ANTI-THYROID AGENTS**

*METHIMAZOLE*

5MG TABLET

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<td>MAR-METHIMAZOLE</td>
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<td>02490625</td>
<td>JAMP-METHIMAZOLE</td>
<td>JPC</td>
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PEI Pharmacare Formulary .........................................................Page - 242 -
10MG TABLET
02296039 TAPAZOLE PAL FNQSW
02480115 MAR-METHIMAZOLE MAR FGNQSW
02490633 JAMP-METHIMAZOLE JPC FGNQSW

*PROPYLTHIOURACIL
50MG TABLET
00010200 PROPYL THYRACIL PAL FNQSW

100MG TABLET
00010219 PROPYL THYRACIL PAL FNQSW

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

80:12.00 VACCINES

HEPATITIS A VACCINE (INACTIVATED)
720 ELISA UNITS PRE-FILLED SYRINGE (0.5ML)
02231056 HAVRIX JUNIOR GSK H

1440 ELISA UNITS PRE-FILLED SYRINGE (1.0ML)
02187078 HAVRIX GSK H

1440 ELISA UNITS (VIAL) (1.0ML)
02187078 HAVRIX GSK H

50U/1.0ML VIAL (ADULT)/I/M SUSPENSION
HEPATITIS A (INACTIVATED) - HEPATITIS B (RECOMBINANT) VACCINE
360 ELISA UNITS & 10MCG PRE-FILLED SYRINGE (0.5ML)
02237548 TWINRIX JUNIOR GSK H

720 ELISA UNITS & 20MCG PRE-FILLED SYRINGE (1.0ML)
02230578 TWINRIX GSK H

HEPATITIS B VACCINE (RECOMBINANT)
5MCG/0.5ML STERILE SUSPENSION
02243676 RECOMBIVAX HB PEDIATRIC MSD H
(PRESERVATIVE FREE)

10MCG/1ML SOLUTION (I/M)
02243676 RECOMBIVAX HB MSD H
(PRESERVATIVE FREE)

20MCG/ML STERILE SUSPENSION
01919431 ENGERIX-B GSK H

40MCG/ML STERILE SUSPENSION (1ML)
02245977 RECOMBIVAX HB (DIALYSIS) MSD H
(PRESERVATIVE FREE)

84:04.04 ANTI INFECTIVES (ANTIBIOTICS)

CLINDAMYCIN PHOSPHATE
1% TOPICAL SOLUTION
00582301 DALACIN T PFI FQW
02266938 TARO-CLINDAMYCIN TAR FQW
02483769 CLINDAMYCIN TLG FQW

FRAMYCETIN SULFATE
1% OINTMENT DRESSING (10CM X 10CM)
01988840 SOFRA TULLE ERF FNQSW

FUSIDIC ACID
2% TOPICAL CREAM
00586668 FUCIDIN LEO FNQSW
<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Strength</th>
<th>Type</th>
<th>Code</th>
<th>Ref.</th>
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<td>1%</td>
<td>TOPICAL CREAM</td>
<td>02156091</td>
<td>NORITATE</td>
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<tr>
<td><strong>MUPIROCIN</strong></td>
<td>2%</td>
<td>TOPICAL OINTMENT</td>
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<td>TARO-MUPIROCIN</td>
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<tr>
<td><strong>POLIMYXIN B &amp; BACITRACIN</strong></td>
<td>10,000U &amp; 500U/G TOPICAL OINTMENT</td>
<td>02237227</td>
<td>POLYSPORIN</td>
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<td>02357569</td>
<td>JAMPOLYCN</td>
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<tr>
<td><strong>POLMYXIN B &amp; GRAMICIDIN</strong></td>
<td>10,000U &amp; 250U/G TOPICAL CREAM</td>
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<td><strong>SODIUM FUSIDATE</strong></td>
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### 84:04.08 ANTI INFECTIVES (FUNGICIDES)

<table>
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<tr>
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<td>1%</td>
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<td><strong>CLOTRIMAZOLE</strong></td>
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<td>CLOTIRMADERM</td>
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<td>00812366</td>
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<td>1%</td>
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<td></td>
<td>2%</td>
<td>VAGINAL CREAM</td>
<td>02150905</td>
<td>CANESTEN 3</td>
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</table>
## KETOCONAZOLE

2% TOPICAL CREAM
- 02245662 KETODERM

2% SHAMPOO
- 02182920 NIZORAL

## MICONAZOLE NITRATE

2% TOPICAL CREAM
- 02085852 MICATIN
- 02126567 MONISTAT DERM

2% VAGINAL CREAM
- 02084309 MONISTAT-7
- 02231106 MICOZOLE

400MG VAGINAL OVULE
- 02126605 MONISTAT-3

100MG VAGINAL SUPPOSITORY & 2% TOPICAL CREAM (COMBINATION PACKAGE)
- 02126257 MONISTAT-7

400MG VAGINAL OVULE & 2% TOPICAL CREAM (COMBINATION PACKAGE)
- 02126249 MONISTAT-3 COMBINATION

## NYSTATIN

100,000U/G TOPICAL CREAM
- 00716871 NYADERM

100,000U/G TOPICAL OINTMENT
- 02194228 RATIO-NYSTATIN

25,000U/G VAGINAL CREAM
- 00716901 NYADERM

100,000U/G VAGINAL CREAM
- 02194163 RATIO-NYSTATIN

## TERBINAFINE HCL

SEE APPENDIX A FOR SA CRITERIA

1% TOPICAL CREAM
- 02031094 LAMISIL (SA)

## TOLNAFTATE

1% TOPICAL CREAM
ISOPROPYL MYRISTATE
50% TOPICAL LIQUID
02279592 RESULTZ MFI CNW

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

METRONIDAZOLE
1% TOPICAL GEL
02297809 METROGEL GAC FNQSW

10% VAGINAL CREAM
01926861 FLAGYL AVN FNQSW

SILVER SULFADIAZINE
1% TOPICAL CREAM
00323098 FLAMAZINE SNE FNQSW
### 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.

<table>
<thead>
<tr>
<th><strong>AMCINONIDE</strong></th>
<th>0.1% TOPICAL CREAM</th>
<th>Taro-AMCINONIDE</th>
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<table>
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<th>RPH FGQNSW</th>
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<th>PAL FNQSW</th>
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<table>
<thead>
<tr>
<th><strong>BETAMETHASONE DIPROPIONATE</strong></th>
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<th>RATIO-TOPILENE GLYCOL</th>
<th>RPH GFNQSW</th>
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<tbody>
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<td>00849669</td>
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</table>
0.05% TOPICAL GLYCOL LOTION
01927914  TEVA-TOPILENE  TEV  FGNQSW

BETAMETHASONE DIPROPIONATE & CALCIPOTRIOL
SEE APPENDIX A FOR SA CRITERIA
50MCG/0.5MG/GM TOPICAL GEL
02319012  DOVOBET (SA)  LEO  FNQSW

BETAMETHASONE DIPROPIONATE & SALICYLIC ACID
0.05% & 2% TOPICAL LOTION
00578428  DIPROSALIC  MSD  FNQSW
02245688  RATIO-TOPISALIC  RPH  FGNQSW

0.05% & 3% TOPICAL OINTMENT
00578436  DIPROSALIC  MSD  FNQSW

BETAMETHASONE VALERATE
0.05% TOPICAL CREAM
00535427  RATIO-ECTOSONE  RPH  FGNQSW
00716618  BETADERM  TAR  FGNQSW
02357860  CELESTODERM V/2  VAL  FNQSW

0.1% TOPICAL CREAM
00535435  RATIO-ECTOSONE  RPH  FGNQSW
00716626  BETADERM  TAR  FGNQSW
02357844  CELESTODERM V  VAL  FNQSW

0.05% TOPICAL OINTMENT
00716642  BETADERM  TAR  FGNQSW
02357879  CELESTODERM V/2  VAL  FNQSW

0.1% TOPICAL OINTMENT
00716650  BETADERM  TAR  FGNQSW
02357852  CELESTODERM V  VAL  FNQSW

0.05% TOPICAL LOTION
00653209  RATIO-ECTOSONE  RPH  FGNQSW

0.1% TOPICAL LOTION
00750050  RATIO-ECTOSONE  RPH  FGNQSW

0.1% SCALP LOTION
00027944  VALISONE  VAL  FNQSW
00653217  RATIO-ECTOSONE  RPH  FGNQSW
00716634  BETADERM  TAR  FGNQSW
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<th><strong>CLOBETASOL 17 PROPIONATE</strong></th>
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<tbody>
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<tr>
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<td>TEV FGNQSW</td>
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<td>02024187 MYLAN-CLOBETASOL</td>
<td>MYL FGNQSW</td>
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<td>02213265 DERMOVATE</td>
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<td>02245523 TARO-CLOBETASOL</td>
<td>TAR FGNQSW</td>
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<td>PMS FGNQSW</td>
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<tr>
<td>02213273 DERMOVATE</td>
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<tr>
<td>02245524 TARO-CLOBETASOL</td>
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PEI Pharmacare Formulary ...............................................................Page - 252 -
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**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

84:16.00  CELL STIMULANTS AND PROLIFERANTS

TRETINOIN
0.01% TOPICAL CREAM
00657204  STIEVA-A  GSK  FQW

0.025% TOPICAL CREAM
00578576  STIEVA-A  GSK  FQW

0.05% TOPICAL CREAM
00443794  RETIN A  VAL  FQW
00518182  STIEVA-A  GSK  FQW

0.1% TOPICAL CREAM
00870021  RETIN A  VAL  FQW

0.01% TOPICAL GEL
00870013  RETIN A  VAL  FQW

0.025% TOPICAL GEL
00443816  RETIN A  VAL  FQW
01926470  VITAMIN A ACID  VAL  FQW

0.05% TOPICAL GEL
01926489  VITAMIN A ACID  VAL  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
SEE APPENDIX A FOR SA CRITERIA
10MG CAPSULE
02070847 SORIATANE (SA) HLR FNQSW
02466074 TARO-ACITRETIN (SA) TAR FGNQSW
02468840 MINT-ACITRETIN (SA) MNT FGNQSW

25MG CAPSULE
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### AZELAIC ACID
15% TOPICAL GEL
02270811 FINACEA LEO FNQSW

### BRODALUMAB
SEE APPENDIX A FOR SA CRITERIA
210MG/1.5ML SYRINGE
02473623 SILIQ (SA) VAL MQ

### CALCIPOTRIOL
50UG/G TOPICAL OINTMENT
01976133 DOVONEX LEO FNQSW

### FLUOROURACIL
5% TOPICAL CREAM
00330582 EFUDEX VAL FNQSW

### IMIQUIMOD
5% TOPICAL CREAM
02239505 ALDARA VAL FNQSW
02482983 TARO-IMIQUIMOD TAR FGNQSW

### ISOTRETINOIN
10MG CAPSULE
00582344 ACCUTANE HLR 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 HLR 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 MQ

80MG/ML SYRINGE
02455110 TALTZ (SA) LIL MQ

PODOPHYLLUM RESIN
25% TOPICAL LIQUID
00598208 PODOFILM PAL FQW

RISANKIZUMAB
SEE APPENDIX A FOR CRITERIA
75MG/0.83ML PREFILLED SYRINGE
02487454 SKYRIZI (SA) ABV MQ

SECUKINUMAB
SEE APPENDIX A FOR CRITERIA
150MG/ML INJECTION
02438070 COSENTYX (SA) NVR MQ

TACROLIMUS
SEE APPENDIX A FOR CRITERIA
0.1% OINTMENT
02244148 PROTOPIC (SA) LEO FNQSW

SEE APPENDIX A FOR CRITERIA
0.03% TOPICAL OINTMENT
02244149 PROTOPIC (SA) LEO FNQSW

USTEKINUMAB
SEE APPENDIX A FOR CRITERIA
45MG/0.5ML SYRINGE
02320673 STELARA (SA) JAN MQ

90MG/ML SYRINGE
02320681 STELARA (SA) JAN MQ

86:12.00 GENITOURINARY SMOOTH MUSCLE RELAXANTS
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TOLTERODINE
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2MG TABLET
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2MG EXTENDED RELEASE CAPSULE
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4MG EXTENDED RELEASE CAPSULE
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### TROSPUISM

*SEE APPENDIX A FOR SA CRITERIA*

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#### 86:16.00 RESPIRATORY SMOOTH MUSCLE RELAXANTS

### THEOPHYLLINE ANHYDROUS

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#### 88:08.00 VITAMIN B

### CYANOCOBALAMIN

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<td>01987003</td>
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PEI Pharmacare Formulary ..........................................................Page - 260 -
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 FGNNW
02285673 SANDOZ-FOLIC ACID SDZ FGNNW
02366061 JAMP-FOLIC ACID JPC FGNNW

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
01943200 VITAMIN B6 ODN OX

88:16.00 VITAMIN D

CALCITRIOL
0.25UG CAPSULE
00481823 ROCALTROL HLR FNQSW
02431637 CALCITRIOL-ODAN ODN FGNNSW
02485710 TARO-CALCITRIOL TAR FGNNSW
02495899 CALCITRIOL STR FGNNSW

0.5UG CAPSULE
00481815 ROCALTROL HLR FNQSW
02431645 CALCITRIOL-ODAN ODN FGNNSW
02485729 TARO-CALCITRIOL TAR FGNNSW
02495902 CALCITRIOL STR FGNNSW

VITAMIN D
1000IU TABLET
00999869 VITAMIN D N

PEI Pharmacare Formulary ..................................................Page - 261 -
Note: The Drug Identification Number listed is for billing purposes only.

**VITAMIN D2**
50,000IU CAPSULE
02237450 D-FORTE SDZ FNQSW

**88:20.00 VITAMIN E**

**VITAMIN E (D-ALPHA TOCOPHERYL ACETATE)**
200UNIT CAPSULE
00999849 VITAMIN E CN
Note: The Drug Identification Number listed is for billing purposes only.

400UNIT 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**

**ALEMTUZUMAB**
SEE APPENDIX A FOR SA CRITERIA
12MG/1.2ML VIAL
02418320 LEMTRADA (SA) GZY MQ

**CINACALCET**
SEE APPENDIX A FOR CRITERIA
30MG TABLET
02441624 TEVA-CINACALCET (SA) TEV FGNQSW
02452693 APO-CINACALCET (SA) APX FGNQSW
02480298 MAR-CINACALCET (SA) MAR FGNQSW
02500094 JAMP-CINACALCET (SA) JPC FGNQSW
60MG TABLET
02441632  TEVA-CINACALCET (SA)  TEV  FGNQSW
02452707  APO-CINACALCET (SA)  APX  FGNQSW
02480301  MAR-CINACALCET (SA)  MAR  FGNQSW
02500108  JAMP-CINACALCET (SA)  JPC  FGNQSW

90MG TABLET
02441640  TEVA-CINACALCET (SA)  TEV  FGNQSW
02452715  APO-CINACALCET (SA)  APX  FGNQSW
02480328  MAR-CINACALCET (SA)  MAR  FGNQSW
02500116  JAMP-CINACALCET (SA)  JPC  FGNQSW

DIMETHYL FUMARATE
SEE APPENDIX A FOR SA CRITERIA
120MG CAPSULE
02404508  TECFIDERA (SA)  BGN  MQ

240MG CAPSULE
02420201  TECFIDERA (SA)  BGN  MQ

ETHINYL ESTRADIOL & CYPROTERONE
0.035MG & 2MG TABLET
02233542  DIANE-35  BAY  FQW
02290308  CYESTRA-35  PAL  FGQW
02309556  TEVA-CYPROTERONE/ETHINYL ESTRADIOL  TEV  FGQW

ETIDRONATE DISODIUM
SEE APPENDIX A FOR SA CRITERIA
200MG TABLET
02248686  ACT-ETIDRONATE (SA)  ATV  FGNQSW

ETIDRONATE DISODIUM & CALCIUM CARBONATE
400MG & 500MG TABLET (PACKAGE)
02263866  ACT-ETIDROCAL  ATV  FGNQSW

FINGOLIMOD
SEE APPENDIX A FOR CRITERIA
0.5MG CAPSULE
02365480  GILENYA (SA)  NVR  MQ
02469561  TEVA-FINGOLIMOD (SA)  TEV  MQ
02469618  TARO-FINGOLIMOD (SA)  TAR  MQ
02469715  MYLAN-FINGOLIMOD (SA)  MYL  MQ
02469782  PMS-FINGOLIMOD (SA)  PMS  MQ
02469936  APO-FINGOLIMOD (SA)  APX  MQ
02474743  MAR-FINGOLIMOD (SA)  MAR  MQ
GLATIRAMER ACETATE
SEE APPENDIX A FOR SA CRITERIA
20MG PRE-FILLED SYRINGE
02245619 COPAXONE (SA) TEV MQ

GLUCAGON (RECOMBINANT DNA ORIGIN)
SEE APPENDIX A FOR SA CRITERIA (NURSING HOME PROGRAM DOES NOT REQUIRE A SPECIAL AUTHORIZATION REQUEST.)
INJECTION KIT
02243297 GLUCAGON KIT (SA) LIL NQW

GLUCAGON (HUMAN RECOMBINANT)
SEE APPENDIX A FOR SA CRITERIA
INJECTION VIAL
02333619 GLUCAGEN VIAL (SA) PAL QW
INJECTION KIT
02333627 GLUCAGEN KIT (SA) PAL QW

INTERFERON BETA-1A
SEE APPENDIX A FOR SA CRITERIA
30MCG INJECTION POWDER
02269201 AVONEX (SA) BGN MQ
30MCG PREFILLED SYRINGE, 30MCG PEN WITH AUTO-INJECTOR
02269201 AVONEX PS (SA) BGN MQ

22MCG SYRINGE
02237319 REBIF (SA) SRO MQ

44MCG SYRINGE
02237320 REBIF (SA) SRO MQ

66MCG/1.5ML PRE-FILLED CARTRIDGE
02318253 REBIF MULTIDOSE (SA) SRO MQ

132MCG/1.5ML PRE-FILLED CARTRIDGE
02318261 REBIF MULTIDOSE (SA) SRO MQ

INTERFERON BETA-1B
SEE APPENDIX A FOR SA CRITERIA
0.3MG INJECTION POWDER
LEFLUNOMIDE
10MG TABLET
02241888 ARAVA AVN FNQSW
02256495 APO-LEFLUNOMIDE APX FGQNQSW
02261251 TEVA-LEFLUNOMIDE TEV FGQNQSW
02283964 SANDOZ-LEFLUNOMIDE SDZ FGQNQSW
02288265 PMS-LEFLUNOMIDE PMS FGQNQSW
02351668 LEFLUNOMIDE SNS FGQNQSW

20MG TABLET
02241889 ARAVA AVN FNQSW
02256509 APO-LEFLUNOMIDE APX FGQNQSW
02261278 TEVA-LEFLUNOMIDE TEV FGQNQSW
02283972 SANDOZ-LEFLUNOMIDE SDZ FGQNQSW
02288273 PMS-LEFLUNOMIDE PMS FGQNQSW
02351676 LEFLUNOMIDE SNS FGQNQSW

LEVOCARNITINE
SEE APPENDIX A FOR SA CRITERIA
330MG TABLET
02144328 CARNITOR (SA) SIG FNQSW

100MG/ML ORAL SOLUTION
02144336 CARNITOR (SA) SIG FNQSW
02492105 ODAN-LEVOCARNITINE (SA) ODN FGQNQSW

MONTELUKAST
SEE APPENDIX A FOR SA CRITERIA
4MG CHEWABLE TABLET
02243602 SINGULAIR (SA) MSD FGQW
02330385 SANDOZ-MONTELUKAST (SA) SDZ FGQW
02354977 PMS-MONTELUKAST (SA) PMS FGQW
02355507 TEVA-MONTELUKAST (SA) TEV FGQW
02377608 APO-MONTELUKAST (SA) APX FGQW
02382458 MONTELUKAST (SA) SIV FGQW
02399865 MAR-MONTELUKAST (SA) MAR FGQW
02408627 MINT-MONTELUKAST (SA) MNT FGQW
02442353 JAMP-MONTELUKAST (SA) JPC FGQW

5MG CHEWABLE TABLET
02238216 SINGULAIR (SA) MSD FGQW
02330393 SANDOZ-MONTELUKAST (SA) SDZ FGQW
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**10MG TABLET**

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<td>MONTELUKAST SODIUM (SA)</td>
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**4MG GRANULES IN PACKET**

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**OCTREOTIDE**

**SEE APPENDIX A FOR SA CRITERIA**

**200UG/ML INJECTION (5ML)**

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**ONABOTULINUMTOXINA**

**SEE APPENDIX A FOR SA CRITERIA**

**200UNITS/VIAL**

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**PAMIDRONATE DISODIUM**

**SEE APPENDIX A FOR SA CRITERIA**

**30MG INJECTION**

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<td>PAMIDRONATE DISODIUM (SA)</td>
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**60MG INJECTION**
02244551  PAMIDRONATE DISODIUM (SA)  PFI  FGNQSW

90MG INJECTION
02244552  PAMIDRONATE DISODIUM (SA)  PFI  FGNQSW

PEGINTERFERON BETA-1A
SEE APPENDIX A FOR SA CRITERIA
63/94MCG/0.5ML
02444402  PLEGRIDY (SA)  BGN  MQ

125MCG/0.5ML
02444399  PLEGRIDY (SA)  BGN  MQ

PENTOSAN POLYSULFATE SO4
SEE APPENDIX A FOR SA CRITERIA
100MG CAPSULE
02029448  ELMIRON (SA)  JAN  FNQSW

PHENYLALANINE-REDUCED FOODS
NUTRITIONAL FORMULA
00030800  PHENEX-1  ROS  P
04444444  PHENEX-2  ROS  P
00368020  PHENYL-FREE  MJS  P

QUINAGOLIDE
SEE APPENDIX A FOR SA CRITERIA
150MCG TABLET
02223775  NORPROLAC (SA)  FEI  FNQSW

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 CHLORIDE
7% INHALATION LIQUID
80029414  HYPERSAL 7%  KEG  C

SODIUM CROMOGLYCATE
SEE APPENDIX A FOR SA CRITERIA
<table>
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<td>AVN FQSW</td>
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<tr>
<td>1% INHALATION SOLUTION (2ML)</td>
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<td>PMS SODIUM CROMOGLYcate</td>
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<td>200 MG TABLET</td>
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<td>NEXAVAR (SA)</td>
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<td>Sandoz-Tamsulosin</td>
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<td>SEE APPENDIX A FOR SA CRITERIA</td>
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<tr>
<td>80MG/4ML IV VIAL</td>
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<td>400MG/20ML IV VIAL</td>
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<td>ACTEMRA (SA)</td>
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<td>162MG/0.9ML SYRINGE</td>
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PEI Pharmacare Formulary ..............................................................................Page - 268 -
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<td>PANECTYL</td>
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<td>PANECTYL</td>
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**TRIMEPRAZINE TARTRATE**

2.5MG TABLET

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<td>01926306</td>
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<td>ERF FNQW</td>
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<td>PANECTYL</td>
<td>ERF FNQW</td>
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**VEDOLIZUMAB**

SEE APPENDIX A FOR SA CRITERIA

300MG VIAL

<table>
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<th>Manufacturer</th>
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<tr>
<td>02436841</td>
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**ZOLEDRONIC ACID**

SEE APPENDIX A FOR SA CRITERIA

5MG/100ML INJECTION

<table>
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<td>02269198</td>
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**92:00.08 ALFA REDUCTASE INHIBITORS**

**DUTASTERIDE**

0.5MG CAPSULE

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<td>ATV FGNQSW</td>
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**FINASTERIDE**

5MG TABLET

PEI Pharmacare Formulary ..............................................................Page - 269 -
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### 92:16.00 ANTIGOUT AGENTS

**ALLOPURINOL**

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300MG TABLET

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**COLCHICINE**

0.6MG TABLET

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**FEBUXOSTAT**

[See Appendix A](#) for SA CRITERIA

80MG TABLETS

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<td>Mar-Febuxostat</td>
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92:24:00 BONE RESORPTION INHIBITORS

ALENDRONATE & CHOLECALCIFEROL
70MG/5600 UNIT TABLET
02314940  FOSAVANCE                MSD  FNQSW
02403641  TEVA-ALENDRONATE/CHOLECALCIFEROL  TEV  FGQNSW
02454475  APO-ALENDRONATE/VITAMIN D3    APX  FGQNSW

ALENDRONATE SODIUM
10MG TABLET
02247373  TEVA-ALENDRONATE            TEV  FGQNSW
02248728  APO-ALENDRONATE             APX  FGQNSW
02288087  SANDOZ-ALENDRONATE          SDZ  FGQNSW
02381486  ALENDRONATE SODIUM          ACH  FGQNSW
02384701  RAN-ALENDRONATE             RAN  FGQNSW
02388545  AURO-ALENDRONATE            ARO  FGQNSW
02394863  MINT-ALENDRONATE            MNT  FGQNSW

SEE APPENDIX A FOR SA CRITERIA
40MG TABLET
02258102  ACT-ALENDRONATE (SA)       ATV  FGQNSW

70MG TABLET
02245329  FOSAMAX                    MSD  FNQSW
02248730  APO-ALENDRONATE            APX  FGQNSW
02261715  TEVA-ALENDRONATE           TEV  FGQNSW
02284006  PMS-ALENDRONATE            PMS  FGQNSW
02288109  SANDOZ-ALENDRONATE         SDZ  FGQNSW
02299712  ALENDRONATE                SIV  FGQNSW
02352966  ALENDRONATE                SNS  FGQNSW
02381494  ALENDRONATE SODIUM         ACH  FGQNSW
02385031  JAMP-ALENDRONATE           JPC  FGQNSW
02388553  AURO-ALENDRONATE           ARO  FGQNSW
02394871  MINT-ALENDRONATE           MNT  FGQNSW
02485184  AG-ALENDRONATE             ANG  FGQNSW

DENOSUMAB
SEE APPENDIX A FOR SA CRITERIA
60MG/ML SC SYRINGE

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<table>
<thead>
<tr>
<th>Code</th>
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<td>AMG FNQSW</td>
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**RISEDRONATE SODIUM**

5MG TABLET
- 02242518 ACTONEL ALL FNQSW
- 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

**92:32.00 COMPLEMENT INHIBITORS**

**ICATIBANT**
SEE APPENDIX A FOR SA CRITERIA

30MG/3ML SC SYRINGE
- 02425696 FIRAZYR (SA) SHR MQ

**92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS**

**ABATACEPT**
SEE APPENDIX A FOR SA CRITERIA

250 MG VIAL
- 02282097 ORENCIA (SA) BMS MQ

125MG/ML PREFILLED SC SYRINGE
- 02402475 ORENCIA (SA) BMS MQ

**ADALIMUMAB**
SEE APPENDIX A FOR SA CRITERIA
<table>
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<tr>
<th>40MG/0.8ML PRE-FILLED SYRINGE</th>
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**BOSENTAN**

**SEE APPENDIX A FOR CRITERIA**

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**CERTOLIZUMAB**

**SEE APPENDIX A FOR CRITERIA**

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**ETANERCEPT**

**SEE APPENDIX A FOR SA CRITERIA**

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<p>| 50MG/ML PEN INJECTOR |</p>
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<td>KEVZARA (SA)</td>
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**GOLIMUMAB**

SEE APPENDIX A FOR SA CRITERIA

**INFLIXIMAB**

SEE APPENDIX A FOR SA CRITERIA

**SARILUMAB**

SEE APPENDIX A FOR SA CRITERIA

**TOFACITINIB**

SEE APPENDIX A FOR SA CRITERIA
# IMMUNOSUPPRESSIVE AGENTS

## AZATHIOPRINE

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<td>FNQSW</td>
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<td>T</td>
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02378574  MYCOHENOLATE MOFETIL  ACH  T
02380382  JAMP-MYCOHENOLATE  JPC  T
02457377  MYCOHENOLATE MOFETIL  SNS  T

*MYCOHENOLATE SODIUM
180MG ENTERIC-COATED TABLET
02264560  MYFORTIC  NVR  T
02372738  APO-MYCOHENOLIC ACID  APX  T
02511673  MAR-MYCOHENOLIC ACID  MAR  T

360MG ENTERIC-COATED TABLET
02264579  MYFORTIC  NVR  T
02372746  APO-MYCOHENOLIC ACID  APX  T
02511681  MAR-MYCOHENOLIC ACID  MAR  T

NINTEDANIB
SEE APPENDIX A FOR SA CRITERIA
100MG CAPSULE
02443066  OFEV (SA)  BOE  MQ

150MG CAPSULE
02443074  OFEV (SA)  BOE  MQ

PIRFENIDONE
SEE APPENDIX A FOR SA CRITERIA
267MG CAPSULE
02393751  ESBRIET (SA)  HLR  MQ

267MG TABLET
02464489  ESBRIET (SA)  HLR  MQ

801MG TABLET
02464500  ESBRIET (SA)  HLR  MQ

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

1MG CAPSULE
02175991  PROGRAF   AST  T
02416824  SANDOZ-TACROLIMUS  SDZ  T

5MG CAPSULE
02175983  PROGRAF   AST  T
02416832  SANDOZ-TACROLIMUS  SDZ  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

PROFESSIONAL SERVICES

MEDICATION REVIEW

93899926  BASIC MEDICATION REVIEW   DNSW
93899924  BASIC MEDICATION REVIEW FOLLOW-UP   DNSW
93899925  DIABETES MEDICATION REVIEW   DNW
93899923  DIABETES MEDICATION REVIEW FOLLOW-UP   DNW

OTHER SERVICES

93899914  COMPLIANCE PACKAGING   DFMSW
93899916  THERAPEUTIC SUBSTITUTION   FNSW
93899917  REFUSAL TO FILL   FNSVW
93899918  PRESCRIPTION ADAPTATION   DFMNVWZ
APPENDIX A  Special Authorization Criteria

NOTES REGARDING SPECIAL AUTHORIZATION (SA) COVERAGE

- 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
  - Opioid Replacement Therapy 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
  - Immunization Program
  - Meningitis Program
  - Nutrition Services Program
  - Phenylketonuria Program
  - Quit Smoking Program
  - Rabies Program
• Rheumatic Fever Program
• Sexually Transmitted Diseases 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
  • Physician’s name, address, and signature. **No request will be considered without a valid physician’s signature.**

• Special Authorizations with insufficient information to properly assess the request will be returned to the physician.

• Please allow up to three weeks for the processing of Special Authorizations.

• Copies of the Special Authorization Forms are available by contacting the PEI Pharmacare office at 1-877-577-3737 or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

• For some drugs a patient application is required in addition to the Special Authorization form. The patient application form is available by contacting the PEI Pharmacare office at 1-877-577-3737 or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

• Patients and prescribers are notified by letter if coverage has been approved. Patients should take a copy of the approval letter to their pharmacy to initiate coverage.

• The duration of approval of Special Authorization coverage may range from a one time only fill to coverage with no end date. This will be based upon the medication requested and the condition being treated.

• Medications approved through the Special Authorization process are limited to a maximum 30 (thirty) day supply per fill unless otherwise noted in drug criteria.
If additional information is required or if the request is denied, a letter is sent to the patient and physician 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 physician 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** - see Rheumatoid Arthritis Biologic Agents

**Abiraterone, tablet, 250mg (Zytiga-JAN and generics)**

In combination with prednisone for the treatment of metastatic prostate cancer (castration-resistant prostate cancer) in patients who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy, or have received prior chemotherapy containing docetaxel after failure of androgen deprivation therapy.

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Patients must apply for coverage to the High-Cost Drug Program.** The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms)

**Abilify** – see Aripiprazole

**Abilify Maintena** – see Aripiprazole

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

For the maintenance of abstinence from alcohol in patients with a diagnosis of alcohol dependence who have been abstinent for at least four days, and who have contraindications to naltrexone (e.g. currently receiving opioids, acute hepatitis or liver failure). Treatment with acamprosate should be part of a comprehensive management plan that includes counseling. The maximum treatment duration is 12 months.

**Acitretin, capsule, 10mg, 25mg (Soriatane-HLR and generics)**
For the treatment of severe intractable psoriasis, Darier’s Disease, ichthyosiform dermatoses, palmoplantar pustulosis and other disorders of keratinization.

**Aclasta** - see Zoledronic Acid

**Actemra** – see Tocilizumab

**Actonel 30mg** - see Risedronate

**Actos** - see Pioglitazone

**Adalimumab** - see Ankylosing Spondylitis Biologic Agents OR
- see Crohn’s Disease Biologic Agents OR
- see Psoriatic Arthritis Biologic Agents OR
- see Ulcerative Colitis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents

**Adempas** – see Riociguat

**Advair** - see Salmeterol & Fluticasone

**Advair Diskus** - see Salmeterol & Fluticasone

**Afatinib, tablet, 20mg, 30mg, 40mg (Giotrif-BOE)**
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 Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Afiblercept, vial, 2mg/0.5ml (Eylea-BAY)**

**Neovascular Age-Related Macular Degeneration:**

Criteria For Initial Coverage (loading dose for 3 consecutive months):
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

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

Retinal vein occlusion (RVO)

For the treatment of visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (BRVO).

Clinical Notes:
1. Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.
2. Treatment should be resumed when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive months.
3. Treatment should be discontinued if there is no improvement after 6 months of initial treatment.
4. Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year

Patients must apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at http://healthpei.ca/pharmacareforms

Agrylin - see Anagrelide

Akynzeo – see Netupitant & Palonosetron

Alendronate, tablet, 40mg (generic)
For the treatment of Paget's disease of the bone for a maximum 6 month period.

Alertec - see Modafinil
Amatine - see Midodrine HCl

Ambrisentan, 5mg, 10mg (Volibris-GSK)
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 must apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at http://healthpei.ca/pharmacareforms.

Amerge - see Naratriptan HCl

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 Special Authorization.

AndroGel - see Testosterone

Ankylosing Spondylitis Biologic Agents
Adalimumab, kit, 40mg/0.8ml (Humira-ABV)
Approvals will be for a maximum adult dose of 40mg every two weeks.

Certolizumab, syringe kit, 400mg/2ml; auto-injector kit, 400mg/2ml (Cimzia-UCB)
Maximum adult dose is 400mg (given as two Sc injections of 200mg) given at 0,2,4 weeks then 200mg every 2 weeks thereafter.

Etanercept, pre-filled syringe, 50mg/ml (Brenzys-MSD; Erelzi-SDZ); auto-injector, 25mg/0.5ml (Erelzi-SDZ); 50mg/ml (Brenzys-MSD; Erelzi-SDZ)
Approvals will be for a maximum adult dose of 50mg per week or 25mg twice weekly. For etanercept-naïve patients whose etanercept therapy is initiated after November 27, 2017,
Brenzys or Erelzi will be the product approved.

**Golimumab, Syringe, 50mg/0.5ml; auto-injector, 50mg/0.5ml (Simponi-JAN)**
Approvals will be for a maximum adult dose of 50mg once monthly.

**Infliximab, injection powder, 100mg/vial (Inflectra-HOS; Remicade-JAN; Renflexis-MSD)**
Approvals will be for a maximum adult dose of 5mg/kg at 0, 2, and 6 weeks then every 6 to 8 weeks.

**Secukinumab, syringe or pen, 150mg/ml (Cosentyx-NVR)**
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 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:**
- 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 pre-treatment score OR
  b) patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as Health Assessment Questionnaire (HAQ) or ability to return to work).

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Ankylosing Spondylitis Special Authorization form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

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Anoro Ellipta – see Umeclidinium Bromide & Vilanterol Trifenatate

Apixaban, tablet, 2.5mg, 5mg (Eliquis-BMS)
For the treatment of venous thromboembolic events (VTE) (deep vein thrombosis [DVT] and pulmonary embolism [PE]) and prevention of recurrent DVT and PE, for a duration of up to six months.

For the prophylaxis of venous thromboembolism (VTE) following total knee replacement surgery for up to 14 days after surgery or total hip replacement surgery for up to 35 days after surgery as an alternative to low molecular weight heparins. The maximum dose of apixaban that will be reimbursed is 2.5mg twice daily.

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 apixaban for atrial fibrillation:

a) Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate < 25 mL/min)
b) Patients 75 years of age or older without documented stable renal function

c) Patients with hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis
d) Patients with prosthetic heart valves

Notes:
1. At-risk patients with atrial fibrillation are defined as those with a CHADS² score of ≥ 1. Prescribers may consider an antiplatelet regimen or oral anticoagulation for patients with a CHADS² score of 1.
2. Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e., adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
3. Documented stable renal function is defined as creatinine clearance or estimated glomerular filtration rate maintained for at least 3 months.
   a) Dosing: the usual recommended dose is 5 mg twice daily; a reduced dose of apixaban 2.5 mg twice daily is recommended for patients with at least two [2] of the following: age ≥ 80 years, body weight ≤ 60 kg, or serum creatinine ≥ 133 micromole/litre.
   b) 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 apixaban product monograph).

c) Patients starting apixaban should have ready access to appropriate medical services to manage a major bleeding event.

d) There is currently no data to support that apixaban provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves. As a result, apixaban is not recommended for these patient populations.

The request for coverage must be made using the Apixaban, Dabigatran, Edoxaban, Rivaroxaban Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Aprepitant, capsule, 80mg, 125mg, 80mg & 125mg package (Emend, Emend Tri-Pack)
In combination with dexamethasone for the prevention of acute and delayed nausea and vomiting in patients receiving:
- highly emetogenic chemotherapy or
- moderately emetogenic chemotherapy who have had inadequate symptom control using a 5-HT3 antagonist and dexamethasone in a previous cycle.

Clinical notes:
- Highly emetogenic chemotherapy (HEC) includes but 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

Aranelp - see Darbepoetin Alfa

Aranesp - see Darbepoetin Alfa

Aricept - see Cholinesterase Inhibitors (ChEI)

Aripiprazole, tablet, 2mg, 5mg, 10mg, 15mg, 20mg, 30mg (Abilify-OTS 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.

Aripiprazole, injection, 300mg, 400mg (Abilify Maintena-OTS)
For the treatment of schizophrenia in patients with documented compliance issues with an oral antipsychotic OR who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects (EPS or TD) or lack of efficacy.
NOTE: Must be requested and prescribed by a psychiatrist. Only doses up to 400mg
monthly will be approved.

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.

**Asenapine, sublingual tablet, 5mg, 10mg (Saphris-MSD)**
For the acute treatment of manic or mixed 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.

**Aubagio** – see Multiple Sclerosis Agents

**Avelox** - see Moxifloxacin

**Avonex** - see Multiple Sclerosis Agents

**Axitinib, tablet, 1 mg, 5 mg (Inlyta-PFI)**
As second line therapy for the treatment of patients with metastatic renal cell carcinoma after failure of prior therapy with either a cytokine or tyrosine kinase 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.

Initial approval period: 6 months.
Renewal period: 1 year.

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Aztreonam, inhalation vial, 75mg/ml (Cayston-GIL)**
For the treatment of chronic pulmonary Pseudomonas aeruginosa infections, when used as a cyclic treatment, in patients with moderate to severe cystic fibrosis and deteriorating clinical condition despite treatment with inhaled tobramycin.
**Clinical Note:**
Cyclic treatment measured in 28-day cycles is defined as 28 days of treatment, followed by 28 days without treatment.

Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Azithromycin, tablet, 250mg, 600mg; oral suspension, 20mg/mL, 40mg/mL (Zithromax-PFI and generics).**
Note: For HIV, Cystic Fibrosis, Sexually Transmitted Diseases, and Tuberculosis Programs, no Special Authorization is required.

a) For the treatment of infections requiring a macrolide antibiotic when the patient has a documented intolerance to clarithromycin
b) For the completion of hospital initiated treatment with azithromycin (maximum 5 days)
c) For the treatment and prevention of non-tuberculosis mycobacterial
d) For the treatment of infections requiring a macrolide antiobiotic when the patient is taking medications that would significantly interact with erythromycin/clarithromycin

**Baraclude** – see Entecavir

**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
  o in patients on maintenance treatment with OCS, there has been no
decrease in the OCS dose in the first 12 months of treatment, or
  o 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.

Patients must apply for coverage through the High-Cost Drug Program. The patient
application is available from the Drug Programs Office or online at
http://healthpei.ca/pharmacareforms.

Benzydamine HCl, oral rinse, 0.15% (Generic)
  For oncology patients only.

Betahistine HCL, tablet, 16mg, 24mg (Serc-BGP and generics)
  For the symptomatic treatment of recurrent episodes of vertigo associated with Meniere’s
disease.

Betamethasone Dipropionate & Calcipotriol, topical gel, 50mcg/0.5mg/gm (Dovobet-LEO)
  For the treatment of patients with scalp psoriasis who have failed a trial with a topical
steroid.

Betaseron - see Multiple Sclerosis Agents

Biphentin - see Methylphenidate

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 must apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Bosulif** – see Bosutinib

**Bosutinib, tablet, 100mg, 500mg (Bosulif-PFI)**

For treatment of adult patients with chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with resistance or intolerance to prior TKI therapy.

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Brexpiprazole, tablet, 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg (Rexulti-OTS)**

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 or response.

**Brilinta** – see Ticagrelor

**Brivaracetam, tablet, 10mg, 25mg 50mg, 75mg, 100mg (Brivlera-UCB)**

For the treatment of partial onset seizures in adult 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 levetiratad.
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 Ankylosing Spondylitis Biologic Agents OR

PEI Pharmacare Formulary ……………………………………………………………..Page - 291 -
see Rheumatoid Arthritis Biologic Agents

**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 clients 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.

**Budesonide, capsule, 3mg (Entocort-AZE)**

For the treatment of Crohn's disease or Colitis in patients for whom Prednisone is contraindicated or in whom significant side effects have occurred.

**Campral – see Acamprosate**

**Canagliflozin, tablet, 100mg, 300mg (Invokana-JAN)**

For the treatment of type 2 diabetes as a third drug added on to metformin and a sulfonlurea for patients with inadequate glycemic control on optimal doses of metformin and a sulfonlurea, and for whom insulin in not an option.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

**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.

**Carnitor – see Levocarnitine**

**Caripul – see Epoprostenol**

**Cayston – see Aztreonam**

**Cefprozil, tablets, 250mg, 500mg; oral suspension, 25mg/mL 50mg/mL (Generics)**
• Step-down care following hospital separation in patients treated with intravenous cephalosporins. Up to 10 days of therapy will be considered.
• For the treatment of patients with asthma or COPD not responding to alternative antibiotics. Up to 10 days of therapy will be considered.
• For the treatment of infections caused by organisms known to be resistant to alternative antibiotics. Up to 10 days of therapy will be considered.
• For the treatment of patients known to be allergic to penicillin and who fail to respond to alternative antibiotics. Up to 10 days of therapy will be considered.

Certolizumab - see Rheumatoid Arthritis Biologic Agents

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)
  Donepezil, tablet, 5mg, 10mg (Aricept-PFI and generics)
  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 a diagnosis of mild to moderate probable Alzheimer’s Disease (AD) or possible Alzheimer’s Disease with a vascular component, with Lewy bodies, or other factors (as specified) and who meet the following criteria:
  a) Initial 90-day Trial
     An initial 90-day trial using an available ChEI is available to patients who:
     • Have a diagnosis of probable or possible AD, AND
     • Are 65 years of age or older (Coverage for patients less than 65 years of age will be considered upon receipt of a written consultation from a neurologist, psychiatrist or geriatrician supporting the diagnosis and treatment), AND
     • Have not previously used a ChEI, AND
     • Have a Mini Mental State Examination (MMSE) score of between 10 and 24. An MMSE score of 25 or 26 will be considered upon receipt of a written consultation from a neurologist, psychiatrist or geriatrician supporting the diagnosis and treatment.

     All MMSEs must be completed within 90-days of the request for coverage.

     Patients unable to tolerate the first ChEI or where their MMSE score remained between 10 and 24, but declined significantly during the trial, may also qualify for a second 90-day trial using a different ChEI. Patients must stop the first ChEI before coverage for the second 90-day trial of a ChEI will be approved.

  b) Continued Coverage
Continued coverage of ChEIs may be available to patients who:
- Participated in a 90-day trial of a ChEI during which their MMSE score remained between 10 and 24 and either stabilized or improved, OR
- Have been previously approved for 12-months of coverage, during which their MMSE score remained above 10 and either stabilized or improved.

All MMSEs must be completed within 90-days of the request for coverage.

Continued coverage will not be approved for patients where their latest MMSE score is less than 10 or has dramatically decreased during the previous trial or monitoring period.

Continued coverage will be approved for a maximum of twelve (12) months at a time.

Requests for initial and continued coverage must be made using the Alzheimers Special Authorization Form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Chronic Obstructive Pulmonary Disease Medications**

- **Acldinium Bromide**, aerosol powder for inhalation, 400ug/dose (Tudorza Genuair-ALM) Acldinium Bromide & Formoterol Fumarate Dyhydrate, aerosol powder, 400mcg/12mcg actuation (Duaklir Genuair-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 (capsule), 12ug/dose (Foradil-NVR); powder for inhalation (inhaler), 6ug/dose, 12ug/dose (Oxeze Turbuhaler-AZE)
- Formoterol & Budesonide, powder for inhalation, 6ug & 100ug per dose, 6ug & 200ug per dose (Symbicort Turbuhaler-AZE)
- Glycopyrronium Bromide, capsule for inhalation, 50mcg (Seebri Breezhaler-NVR)
- Indacaterol, capsule, inhalation powder, 75mcg (Onbrez-NVR)
- Indacaterol & Glycopyrronium powder for inhalation (capsule), 110ug-50ug (Ultibro Breezhaler – NVR)
- Salmeterol Xinafoate, aerosol powder disk, 50μg/dose (Serevent Diskus-GSK)
- Salmeterol & Fluticasone, aerosol inhalation, 25ug & 125ug per dose, 25ug & 250ug per dose (Advair-GSK); inhaled powder disk, 50ug & 100ug per dose, 50ug & 250ug per dose, 50ug & 500ug per dose (Advair Diskus- GSK)
- Tiotropium, capsule for inhalation, 18ug/dose (Spiriva-BOE)
- Tiotropium, mist inhaler, 2.5ug/dose (Spiriva Respimat-BOE)
- Tiotropium &Olodaterol mist inhaler, 2.5ug-2.5ug, (Inspiolo 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 3)

<table>
<thead>
<tr>
<th>LABA</th>
<th>LAAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formoterol fumarate dehydrate (Oxeze Turbuhaler)</td>
<td>Aclidinium (Tudorza Genuair)</td>
</tr>
<tr>
<td>Formoterol fumarate (Foradil)</td>
<td>Glycopyrronium Bromide (Seebri)</td>
</tr>
<tr>
<td>Indacaterol maleate (Onbrez)</td>
<td>Tiotropium (Spiriva) 18mcg; (Spiriva Respimat) 2.5mcg</td>
</tr>
<tr>
<td>Salmeterol (Serevent)</td>
<td>Umeclidinium Bromide (Incruse Ellipta)</td>
</tr>
</tbody>
</table>

For any one agent listed in Table 1:
For the treatment of chronic obstructive pulmonary disease (COPD) as defined by spirometry¹ in patients

AND

• Experiencing persistent symptoms, as defined by Medical Research Council (MRC) score of at least 3² or a COPD Assessment test (CAT) score ≥ 10³ and a post-bronchodilator FEV₁ <80% predicted
OR

• Experiencing 2 or more moderate exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids OR at least 1 acute severe exacerbation of COPD (AECOPD) requiring hospitalization.

NOTE: Coverage for both a LABA and a LAAC as separate inhalers will not be considered. See below for combination LABA/LAAC coverage criteria.

Table 2 (of 3)

<table>
<thead>
<tr>
<th>LABA/LAAC</th>
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</thead>
<tbody>
<tr>
<td>Aclidinium Bromide &amp; Formoterol Fumarate Dihydrate (Duaklir Genuair)</td>
</tr>
<tr>
<td>Indacaterol/Glycopyrronium (Ultibro Breezhaler)</td>
</tr>
<tr>
<td>Tiotropium/Olodaterol (Inspiolto Respimat)</td>
</tr>
<tr>
<td>Umeclidinium Bromide &amp; Vilanterol Trifenatate (Anoro Ellipta)</td>
</tr>
</tbody>
</table>

For any one agent listed in Table 2:
• For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry¹, in patients with inadequate control⁴ 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 is fulfilled.

Table 3 (of 3)

<table>
<thead>
<tr>
<th>LABA/ICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budesonide/formoterol (Symbicort)</td>
</tr>
<tr>
<td>Fluticasone/umeclidinium/vilanterol (Trelegy Ellipta)</td>
</tr>
<tr>
<td>Fluticasone/vilanterol (Breo Ellipta)</td>
</tr>
<tr>
<td>Salmeterol/fluticasone (Advair)</td>
</tr>
</tbody>
</table>

For any one agent listed in Table 3:
- For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry AND
- When the LABA/ICS is part of triple therapy in patients with COPD OR
- In patients with asthma/COPD (ACO) overlap, based on patient history and lung function studies indicating an ACO diagnosis

Clinical Notes:
1. COPD is defined by spirometry as a post bronchodilator FEV<sub>1</sub>/FVC ratio of < 0.70. Spirometry reports from any point in time will be accepted.

2. MRC Grade 3 is 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.

3. 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](http://www.catestonline.org/images/pdfs/CATest.pdf)

4. 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 of at least 3 or a CAT score ≥ 10.

5. 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.


Ciloxan - see Ciprofloxacin, ophthalmic solution

Cimzia – see Rheumatoid Arthritis Biologic Agents or
see Ankylosing Spondylitis Biologic Agents or
see Psoriatic Arthritis Biologic Agents

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)

Cipro - see Ciprofloxacin, tablet

Cipro XL - see Ciprofloxacin, extended release tablet

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; oral suspension, 100mg/ml (Cipro-BAY and generics)
Note: For Cystic Fibrosis, Nursing Home and Tuberculosis Programs, no Special Authorization is required.
- For the treatment of pseudomonas infections not responding to alternative therapy. Up to 10 days of therapy will be considered.
- For the treatment of infections in persons allergic to alternative agents. Up to 10 days of therapy will be considered.
- For the treatment of infections in immunocompromised patients including diabetic foot and complications of orthopaedic surgery. Up to four weeks (28 days) of therapy will be considered.
- For the treatment of chronic bacterial prostatitis. Up to four weeks (28 days) of therapy will be considered.
Ciprofloxacin, extended release tablet, 1000mg (Cipro XL-BAY)
For the treatment of complicated urinary tract infections in patients unresponsive or allergic to other oral agents.

Ciprofloxacin & Dexamethasone, otic suspension, 0.3% / 0.1% (Ciprodex-ALC)

a) For the treatment of patients with acute otitis media with otorrhea through tympanostomy tubes; or with known or suspected tympanic membrane perforation with otorrhea.
b) For the treatment of patients with acute otitis externa in the presence of tympanostomy tubes or known perforation of the tympanic membrane.

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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

Codeine, controlled release tablet, 50mg, 100mg, 150mg, 200mg (Codeine Contin-PFR)
For the treatment of documented mild to moderate chronic pain that is not well controlled by short-acting codeine products or where patients are well controlled on acetaminophen or ASA combinations but the codeine dose is limited by the amount of acetaminophen or ASA. The maximum dose of Codeine Contin that will be reimbursed is 200mg every 12 hours.
**Codeine Contin** - see Codeine

**Comtan** - see Entacapone

**Concerta** – see Methylphenidate

**Copaxone** - see Multiple Sclerosis Agents

**Cosentyx** – see Ankylosing Spondylitis Biologic Agents or see Plaque Psoriasis Biologic Agents or see Psoriatic Arthritis Biologic Agents

**Cotellic** – see Cobimetinib

**Crizotinib, capsule, 200mg, 250mg (Xalkori-PFI)**
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

*Prescriptions written by PEI oncologists do not require Special Authorization.*

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Crohn’s Disease Biologic Agents**

**A) Moderate to Severe Crohn’s Disease**
For the treatment of patients with moderate to severe Crohn’s disease who have active disease and are refractory, intolerant or have contraindications to:
• Prednisone 40mg (or equivalent) daily for ≥ 2 weeks, AND
• Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
• Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
• Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:
• Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
• Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
• Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients who have an aggressive/severe disease course (e.g. extensive disease, a modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.
Claim notes:
• Initial approval: 12 weeks. Renewal Approval: 1 year. Confirmation of continued response is required.
• Maximum dosages as per existing criteria on the PEI Pharmacare Formulary.
• Combined use of more than one biologic DMARD will not be reimbursed.

**Adalimumab, kit, 40mg/0.8ml (Humira-ABV)**
Initial 12 week approval for adults is 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.

**Infliximab, injection powder, 100mg/vial (Inflectra-HOS; Remicade-JAN; Renflexis-MSD)**
Initial approval is for 3 doses of 5mg/kg/dose administered at 0, 2, and 6 weeks. Renewal of coverage will require reassessment of the patient and submission of a new Crohn’s Disease Special Authorization form. Continued coverage will be approved at a dose not exceeding 5mg/kg every 8 weeks.

**Vedolizumab, vial, 300mg (Entyvio-TAK)**
Initial approval for adults is for induction doses of 300mg at weeks 0, 2, and 6. 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.

**B) Fistulizing Crohn’s Disease**
For the treatment of fistulizing Crohn’s Disease in patients who:
1. Have a Harvey Bradshaw Index score of 7 or more, **AND**
2. Have an actively draining perianal or eneurectaneous fistula(e) that have recurred or persisted despite a course of appropriate antibiotic therapy (e.g. Ciprofloxacin with or without Metronidazole for a minimum of 3 weeks), **AND**
3. Have not responded to or are intolerant to immunosuppressive therapy (Azathioprine, Mercaptopurine or Methotrexate) or where such therapy is contraindicated.

**Infliximab, injection powder, 100mg/vial (Inflectra-HOS; Remicade-JAN; Renflexis-MSD)**
Initial approval for Infliximab will allow for 3 doses of 5mg/kg/dose administered at 0, 2, and 6 weeks. Renewal of coverage will require reassessment of the patient and submission of a new Crohn’s Disease Special Authorization form. Continued coverage will be approved at a dose not exceeding 5mg/kg every 8 weeks.

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
Patients must also apply for coverage to the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

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.**

Dabigatran, capsule, 110mg, 150mg (Pradaxa-BOE and generic)
For the prevention of stroke and systemic embolism in at-risk patients with non-valvular atrial fibrillation for whom:

a) Anticoagulation is inadequate following at least a two month trial of warfarin; or
b) Warfarin is contraindicated or not possible due to inability to regularly monitor through International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

The following patient groups are **excluded** from coverage for dabigatran for atrial fibrillation:

a) Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate < 30mL/min)
b) Patients 75 years of age or older without documented stable renal function
c) Patients with hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis
d) Patients with prosthetic heart valves

Notes:
1. At-risk patients with atrial fibrillation are defined as those with a CHADS₂ score of ≥ 1.
2. Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period (i.e. adequate anticoagulation is defined as INR test results that are within the desired INR range for at least 65% of the tests during the monitoring period).
3. Since renal impairment can increase bleeding risk, renal function should be regularly monitored. Other factors that increase bleeding risk should also be assessed and monitored (see dabigatran product monograph).
4. Documented stable renal function is defined as creatinine clearance or estimated glomerular filtration rate that maintained for at least three months (i.e. 30-49 mL/min for 110 mg twice daily dosing or ≥ 50 mL/min for 150 mg twice daily dosing).
5. There is currently no data to support that dabigatran provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so dabigatran is not recommended in these populations.

6. Patients starting dabigatran should have ready access to appropriate medical services to manage a major bleeding event.

The request for coverage must be made using the Apixaban, Dabigatran, Edoxaban, Rivaroxaban Special Authorization form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Dabrafenib, capsule, 50mg, 75mg (Tafinlar-NVR)
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 an ECOG performance status of 0 or 1.
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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Dalteparin - see Low Molecular Weight Heparins

Dapagliflozin, tablet, 5mg, 10mg (Forxiga-AZE)
For the treatment of type 2 diabetes as a third drug added on to metformin and a sulfonylurea for patients with inadequate glycemic control on optimal doses of metformin and a sulfonylurea, and for whom insulin is not an option.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Dapagliflozin and Metformin HCL, tablet, 5mg/850mg, 5mg/1000mg (Xigduo-AZE)
For the treatment of type 2 diabetes for patients for whom insulin is not an option and who are already stabilized on therapy with metformin, a sulfonylurea and dapagliflozin, to replace the individual components of dapagliflozin and metformin in these patients.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

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Darbepoetin Alfa, pre-filled syringe 25ug/mL, 40ug/mL, 100ug/mL, 200ug/mL (Aranesp-AMG)
For the treatment of severe anemia related to chronic renal failure in patients with:
   a) Normocytic normochromic anemia, requiring transfusions in patients who have evidence of iron overload (Ferritin > 1000 ng/mL), OR
   b) Anemia requiring blood transfusions in patients having symptomatic angina and/or heart failure, OR
   c) Anemia requiring transfusion in patients with difficulties in blood grouping and febrile reactions due to antibodies, OR
   d) Anemia requiring transfusions in patients who have high levels of panel reactive anti HLA antibodies, OR
   e) Severe normocytic normochromic anemia (Hb < 100 g/L) whose only symptom is fatigue and have never received transfusions.

The request for coverage must be made by or in consultation with a nephrologist, internal medicine specialist, or oncologist. A copy of the consultation must accompany the request.

The request for coverage must be made using the Erythropoietin Program Approval Form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Darifenacin, extended release tablet, 7.5mg, 15mg (Enablex-NVR)
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.

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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

DDAVP - see Desmopressin

Deferasirox, dispersible tablet, 125mg, 250mg, 500mg (Exjade – NVR and generics)
For the treatment of patients who require iron chelation.

Denosumab, pre-filled syringe, 60mg/ml (Prolia – AMG)
For the treatment of osteoporosis in postmenopausal women and in men who meet the following criteria:

- Have a contraindication to oral bisphosphonates; and
- High risk for fracture, or refractory or intolerant to other available osteoporosis therapies.

**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.

**Desmopressin, oral disintegrating tablet, 60ug, 120ug, 240ug (DDAVP Melt-FEI); tablet, 0.1mg, 0.2mg (DDAVP-FEI and generics)**

a) For the treatment of diabetes insipidus in patients unable to tolerate the intranasal solution or when the intranasal solution is ineffective.

b) For the treatment of enuresis in children over 5 years and under 16 years of age.

**Desmopressin, intranasal solution, 10ug/dose, (DDAVP Rhinyle-FEI); intranasal solution (spray pump), 10ug/dose (generic)**

a) For the treatment of diabetes insipidus. The maximum recommended daily dosage is 40μg.

**Diacomit – see Stiripentol**

**Dicetel – see Pinaverium**

**Didronel - see Etidronate**

**Dienogest, tablet, 2mg (Visanne-BAY and generic)**

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**

**Diflucan – see Fluconazole**

**Dihydroergotamine Mesylate, nasal spray, 4mg/mL (Migranal-NVR)**

For the treatment of migraine headaches where other standard therapies such as oral analgesics have failed.

**Coverage is limited to 6 bottles per 30 day period.** Anyone requiring more than 6
bottles per 30 day period should be considered for migraine prophylaxis therapy if they are not already receiving such therapy.

**Diphenoxylate HCl & Atropine Sulfate, tablet, 2.5mg/0.025mg (Lomotil-PFI)**
An adjunct in the management of diarrhea not responding to alternative therapy.

**Ditropan XL** - see Oxybutynin Chloride

**Donepezil** - see Cholinesterase Inhibitors (ChEI)

**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.

Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Duaklir Genuair** – see Aclidinium Bromide & Formoterol Fumarate Dihydrate

**Duloxetine hydrochloride, delayed release capsule, 30mg, 60mg (Cymbalta – LIL and generics)**
For the treatment of neuropathic pain in diabetic patients who are unresponsive to adequate courses of at least TWO less costly alternative agents such as a tricyclic antidepressant and anticonvulsant agents. The maximum allowable dose is 60 mg daily.

**Edoxaban, tablet, 15mg, 30mg, 60mg (Lixiana-SER)**
For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) for up to six (6) months.
NOTE: The recommended dose of edoxaban for patients initiating DVT or PE treatment is 60mg once daily following initial use of a parenteral anticoagulant for 5 to 10 days.
Edoxaban 30mg once daily is recommended in patients with one of more of the following clinical factors:
- Moderate renal impairment (creatinine clearance (CrCl) 30-50 mL/min)
- Low body weight less than or equal to 60Kg, or
- Concomitant use of P-glycoprotein (P-gp) inhibitors except amiodarone and verapamil

Since renal impairment can increase bleeding risk, it is important to monitor renal function regularly. Other factors that increase bleeding risks should also be assessed and monitored (see product monograph).

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 edoxaban 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 who have hemodynamically significant rheumatoid valvular heart disease (especially mitral stenosis), or who have prosthetic heart valves.
   - Safety and efficacy have not been studied in patients with prosthetic (mechanical or biological) heart valves or those with hemodynamically significant rheumatic heart disease, especially mitral stenosis.

The recommended dose of edoxaban for patients initiating treatment is 60mg once daily. Edoxaban 30mg once daily is recommended in patients with one or more of the following clinical factors: moderate renal impairment (creatinine clearance 30mL/min to 50mL/min); low body weight ≤ 60kg; or concomitant use of P-glycoprotein inhibitors, except amiodarone and verapamil.

The request for coverage must be made using the Apixaban, Dabigatran, Edoxaban, Rivaroxaban Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Effient – see Prasugrel

Elmiron - see Pentosan Polysulfate Sodium

Emend - see Aprepitant

Empagliflozin, tablet, 10mg, 25mg (Jardiance-BOE)

For the treatment of type 2 diabetes as a third drug added on to metformin and a sulfonylurea for patients with inadequate glycemic control on optimal doses of metformin and a sulfonylurea, and for whom insulin is not an option

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:
Established cardiovascular disease is defined as one of the following (details must be provided):
   - History of myocardial infarction (MI).
• Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status).
• Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within 12 months prior to selection.
• Last episode of unstable angina ≥2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease.
• History of ischemic or hemorrhagic stroke.
• Occlusive peripheral artery disease.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Empagliflozin & Metformin, tablet, 5mg & 500mg, 5mg & 850mg, 5mg & 1000mg, 12.5mg & 500mg, 12.5mg & 850mg, 12.5mg & 1000mg (Synjardy-BOE)
For patients with type 2 diabetes mellitus who are already stabilized on therapy with metformin and empagliflozin, to replace the individual components of metformin and empagliflozin in these patients.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Enablex – see Darifenacin

Enbrel - see Plaque Psoriasis Biologic Agents OR
- see Psoriatic Arthritis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents (pediatric indication)

Enfuvirtide, injection kit, 90mg/mL (Fuzeon-HLR)
For patients:
   a) Who have a CD4 count greater than 100 cells/mm³; AND
   b) Who have a viral load less than 100,000 copies/mL; AND
   c) Who have previously received less than 11 antiretroviral agents; AND
   d) Where therapy with Enfuvirtide is planned in combination with at least one other antiretroviral drug to which sensitivity has been demonstrated on resistance testing.

Requests for Enfuvirtide (Fuzeon-HLR) must be made using the Enfuvirtide Special Authorization form which is available from the Drug Programs office or on-line at http://healthpei.ca/pharmacareforms.

Enoxaparin - see Low Molecular Weight Heparins
Entacapone, tablet, 200mg (Comtan-NVR and generics)
Note: For Nursing Home Program, no Special Authorization is required.

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.**

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.

Entocort - see Budesonide

Entresto – see Sacubitril & Valsartan

Entvyvio - see Crohn’s Disease Biologic Agents or
- see Ulcerative Colitis Biologic Agents

**Enzalutamide, capsule, 40mg (Xtandi-AST)**
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 midly 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

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program.** The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**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 fiscal year. Additional units require an exception status request.

**EpiPen** - see Epinephrine

**EpiPen Jr.** - see Epinephrine

**Epoetin Alfa, pre-filled syringe, 10,000IU/mL (Eprex-JAN)**

For the treatment of severe anemia related to chronic renal failure in patients with:

a) Normocytic normochromic anemia, requiring transfusions in patients who have evidence of iron overload (Ferritin > 1000 ng/mL), **OR**

b) Anemia requiring blood transfusions in patients having symptomatic angina and/or heart failure, **OR**

c) Anemia requiring transfusion in patients with difficulties in blood grouping and febrile reactions due to antibodies, **OR**

d) Anemia requiring transfusions in patients who have high levels of panel reactive anti HLA antibodies, **OR**

e) Severe normocytic normochromic anemia (Hb < 100 g/L) whose only symptom is fatigue and have never received transfusions.

The request for coverage must be made by or in consultation with a nephrologist, internal medicine specialist, or oncologist. A copy of the consultation must accompany the request.

The request for coverage must be made using the Erythropoietin Program Approval Form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Epoprostenol, vials, 0.5mg, 1.5mg (Caripul-ACT, Flolan-GSK)**

For the treatment of World Health Organization (WHO) class III or IV idiopathic pulmonary arterial hypertension in patients who do not demonstrate vasoreactivity on testing or who demonstrate vasoreactivity on testing but fail a trial of, or are intolerant to, calcium channel blockers.

For the treatment of WHO class III or IV pulmonary arterial hypertension associated with scleroderma in patients who do not respond adequately to conventional therapy.

Note: Coverage will be limited to medication and associated diluent costs only. No coverage will be provided for equipment or medical supplies (e.g. pumps, IV tubing, IV catheters, etc.).

Coverage must be requested and medications prescribed by a Pulmonary Arterial Hypertension (PAH) specialist.

Patients must apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at

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Eprex - see Epoetin Alfa

Erelzi - see Ankylosing Spondylitis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents

Erivedge – see Vismodegib

Erlotinib, tablet, 25mg, 100mg, 150mg (Tarceva-HLR and 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 Special Authorization.

Patients requesting coverage under the High-Cost Drug Program must apply to this program using the application that is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Esbriet – see Pirfenidone

Eslicarbazepine Acetate, tablet, 200mg, 400mg, 600mg, 800mg (Aptiom-SNV)
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.

Estradiol, transdermal patch, 25ug, 50ug, 75ug, 100ug (Estradot-NVR and generics)
For the treatment of patients with a documented intolerance to oral estrogen products.

Estradot - see Estradiol

Etanercept - see Ankylosing Spondylitis Biologic Agents OR
- see Psoriatic Arthritis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents

Etidronate, tablet, 200mg (Didronel-PGA and generics)
For the treatment of symptomatic Paget's disease of the bone for a 6 month period.
Coverage can be renewed after a drug holiday of at least 90 days.

Exelon - see Cholinesterase Inhibitors (ChEI)

Extavia - see Multiple Sclerosis Agents

Eylea – see Aflibercept
Ezetrol - see Ezetimibe

Ezetimibe, tablet, 10mg (Ezetrol-FRS and generics)
   a) For the treatment of hypercholesterolemia, as adjunctive therapy with statins, in patients who have not reached treatment goals on maximum tolerated statin therapy alone.
   b) For the treatment of hypercholesterolemia, as monotherapy, in patients who are intolerant to statins and, when appropriate, fibrates.

Fasenra – see Benralizumab

Febuxostat, tablet, 80mg (Uloric-TAK and 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, 12ug/hr, 25ug/hr, 37ug/hr, 50ug/hr, 75ug/hr, 100ug/hr (Generics)
   For the treatment of severe chronic pain that is not well controlled by short and long-acting Morphine and Hydromorphone products.

Fesoterodine Fumarate, extended release tablet, 4mg,8mg (Toviaz-PFI)
   For the treatment of over active bladder (not stress incontinence) in patients who cannot tolerate or have an insufficient response to an adequate trial (e.g. 3 months) of immediate release oxybutynin, solifenacin, or tolterodine.

Fidaxomicin, tablet, 200mg (Dificid-MER)
   For the treatment of patients with documented Clostridium Difficile Infection, when prescribed in consultation with an infectious diseases consultant AND
   • Where there is demonstrated intolerance or contraindication to vancomycin; OR
   • For use in patients with prior Clostridium Difficile Infection after other current Clostridium Difficile Infection treatment options fail.

Filgrastim, prefilled syringe, 300mcg/0.5ml, 480mcg/0.8ml (Grastofil-APX)
   Chemotherapy Support
   a) For use in patients treated with curative intent, where maintaining maximal dose intensity is likely to improve the cure rate, and where the risk of neutropenic fever is greater than 20%.
   b) For use in patients treated with curative intent, after an episode of neutropenic fever or where treatment is delayed beyond one week due to neutropenia.

   High Dose Chemotherapy With Stem Cell Support
   For use in mobilizing stem cells in preparation for stem cell collection.

   Neutropenic fever is defined as a body temperature of ≥ 38.5°C (as a single
measurement) or > 38°C three times in a 24 hour period and neutropenia with an absolute neutrophil count (ACN) < 0.5 x 10⁹/L.

**Must be requested and prescribed by a specialist in hematology or medical oncology.**

The manufacturer recommends an initial dose of 5mcg/kg/day. The dosage can be rounded off to 300mcg or 480mcg to avoid wastage.

When dose scavenging techniques are not available, the following recommendations are suggested:

- Patients ≤ 70 kg use 1 mL vial (300mcg)
- Patients > 70 kg use 1.6 mL vial (480mcg)

Coverage will be limited to a maximum of 3 months. Coverage beyond this will require completion and submission of a new Special Authorization form.

**All requests for coverage of filgrastim for adult patients will be approved for Grastofil brand only. Neupogen brand will be considered for pediatric patients.**

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.**

**Fingolimod** - See Multiple Sclerosis Agents

**Firazyr** – see Icatibant

**Flolan** - see Epoprostentol

**Fluconazole, tablet, 50mg, 100mg, 150mg (Diflucan-PFI and generics)**

  Note: For HIV program no Special Authorization is required.
  a) For the treatment of severe or life-threatening systemic fungal infections.
  b) For the treatment of severe dermatophytoses not responding to other forms of therapy.

**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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Fluoxetine, oral solution, 20mg/5ml (Generics)**
For use in patients for whom oral capsules are not an option.

**Fluticasone Furoate/Vilanterol, Inhaler, 100/25mcg/dose, 200/25mcg/dose (Breo Ellipta-GSK)**
- 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.

**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.

**Foradil** - see Formoterol

**Formoterol Fumerate, powder for inhalation (capsule), 12ug/dose (Foradil-NVR); powder for inhalation (inhaler), 6ug/dose, 12ug/dose (Oxeze Turbuhaler-AZE)**
- For the treatment of asthma when used in patients on concurrent steroid therapy.
- 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, 6ug & 100ug per dose, 6ug & 200ug per dose (Symbicort Turbuhaler-AZE)**
- 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.
- 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.

**Forxiga** – see Dapagliflozin

**Fosamax 40mg** - see Alendronate

**Fosfomycin, sachet, 3g (Monurol-PAL)**
- Note: For Nursing Home, no Special Authorization is required.
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

**Fragmin** - see Low Molecular Weight Heparins

**Fulvestrant, syringe, 250mg/5ml (Generics)**
For the treatment of postmenopausal women with non-visceral locally advanced or metastatic estrogen receptor positive, HER2 negative breast cancer, who have not been previously treated with endocrine therapy.

Clinical Note:
1. Patients must have a good performance status
2. Coverage will not be considered in combination with CDK4/6 inhibitors
3. Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.

**Fuzeon** - see Enfuvirtide

**Fycompa** – see Perampanel

**Galantamine** - see Cholinesterase Inhibitors (ChEI)

**Gatifloxacin, ophthalmic drops, 0.3% (Zymar-ALL)**
For the treatment/prevention of bacterial conjunctivitis associated with eye surgery.

**Glatiramer Acetate** - see Multiple Sclerosis Agents

**Gleevec** - see Imatinib

**Gilenya** – see Multiple Sclerosis Agents

**Giotrif** – see Afatinib

**Glucagon** – see Glucagon (Human Recombinant)

**Glucagon (Human Recombinant), vial, 1mg; kit, 1mg (Glucagen - PAL)**
*Note: IM administration only.*
For emergency treatment of severe hypoglycaemia in patients treated with insulin when unconsciousness precludes oral carbohydrates.

Coverage is limited to one unit at a time.

To allow for the replacement of used or expired units, the pharmacy must contact the PEI Pharmacare office and coverage will be provided on the day of the fill.
Additional physician requests are not required for replacement units once the initial request has been approved.

**Glucagon** – see Glucagon (Recombinant DNA Origin)

**Glucagon (Recombinant DNA Origin), vial,1mg (Glucagon – LIL)**

*Note: Nursing Home Program does not require a special authorization.*

For emergency treatment of severe hypoglycaemia in patients treated with insulin when unconsciousness precludes oral carbohydrates.

Coverage is limited to one unit at a time.

To allow for the replacement of used or expired units, the pharmacy must contact the PEI Pharmacare office and coverage will be provided on the day of the fill.

Additional physician requests are not required for replacement units once the initial request has been approved.

**Golimumab** – see Ankylosing Spondylitis Biologic Agents OR

- see Psoriatic Arthritis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents

**Grastofil** – see Filgrastim

**Hp-PAC** - see Lansoprazole & Clarithromycin & Amoxicillin

**Humira** - see Ankylosing Spondylitis Biologic Agents OR

- see Crohn’s Disease Biologic Agents OR
- see Plaque Psoriasis Biologic Agents OR
- see Psoriatic Arthritis Biologic Agents OR
- see Ulcerative Colitis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents

**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.

**Hydromorphone HP** - see Hydromorphone, injection solution

**Ibrance** – see Palbociclib

**Ibrutinib, capsule, 140mg (Imbruvica-JAN)**
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.

AND

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.

AND

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 Special Authorization.

Patients requesting coverage under the High-Cost Drug Program must apply to this program using the application that is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Icatibant, syringe, 30mg/3ml (Firazyr-SHR)
For the treatment of acute attacks of hereditary angioedema (HAE) in adults with lab confirmed c1-esterase inhibitor deficiency (type I or type II) if the following conditions are met:
- Treatment of non-laryngeal attacks of at least moderate severity, or
- Treatment of acute laryngeal attacks
Limited to a single dose for self-administration per attack AND prescribed by physicians with experience in the treatment of HAE

The Special Authorization form is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Iclusig – see Ponatinib

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.

**Prescriptions written by PEI oncologists do not require Special Authorization.**

Patients requesting coverage under the High-Cost Drug Program must apply to this program using the application that is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Imbruvica** – see Ibrutinib

**Imitrex** - see Sumatriptan

**Incruse Ellipta** – see Umeclidinium Bromide

**Infliximab (Inflectra)** - see Ankylosing Spondylitis Biologic Agents OR
- see Crohn's Disease Biologic Agents OR
- see Plaque Psoriasis Biologic Agents OR
- see Psoriatic Arthritis Biologic Agents OR
- see Ulcerative Colitis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents

**Infliximab (Remicade)** - see Ankylosing Spondylitis Biologic Agents OR
- see Crohn's Disease Biologic Agents OR
- see Plaque Psoriasis Biologic Agents OR
- see Psoriatic Arthritis Biologic Agents OR
- see Ulcerative Colitis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents

**Infliximab (Renflexis)** - see Ankylosing Spondylitis Biologic Agents OR
- see Crohn's Disease Biologic Agents OR
- see Plaque Psoriasis Biologic Agents OR
- see Psoriatic Arthritis Biologic Agents OR
- see Ulcerative Colitis Biologic Agents OR
- see Rheumatoid Arthritis Biologic Agents
Inlyta - see Axitinib

Innohep – see Low Molecular Weight Heparins

Inspiolto Respimat – see Tiotropium/Olodaterol

Insulin Detemir, cartridge, prefilled pen; 100 unit/ml (Levemir-NNO)
For the treatment of patients who have been diagnosed with type 1 or type 2 diabetes requiring insulin and have previously taken all open benefit long acting insulin analogues daily at optimal dosing AND have experienced unexplained nocturnal hypoglycaemia at least once a month despite optimal management OR have documented severe or continuing systemic or local allergic reaction to existing insulin(s).

The request for coverage must be made using the Long Acting Insulin Analogues Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Insulin Glargine, cartridge, prefilled pen, vial; 100 unit/ml (Lantus-AVN)
For the treatment of patients who have been diagnosed with type 1 or type 2 diabetes requiring insulin and have previously taken all eligible open benefit long acting insulin analogues daily at optimal dosing AND have experienced unexplained nocturnal hypoglycaemia at least once a month despite optimal management OR have documented severe or continuing systemic or local allergic reaction to existing insulin(s).

The request for coverage must be made using the Long Acting Insulin Analogues Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Insulin Glargine, prefilled pen, 300 unit/ml (Toujeo-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.

The request for coverage must be made using the Long Acting Insulin Analogues Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Interferon Beta-1A - see Multiple Sclerosis Agents
**Interferon Beta-1B** - see Multiple Sclerosis Agents

**Invega Sustenna** – see Paliperidone

**Invokana** – see Canagliflozin

**Itraconazole, capsule, 100mg (Sporanox-JAN and generics)**

a) For the treatment of severe systemic fungal infections not responding to alternative therapy.

b) For the treatment of severe or resistant fungal infections in immunocompromised patients not responding to alternative therapy.

c) For the treatment of severe onychomycosis caused by dermatophyte fungi not responding to alternative therapy, as diagnosed by a dermatologist or attending physician.

**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:

- Age 6 years and older; AND
- Patient has documented G551D mutation in the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) gene.

Initial renewal criteria:
Renewals will be considered in patients with documented response to treatment (after at least 6 months of therapy), as evidenced by the following:
In cases where the patient’s sweat chloride levels prior to commencing therapy were above 60 mmol/litre:
  i. the patient’s sweat chloride level fell below 60 mmol/litre; OR
  ii. the patient’s sweat chloride level is 30% lower than the level reported in a previous test;
In cases where the patient’s sweat chloride levels prior to commencing therapy were below 60 mmol/litre:
  i. the patient’s sweat chloride level is 30% lower than the level reported in a previous test; OR
  ii. the patient demonstrates a sustained absolute improvement in FEV1 of at least 5% when compared to the FEV1 test conducted prior to the commencement of therapy.

If the expected reduction does not occur, a sweat chloride test should be performed again one week later. If the criteria are not met, funding will be discontinued.

Subsequent renewal criteria after the patient has met the initial renewal criteria:
The patient is continuing to benefit from therapy with Kalydeco.
The patient’s sweat chloride level and FEV1 must be provided with each request.

Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Jakavi – see Ruxolitinib

Januvia – see Sitagliptin

Janumet – see Sitagliptin & Metformin Hydrochloride

Janumet XR – see Sitagliptin & Metformin Hydrochloride

Jardiance – see Empagliflozin

Jentadueto – see Linagliptin & Metformin Hydrochloride

Jetrea – see Ocriplasmin

Kalydeco – see Ivacaftor

Ketoconazole, tablet, 200mg (generics)
  Note: For HIV program no Special Authorization is required.
  a) For the treatment of severe or life-threatening systemic fungal infections.
  b) For the treatment of severe dermatophytoses not responding to other forms of therapy.

Kevzara – see Rheumatoid Arthritis Biologic Agents

Komboglyze – see Saxagliptin & Metformin Hydrochloride
Lacosamide, tablet, 50mg, 100mg, 150mg, 200mg (Vimpat-UCB and generics)
For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
   a) Are under the care of a physician experienced in the treatment of epilepsy, AND
   b) Are currently receiving two or more antiepileptic drugs, AND
   c) In whom all other antiepileptic drugs are ineffective or not appropriate.

Lactulose 667mg/ml syrup
For the treatment of hepatic encephalopathy.

Lamisil - see Terbinafine

Lancora – see Ivabradine

Lansoprazole - see Proton Pump Inhibitors

Lansoprazole & Clarithromycin & Amoxicillin, 7-day package, 30mg & 500mg & 500mg (Hp-PAC-TAK and generics)
One week of therapy will be considered for individuals with documented duodenal or gastric ulcers and a recent documented positive helicobacter pylori test.

Lantus – see Insulin Glargine

Latuda – see Lurasidone

Lemtrada - see Multiple Sclerosis Agents

Lenalidomide, capsule, 5mg, 10mg, 15mg, 25mg (Revlimid-CEL)
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 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

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;
- treat until progression or development of unacceptable toxicity requiring discontinuation of lenalidomide;
- initial dose 10mg lenalidomide PO daily, AND
- dose adjustments (5-15mg) may be necessary based on individual patient characteristics/responses.

**Clinical Note:** Due to its structural similarities to thalidomide, lenalidomide (Revlimid) is only available through a controlled distribution program called RevAidSM to minimize the risk of fetal exposure. Only prescribers and pharmacists registered with this program are able to prescribe and dispense lenalidomide (Revlimid). In addition, patients must be registered and meet all the conditions of the program in order to receive the product. For information, call 1-888-RevAid1 or log onto [www.RevAid.ca](http://www.RevAid.ca).

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program.** The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Levemir** – see Insulin Detemir

**Levocarnitine, tablet, oral solution, 330mg, 100mg/ml (Carnitor-SIG and generic)**
1. For the treatment of patients with primary systemic carnitine deficiency.
2. For the treatment of patients with an inborn error of metabolism that results in secondary carnitine deficiency.

**Levodopa & Carbidopa, controlled release tablet, 100mg & 25mg, 200mg & 50mg (Sinemet CR-BMS and generics)**

Note: For Nursing Home Program, no Special Authorization is required.

For patients with dyskinesia who have experienced adverse effects related to drug level fluctuations, such as On/Off or wearing-off phenomena, while being treated with immediate release Levodopa and Carbidopa.

**Levofloxacin, tablet, 250mg, 500mg (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.

Lisdexamfetamine, capsule, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg (Vyvanse-SHR)
For treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older who:
• Have experienced unsatisfactory results due to poor symptom control, side effects, administrative barriers and/or societal barriers. AND
• Have been tried on methylphenidate (immediate release or long-acting formulation) or dexamphetamine (immediate release or long-acting formulation) with unsatisfactory results.

Requests will be considered from specialists in pediatric psychiatry, pediatricians or general practitioners with expertise in ADHD.

The maximum dose reimbursed is 60mg daily.

Concurrent use of long acting formulations of drugs for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) will not be approved.

Linagliptin, tablet, 5mg (Trajenta-BOE)
For the treatment of type 2 diabetes as a third drug added on to metformin and a sulfonylurea for patients with inadequate glycemic control on optimal doses of metformin and a sulfonylurea, and for whom insulin is not an option.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms .

Linagliptin & Metformin Hydrochloride, tablet, 2.5mg/500mg, 2.5mg/850mg, 2.5mg/1000mg (Jentadueto-BOE)
For patients with type 2 diabetes for whom insulin is not an option and who are already stabilized on therapy with metformin, a sulfonylurea and linagliptin, to replace the individual components of linagliptin and metformin in these patients.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms .

Linezolid, tablet, 600mg (Zyvoxam-PHU and generics)
(a) For the treatment of proven VRE (Vancomycin-Resistant Enterococcus) infections. Must be prescribed in consultation with a specialist in infectious diseases. A copy of a C&S report demonstrating Vancomycin resistance must accompany the request. Up to 28 days of therapy will be considered.

(b) For the treatment of proven MRSA (Methicillin-Resistant Staph. Aureus) and MRSE (Methicillin-Resistant Staph. Epidermidis) infections in patients who are unresponsive or intolerant to Vancomycin. Must be prescribed in consultation with a specialist in infectious diseases. A copy of a C&S report demonstrating Vancomycin resistance must accompany the request. Up to 28 days of therapy will be considered.

Lixiana – see Edoxaban

Lomotil – see Diphenoxylate HCl & Atropine Sulfate

Losec – see Proton Pump Inhibitors

Lovenox – see Low Molecular Weight Heparins

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-Pfizer)

  Enoxaparin, pre-filled syringe, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg, 150mg; multi-dose vial, (3ml) 100mg/ml (Lovenox-Sanofi)

  Tinzaparin, vial, 10000unit/mL, 20000unit/mL; syringe, 2500unit/0.25mL, 3500unit/0.35mL, 4500unit/0.45mL, 10000unit/0.5mL, 14000unit/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.

The request for coverage must be made using the Low Molecular Weight Heparin Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Lucentis - see Ranibizumab

Lurasidone, tablet, 20mg, 40mg, 60mg, 80mg, 120mg (Latuda-SNV)
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.

Magic Bullet - see Bisacodyl

Megestrol Acetate, tablet, 40mg, 160mg (Generics)
Note: For HIV Program, no Special Authorization is required.
   a) For the adjunctive or palliative treatment of recurrent, inoperable or metastatic carcinoma of the breast and endometrium.
   b) For the palliative treatment of hormone responsive advanced (Stage D2) carcinoma of the prostate.

Mekinist – see Trametinib

Mepolizumab, 100mg, vial, 100mg/ml, autoinjector, syringe (Nucala-GSK)
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
  o 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
  o in patients on maintenance treatment with OCS, there has been no
    decrease in the OCS dose in the first 12 months of treatment, or
  o 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.

Patients must apply for coverage through the High-Cost Drug Program. The patient
application is available from the Drug Programs Office or online at
http://healthpei.ca/pharmacareforms.

Metadol - see Methadone

Methadone, tablet, 1mg, 5mg, 10mg, 25mg (Metadol-PMS)
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)
For treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and
older who:
  • Have experienced unsatisfactory results due to poor symptom control, side effects,
    administrative barriers and/or societal barriers. AND
  • Have been tried on methylphenidate (immediate release or long-acting formulation) or
dexamphetamine (immediate release or long-acting formulation) with unsatisfactory
results.

Must be prescribed or recommended by a pediatrician, psychiatrist, or general
practitioner with expertise in the treatment of ADHD.

The maximum daily approved dosage will be 1mg/kg/day to a maximum of 80mg per
day.

Methylphenidate HCL, extended release tablet, 18mg, 27mg, 36mg, 54mg (Concerta-JAN

PEI Pharmacare Formulary ........................................................................Page - 326 -
and generics)
For treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older who:
• Have experienced unsatisfactory results due to poor symptom control, side effects, administrative barriers and/or societal barriers. AND
• Have been tried on methylphenidate (immediate release or long-acting formulation) or dexamphetamine (immediate release or long-acting formulation) with unsatisfactory results.

Must be prescribed or recommended by a pediatrician, psychiatrist, or general practitioner with expertise in the treatment of ADHD.

Only appropriate dosing as shown in the current Compendium of Pharmaceuticals and Specialties (CPS) will be considered.

Midodrine HCl, tablet, 2.5mg, 5mg (Generic)
For the treatment of neurogenic types of idiopathic orthostatic hypotension, that is in the Bradbury-Eggleston or Shy-Drager Syndromes.

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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

Migranal - see Dihydroergotamine Mesylate

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 tolerodine 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 12 years of age and older 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

**Montelukast, chewable tablet, 4mg, 5mg; tablet, 10mg (Singulair-MSD and generics)**

For the adjunctive treatment of asthma in patients not well controlled with regular use of inhaled corticosteroids. Only appropriate dosing as shown in the current Compendium of Pharmaceuticals and Specialties (CPS) will be considered.

**Monoval – 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 (Avelox-BAY and 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, capsule, 120mg, 240mg (Tecfidera-BGN)**
- **Glatiramer Acetate, syringe, 20mg/mL (Copaxone-TEV)**
- **Interferon Beta-1A, injection powder, 30mcg (Avonex-BGN); pre-filled syringe, 30mcg (Avonex PS-BGN); 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); injection powder, 0.3mg (Extavia-NVR)**
Peginterferon Beta-1A, SC injection, 63/94mcg/0.5ml, 125mcg/0.5ml (Plegridy-BGN)
Teriflunomide, tablet, 14mg (Aubagio-GZY)

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 using the PEI Multiple Sclerosis Medications Program Medical Screening Form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Patients must also apply for coverage using the PEI Multiple Sclerosis Medications Program Patient Application Form. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms

Fingolimod, capsule, 0.5mg (Gilenya-NVR and generics)

For the treatment of patients with Relapsing Remitting Multiple Sclerosis (RRMS) who meet all of the following criteria:

a) Failure to respond to full and adequate courses* of at least one disease modifying therapy (DMT) publicly insured under PEI Pharmacare as an initial therapy, or has intolerance** to at least two initial publicly funded therapies.

b) One or more clinically disabling relapses in the previous year.

c) Significant increase in T2 lesion load compared with that from a previous MRI scan (i.e. 3 or more new lesions) or at least one gadolinium-enhancing lesion.

d) Requested and followed by a neurologist experienced in the management of RRMS.

e) Recent Expanded Disability Status Scale (EDSS) score of less than or equal to 5.5 (i.e. patients must be able to ambulate at least 100 meters without assistance)

* Failure to respond to full and adequate courses: defined as a trial of at least 6 months of a publicly funded DMT AND experienced at least one disabling relapse (attack) while on a publicly funded DMT (MRI report does not need to be submitted with the request).

**Intolerance is defined as: documented serious adverse effects or contraindications that are incomplete with further use of that class of drug.

Dosage: 0.5 mg once daily
Approval period: Up to 12 months

**Exclusion Criteria:**

a) Do not fund combination therapy of Gilenya with other disease modifying therapies (e.g. Avonex, Betaseron, Copaxone, Rebif, Extavia, 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 using the PEI Multiple Sclerosis Medications Program Medical Screening Form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms)

Patients must also apply for coverage using the PEI Multiple Sclerosis Medications Program Patient Application Form. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms)

**Alemtuzumab, vial, 12mg/1.2ml (Lemtrada-GZY)**

For the management of adult patients with relapsing-remitting multiple sclerosis (RRMS), with active disease defined by clinical and imaging features, who have had an inadequate
response to two other disease-modifying therapies (DMT’s), except for when any other DMT is contraindicated or unsuitable, if the following clinical criteria are met:

- At least two attacks (first episode or relapse) in the previous two years, with at least one attack in the previous year;
- At least one relapse while on at least six months of two different disease modifying therapies within the last 10 years; except for when any other DMT is contraindicated or unsuitable,
- An Expanded Disability Status Scale (EDSS) score of five (5) or less;
- Prescribed by a specialist with experience in the treatment of multiple sclerosis

The request for coverage must be made by a neurologist using the PEI Multiple Sclerosis Medications Program Medical Screening Form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Patients must also apply for coverage using the PEI Multiple Sclerosis Medications Program Patient Application Form. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms

Myrbetriq – see Mirabegron

Nabilone, capsules, 0.5mg, 1mg (Cesamet-VAL and generics)
   a) 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.
   b) For the treatment of acquired immune deficiency syndrome (AIDS)-related anorexia associated with weight loss.

Nabumetone, tablets, 500mg (Relafen-GSK and generics)
   For patients requiring treatment with an NSAID where there has been failure or intolerance to at least three NSAIDS (including at least one enteric coated NSAID).

Nalcrom - see Sodium Cromoglycate

Naltrexone, tablet, 50mg (Revia-TEV and generics)
   For the treatment of alcohol dependence, as an adjunct to a comprehensive psychotherapeutic or psychological alcoholism counseling program to support abstinence, and reduce the risk of relapse.

Eligibility is initially restricted to a three month period with reassessment at that time for further coverage. Continued coverage will require information on the outcome of therapy as well as the patient’s compliance with treatment programs.

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.

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.

Neupogen - see Filgrastrim
Neupro – see Rotigotine
Nexavar - see Sorafenib

Nilotinib, capsule, 150mg, 200mg (Tasigna-NVR)
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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at
Nilutamide, tab, 50mg (Anandron-AVN)
In the treatment of metastatic prostatic carcinoma (Stage D2) in conjunction with surgical or chemical castration.

Nintedanib, capsule, 100mg, 150mg (Ofev-BOE)
**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 (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 Idiopathic Pulmonary Fibrosis Special Authorization form which is available from the Drug Programs office or on-line at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Nitoman - see Tetrabenazine

Nizoral - see Ketoconazole
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)

Norprolac – see Quinagolide

Nucala – see Mepolizumab

Ocuflox - see Ofloxacin

Ocriplasmin, 0.5mg/2ml, vial (Jetrea-ALC)
For the treatment of symptomatic vitreomacular adhesion (VMA) if the following clinical criteria and conditions are met:
Clinical Criteria:
   • Diagnosis of VMA should be confirmed through optical coherence tomography
   • Patient does not have any of the following: large diameter macular holes (>400 micrometre), high myopia (>8 dioptre spherical correction or axial length > 28 millimetre), aphakia, history of retinal detachment, lens zonule instability, recent ocular surgery or intraocular injection (including laser therapy), proliferative diabetic retinopathy, ischemic retinopathies, retinal vein occlusions, exudative age related macular degeneration, or vitreous hemorrhage.
Conditions:
   • Ocriplasmin should be administered by a retinal specialist.
   • Treatment with ocriplasmin should be limited to a single injection per eye (i.e. retreatments are not covered).

Octreotide, injection, 200ug/mL (5mL) (Sandostatin-NVR)
For the management of terminal malignant bowel obstruction.

Ofev – see Nintedanib

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.

Olanzapine, orally disintegrating tablet, 5mg, 10mg, 15mg (Zyprexa Zydis-LIL and
For the treatment of patients with schizophrenia and related psychotic disorders and the acute treatment of manic or mixed episodes in bipolar disorder:
(a) Upon prescription by a psychiatrist or geriatrician; or
(b) From other practitioners in consultation with a psychiatrist or geriatrician. Consultation with the psychiatrist or geriatrician may be in person or by phone. A statement such as A prescribed in consultation with Dr. ***** will be required on the prescription or if ordered by telephone, the pharmacist must request and include the name of the consulting psychiatrist or geriatrician on the transcribed prescription.

For the treatment of patients with schizophrenia and related psychotic disorders and the acute treatment of manic or mixed episodes in bipolar disorder upon written request or recommendation of a psychiatrist or geriatrician. A copy of the recommendation must accompany the Special Authorization.

Omalizumab, vial, 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 must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Omeprazole** - see Proton Pump Inhibitors

**Onabotulinumtoxina, injection, 200units/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)**

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:

- Experienced adverse effects to Metoclopramide, Prochlorperazine, or Dexamethasone or have a specific contraindication which does not allow use of these drugs as antiemetics or,

- 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:

- 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

**Osimertinib, tablet, 40mg, 80mg (Tagrisso-AZE)**

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:
1. Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.
2. Prior treatment with EGFR TKI therapy is not required in patients with de novo T790M mutation-positive NSCLC.

Prescriptions written by PEI oncologists do not require Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Oxeze** - see Formoterol

**Oxybutynin Chloride, extended release tablet, 5mg, 10mg (Ditropan XL-JAN)**

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.

**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.

**Ozempic** – see Semaglutide

**Palbociclib, capsule, 75mg, 100mg, 125mg (Ibrance-PFI)**
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

**Paliperidone, injection, 50mg, 75mg, 100mg, 150mg (Invega Sustenna-JAN)**
For the treatment of schizophrenia or schizoaffective disorder in patients who have:
- A history of non adherence  
  OR  
- Inadequate control or significant side effects from two or more oral antipsychotic medications  
  OR  
- 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.

**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

**Pazopanib, tablet, 200mg (Votrient-GSK)**
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 Special Authorization.*

*Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).*

**Pentosan Polysulfate Sodium, capsule, 100mg (Elmiron-JAN)**
For the treatment of interstitial cystitis where other treatments have failed.

**Perampanel, tablet, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg (Fycompa-EIS)**
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.

**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.

**Pioglitazone, tablet, 15mg, 30mg, 45mg (Actos-LIL and generics)**
For the treatment of patients diagnosed with type 2 diabetes, and who have:

a) Inadequate glycemic control on optimal doses of Sulfonylurea and Metformin; **OR**
b) Demonstrated intolerance or contraindication to Metformin and are on optimal doses
of Sulfonylurea; OR

c) Demonstrated intolerance or contraindication to Sulfonylurea and are on optimal doses of Metformin.

1 Most recent (within the past 12 months) HbA1c required: >7% and <10%. The addition of a thiazolidinedione would not be expected to decrease the HbA1c to satisfactory levels in patients with a HbA1c greater than 10.

2 Maximum doses: Metformin 2500mg/day, Chlorpropamide 500mg/day, Gliclazide regular tablets 320 mg/day, Gliclazide modified-release tablets 120 mg/day, Glimepiride 4mg/day, Glyburide 20 mg/day.

3 Metformin: Intolerance - GI adverse effects; Contraindications - renal impairment (SrCr > 130mmol/L) or hepatic failure, acute or chronic metabolic acidosis.

4 Sulfonylureas: Intolerance - Hypoglycemia; Contraindications - sulfa allergy, severe renal insufficiency (CrCl < 50mL/min).

**Pirfenidone, capsule, 267mg, tablet, 267mg, tablet, 801mg (Esbriet-HLR)**

**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 Idiopathic Pulmonary Fibrosis Special Authorization form which is available from the Drug Programs office or on-line at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**
Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

Plaque Psoriasis Biologic Agents

**Adalimumab, kit, 40mg/0.8ml (Humira-ABV)**
Approvals will be for a maximum adult dose of 80 mg administered once, followed by 40 mg after 1 week of initial dose, then 40 mg 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.

**Brodalumab, syringe, 210mg/1.5ml (Siliq-VAL)**
Approvals will be for a maximum adult dose of 210 mg administered at 0, 1 and 2 weeks followed by 210 mg every 2 weeks. If response criteria is met at 16 weeks, approval will be continued at a dose of 210 mg every two weeks up to one year.

**Etanercept, pre-filled syringe, 50mg/ml; injection powder, 25mg/kit (Enbrel-AMG)**
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 up to one year.

**Infliximab, injection powder, 100mg/vial (Inflectra-HOS; Remicade-JAN; Renflexis-MSD)**
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 5 mg/kg every 8 weeks up to one year.

**Ixekizumab, autoinjector, syringe, 80mg/ml (Taltz-LIL)**
Approvals will be for a maximum adult dose of 160 mg at week 0, followed by 80 mg 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.

**Risankizumab, prefilled syringe, 75mg/0.83ml (Skyrizi-ABV)**
Approvals will be for a maximum adult dose of 150 mg (two 75 mg injections) 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 150 mg every 12 weeks up to one year.

**Secukinumab, syringe or pen, 150mg/ml (Cosentyx-NVR)**
Approvals will be for a maximum adult dose of 300 mg at weeks 0, 1, 2 and 3 followed by monthly maintenance dosing starting at week 4, up to 12 weeks. If response criteria is met at 12 weeks, approval will be continued to a maximum dose of 300 mg every month up to one year.
**Ustekinumab, syringe, 45mg/0.5ml, 90mg/ml (Stelara-JAN)**

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.

For the treatment of patients with chronic moderate to severe plaque psoriasis who meet all of the following criteria:

- Psoriasis Area Severity Index (PASI) > 10; and Dermatology Life Quality Index (DLQI) > 10; or
- Major involvement of visible areas, scalp, genitals, at least two finger nails, presence of itch leading to scratching or the presence of recalcitrant plaques; AND
- Refractory, intolerant or have contraindications to:
  - Phototherapy (unless restricted by geographic location); and
  - 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

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:

- Combined use of more than one biologic DMARD will not be reimbursed
- Maximum dosages as per existing criteria on the PEI Pharmacare Formulary
- Initial approval: 16 weeks. Renewal approval: 1 year. Confirmation of continued response is required

**Requests for Plaque Psoriasis Biologic Agents must be requested by a dermatologist using the Plaque Psoriasis Special Authorization form which is available from the Drug Programs office or on-line at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Plegridy** – see Multiple Sclerosis Agents

**Pomalidomide, capsule, 1mg, 2mg, 3mg, 4mg (Pomalyst-CEL)**

For patients with relapsed and/or refractory multiple myeloma who have previously failed at least two treatments, including both bortezomib and lenalidomide and demonstrated

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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 Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Pomalyst** – see Pomalidomide

**Ponatinib – tablet, 15mg (Iclusig-ARI)**
For the treatment of patients with chronic, accelerated or blast phase chronic myelogenous leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL) who have:
- resistance or intolerance to two or more tyrosine kinase inhibitors (TKIs), OR
- confirmed T315i mutation positive disease.
**Clinical Notes:**
1. Patients must have an ECOG performance status of ≤2.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Pulmozyme** – see Dornase Alfa

**Pradaxa** – see Dabigatran

**Prasugrel, tablet, 10mg (Effient-LIL)**
For use in combination with ASA for patients with:
- ST-elevated myocardial infarction (STEMI) undergoing primary percutaneous coronary intervention (PCI) who have not received antiplatelet therapy prior to arrival in the catheterization lab. Treatment must be initiated in hospital.
  OR
- Acute coronary syndrome who failed on optimal clopidogrel and ASA therapy as defined by definite stent thrombosis, or recurrent STEMI or UA after prior revascularization via PCI.
  Approval: up to 12 months

**Prevacid** - see Proton Pump Inhibitors
**Prevacid Fastab** - see Proton Pump Inhibitors

**Prolia** – see Denosumab

**Proton Pump Inhibitors**

- Lansoprazole, delayed release capsule, 15mg, 30mg (Prevacid-ABB and generics);
- Lansoprazole, delayed release tablet, 15mg, 30mg (Prevacid Fastab-ABB);
- Omeprazole, capsule, 20mg (Losec-AZE and generics);
- Omeprazole, delayed release tablet, 20mg (Losec-AZE and generics);
- Pantoprazole Magnesium, enteric tablet, 40mg (Tecta-TAK and generics);
- Pantoprazole Sodium, enteric tablet, 20mg, 40mg (Pantoloc-TAK and generics);
- Rabeprazole, tablet, 10mg, 20mg (Pariet-JAN and generics)

* Doses of Omeprazole 20mg daily, Pantoprazole Magnesium 40mg daily, Pantoprazole Sodium 20mg or 40mg up to one unit daily, and up to Rabeprazole 20mg daily DO NOT require a Special Authorization.

For doses of Omeprazole and Rabeprazole greater than 20mg per day and greater than 40mg per day of Pantoprazole Magnesium, greater than one unit/day of Pantoprazole Sodium 20mg or 40mg, and all doses of Lansoprazole **WHERE** evidence is provided of resistance to two recent 12 week trials (ie within 6 months) of a standard dose (20mg daily) of Omeprazole, Rabeprazole, Pantoprazole Magnesium 40mg daily and greater than one unit per day of Pantoprazole Sodium 20mg or 40mg.

Up to 12 weeks of therapy will be considered for
a) Gastric and Duodenal Ulcers
b) Esophagitis

g) Erosive Esophagitis
d) Barrett’s Esophagitis
e) Zollinger-Ellison Syndrome
f) Helicobacter pylori Eradication – Up to 14 days of twice daily dosing for clients who are registered in an eligible Pharmacare Program, are symptomatic and have a documented positive Helicobacter Pylori test

**Protopic** - see Tacrolimus

**Psoriatic Arthritis Biologic Agents**

- **Adalimumab**, kit, 40mg/0.8ml (Humira-ABV)
  Approvals will be for a maximum adult dose of 40mg every two weeks.

- **Certolizumab**, syringe kit, 400mg/2ml; auto-injector kit, 400mg/2ml (Cimzia-UCB)
  Approvals will be for a maximum adult dose of 400mg (given as two Sc injections of
200mg) given at 0, 2, 4 weeks then 200mg every 2 weeks thereafter.

**Etanercept, pre-filled syringe, 50mg/ml (Enbrel-AMG; Erelzi-SDZ); injection powder, 25mg/kit (Enbrel-AMG); pen injector, 50mg/ml (Erelzi-SDZ); syringe, 25mg/0.5ml (Erelzi-SDZ)**

Approvals will be for a maximum adult dose of 50mg per week or 25 mg twice weekly.

**Golimumab, Syringe, 50mg/0.5ml; auto-injector, 50mg/0.5ml (Simponi-MSD)**

Approvals will be for a maximum adult dose of 50mcg once monthly.

**Infliximab, injection powder, 100mg/vial (Inflectra-HOS; Remicade-JAN; Renflexis-MSD)**

Approvals will be for a maximum adult dose of 5mg/kg at 0, 2, and 6 weeks then every 8 weeks thereafter.

**Ixekizumab, auto-injector, syringe, 80mg/ml (Taltz-LIL)**

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.

**Secukinumab, syringe or pen, 150mg/ml (Cosentyx-NVR)**

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).

- 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.

- 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:
• Combined use of more than one biologic DMARD will not be reimbursed.
• Initial approval duration and maximum dosages as per existing criteria on the PEI Pharmacare Formulary.
• Initial approval 16 weeks. Renewal approval: 1 year. Confirmation of continued response is required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Psoriatic Arthritis Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at http://healthpei.ca/pharmacareforms

Pulmicort Nebuamps - see Budesonide

| Quetiapine, tablet, 25mg, 100mg, 150mg, 200mg, 300mg (Seroquel-AZE and generics) |
|---------------------|---------------------------------------------------------------|
| Family Health Benefit and Financial Assistance Programs (No Special Authorization Required) | Nursing Home Program, Seniors Drug Program, Catastrophic Drug Program & Generic Drug Program (Special Authorization) |
| For the treatment of patients with schizophrenia and related psychotic disorders and the acute treatment of manic or mixed episodes in bipolar disorder: | For the treatment of patients with schizophrenia and related psychotic disorders and the acute treatment of manic or mixed episodes in bipolar disorder upon written request or recommendation of a psychiatrist or geriatrician. **A copy of the recommendation must accompany the Special Authorization.** |
| (a) Upon prescription by a psychiatrist or geriatrician; or | |
| (b) From other practitioners in consultation with a psychiatrist or geriatrician. Consultation with the psychiatrist or geriatrician may be in person or by phone. **A statement such as APrescribed in Consultation With Dr. **** will be required on the prescription or if ordered by telephone, the pharmacist must request and include the name of the consulting psychiatrist or geriatrician on the transcribed prescription.** | |
Quinagolide, tablet, 75mcg, 150mcg (Norprolac-FEI)
For the treatment of patients with hyperprolactinemia who have failed or are intolerant to bromocriptine.

Rabeprazole - see Proton Pump Inhibitors

Ranibizumab, vial, 2.3mg/ 0.23ml  (Lucentis-NVR)

1. Neovascular Age-Related Macular Degeneration

   Initial Coverage (loading dose for 3 consecutive months):
   For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) where all of the following apply:
   a) Best Corrected Visual Acuity (BCVA) is between 6/12 and 6/96 AND
   b) The lesion size is less than or equal to 12 disc areas in greatest linear dimension AND
   c) There is evidence of recent (< 3 months) presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, optical coherence tomography (OCT), or recent visual acuity changes.

   The interval between doses should not be shorter than one month. Administration is to be done by a qualified ophthalmologist experienced in intravitreal injections.

   Criteria For Continued Coverage:
   Treatment with ranibizumab should be continued only in people who maintain adequate response to therapy.
   Ranibizumab should be discontinued if any of the following occur:
   a) Reduction in BCVA in the treated eye to less than 15 letters (absolute) on 2 consecutive visits in the treated eye, attributed to AMD in the absence of other pathology OR
   b) Reductions in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect, adverse events, or both OR
   c) There is evidence of deterioration of the lesion morphology despite optimum treatment over 3 consecutive visits.

   Coverage will not be approved for patients :
   a) Receiving concurrent treatment with verteporfin.
   b) With permanent retinal damage as defined by the Royal College of Ophthalmology guidelines.

   Coverage is limited to a maximum of one vial per eye in any 30 day period. Coverage must be renewed every 12 months.

2. Diabetic macular edema (DME)

   Initial coverage:
   For the treatment of visual impairment due to diabetic macular edema (DME) in patients
who meet all of the following criteria:

- clinically significant centre-involving macular edema for whom laser photocoagulation is also indicated
- hemoglobin A1c test in the past 6 months with a value of less than or equal to 11%
- best corrected visual acuity of 20/32 to 20/400
- central retinal thickness greater than or equal to 250 micrometers

Renewal Criteria:

- confirm that a hemoglobin A1c test in the past 6 months had a value of less than or equal to 11%
- date of last visit and results of best corrected visual acuity at that visit
- date of last OCT and central retinal thickness on that examination
- if ranibizumab is being administered monthly, please provide details on the rationale

Clinical Notes:

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 three consecutive treatments.
4. Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year

3. Retinal vein occlusion (RVO)

For the treatment of visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (BRVO).

Clinical Notes:

1. Treatment should be given monthly until maximum visual acuity is achieved (i.e. stable visual acuity for three consecutive months). Thereafter, visual acuity should be monitored monthly.
2. Treatment should be resumed when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive months.
3. Treatment should be discontinued if there is no improvement after 6 months of initial treatment.
4. Injection will be by a qualified ophthalmologist with experience in administering intravitreal injections.

Approval Period: 1 year
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 must apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at**

[http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms)

*Rebif* - see Multiple Sclerosis Agents

*Relafen* - see Nabumetone

*Remicade* – see Crohn’s Disease Biologic Agents (pediatric indication)

*Renagel* - see Sevelamer

*Rexulti* – see Brexpiprazole

*Revatio* - see Sildenafil

*ReVia* - see Naltrexone

*Revlimid* – see Lenalidomide

*Requip* - see Ropinirole

**Rheumatoid Arthritis Biologic Agents**

*Abatacept, vial, 250mg; 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.
**Abatacept, syringe, 125mg/ml (Orencia-BMS)**
For adult Orencia-naïve patients, a single loading dose of up to 1000mg, then 125mg sc injection should be given within a day, and once weekly thereafter.

**Adalimumab, pre-filled syringe, 40mg/0.8mL (Humira-ABV)**
Maximum adult dose is 40mg every two weeks.

For the treatment of Polyarticular Juvenile Idiopathic Arthritis (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.

**Certolizumab, syringe kit, 400mg/2ml; auto-injector kit, 400mg/2ml (Cimzia-UCB)**
Maximum adult dose for Rheumatoid Arthritis is 400mg (given as two sc injections of 200mg) given at 0, 2, 4 weeks then 200mg every 2 weeks thereafter.

*Initial approval is three (3) months.

**Etanercept, injection powder, 25mg/kits (Enbrel-AMG); pre-filled syringe, 50mg/ml; auto-injector, 25mg/0.5ml (Erelzi-SDZ); 50mg/ml (Brenzys-MSD; Erelzi-SDZ)**
Maximum adult dose is 50mg weekly or 25mg twice weekly.
For Etanercept-naïve adult patients whose etanercept therapy is initiated after November 27, 2017, Brenzys or Erelzi will be the product approved.
Erelzi will be approved for pediatric patients 4-17 years of age, and coverage is for 0.8mg/kg/weekly to a maximum of 50mg weekly.

**Golimumab, Syringe, 50mg/0.5ml; auto-injector, 50mg/0.5ml (Simponi-MSD)**
Approvals will be for a maximum adult dose of 50mcg once monthly.

**Infliximab, injection powder, 100mg/vial (Inflectra-HOS; Remicade-JAN; Renflexis-MSD)**
Approvals for adults is 3mg/kg/dose given at 0, 2, and 6 weeks, and then every 8 weeks thereafter.

**Sarilumab, syringe, 150mg/1.14ml, 200mg/1.14ml; pen, 150mg/1.14ml, 200mg/1.14ml (Kevzara-AVN)**
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.

**Tocilizumab, IV Vial, 80mg/4ml, 200mg/10ml, 400mg/20ml, 162mg/0.9ml (Actemra-HLR)**
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.

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) at a dose of ≥ 20 mg weekly (≥15mg if patient is ≥65 years of age), (or use in combination with another DMARD) 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 of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 6 months
- Renewal Approval: 1 year. Confirmation of continued response is required.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Rifaximin, tablet, 550mg (Zaxine-LUP)
For reducing the risk of overt hepatic encephalopathy (HE) recurrence (i.e., 2 or more episodes), if the following clinical criteria are met:

Clinical Criteria:
• Patients are unable to achieve adequate control of HE recurrence with maximal tolerated dose of lactulose alone.
• Must be used in combination with maximal tolerated doses of lactulose.
• For patients not maintained on lactulose, information is required regarding the nature of the patient’s intolerance to lactulose.

**Riociguat, tablet, 0.5mg, 1mg, 1.5mg, 2mg, 2.5mg (Adempas-BAY)**
For the treatment of inoperable chronic thromboembolic pulmonary hypertension (CTEPH, World Health Organization [WHO] Group 4) or persistent or recurrent CTEPH after surgical treatment in adult patients (>18 years of age) with WHO Functional Class (FC) II or III pulmonary hypertension (PH).
Should be prescribed by a clinician with experience in the diagnosis and treatment of CTEPH.

**Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Rituximab, vial, 10mg/ml (Rituxan-HLR)**
Maximum adult dose is 1000 mg by IV infusion followed two weeks later by the second 1000 mg IV infusion.

For the treatment of adult patients with severe active **Rheumatoid Arthritis** who have failed to respond to an adequate trial with an anti-TNF agent.
  a) Rituximab will NOT be considered in combination with other biologic agents.
  b) Approval for re-treatment with rituximab will only be considered for patients who have achieved a response, followed by a subsequent loss of effect and, after an interval of no less than six months from the previous dose.

For the induction of remission in patients with severely active granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) who have severe intolerance or other contraindication to cyclophosphamide, or who have failed an adequate trial of cyclophosphamide.

**The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

**Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).**

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Risedronate 5mg & 35mg - see Bisphosphonates

Risedronate, tablet, 30mg (Actonel-PGA and generics)
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

Risperdal M-Tab - see Risperidone orally disintegrating tablet

Risperidone, orally disintegrating tablet, 0.5mg, 1mg, 2mg, 3mg, 4mg (Risperdal M-Tab-JAN and generics)
Coverage will be limited to patients who are unable to use regular Risperidone tablets.

Risperidone, prolonged release injection, 12.5mg/2mL, 25mg/2mL, 37.5mg/2mL, 50mg/2mL (Risperdal Consta-JAN)
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.

Rituxan – see Rheumatoid Arthritis Biologic Agents

Rituximab – see Rheumatoid Arthritis Biologic Agents

Rivaroxaban, tablet, 10mg, 15mg, 20mg (Xarelto-BAY)
For the treatment of venous thromboembolism (DVT and PE) and prevention of recurrent DVT and PE, for a duration of up to six months.

For the prophylaxis of venous thromboembolism (VTE) following total knee replacement surgery for up to 14 days after surgery or total hip replacement surgery for up to 35 days after surgery as an alternative to low molecular weight heparins. The maximum dose of rivaroxaban that will be reimbursed is 10 mg daily.

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 rivaroxaban for atrial fibrillation:

a) Patients with impaired renal function (creatinine clearance or estimated glomerular filtration rate <30 mL/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\textsuperscript{2} score of ≥ 1. Although the ROCKET-AF trial included patients with higher CHADS\textsuperscript{2} scores (≥2), other landmark studies with the other newer oral anticoagulants demonstrated a therapeutic benefit in patients with a CHADS\textsuperscript{2} score of 1. Prescribers may consider an antiplatelet regimen or oral anticoagulation for patients with a CHADS\textsuperscript{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 rivaroxaban product monograph).

4. Documented stable renal function is defined as creatinine clearance or estimated glomerular filtration rate that is maintained for at least three months (i.e. 30-49 mL/min for 15 mg once daily dosing or ≥ 50 mL/min for 20 mg once daily dosing).

5. There is currently no data to support that rivaroxaban provides adequate anticoagulation in patients with rheumatic valvular disease or those with prosthetic heart valves, so rivaroxaban is not recommended in these populations.

6. Patients starting rivaroxaban should have ready access to appropriate medical services to manage a major bleeding event.

The request for coverage must be made using the Apixaban, Edoxaban, Dabigatran, Rivaroxaban Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Rivastigmine - see Cholinesterase Inhibitors (ChEI)
Ropinirole, tablet, 0.25mg, 1mg, 2mg, 5mg (Requip-GSK and generics)
Note: For Nursing Home Program, no Special Authorization is required.

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.

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.

Rufinamide, tablet, 100mg, 200mg, 400mg (Banzel-EIS)
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.

Ruxolitinib, tablet, 5mg, 10mg, 15mg, 20mg (Jakavi-NVR)
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.

Prescriptions written by PEI oncologists do not require Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

Rydapt – see Midostaurin

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, 25μg & 125μg per dose, 25μg & 250μg per dose (Advair-GSK); inhaled powder disk, 50μg & 100μg per dose, 50μg & 250μg per dose, 50μg & 500μg 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 corticosteroid therapy prior to the request for combination therapy. Continuation of current coverage requires regular use of an adequate dose of this medication.
  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.

Sandostatin - see Octreotide

Sarilumab – see Rheumatoid Arthritis Biologic Agents

Saxagliptin, tablet, 2.5mg, 5mg (Onglyza-AZE)
  For the treatment of type 2 diabetes as a third drug added on to metformin and a sulfonylurea for patients with inadequate glycemic control on optimal doses of metformin and a sulfonylurea, and for whom insulin is not an option.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.
Saxagliptin & Metformin Hydrochloride, 2.5mg/500mg, 2.5mg/850mg/2.5mg/1000mg (Komboglyze-AZE)
For patients with type 2 diabetes for whom insulin is not an option and who are already stabilized on therapy with metformin, a sulfonylurea and saxagliptin, to replace the individual components of saxagliptin and metformin in these patients.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Secukinumab – see Ankylosing Spondylitis Biologic Agents or see Plaque Psoriasis Biologic Agents or see Psoriatic Arthritis Biologic Agents

Seebri Breezhaler – see Glycopyrronium Bromide

Selexipag, tablet, 200mcg, 400mcg, 600mcg, 800mcg, 1000mcg, 1200mcg, 1400mcg, 1600mcg (Uptravi-ACT)
For the long-term treatment of idiopathic pulmonary arterial hypertension (PAH), heritable PAH, PAH associated with connective tissue disorders, and PAH associated with congenital heart disease, in adult patients with World Health Organization (WHO) functional class (FC) II to III to delay disease progression, if the following clinical criterion and conditions are met:
• Inadequate control with a first and second-line PAH therapy
• Prescribed by a clinician with experience in the diagnosis and treatment of PAH

NOTE:
Combination therapy with prostacyclin or prostacyclin analogs therapies will not be covered

Patients must also apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

Semaglutide, pen injector, 0.25-0.5mg, 1mg (Ozempic-NNO)
For the treatment of type 2 diabetes in combination with metformin and a sulfonylurea, when diet and exercise plus dual therapy with metformin and a sulfonylurea do not achieve adequate glycemic control.

Serc - see Betahistine

Serevent - see Salmeterol

Serevent Diskus - see Salmeterol

Seroquel - see Quetiapine

Sevelamer carbonate, tablet, 800mg (Accel-Sevelamer)
For the treatment of hyperphosphhetemia (>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 hyperphosphatemia (>1.8 mmol/L) in patients with end stage renal disease (eGFR<15ml/min) who have:
- Inadequate control of phosphate levels on a calcium based phosphate binder, or
- Hypercalcemia (corrected for albumin), or
- Calciphylaxis (calcific arteriolopathy)

**NOTE**
Initial approval for 6 months, renewed at 1 year intervals with demonstration of clinically meaningful improvement of phosphate levels (lab values must be provided).

**Sildenafil, tablet, 20mg (Revatio-PFI and generics)**
For the treatment of patients with World Health Organization (WHO) functional class III idiopathic pulmonary arterial hypertension (IPAH) who do not demonstrate vasoreactivity on testing or who do demonstrate vasoreactivity on testing but fail a trial of calcium channel blockers.

For the treatment of patients with World Health Organization (WHO) functional class III pulmonary arterial hypertension (PAH) associated with connective tissue diseases who do not respond to conventional therapy.

Diagnosis of PAH should be confirmed by cardiac catheterization.

Coverage must be requested and medications prescribed by a Pulmonary Arterial Hypertension (PAH) specialist.

**Claim Note:**
The maximum dose of sildenafil that will be reimbursed is 20mg three times daily.

**Patients requesting coverage through the High-Cost Drug Program must submit a patient application, available from the Drug Programs Office or online at**
[http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Siliq** – see Plaque Psoriasis Biologic Agents

**Simponi** – see Ankylosing Spondylitis Biologic Agents OR
see Psoriatic Arthritis Biologic Agents OR
see Rheumatoid Arthritis Biologic Agents
Sinemet CR - see Levodopa & Carbidopa

Singulair - see Montelukast

Sitagliptin, tablet, 25mg, 50mg, 100mg (Januvia-MSD)
For the treatment of type 2 diabetes as a third drug added on to metformin and a sulfonylurea for patients with inadequate glycemic control on optimal doses of metformin and a sulfonylurea, and for whom insulin is not an option.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Sitagliptin & Metformin Hydrochloride, tablet, 50mg/500mg, 50mg/850mg, 50mg/1000mg, (Janumet-MSD)
For the treatment of type 2 diabetes for patients for whom insulin is not an option and who are already stabilized on therapy with metformin, a sulfonylurea and sitagliptin, to replace the individual components of sitagliptin and metformin.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Sitagliptin & Metformin Hydrochloride, extended release tablet, 50mg/500mg, 50mg/1000mg, 100mg/1000mg, (Janumet XR-MSD)
For the treatment of type 2 diabetes for patients for whom insulin is not an option and who are already stabilized on therapy with metformin, a sulfonylurea and sitagliptin, to replace the individual components of sitagliptin and metformin.

The request for coverage must be made using the DPP-4/SGLT2 Inhibitors Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms.

Skyrizi – see Plaque Psoriasis Biologic Agents

Sodium Cromoglycate, capsule, 100mg (Nalcrom-AVN)
For the treatment of patients who experience severe reactions to foods which cannot be avoided.

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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Soriatane - see Acitretin

Spiriva - see Tiotropium

Spiriva Respimat – see Tiotropium

Sporanox - see Itraconazole

Sprycel - see Dasatinib

Stalevo – see Carbidopa & Levodopa & Entacapone

Stelara – see Plaque Psoriasis Biologic Agents

Stiripentol, capsules, powder for inhalation, 250mg, 500mg (Diacomit-BIO)
For use in combination with clobazam and valproate as adjunctive therapy of refractory generalized tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy (Dravet syndrome), whose seizures are not adequately controlled with clobazam and valproate alone.
The patient must be under the care of a neurologist or a pediatrician.

Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

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)**

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.

**Prescriptions written by PEI oncologists do not require Special Authorization.**

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

- **Sutent** - see Sunitinib
- **Symbicort Turbuhaler** - see Formoterol & Budesonide
- **Synjardy** – see Empagliflozin & Metformin
- **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.

- **Tafinlar** – see Dabrafenib
- **Tagrisso** – see Osimertinib
Tarceva – Erlotinib

Tasigna – see Nilotinib

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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

Terbinafine, tablet, 250mg; cream, 1% (Lamisil-GSK and various generics)
For the treatment of severe onychomycosis caused by dermatophyte fungi.

Testim – see Testosterone

Testosterone, transdermal gel, 25mg/2.5gm packet, 50mg/5gm packet (AndroGel-BGP); 50mg/5gm tube (Testim-PAL)
For the treatment of congenital and acquired primary or secondary hypogonadism in males with a specific diagnosis of:
Primary - Cryptorchidism, Klinefelter's, orchiectomy, and other established causes.
Secondary - Pituitary-hypothalamic injury due to tumors, trauma, radiation. Testosterone deficiency should be clearly demonstrated by clinical features and confirmed by two separate biochemical tests before initiating any testosterone therapy. Limited to 5 g/day gel.

Older males with non-specific symptoms of fatigue, malaise or depression who have low testosterone (T) levels do not satisfy these criteria.

Testosterone Undecanoate, capsule, 40mg (Generics)
For patients with a documented deficiency in whom treatment with depo-testosterone products have been unsuccessful, intolerable or are medically contraindicated.

Tetrabenazine, tablet, 25mg (Nitoman-PRS and generics)
For the treatment of hyperkinetic movement disorders such as Huntington's chorea, Hemiballismus, Senile Chorea, Tic and Gille's de la Tourette Syndrome and Tardive Dyskinesia.
Tofacitinib, tablet, 5mg (Xeljanz-PFI); extended release tablet, 11mg (Xeljanz XR-PFI)
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) at a dose of ≥ 20mg weekly (≥ 15mg in patient is ≥ 65 years of age), (or use in combination with another DMARD) for a minimum of 12 weeks
AND
Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks
NOTE:
Must be prescribed by a rheumatologist.
Combined use of more than one biologic DMARD will not be reimbursed.

The request for coverage must be made by a rheumatologist or prescriber with a specialty in rheumatology, using the Rheumatoid Arthritis Special Authorization form available from the Drug Programs office or online at http://healthpei.ca/pharmacareforms

Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at http://healthpei.ca/pharmacareforms

Topamax – see Topiramate

Topiramate, 15mg, 25mg, sprinkle capsule (Topamax-JAN)
For patients who require topiramate, cannot take the tablet form, and require sprinkle capsules for proper administration

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 clients 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)**
To be taken in combination with ASA 75mg -150mg daily 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**
- STEMI patients undergoing primary PCI

**NSTEMI or Unstable Angina**
- Presence of high risk features irrespective of intent to perform revascularization:
  - High GRACE risk score (>140)
  - High TIMI risk score (5-7)
  - Second ACS within 12 months
  - Complex or extensive coronary artery disease e.g. diffuse three vessel disease
  - Definite documented cerebrovascular or peripheral vascular disease
  - Previous CABG

OR

- Undergoing PCI + high risk angiographic anatomy

**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, 162mg/0.9ml (Actemra-HLR)**
- see Rheumatoid Arthritis Biologic Agents for adult information

**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.
- Continued coverage will be dependent on a positive patient response as determined by a pediatric rheumatologist. Initial approval period: 16 weeks. Renewal period: 1 year

**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.
- Continued coverage will be dependent on a positive patient response as determined by a pediatric rheumatologist. Initial approval period: 16 weeks. Renewal period: 1 year
Patients must also apply for coverage through the High-Cost Drug Program. The patient application is available from the Drug Programs Office or online at http://healthpei.ca/pharmacareforms.

**Toujeo** – see insulin Glargine

**Tracleer** - see Bosentan

**Trajenta** – see Linagliptin

**Trametinib, tablet, 0.5mg, 2mg (Mekinist-NVR)**
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 an ECOG performance status of 0 or 1.
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 Special Authorization.**

**Trelegy Ellipta** – see Fluticasone & Umeclidinium & Vilanterol

**Tretinoin, capsule, 10mg (Vesanoid – ROC)**
For the treatment of leukemia (Acute Promyelocytic Leukemia) in combination with arsenic trioxide (Trisenox) in the first-line setting as a treatment for the induction of remission and/or consolidation of low to intermediate risk acute promyelocytic leukemia (APL) and as a consolidation treatment for high risk APL after induction with ATRA plus chemotherapy for patients with the t(15;17) translocation and PML/RAR-alpha gene expression.

**Prescriptions written by PEI oncologists do not require Special Authorization.**

**Trileptal** - see Oxcarbazepine
**Trosec** - see Trospium

**Trospium, tablet, 20mg (Trosec-SNV)**
For the treatment of over-active bladder (not stress incontinence) after a reasonable trial (e.g. 3 months) of immediate release oxybutynin, solifenacin, or tolterodine is not tolerated.

**Turdoze Genuair** – see Aclidinium Bromide

**Twinject** - see Epinephrine

**Ulcerative Colitis Biologic Agents**
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: As per induction approval.
- Renewal Approval: 1 year.

**Adalimumab, pre-filled syringe, 40mg/0.8mL (Humira-ABV)**
Initial 8 week approval is 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 Ulcerative Colitis Special Authorization form. Continued coverage will be approved at a dose not exceeding 40mg.
every 2 weeks.

**Infliximab, injection powder, 100mg/vial (Inflectra-HOS; Remicade-JAN; Renflex-MSD)**

Initial approval is for 3 doses of 5mg/kg/dose administered at 0, 2, and 6 weeks. Renewal of coverage will require reassessment of the patient and submission of a new Ulcerative Colitis Special Authorization form. Continued coverage may be approved at a dose not exceeding 5mg/kg every 8 weeks.

**Vedolizumab, vial, 300mg (Entyvio-TAK)**

Initial approval is for induction doses of 300mg at weeks 0, 2, and 6. 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.

The request for coverage must be made by a gastroenterologist using the Ulcerative Colitis Special Authorization form available from the Drug Programs office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

Patients must also apply for coverage to the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at [http://healthpei.ca/pharmacareforms](http://healthpei.ca/pharmacareforms).

**Ultibro Breezhaler** – see Indacaterol & Glycopyrronium

**Uptravi** – see Selexipag

**Urispas** - see Flavoxate

**Urso** - see Ursodiol

**Ursodiol, tablet, 250mg, 500mg (Urso-ALL and generics)**

(a) For the dissolution of radiolucent, noncalcified gallstones of less than 20mm in size in patients who cannot undergo a cholecystectomy.

(b) For the management of cholestatic liver disease such as primary biliary cirrhosis.

**Ustekinumab** – see Plaque Psoriasis Biologic Agents

**Valcyte** - see Valganciclovir

**Valganciclovir, tablet, 450mg (Valcyte-HLR 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 +).

**Velaglucerase alfa, vial, 400 unit (VPRIV-SHR)**

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PEI Pharmacare Formulary .................................................................Page - 368 -
For patients with Gaucher disease type 1 (GD1) who meet established clinical criteria.

**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 Special Authorization.**

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

**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 Special Authorization.

Patients must apply for coverage by the High-Cost Drug Program. The patient application is available from the Drug Program Office or online at http://healthpei.ca/pharmacareforms.

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.

Votrient – see Pazopanib

VPRIV – see Velaglucerase Alfa

Vyvanse – see Lisdexamfetamine

Xalkori – see Crizotinib

Xeljanz – see Tofacitinib

Xeljanz XR – see Tofacitinib

Xarelto – see Rivaroxaban

Xigduo – see Dapagliflozin and Metformin HCL

Xolair – see Omalizumab

Xtandi – see Enzalutamid

Zaxine – see Rifaximin

Zelboraf – see Venurafenib

Ziprasidone hydrochloride. Capsule, 20mg, 40mg, 60mg, 80mg (Zeldox-PFI and generic)
For the treatment of schizophrenia and schizoaffective disorders in patients who have a contraindication to a trial of at least TWO less expensive antipsychotic agents because of intolerance or lack of response.
**Zithromax** - see Azithromycin

**Zofran** - see Ondansetron

**Zoledronic acid, injection, 5mg/100mL (Aclasta-NVR)**

1. For the treatment of Paget’s disease of the bone
2. For the treatment of osteoporosis in postmenopausal women who:
   - Have experienced further significant decline in bone mineral density (BMD) after 1 year of continuous oral bisphosphonate therapy.
   - OR
   - Have experienced serious intolerance to oral bisphosphonates.
   - OR
   - Have a contraindication to oral bisphosphonates.

Note: Serious intolerance is defined as esophageal ulceration, erosion or stricture, or lower gastrointestinal symptoms severe enough to cause discontinuation of oral bisphosphonates, or swallowing disorders that will increase the risk of esophageal ulceration from oral bisphosphonates.

**Zymar** – see Gatifloxacin

**Zyprexa** - see Olanzapine

**Zyprexa Zydis** - see Olanzapine

**Zytiga** – see Abiraterone

**Zyvoxam** - see Linezolid
APPENDIX B
Links to Drug Program Forms

Special Authorization Forms
Alzheimer’s Special Authorization Form
Ankylosing Spondylitis Special Authorization Form
Apixaban, Dabigatran, Edoxaban, Rivaroxaban Special Authorization Form
Crohn’s Disease Special Authorization Form
DPP-4/SGLT2 Inhibitors
Enfuvirtide Special Authorization Form
Idiopathic Pulmonary Fibrosis Special Authorization Form
Long Acting Insulin Analogues Special Authorization Form
Low Molecular Weight Heparin Special Authorization Form
Multiple Sclerosis Medications Program Special Authorization Form
Plaque Psoriasis Special Authorization Form
Psoriatic Arthritis Special Authorization Form
Rheumatoid Arthritis Special Authorization Form
Standard Special Authorization Form
Ulcerative Colitis Special Authorization Form

Program Application Forms
Catastrophic Drug Program Application Form
Diabetes Referral Form
Erythropoietin Program Approval Form
Family Health Benefits Drug Program - Application Form
High-Cost Drug Program - Application Form
Home Oxygen Program - Application Form
Ostomy Supplies Program Application Form
Ostomy Supplies Program Registration Form for Health Care Providers
## APPENDIX C  List of Manufacturer Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Company Name</th>
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<tr>
<td>AAA</td>
<td>AA Pharmaceuticals Inc.</td>
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<tr>
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<td>Abbott Laboratories Ltd.</td>
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<td>ABC</td>
<td>Abbott Diabetes Care</td>
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<td>Abbvie Corporation</td>
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<td>ACC</td>
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<td>MDA Inc.</td>
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<td>MFI</td>
<td>Medical Futures Inc.</td>
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<td>MNT</td>
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<tr>
<td>MJS</td>
<td>Mead Johnson Canada, Division of Bristol-Myers Squibb Canada Inc.</td>
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<td>MRS</td>
<td>Merus Labs</td>
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<td>MSD</td>
<td>Merck Frosst Canada Ltd.</td>
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<td>Nova Biomedical Corp.</td>
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<td>Novo Nordisk Canada Inc.</td>
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<td>NOP</td>
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<td>NVR</td>
<td>Novartis Pharmaceuticals Canada Inc.</td>
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<td>ODN</td>
<td>Odan Laboratories Ltd.</td>
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<td>OMG</td>
<td>Omega Laboratories Ltd.</td>
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<tr>
<td>ORI</td>
<td>Orimed Pharma</td>
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</table>
# Appendix D Approved Vendors List

*Revised January 21st, 2015*

## Animas Canada Insulin Pumps and Supplies

<table>
<thead>
<tr>
<th>Device Name</th>
<th>Model Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>One Touch® Ping® Glucose Management System (Pump and Meter Remote)</td>
<td>101-56x-51</td>
<td>2.0 ml Insulin Pump and Wireless Meter Remote</td>
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<tr>
<td></td>
<td></td>
<td>• Blue (0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Black (1)</td>
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<tr>
<td></td>
<td></td>
<td>• Silver (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pink (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Green (5)</td>
</tr>
<tr>
<td>Animas® Vibe™ Insulin Pump</td>
<td>112-51x-51</td>
<td>2.0 ml Insulin Pump</td>
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<tr>
<td></td>
<td></td>
<td>• Blue (0)</td>
</tr>
<tr>
<td></td>
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<tr>
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<td>• Silver (2)</td>
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<tr>
<td></td>
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<td>• Pink (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Green (5)</td>
</tr>
<tr>
<td>Animas 2.0 ml cartridge</td>
<td>100-124-51</td>
<td>2.0 cartridge (10/box)</td>
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<tr>
<td>Inset® 30</td>
<td>100-396-xx</td>
<td>13 mm teflon cannula infusion set with 60cm (23”) tubing  (10 cannula and 10 tubing / box)</td>
</tr>
<tr>
<td>• Angled infusion set (30° angle of insertion)</td>
<td></td>
<td>• Grey (00)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Blue (01)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pink (02)</td>
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<td>100-396-33</td>
<td>13 mm teflon cannula infusion set with 110 cm (43”) tubing  (10 cannula and 10 tubing / box)</td>
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<td>• Grey only</td>
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<tr>
<td>Inset® II</td>
<td>100-410-xx</td>
<td>6 mm teflon cannula infusion set with 60cm (23”) tubing  (10 cannula and 10 tubing / box)</td>
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<td>• Straight infusion set (90° angle of insertion)</td>
<td></td>
<td>• Grey (00)</td>
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<tr>
<td></td>
<td></td>
<td>• Blue (01)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pink (02)</td>
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<tr>
<td></td>
<td>100-411-xx</td>
<td>9 mm teflon cannula infusion set with 60cm (23”) tubing  (10 cannula and 10 tubing / box)</td>
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<tr>
<td></td>
<td></td>
<td>• Grey (00)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Blue (01)</td>
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<tr>
<td></td>
<td></td>
<td>• Pink (02)</td>
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<tr>
<td></td>
<td>100-412-00</td>
<td>6 mm teflon cannula infusion set with 110 cm (43”) tubing  (10 cannula and 10 tubing / box)</td>
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</tbody>
</table>
### Grey only
- 9mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
- 17mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)
- 17mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
- 17mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 5 tubing / box)
- 17mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 5 tubing / box)
- 6mm needle infusion set with 60cm (23") tubing (10 needles & 10 tubing / box)
- 8mm needle infusion set with 60cm (23") tubing (10 needles & 10 tubing / box)
- 6mm needle infusion set with 110cm (43") tubing (10 needles & 10 tubing / box)
- 8mm needle infusion set with 110cm (43") tubing (10 needles & 10 tubing / box)

### Comfort™
- Angled Infusion Set (20° - 45° angle of insertion)
- 17mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)
- 17mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
- 17mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 5 tubing / box)
- 17mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 5 tubing / box)

### Comfort Short
- Angled Infusion Set (20° - 45° angle of insertion) Short 13mm cannula
- 13mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 10 tubing / box)
- 13mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 10 tubing / box)
- 13mm teflon cannula infusion set with 60cm (23") tubing (10 cannula and 5 tubing / box)
- 13mm teflon cannula infusion set with 110cm (43") tubing (10 cannula and 5 tubing / box)

### Contact Detach
- Needle infusion set (90° angle of insertion)
- 6mm needle infusion set with 60cm (23") tubing (10 needles & 10 tubing / box)
- 8mm needle infusion set with 60cm (23") tubing (10 needles & 10 tubing / box)
- 6mm needle infusion set with 110cm (43") tubing (10 needles & 10 tubing / box)
- 8mm needle infusion set with 110cm (43") tubing (10 needles & 10 tubing / box)

### Additional supplies – Skin Preparation and Skin Tape
<table>
<thead>
<tr>
<th>Skin Prep</th>
<th>594-204-25</th>
<th>Adhesive wipes (box of 50)</th>
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<tr>
<td>Remove Wipes</td>
<td>403120</td>
<td>Adhesive remover wipes (box of 50)</td>
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<td>Skin Tac</td>
<td>100-144-00</td>
<td>Tacky adhesive wipes (box of 50)</td>
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<tr>
<td>Bioclusive Transparent Dressing</td>
<td>ANM2461</td>
<td>Transparent dressing / tape (100 / box)</td>
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### Medtronic of Canada Insulin Pumps and Supplies

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<tr>
<th>Device Name</th>
<th>Model Number</th>
<th>Description</th>
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<tr>
<td>MiniMed®Paradigm ®Veo® Insulin Pump</td>
<td>MMT-554xxx</td>
<td>Pump 1.8 mls reservoir capacity</td>
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<tr>
<td></td>
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<tr>
<td></td>
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<td>• Pink (CMH)</td>
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<td></td>
<td></td>
<td>• Clear (CML)</td>
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<tr>
<td>Reservoir for 5 series MiniMed® Paradigm® Pump</td>
<td>MMT-326A</td>
<td>1.76 mls reservoir for use in either 5 or 7 series Paradigm Insulin Pump (10 reservoirs /box)</td>
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<tr>
<td>Reservoir for 7 Series MiniMed® Paradigm® Pump</td>
<td>MMT-332A</td>
<td>3.0 mls reservoir for use in 7 series Paradigm Insulin Pump only (10 reservoirs /box)</td>
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<td>Quick –Serter</td>
<td>MMT-395</td>
<td>Insertion device for Quickset infusion sets</td>
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<tr>
<td>Sil-Serter</td>
<td>MMT -385</td>
<td>Insertion device for Silhouette infusion sets</td>
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<td>Quickset® Infusion Sets</td>
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<tr>
<td>• 6mm or 9mm cannula</td>
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<tr>
<td>MMTP-394600</td>
<td>6 mm teflon cannula infusion set with 45cm (18”) tubing (10 cannula and 10 tubing / box)</td>
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<tr>
<td>MMTP-399600</td>
<td>6 mm teflon cannula infusion set with 60cm (23”) tubing (10 cannula and 10 tubing / box)</td>
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<tr>
<td>MMTP-387600</td>
<td>6 mm teflon cannula infusion set with 80cm (32”) tubing (10 cannula and 10 tubing / box)</td>
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<td>MMTP-398600</td>
<td>6 mm teflon cannula infusion set with 110cm (43”) tubing (10 cannula and 10 tubing / box)</td>
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<td>MMTP-397600</td>
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<tr>
<td>MMTP-386600</td>
<td>9 mm teflon cannula infusion set with 80cm (32”) tubing (10 cannula and 10 tubing / box)</td>
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<td>MMTP-396600</td>
<td>9 mm teflon cannula infusion set with 110cm (43”) tubing (10 cannula and 10 tubing / box)</td>
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<tr>
<td>mio™ Infusion Sets</td>
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<td>• All in one infusion set and insertion device</td>
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<tr>
<td>• 6mm or 9mm cannula</td>
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<td>MMTP-921600</td>
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<tr>
<td>MMTP-941600</td>
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<td>Silhouette® Infusion Sets</td>
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<td>MMT-383600</td>
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<td>17 mm teflon cannula infusion set with 80cm (32”) tubing (10 cannula and 10 tubing / box)</td>
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</tr>
<tr>
<td>MMT-377600</td>
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<tr>
<td>MMT-862</td>
<td>6mm needle infusion set with 45cm (18”) tubing (10 needles &amp; 10 tubing / box)</td>
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<td>MMT-864</td>
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<tr>
<td>MMT-874</td>
<td>8mm needle infusion set with 60cm (23”) tubing (10 needles &amp; 10 tubing / box)</td>
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</table>

**Sure-T Infusion Sets**
- Needle infusion set
- (90° angle of insertion)

**Additional supplies – Skin Preparation and Skin Tape**

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Skin Prep Wipes</td>
<td>HMS-59420425</td>
<td>Adhesive wipes (box of 50)</td>
</tr>
<tr>
<td>Transparent dressing</td>
<td>HMS-66800786</td>
<td>Adhesive transparent dressing (box of 30)</td>
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**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