BULLETIN # 112

Manitoba Drug Benefits and Interchangeability Formulary Amendments

The following amendments will take effect on August 5, 2021

The amended Manitoba Specified Drug Regulation and Drug Interchangeability Formulary Regulation will be available on the Manitoba Health website *http://www.gov.mb.ca/health/mdbif* on the effective date of August 5, 2021

Bulletin 112 is currently available for download:
http://www.gov.mb.ca/health/mdbif/bulletin112.pdf

Please also refer to the psv/excel files* found on the Manitoba Health website under "Notices" here:

https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html

***The psv/excel files contain the following information: DIN, PRODUCT NAME, UNIT PRICE (List Price + 5%) & LOWEST GENERIC PRICE (List Price + 5%)**

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Part 1 Additions

DIN	TRADE NAME	GENERIC	STRENGTH	FORM	MFR*
02450860 02450879 02450887 02450895 02450909	**ACH Quetiapine Fumarate XR**	quetiapine	50 mg 150 mg 200 mg 300 mg 400 mg	Extended Release Tablets	ACH
02480778	**AG-Pregabalin**	pregabalin	300 mg	Capsule	ANP
02510987	**Apo-Fluticasone HFA**	fluticasone propionate	250 mcg	Inhaler	APX
02297574 02453061	**Apo-Perindopril-Indapamide**	perindopril/indapamide	4 mg/1.25 mg 8 mg/2.5 mg	Tablet	APX
02467895 02467909 02467917	**Aermony Respiclick**	fluticasone propionate	55 mcg 113 mcg 232 mcg	Inhaler	TEV
02500213	**Auro-Buspirone**	buspirone	10 mg	Tablet	AUP
02436299 02436302	**Celecoxib**	celecoxib	100 mg 200 mg	Capsule	SAH
02357194 02357208	**Jamp-Amlodipine**	amlodipine	5 mg 10 mg	Tablet	JPC
02507110 02507129	**Jamp Lamivudine**	lamivudine	150 mg 300 mg	Tablet	JPC
02495783	**Jamp Methadone**	methadone HCl	10 mg/mL	Oral Solution	JPC
02392623	**Jamp Pantoprazole Sodium**	pantoprazole	40 mg	Tablet	JPC
02498340 02498359 02498367	**Jamp Rosuvastatin Calcium**	rosuvastatin	10 mg 20 mg 40 mg	Tablet	JPC
02497557	**Jamp Sodium Polystyrene Sulfonate**	sodium polystyrene sulfonate	1 mEq/g	Powder	JPC
02440598	**Jamp Valacyclovir**	valacyclovir	500 mg	Tablet	JPC
02504472	**Letrozole**	letrozole	2.5 mg	Tablet	SAH
02476177 02476185	**Mar-Flecainide**	flecainide	50 mg 100 mg	Tablet	MAR
02464365	**Methotrexate** *(with preservatives)*	methotrexate	25 mg/mL	Injection	ACH
02496828	**Mint-Leucovorin**	leucovorin	5 mg	Tablet	MPH
02479117 02479125 02479133 02479168	**NRA-Pregabalin**	pregabalin	25 mg 50 mg 75 mg 150 mg	Capsule	NRA
02486237	**NRA-Quetiapine**	quetiapine	25 mg	Tablet	NRA
02486172 02486180 02486199	**NRA-Ramipril**	ramipril	2.5 mg 5 mg 10 mg	Capsule	NRA
02477491 02477505 02477513	**NRA-Rosuvastatin**	rosuvastatin	10 mg 20 mg 40 mg	Tablet	NRA
02488434 02488442 02488450	**NRA-Sertraline**	sertraline	25 mg 50 mg 100 mg	Capsule	NRA

02504146 02504138	**NRA-Telmisartan HCTZ**	telmisartan/HCTZ	80/12.5 mg 80/25 mg	Tablet	NRA
02477378 02477386	**NRA-Zopiclone**	zopiclone	5 mg 7.5 mg	Tablet	NRA
02495872	**Odan-Methadone *(cherry flavoured)***	methadone HCl	10 mg/mL	Oral Solution	ODN
02495880	**Odan-Methadone *(unflavoured)***	methadone HCl	10 mg/mL	Oral Solution	ODN
02504294	**Omeprazole**	omeprazole	20 mg	Tablet	SAH
02464640 02464659	**pms-Fluoxetine**	fluoxetine	40 mg 60 mg	Capsule	PMS
02503131	**pms-Fluticasone HFA**	fluticasone propionate	250 mcg	Inhaler	PMS
02380897	**pms-Nabilone**	nabilone	0.25 mg	Capsule	PMS
02499622 02499630	**pms-Telmisartan**	telmisartan	40 mg 80 mg	Tablet	PMS
02458543	**pms-Zopiclone**	zopiclone	3.75 mg	Tablet	PMS
02493039 02493047	**PRZ-Solifenacin**	solifenacin	5 mg 10 mg	Tablet	PRZ
02506882	**Sandoz Ciprofloxacin/ Dexamethasone**	ciprofloxacin/ dexamethasone	0.3 %/0.1 %	Otic Suspension	SDZ
02481979	**Sandoz Methadone**	methadone HCl	10 mg/mL	Oral Solution	SDZ
02284723 02284731 02284758 02284766 02284774	**Simvastatin**	simvastatin	5 mg 10mg 20 mg 40 mg 80 mg	Tablet	SAH
02392925	**Teva-Nabilone**	nabilone	0.25 mg	Capsule	TEV
02508087	**Tri-Cira 21**	ethinyl estradiol/ norgestimate	-	Tablet	APX
02508095	**Tri-Cira 28**	ethinyl estradiol/ norgestimate	-	Tablet	APX
02502593 02502607	**Vancomycin Hydrochloride**	vancomycin	500 mg 1 G	Powder for Injection	JPC

Part 2 Additions

02492490	**AG-Rizatriptan ODT**	rizatriptan	10 mg	Orally Disintegrating Tablet	ANP

For the treatment of ACUTE migraine attacks in patients where standard therapy has failed.
- to a maximum of 144 tablets per benefit year.

02244290	**Metadol-D *(moved from Part 1)***	methadone HCl	10 mg/mL	Oral Solution	PAL

For treatment of patients who:
a) are being treated with Metadol-D, or
b) have previously been treated with two or more methadone products listed under Part 1.

02394596	**Methadose** ***(moved from Part 1)***	methadone HCl	10 mg/mL	Oral Solution	MCU
02394618	**Methadose** ***(unflavoured)*** ***(moved from Part 1)***	methadone HCl	10 mg/mL	Oral Solution	MCU

For treatment of patients who:
a) are being treated with Methadose, or
b) have previously been treated with two or more methadone products listed under Part 1.

02480018	**Olumiant**	baricitinib	2 mg	Tablet	LIL

For the treatment of patients 18 years of age or older who have moderate to severe active rheumatoid arthritis and have:
- failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide, unless intolerance or contraindications to these agents is documented,
- tried one combination therapy of DMARDS, and
- documented disease activity (such as the number of tender joints, the number of swollen joints, the erythrocyte sedimentation rate or the C-reactive protein value).

NOTE: Coverage will be provided only if prescribed by a specialist in rheumatology.

02490587	**Priva-Dustasteride**	dutasteride	0.5 mg	Capsule	PRZ

For the treatment of symptomatic benign hyperplasia.

Part 3 Additions

The following products will be considered for Pharmacare reimbursement upon an individual prescriber/patient request basis.

02464276 02464284	**Adlyxine**	lixisenatide	10 mcg 20 mcg	Injection	SAA

For treatment of type 2 diabetes in combination with a basal insulin with or without metformin in patients who have been uncontrolled on, or are intolerant to, a sulfonylurea and metformin.

02459310 02459299 02459302	**Amegvita** *(biosimilar)*	adalimumab	50 mg/mL	Injection	AMA

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients.
Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

• Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
• Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine and 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.
Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients.
Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried.
Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:
• Psoriasis Area and the Severity Index (PASI) ≥ 10
• Body Surface Area (BSA) > 10%
• Significant involvement of the face, hands, feet or genital region
• Dermatology Life Quality Index (DLQI) > 10 AND
• Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:
• ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI
• ≥ 75 % reduction in the PASI score
• ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:
• A total abscess and nodule count of 3 or greater
• Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
• An inadequate response to a 90-day trial of oral antibiotics
• Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

02455897	**Apo-Cabergoline**	cabergoline	0.5 mg	Tablet	APX
02242471	**Dostinex**	cabergoline	0.5 mg	Tablet	PAL

For treatment of:
a) Hyperprolactinemic disorders in patients unresponsive to bromocriptine.
b) Hyperprolactinemic disorders in patients intolerant to bromocriptine.

02507471 02507498	**Apo-Saxagliptin**	saxagliptin	2.5 mg 5 mg	Tablet	APX
02468603 02468611	**Sandoz Saxagliptin**	saxagliptin	2.5 mg 5 mg	Tablet	SDZ

For the treatment of patients with type 2 diabetes who have previously been treated with metformin and a sulfonylurea. Should be used in patients with diabetes who are not adequately controlled on or intolerant to metformin and a sulfonylurea, and for whom insulin is not an option.

02470365 02492504 02510049	**Dupixent**	dupilumab	150 mg/mL 200 mg/1.14 mL 150 mg/mL	Injection	SAA

For the treatment of atopic dermatitis only if the following conditions are met;

Initiation Criteria

• Patients aged 12 years and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.
• Patients must have had an adequate trial or be ineligible for each of the following therapies: phototherapy (where available), methotrexate, and cyclosporine.
• Patients who have had an adequate trial of phototherapy, methotrexate, and/or cyclosporine must have documented refractory disease or intolerance.
• The physician must provide the Eczema Area and Severity Index (EASI) score and Physician Global Assessment score at the time of initial request for reimbursement.
• The maximum duration of initial authorization is six months.

Renewal Criteria

• The physician must provide proof of beneficial clinical effect when requesting continuation of reimbursement, defined as a 75% or greater improvement from baseline in the EASI score (EASI-75) six months after treatment initiation.
• The physician must provide proof of maintenance of EASI-75 response from baseline every six months for subsequent authorizations.

Prescribing Conditions

• The patient must be under the care of a dermatologist.
• Dupilumab is not to be used in combination with phototherapy or immunosuppressant drugs, such as methotrexate or cyclosporine.

02496135	**Fasenra** *(new format)*	benralizumab	30 mg/mL	Injection	AZC

As add-on maintenance treatment for adult patients with severe eosinophilic asthma, if the following criteria are met:

Initiation Criteria

1. Patient must have a documented diagnosis of asthma.
2. Patient is inadequately controlled with high-dose inhaled corticosteroids, defined as greater or equal to 500 mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists).
3. Patient has one of the following:
   3.1. 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
   3.2. blood eosinophil count of ≥ 150 cells/μL AND is receiving maintenance treatment with oral corticosteroids (OCS).

Administration Criteria

1. Benralizumab should not be used in combination with other biologics used to treat asthma.
2. A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of benralizumab treatment.
3. Patients should be managed by a physician with expertise in treating asthma.

Renewal Criteria

1. The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue.
2. Reimbursement of treatment should be discontinued if:
   2.1. the 12 month asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment, or
   2.2. the asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
   2.3. the number of clinically significant exacerbations has increased within the previous 12 months, or
   2.4. in patients on maintenance treatment with OCS, there has been no decrease in the OCS dose in the first 12 months of treatment, or
   2.5. 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.

02473097 02473100	**Hadlima** *(biosimilar)*	adalimumab	40 mg/0.8 mL	Injection	SBC

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

• Presence of fistula that has persisted despite a course of antibiotic therapy (e.g.ciprofloxacin and/or metronidazole) AND
• Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried.
Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis
For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Ankylosing Spondylitis
For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Psoriasis
For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:
• Psoriasis Area and the Severity Index (PASI) ≥ 10
• Body Surface Area (BSA) > 10%
• Significant involvement of the face, hands, feet or genital region
• Dermatology Life Quality Index (DLQI) > 10 AND
• Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:
• ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI
• ≥ 75 % reduction in the PASI score
• ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis
For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab

Ulcerative Colitis
For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa
For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:
• A total abscess and nodule count of 3 or greater
• Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
• An inadequate response to a 90-day trial of oral antibiotics
• Prescribed by a practitioner with expertise in the management of patients with HS □

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

02502399 02502402	**Hulio** *(biosimilar)*	adalimumab	40 mg/0.8 mL	Injection	BGP

Crohn's Disease
For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology

For Adults: Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease
For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:
• Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND □
• Have had inadequate response, intolerance or contraindications to an□immunosuppressive agent (e.g. azathioprine □ or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis
For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis
For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Ankylosing Spondylitis
For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Psoriasis
For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:
• Psoriasis Area and the Severity Index (PASI) ≥ 10
• Body Surface Area (BSA) > 10%
• Significant involvement of the face, hands, feet or genital region
• Dermatology Life Quality Index (DLQI) > 10 AND
• Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:
• ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI
• ≥ 75 % reduction in the PASI score
• ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

• A total abscess and nodule count of 3 or greater
• Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III □
• An inadequate response to a 90-day trial of oral antibiotics
• Prescribed by a practitioner with expertise in the management of patients with HS □

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab.

02492156 02492164 02505258	**Hyrimoz** *(biosimilar)*	adalimumab	40 mg/0.8 mL 40 mg/0.8 mL 20 mg/0.4 mL	Injection	SDZ

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

• Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND □
• Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or □ 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis
For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis
For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Ankylosing Spondylitis
For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Psoriasis
For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:
• Psoriasis Area and the Severity Index (PASI) ≥ 10
• Body Surface Area (BSA) > 10%
• Significant involvement of the face, hands, feet or genital region
• Dermatology Life Quality Index (DLQI) > 10 AND
• Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:
• ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI
• ≥ 75 % reduction in the PASI score
• ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis
For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab

Ulcerative Colitis
For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa
For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:
• A total abscess and nodule count of 3 or greater
• Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III □
• An inadequate response to a 90-day trial of oral antibiotics
• Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

02502674	**Idacio** *(biosimilar)*	adalimumab	40 mg/0.8 mL	Injection	FKC

Crohn's Disease
For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease
For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:
• Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
• Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis
For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
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Psoriatic Arthritis
For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
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Ankylosing Spondylitis
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Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
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Psoriasis
For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:
• Psoriasis Area and the Severity Index (PASI) ≥ 10
• Body Surface Area (BSA) > 10%
• Significant involvement of the face, hands, feet or genital region
• Dermatology Life Quality Index (DLQI) > 10 AND
• Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:
• ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI
• ≥ 75 % reduction in the PASI score
• ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis
For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab

Ulcerative Colitis
For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa
For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:
• A total abscess and nodule count of 3 or greater
• Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III □
• An inadequate response to a 90-day trial of oral antibiotics
• Prescribed by a practitioner with expertise in the management of patients with HS □

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naive patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

02504596 02504618	**Imatinib**	imatinib	100 mg 400 mg	Tablet	SAH
02495066 02495074	**Jamp Imatinib**	imatinib	100 mg 400 mg	Tablet	JPC

Criteria may be obtained from the EDS office at Manitoba Health.

02507501 02507528 02507536 02507544 02507552 02507560 02507579	**Inclunox** *(biosimilar)*	enoxaparin sodium	30 mg/0.3 mL 40 mg/0.4 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/1 mL 120 mg/0.8 mL 150 mg/1 mL	Injection	SDZ
02507560 02507579	**Inclunox-HP** *(biosimilar)*	enoxaparin sodium	120 mg/0.8 mL 150 mg/1 mL	Injection	SDZ

Criteria may be obtained from the EDS office at Manitoba Health

02502305	**Jamp Abiraterone**	abiraterone	250 mg	Tablet	JPC
02503980 02503999	**Mar-Abiraterone**	abiraterone	250 mg 500 mg	Tablet	MAR
02477114	**Reddy-Abiraterone**	abiraterone	250 mg	Tablet	DRL

For the treatment of histologically confirmed metastatic castrate-resistant prostate cancer with disease progression after prior androgen deprivation therapy OR with disease progression after prior chemotherapy with Docetaxel.

02503727	**Jamp Modafinil**	modafinil	100 mg	Tablet	JPC

As per Alertec criteria (http://www.gov.mb.ca/health/mdbif/edsnotice.pdf).

02469669	**Jamp-Sildenafil R**	sildenafil R	20 mg	Tablet	JPC

When prescribed by a specialist in the treatment of Pulmonary Arterial Hypertension (PAH) for the following indications noted in WHO Group 1 PAH:
1. Idiopathic Pulmonary Arterial Hypertension (IPAH) in WHO functional class II or III, OR
2. PAH secondary to connective tissue disease in patients with WHO functional class II or III
3. Indications associated with pulmonary arterial hypertension secondary to congenital heart disease (CHD) in patients who have not responded to conventional therapy or tolerated other treatments.

Note:Diagnosis of PAH should be confirmed by right heart catheterization.
The maximum daily dosage allowed for coverage of sildenafil is 20 mg three times daily.
On written request by PAH specialist only.

02511673 02511681	**Mar-Mycophenolic Acid**	mycophenolic acid	180 mg 360 mg	Tablet	MAR

For the prophylaxis of organ rejection in patients receiving allogeneic renal transplants.

02467550	**Maviret** *(criteria update)*	glecaprevir/pibrentasvir	100/40 mg	Tablet	ABV

For treatment-naïve or treatment-experienced adult patients with chronic hepatitis C genotype 1, 2, 3, 4, 5 or 6 infection. Complete criteria may be obtained from the EDS office at Manitoba Health.

Request for coverage must be made by a hepatologist, gastroenterologist or an infectious disease specialist.

02499568 02499576 02499584 02499592	**NRA-Lacosamide**	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet	NRA

For use as an adjunctive therapy in patients in the management of refractory partial-onset seizures (POS) in adult patients with epilepsy who are not satisfactorily controlled with conventional therapy and who meet all of the following criteria:
(a) are under the care of a physician experienced in the treatment of epilepsy,
(b) are currently receiving two or more antiepileptic drugs, and
(c) in whom all other antiepileptic drugs are ineffective or not appropriate.

02499193 02499207 02499215	**NRA-Levetiracetam**	levetiracetam	250 mg 500 mg 750 mg	Tablet	NRA

As an add-on anticonvulsant or for control of pain where initiated by a pain clinic and where other similar agents have failed e.g. gabapentin, lamotrigine, valproic acid or topiramate.

02496348	**Nubeqa**	darolutamide	300 mg	Tablet	BAY

In combination with androgen-deprivation therapy (ADT) for the treatment of patients with non-metastatic castration-resistant prostate cancer (nmCRPC) who are at high risk of developing metastases. High risk is defined as a prostate-specific antigen doubling time (PSADT) of ≤ 10 months during continuous ADT and castration-resistant according to the Prostate Cancer Working Group 2 (PCWG2) criteria which was used in the ARAMIS trial. Absence of metastases was determined by a negative CT scan and negative bone scan. Patients should have good performance status.
Treatment should continue until unacceptable toxicity or radiographic disease progression.

02509075 02509083 02509091 02509105 02509113 02509121	**Redesca** *(biosimilar)*	enoxaparin sodium	30 mg/0.3 mL 40 mg/0.4 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/mL 300 mg/3 mL	Injection	VPI
02509148 02509156	**Redesca HP** *(biosimilar)*	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Injection	VPI

Criteria may be obtained from the EDS office at Manitoba Health

02478293	**Soliqua**	insulin glargine/lixisenatide	100 U/33 mcg	Injection	SAA

For treatment of patients with type 2 diabetes who would be eligible for Adlyxine but will also be treated with a basal insulin (less than 60U/day) to achieve adequate glycemic control.

02499282 02499304 02499312 02499320 02499339	**Taro-Dasatinib**	dasatinib	20 mg 50 mg 70 mg 80 mg 100 mg	Tablet	TAR

According to CancerCare Manitoba treatment protocols

02495732	**Vyndaqel**	tafamidis meglumine	20 mg	Capsule	PFI

For the treatment of adult patients with cardiomyopathy due to transthyretin (TTR)-mediated amyloidosis.
Complete criteria may be obtained from the EDS office at Manitoba Health.

02495058	**Xospata**	gilteritinib	40 mg	Tablet	ASP

For the treatment of adult patients who have relapsed or refractory AML with a FLT3 mutation.

Eligible patients include adults with relapsed or refractory AML whose FLT3 mutation status is confirmed by a validated test and who have good performance status.

Treatment with gilteritinib should continue as long as clinical benefit is observed or until unacceptable toxicity occurs. In the absence of disease progression or unacceptable toxicity, treatment may be given for a minimum of six months to determine clinical benefit as a delay in clinical response can occur.

New Interchangeable Categories

Cabergoline - 0.5 mg - Tablets			$	$ + 5%
02242471	Dostinex	PAL	19.7588	20.7467
02455897	Apo-Cabergoline	APX	12.3940	13.0137

Ethinyl Estradiol/Norgestimate - 0.035/0.18 mg, 0.035/0.215 mg, 0.035/0.25 mg - Tablets			$	$ + 5%
02508087	Tri-Cira 21	APX	0.6852	0.7195
02486296	Tri-Jordyna 21	GLM	0.6852	0.7195

Ethinyl Estradiol/Norgestimate - 0.035/0.18 mg, 0.035/0.215 mg, 0.035/0.25 mg - Tablets			$	$ + 5%
02508095	Tri-Cira 28	APX	0.5139	0.5396
02486318	Tri-Jordyna 28	GLM	0.5139	0.5396

Fluticasone Propionate - 250 mcg - Metered Dose Inhaler			$	$ + 5%
02244293	Flovent HFA	GSK	0.7804	0.8194
02510987	Apo-Fluticasone HFA	APX	0.3752	0.3940
02503131	pms-Fluticasone HFA	PMS	0.3752	0.3940

Methotrexate - 25 mg/mL - Injection			$	$ + 5%
02182777	Methotrexate	PFI	9.7257	10.2120
02464365	Methotrexate	ACH	3.1220	3.2781

Mirtazapine - 45 mg - Tablets			$	$ + 5%
02411717	Auro-Mirtazapine	AUP	1.1250	1.1813
02286637	Apo-Mirtazapine	APX	0.6930	0.7277

Nabilone - 0.25 mg - Capsules			$	$ + 5%
02312263	Cesamet	BHC	1.9196	2.0156
02380897	pms-Nabilone	PMS	1.0268	1.0781
02392925	Teva-Nabilone	TEV	1.0268	1.0781

Saxagliptin - 2.5 mg - Tablets			$	$ + 5%
02375842	Onglyza	AZC	2.4260	2.5473
02507471	Apo-Saxagliptin	APX	1.2650	1.3283
02468603	Sandoz Saxagliptin	SDZ	1.2650	1.3283

Saxagliptin - 5 mg - Tablets			$	$ + 5%
02333554	Onglyza	AZC	2.8957	3.0405
02507498	Apo-Saxagliptin	APX	1.5195	1.5955
02468611	Sandoz Saxagliptin	SDZ	1.5195	1.5955

Vancomycin - 500 mg - Powder for Injection			$	$ + 5%
02502593	Vancomycin Hydrochoride	JPC	9.8669	10.3602
02394626	Vancomycin Hydrochoride	SDZ	9.8669	10.3602

Vancomycin - 1 g - Powder for Injection			$	$ + 5%
02420309	Jamp-Vancomycin	JPC	18.7810	19.7201
02502607	Vancomycin Hydrochoride	JPC	18.7810	19.7201
02394634	Vancomycin Hydrochoride	SDZ	18.7810	19.7201

New Interchangeable Products

The following products have been added to existing interchangeable drug categories:

Abiraterone - 250 mg - Tablets				**$**	**$ + 5%**
	02502305	Jamp Abiraterone	JPC	7.6563	8.0391
	02503980	Mar-Abiraterone	MAR	7.6563	8.0391
	02477114	Reddy-Abiraterone	DRL	7.6563	8.0391

Abiraterone - 500 mg - Tablets				**$**	**$ + 5%**
	02503999	Mar-Abiraterone	MAR	15.3125	** 16.0781

Amlodipine - 5 mg - Tablets				**$**	**$ + 5%**
	02357194	Jamp-Amlodipine	JPC	0.1343	0.1410

Amlodipine - 10 mg - Tablets				**$**	**$ + 5%**
	02357208	Jamp-Amlodipine	JPC	0.1993	0.2093

Buspirone - 10 mg - Tablets				**$**	**$ + 5%**
	02500213	Auro-Buspirone	AUP	0.2713	** 0.2849

Celecoxib - 100 mg - Capsules				**$**	**$ + 5%**
	02436299	Celecoxib	SAH	0.1279	0.1343

Celecoxib - 200 mg - Capsules				**$**	**$ + 5%**
	02436302	Celecoxib	SAH	0.2558	0.2686

Ciprofloxacin/Dexamethasone - 0.3 %/0.1 % - Otic Suspension				**$**	**$ + 5%**
	02506882	Sandoz Ciprofloxacin Dexamethasone	SDZ	1.9227	** 2.0188

Dasatinib - 20 mg - Tablets				**$**	**$ + 5%**
	02499282	Taro-Dasatinib	TAR	19.3425	** 20.3096

Dasatinib - 50 mg - Tablets				**$**	**$ + 5%**
	02499304	Taro-Dasatinib	TAR	38.9284	** 40.8748

Dasatinib - 70 mg - Tablets				**$**	**$ + 5%**
	02499312	Taro-Dasatinib	TAR	42.9021	** 45.0472

Dasatinib - 80 mg - Tablets				**$**	**$ + 5%**
	02499320	Taro-Dasatinib	TAR	69.0150	** 72.4658

Dasatinib - 100 mg - Tablets				**$**	**$ + 5%**
	02499339	Taro-Dasatinib	TAR	77.8042	** 81.6944

Dutasteride - 0.5 mg - Capsules				**$**	**$ + 5%**
	02490587	Priva-Dutasteride	PRZ	0.3027	0.3178

Fleacainide - 50 mg - Tablets				**$**	**$ + 5%**
	02476177	Mar-Flecainide	MAR	0.1389	0.1458

Flecainide - 100 mg - Tablets				**$**	**$ + 5%**
	02476185	Mar-Flecainide	MAR	0.2779	0.2918

Fluvoxamine - 50 mg - Tablets			**$**	**$ + 5%**
02255529	ACT Fluvoxamine	TEV	0.4952	0.5200

Imatinib - 100 mg - Tablets			**$**	**$ + 5%**
02504596	Imatinib	SAH	5.2079	5.4684
02495066	Jamp Imatinib	JPC	5.2079	5.4684

Imatinib - 400 mg - Tablets			**$**	**$ + 5%**
02504618	Imatinib	SAH	20.8314	21.8729
02495074	Jamp Imatinib	JPC	20.8314	21.8729

Lacosamide - 50 mg - Tablets			**$**	**$ + 5%**
02499568	NRA-Lacosamide	NRA	0.6313	0.6629

Lacosamide - 100 mg - Tablets			**$**	**$ + 5%**
02499576	NRA-Lacosamide	NRA	0.8750	0.9188

Lacosamide - 150 mg - Tablets			**$**	**$ + 5%**
02499584	NRA-Lacosamide	NRA	1.1763	1.2351

Lacosamide - 200 mg - Tablets			**$**	**$ + 5%**
02499592	NRA-Lacosamide	NRA	1.4500	1.5225

Lamivudine - 150 mg - Tablets			**$**	**$ + 5%**
02507110	Jamp Lamivudine	JPC	2.7323	** 2.8689

Lamivudine - 300 mg - Tablets			**$**	**$ + 5%**
02507129	Jamp Lamivudine	JPC	5.4857	** 5.7600

Letrozole - 2.5 mg - Tablets			**$**	**$ + 5%**
02504472	Letrozole	SAH	1.3780	1.4469

Leucovorin - 5 mg - Tablets			**$**	**$ + 5%**
02496828	Mint-Leucovorin	MPH	3.6776	** 3.8615

Levetiracetam - 250 mg - Tablets			**$**	**$ + 5%**
02499193	NRA-Levetiracetam	NRA	0.3210	0.3371

Levetiracetam - 500 mg - Tablets			**$**	**$ + 5%**
02499207	NRA-Levetiracetam	NRA	0.3911	0.4107

Levetiracetam - 750 mg - Tablets			**$**	**$ + 5%**
02499215	NRA-Levetiracetam	NRA	0.5416	0.5687

Modafinil - 100 mg - Tablets			**$**	**$ + 5%**
02503727	Jamp Modafinil	JPC	0.3427	0.3598

Mycophenolic Acid - 180 mg - Tablets			**$**	**$ + 5%**
02511673	Mar-Mycophenolic Acid	MAR	0.9989	** 1.0488

Mycophenolic Acid - 360 mg - Tablets			**$**	**$ + 5%**
02511681	Mar-Mycophenolic Acid	MAR	1.9977	** 2.0976

Nystatin - 100,000 U/mL - Oral Liquid			**$**	**$ + 5%**
02433443	Jamp-Nystatin	JPC	0.0647	0.0679

Omeprazole - 20 mg - Tablets			**$**	**$ + 5%**
02504294	Omeprazole	SAH	0.2287	0.2401

Pantoprazole - 40 mg - Tablets			**$**	**$ + 5%**
02392623	Jamp Pantoprazole Sodium	JPC	0.2016	0.2117

Perindopril/Indapamide - 4 mg/1.25 mg - Tablets			**$**	**$ + 5%**
02297574	Apo-Perindopril-Indapamide	APX	0.2556	** 0.2684

Perindopril/Indapamide - 8 mg/2.5 mg - Tablets			**$**	**$ + 5%**
02453061	Apo-Perindopril-Indapamide	APX	0.2859	** 0.3002

Pregabalin - 25 mg - Capsules			**$**	**$ + 5%**
02479117	NRA-Pregabalin	NRA	0.1481	0.1555

Pregabalin - 50 mg - Capsules			**$**	**$ + 5%**
02479125	NRA-Pregabalin	NRA	0.2324	0.2440

Pregabalin - 75 mg - Capsules			**$**	**$ + 5%**
02479133	NRA-Pregabalin	NRA	0.3007	0.3157

Pregabalin - 150 mg - Capsules			**$**	**$ + 5%**
02479168	NRA-Pregabalin	NRA	0.4145	0.4352

Pregabalin - 300 mg - Capsules			**$**	**$ + 5%**
02480778	AG-Pregabalin	ANP	0.4145	0.4352

Quetiapine - 25 mg - Tablets			**$**	**$ + 5%**
02486237	NRA-Quetiapine	NRA	0.0494	0.0519

Quetiapine - 50 mg - Extended Release Tablets			**$**	**$ + 5%**
02450860	ACH-Quetiapine Fumarate XR	ACH	0.2501	0.2626

Quetiapine - 150 mg - Extended Release Tablets			**$**	**$ + 5%**
02450879	ACH-Quetiapine Fumarate XR	ACH	0.4926	0.5172

Quetiapine - 200 mg - Extended Release Tablets			**$**	**$ + 5%**
02450887	ACH-Quetiapine Fumarate XR	ACH	0.6661	0.6994

Quetiapine - 300 mg - Extended Release Tablets			**$**	**$ + 5%**
02450895	ACH-Quetiapine Fumarate XR	ACH	0.9776	1.0265

Quetiapine - 400 mg - Extended Release Tablets			**$**	**$ + 5%**
02450909	ACH-Quetiapine Fumarate XR	ACH	1.3270	1.3934

Ramipril - 2.5 mg - Capsules			**$**	**$ + 5%**
02486172	NRA-Ramipril	NRA	0.0817	0.0858

Ramipril - 5 mg - Capsules			**$**	**$ + 5%**
02486180	NRA-Ramipril	NRA	0.0817	0.0858

Ramipril - 10 mg - Capsules			**$**	**$ + 5%**
02486199	NRA-Ramipril	NRA	0.1034	0.1086

Rizatriptan - 10 mg - Orally Disintegrating Tablets			**$**	**$ + 5%**
02492490	AG-Rizatriptan ODT	ANP	3.7050	3.8903

Rosuvastatin - 10 mg - Tablets			**$**	**$ + 5%**
02498340	Jamp Rosuvastatin	JPC	0.1354	0.1422
02477491	NRA-Rosuvastatin	NRA	0.1354	0.1422

Rosuvastatin - 20 mg - Tablets			**$**	**$ + 5%**
02498359	Jamp Rosuvastatin	JPC	0.1692	0.1777
02477505	NRA-Rosuvastatin	NRA	0.1692	0.1777

Rosuvastatin - 40 mg - Tablets			**$**	**$ + 5%**
02498367	Jamp Rosuvastatin	JPC	0.1990	0.2090
02477513	NRA-Rosuvastatin	NRA	0.1990	0.2090

Sertraline - 25 mg - Capsules			**$**	**$ + 5%**
02488434	NRA-Sertraline	NRA	0.1516	0.1592

Sertraline - 50 mg - Capsules			**$**	**$ + 5%**
02488442	NRA-Sertraline	NRA	0.3032	0.3184

Sertraline - 100 mg - Capsules			**$**	**$ + 5%**
02488450	NRA-Sertraline	NRA	0.3303	0.3468

Sildenafil R - 20 mg - Tablets			**$**	**$ + 5%**
02469669	Jamp-Sildenafil R	JPC	2.9620	** 3.1101

Simvastatin - 5 mg - Tablets			**$**	**$ + 5%**
02284723	Simvastatin	SAH	0.1023	0.1074

Simvastatin - 10 mg - Tablets			**$**	**$ + 5%**
02284731	Simvastatin	SAH	0.2023	0.2124

Simvastatin - 20 mg - Tablets			**$**	**$ + 5%**
02284758	Simvastatin	SAH	0.2501	0.2626

Simvastatin - 40 mg - Tablets			**$**	**$ + 5%**
02284766	Simvastatin	SAH	0.2501	0.2626

Simvastatin - 80 mg - Tablets			**$**	**$ + 5%**
02284774	Simvastatin	SAH	0.2501	0.2626

Sodium Polystyrene Sulfonate - 1 mEq/g - Oral Powder			**$**	**$ + 5%**
02497557	Jamp Sodium Polystyrene Sulfonate	JPC	0.0648	**0.0680

Solifenacin - 5 mg - Tablets			**$**	**$ + 5%**
02493039	PRZ-Solifenacin	PRZ	0.3041	0.3193

Solifenacin - 10 mg - Tablets			**$**	**$ + 5%**
02493047	PRZ-Solifenacin	PRZ	0.3041	0.3193

Telmisartan - 40 mg - Tablets			**$**	**$ + 5%**
02499622	pms-Telmisartan	PMS	0.2161	0.2269

Telmisartan - 80 mg - Tablets			**$**	**$ + 5%**
02499630	pms-Telmisartan	PMS	0.2161	0.2269

Telmisartan/HCTZ - 80/12.5 mg - Tablets			**$**	**$ + 5%**
02504146	NRA-Telmisartan HCTZ	NRA	0.2098	0.2203

Telmisartan/HCTZ - 80/25 mg - Tablets			**$**	**$ + 5%**
02504138	NRA-Telmisartan HCTZ	NRA	0.2098	0.2203

Valacyclovir - 500 mg - Tablets			**$**	**$ + 5%**
02440598	Jamp Valacyclovir	JPC	0.6198	0.6508

Zopiclone - 5 mg - Tablets			**$**	**$ + 5%**
02477378	NRA-Zopiclone	NRA	0.0990	0.1040

Zopiclone - 7.5 mg - Tablets			**$**	**$ + 5%**
02477386	NRA-Zopiclone	NRA	0.1250	0.1313

** The price has resulted in a change to the lowest price in the category.

Product Deletions

(as identified for deletion in Bulletin # 111)

The following products have been deleted.

01997580	Asacol	mesalazine	400 mg	Tablet
02357860	Celestoderm V/2	betamethasone	0.05%	Cream
02357844	Celestoderm V	betamethasone	0.1 %	Cream
00836362	DDAVP	desmopressin	10 mcg	Spray
02264323 02264331 02264358 02264366 02264374 02264390 02264404 02264412 02264420 02264439 02264447 02264455	Euthyrox	levothyroxine sodium	25 mcg 50 mcg 75 mcg 88 mcg 100 mcg 112 mcg 125 mcg 137 mcg 150 mcg 175 mcg 200 mcg 300 mcg	Tablet
02250004	Fenomax 160 mg	fenofibrate	160 mg	Capsule
00716782 00716790	Fluoderm	fluocinolone acetonide	0.01 % 0.025 %	Cream
00716812	Fluoderm	fluocinolone acetonide	0.025 %	Ointment
02223767	Norprolac	quingolide HCl	0.075 mg	Tablet
02091887 02092808	Rifadin	rifampin	150 mg 300 mg	Capsule

02014165 02014181	Uniphyl	theophylline	400 mg 600 mg	Tablet
00497533	Vitamin B^{12}	vitamin b^{12}	0.1mg/mL	Injection
02255545 02255553	ACT-Atenolol	atenolol	50 mg 100 mg	Tablet
02263866	ACT Etidrocal	calcium/etidronate	500/400 mg	Kit
02295385	Apo-Glimepiride	glimepiride	2 mg	Tablet
02389088	Mar-Olanzapine ODT	olanzapine	5 mg	Orally Disintigrating Tablets
02393018	Mint-Irbesartan/HCTZ	irbesartan/HCTZ	300 mg/12.5 mg	Tablet
02273756	Novo-Glimepiride	glimepiride	1 mg	Tablet
02278111	pms-Famciclovir	famciclovir	500 mg	Tablet
02358921	pms-Raloxifene	raloxifene	60 mg	Tablet
02247917 02247918 02247919	pms-Ramipril	ramipril	2.5 mg 5 mg 10 mg	Capsule
02397110 02397129	Ran-Quetiapine	quetiapine	200 mg 300 mg	Tablet
02273101 02273128	Ratio-Glimepiride	glimepiride	1 mg 2 mg	Tablet
00557102	Riva-Dicylomine	dicyclomine HCl	10 mg	Capsule
02247439 02247440	Sandoz Bisoprolol	bisoprolol	5 mg 10 mg	Tablet
02314010 02314029	Sandoz Quetiapine	quetiapine	200 mg 300 mg	Tablet
02243229 02243230	Sandoz Ranitidine	ranitidine	150 mg 300 mg	Tablet
02245161	Sandoz Sertraline	sertraline	100 mg	Capsule
02442639 02442647	SDZ Celecoxib	celecoxib	100 mg 200 mg	Capsule
02108151	Teva-Minocycline	minocycline HCl	100 mg	Capsule

Category Deletions

- Desmopresssin Acetate - 10 mcg - Spray
- Mesalazine - 400 mg - Tablets
- Rifampin - 150 mg - Capsules
- Rifampin - 300 mg - Capsules
- Theophylline - 400 mg - Tablets
- Theophylline - 600 mg - Tablets

Interchangeable Product Price Changes

The following changes in prices have occurred: **($)** **($ + 5%)**

02182815	Cozaar	losartan	25 mg	Tablet	1.8423	1.9344
02182874	Cozaar	losartan	50 mg	Tablet	1.8423	1.9344
02182882	Cozaar	losartan	100 mg	Tablet	1.8423	1.9344
00851744	Elocom	mometasone furoate	0.1 %	Cream	0.7393	0.7763
00871095	Elocom	mometasone furoate	0.1 %	Lotion	0.5255	0.5518
00851736	Elocom	mometasone furoate	0.1 %	Ointment	0.7342	0.7709
02230047	Hyzaar	losartan/HCTZ	50/12.5 mg	Tablet	1.8423	1.9344
02297841	Hyzaar	losartan/HCTZ	100/12.5 mg	Tablet	1.8038	1.8940
02241007	Hyzaar DS	losartan/HCTZ	100/25 mg	Tablet	1.8423	1.9344
02318660	Olmetec	olmesartan	20 mg	Tablet	1.3327	1.3993
02318679	Olmetec	olmesartan	40 mg	Tablet	1.3327	1.3993
02319616	Olmetec Plus	olmesartan/HCTZ	20 mg/12.5 mg	Tablet	1.3327	1.3993
02319624	Olmetec Plus	olmesartan/HCTZ	40 mg/12.5 mg	Tablet	1.3327	1.3993
02319632	Olmetec Plus	olmesartan/HCTZ	40 mg/25 mg	Tablet	1.3327	1.3993
02243910	Remeron	mirtazepine	30 mg	Tablet	1.8987	1.9936
02248542	Remeron RD	mirtazepine	15 mg	Orally Disintegrating Tablet	0.5529	0.5805
02248543	Remeron RD	mirtazepine	30 mg	Orally Disintegrating Tablet	1.1052	1.1605
02248544	Remeron RD	mirtazepine	45 mg	Orally Disintegrating Tablet	1.6580	1.7409
00657298	Vaseretic	enalapril/HCTZ	10 mg/25 mg	Tablet	1.5465	1.6238
02248763	AA-Atenidone	atenolol/ chlorthalidone	50 mg/25 mg	Tablet	0.5342	** 0.5609
02248764	AA-Atenidone	atenolol/ chlorthalidone	100 mg/25 mg	Tablet	0.8755	** 0.9193
02496119	Accel-Pilocarpine	pilocarpine	5 mg	Tablet	1.2196	** 1.2806
02491400	Apo-Abiraterone	abiraterone acetate	500 mg	Tablet	15.3125	** 16.0781
02211076	Apo-Buspirone	buspirone	10 mg	Tablet	0.2713	** 0.2849
02470705	Apo-Dasatinib	dasatinib	20 mg	Tablet	19.3425	** 20.3096
02470713	Apo-Dasatinib	dasatinib	50 mg	Tablet	38.9284	** 40.8748
02481499	Apo-Dasatinib	dasatinib	70 mg	Tablet	42.9021	** 45.0472
02481502	Apo-Dasatinib	dasatinib	80 mg	Tablet	69.0150	** 72.4658
02470721	Apo-Dasatinib	dasatinib	100 mg	Tablet	77.8042	** 81.6944
02369052	Apo-Lamivudine	lamivudine	150 mg	Tablet	2.7323	** 2.8689

02369060	Apo-Lamivudine	lamivudine	300 mg	Tablet	5.4857	** 5.7600
02372738	Apo-Mycophenolic Acid	mycophenolic acid	180 mg	Tablet	0.9989	** 1.0488
02372746	Apo-Mycophenolic Acid	mycophenolic acid	360 mg	Tablet	1.9977	** 2.0976
02415739	Apo-Travoprost Z	travoprost	0.004 %	Ophthalmic Solution	5.7520	** 6.0396
02248639	Octreotide Acetate Omega	octreotide acetate	50 mcg/mL	Injection	4.0080	** 4.2084
02248640	Octreotide Acetate Omega	octreotide acetate	100 mcg/mL	Injection	7.5660	** 7.9443
02248642	Octreotide Acetate Omega	octreotide acetate	200 mcg/mL	Injection	14.5545	** 15.2822
02501503	pms-Abiraterone	abiraterone acetate	500 mg	Tablet	15.3125	** 16.0781
02230942	pms-Buspirone	buspirone	10 mg	Tablet	0.2713	** 0.2849
02231543	pms-Carbamazepine CR	carbamazepine	200 mg	Tablet	0.2563	** 0.2691
02231544	pms-Carbamazepine CR	carbamazepine	400 mg	Tablet	0.5126	** 0.5382
02231506	pms-Diclofenac	diclofenac sodium	50 mg	Suppository	0.8545	** 0.8972
02273942	pms-Mirtazapine	mirtazepine	15 mg	Tablet	0.2310	** 0.2426
02380919	pms-Nabilone	nabilone	1 mg	Capsule	3.6669	** 3.8502
02412179	pms-Sildenafil R	sildenafil R	20 mg	Tablet	2.9620	** 3.1101
02493357	Riva Leucovorin	leucovorin	5 mg	Tablet	3.6776	** 3.8615
02261839	Sandoz Carbamazepine CR	carbamazepine	200 mg	Tablet	0.2563	** 0.2691
02261847	Sandoz Carbamazepine CR	carbamazepine	400 mg	Tablet	0.5126	** 0.5382
02261928	Sandoz Diclofenac	diclofenac sodium	50 mg	Suppository	0.8545	** 0.8972
02250594	Sandoz Mirtazapine	mirtazepine	15 mg	Tablet	0.2310	** 0.2426
02470438	Sandoz Perindopril/ Indapamide	perindopril/indapamide	4 mg/1.25 mg	Tablet	0.2556	** 0.2684
02470446	Sandoz Perindopril/ Indapamide	perindopril/indapamide	8 mg/2.5 mg	Tablet	0.2859	** 0.3002
02413167	Sandoz Travoprost	travoprost	0.004 %	Ophthalmic Solution	5.5720	** 6.0396
00755338	Solystat	sodium polystyrene sulfonate	1 mEq/g	Oral Powder	0.0648	** 0.0680
02481901	Taro-Ciprofloxacin/ Dexamethasone	ciprofloxacin/ dexamethasone	0.3 %/0.1 %	Otic Suspension	1.9227	** 2.0188
02231492	Teva-Buspirone	buspirone	10 mg	Tablet	0.2713	** 0.2849
02384892	Teva-Nabilone	nabilone	1 mg	Capsule	3.6669	** 3.8502
02464020	Teva-Perindopril/ Indapamide	perindopril/indapamide	4 mg/1.25 mg	Tablet	0.2556	** 0.2684
02464039	Teva-Perindopril/ Indapamide	perindopril/indapamide	8 mg/2.5 mg	Tablet	0.2859	** 0.3002
02319500	Teva-Sildenafil R	sildenafil R	20 mg	Tablet	2.9620	** 3.1101

** The price has resulted in a change to the lowest price in the category.

Discontinued Products

The following products will be deleted with the next Formulary amendments and will appear as "Product Deletions" on Bulletin # 113.

02234510	282	acetylsalicylic acid/codeine	375/30/15 mg	Tablet
02237618 02155990	Adalat XL	nifedipine	20 mg 60 mg	Tablet
02267217	Asacol	mesalazine	800 mg	Tablet
02241113	Avandia	rosiglitazone	4 mg	Tablet
02212277 02212285	Ceftin	cefuroxime	250 mg 500 mg	Tablet
02155966	Cipro	ciprofloxacin	500 mg	Tablet
01968440 01992872	Cyclen	norgestimate	-	Tablet
00402516	DDAVP Rhinyle	desopressin acetate	0.1 mg/mL	Nasal Solution
02212218	Fortaz	ceftazidime	1 G	Powder for Solution
02216965	Invirase	saquinavir	200 mg	Capsule
02279320	Invirase	saquinavir	500 mg	Tablet
00000841	Isopto Carpine	pilocarpine HCL	1 %	Ophthalmic Solution
02454408	Lynparza	olaparib	50 mg	Capsule
00899348	Manerix	moclobemide	100 mg	Tablet
02162806 02163527 02163535	Minitran	nitroglycerin	0.2 mg/hr 0.4 mg/hr 0.6 mg/hr	Transdermal Patch
01980696 01964437 01964429	Morphine Sulfate	morphine sulfate	1 mg/mL 2 mg/mL 5 mg/mL	Injection
00850314 00850322 00850330	Morphine Sulfate	morphine sulfate	2 mg/mL 10 mg/mL 15 mg/mL	Injection
80027202 00225819	Phosphate Novartis	-	-	Tablet
02453754 02453762	Praluent	alirocumab	75 mg/mL 150 mg/mL	Injection
00893757 02222051	Pravachol	pravastatin sodium	20 mg 40 mg	Tablet
02043394 02043408 02043424	Premarin	conjugated estrogen	0.3 mg 0.625 mg 1.25 mg	Tablet
02242878 02242879	Premplus	conjugated estrogen/ medroxyprogesterone	0.625/2.5 mg 0.625/5 mg	Tablet
00840533	Prevex HC	hydrocortisone	1 %	Cream

00638676 00638684	Procan SR	procainamide HCL	500 mg 750 mg	Tablet
02256711	Ranitidine	ranitidine	50 mg/2 mL	Injection
00839213	Sandostatin	octreotide	500 mcg/mL	Injection
00584274	Sinequan	doxepin	150 mg	Capsule
00632228 00632201	Statex	morphine sulfate	5 mg 10 mg	Suppository
02162504	Synalar	fluocinolone acetonide	0.01 %	Topical Solution
02049961 02049988	Tenoretic	atenolol/chlorthalidone	50/25 mg 100/25 mg	Tablet
02162776	Ticlid	ticlopidine	250 mg	Tablet
02028700 02029421	Tri-Cyclen	ethinyl estradiol/ norgestimate	-	Tablet
02258560 02258587	Tri-Cyclen LO	ethinyl estradiol/ norgestimate	-	Tablet
00027944	Valisone	betamethasone	0.1 %	Lotion
00497541 00497568	Vitamin K[1]	vitamin k[1]	2 mg/mL 10 mg/mL	Injection
02393603	ACT Nabilone	nabilone	1mg	Capsule
02262754	ACT Paroxetine	paroxetine	20 mg	Tablet
02295385	Apo-Glimepiride	glimepiride	2 mg	Tablet
02383055 02383063	Bisoprolol	bisoprolol	5 mg 10 mg	Tablet
02351102 02351110	Famotidine	famotidine	20 mg 40 mg	Tablet
02023822	Gentamicin	gentamicin sulfate	0.3 %	Ophthalmic Solution
02386496	Jamp-Candesartan	candesartan	4 mg	Tablet
02380722 02380730	Jamp-Metformin *(Blackberry)*	metformin	500 mg 850 mg	Tablet
02353229 02353237	Lovastatin	lovastatin	20 mg 40 mg	Tablet
02350890	Morphine SR	morphine sulfate	30 mg	Tablet
00811882	pms-Chloral Hydrate	chloral hydrate	500 mg	Capsule
02046113	pms-Sodium Cromoglycate	cromolyn sodium	1 %	Inhalation Solution
02358085 02358093	Ran-Nabilone	nabilone	0.5 mg 1 mg	Capsule
02403617	Ran-Omeprazole	omeprazole	20 mg	Capsule
02230386	Sandoz Cortimyxin	hydrocortisone/neomycin/ plolymyxin b	10 mg/3.5 mg/ 10000 U/mL	Otic Solution
02261960	Sandoz Diclofenac	diclofenac sodium	50 mg	Tablet
02237313 02237314	Sandoz Minocycline	minocycline	50 mg 100 mg	Capsule
02291401 02291428 02291436	Sandoz Ramipril	ramipril	2.5 mg 5 mg 10 mg	Capsule

02248529	Sandoz Triflurdine	trifluridine	1 %	Ophthalmic Solution
02008203	Sandoz Zopiclone	zopiclone	7.5 mg	Tablet
02350475 02350483 02350491 02350505	Terazosin	terazosin HCl	1 mg 2 mg 5 mg 10 mg	Tablet
02246063	Testosterone Cypionate	testosterone cypionate	100 mg/mL	Injection