

PART 3 EXCEPTION DRUG STATUS (EDS)

Certain drugs are approved for coverage under the Exception Drug Status (EDS) Program when they meet specific criteria and upon review and recommendation of the Manitoba Drug Standards and Therapeutics Committee (MDSTC). The drugs usually fall into one of the following categories:

- The drug is ordinarily administered only to hospital in-patients but is being administered outside of a hospital because of unusual circumstances.
- The drug is not ordinarily prescribed or administered in Manitoba, but is being prescribed because it is required in the diagnosis or treatment of an illness, disability, or condition rarely found in Manitoba.
- Evidence, including therapeutic and economic evidence, provided to the minister in accordance with the criteria established by him or her, supports a specific treatment regime which includes use of the drug or other item.

Over-the-counter (OTC) products are generally not included as benefits of the Drug Plan. Exception Drug Status is not granted for appetite suppressants, drugs for the treatment of erectile dysfunction and vaccines normally provided by Public Health.

When an EDS drug is approved as a benefit, the cost will be covered through the Pharmacare Program during the time period authorized by the EDS Program and after the clients Pharmacare deductible has been met.

CHANGES TO APPROVAL PROCESS AND EXPIRY DATES - EFFECTIVE OCTOBER 2017

Effective October 1, 2017 many Part 3 drugs will no longer require EDS renewal for coverage under Manitoba's Provincial Drug Programs (PDP) and the Employment and Income Assistance Drug Program (EIA). All Part 3 EDS drugs will still require initial approval, but for many drugs, if coverage approval is granted, this approval will be indefinite and prescribers will no longer need to reapply for extending or renewing this coverage. Any patient that has an active EDS approval (as of October 1, 2017) for any of the drugs affected by this change will automatically have the approval extended indefinitely. This change will affect only products identified on the List of Designated Drugs and may be updated from time to time. Details can be found online at:

http://www.gov.mb.ca/health/pharmacare/profdocs/list_designated_eds.pdf

INFORMATION REQUIRED WHEN MAKING A REQUEST FOR COVERAGE:

- Prescriber Information - Name (including first initial), Address, Phone Number and Prescriber Number.
- Client Information - Client Name, Address, Manitoba Health Registration Number (MHRN), Personal Health Identification Number (PHIN) and Date of Birth.
- Drug Information - Drug Name (trade and/or generic name), Dosage Form, Strength, Expected Dosing and Expected Therapy Duration.
- Justification - Diagnosis and/or Indications for Use.

EDS request forms are now available online, please visit:

<http://www.gov.mb.ca/health/pharmacare/healthprofessionals.html#b>

NOTES REGARDING THE EXCEPTION DRUG STATUS (EDS) PROGRAM:

- Duly licensed practitioners prescribing within their scope of practice may apply for EDS.
- Requests can be submitted by mail or by fax. The fax number is (204) 942-2030 or 1-877-208-3588. These numbers are for health professionals only.
- To ensure eligible benefit coverage, approval must take place prior to purchase or dispensing of a

prescription drug. Retroactive coverage is not provided, no exceptions.

- EDS requests are prioritized by date received and the urgency of the request.
- To ensure continuity of coverage, requests for renewal should be forwarded prior to the expiry date. Please allow at least one to two business days.

Urgent requests received during regular business hours will usually be processed within 24 hours.

- Patients are notified by letter if a request for coverage has been approved or denied.
- If a drug is approved for coverage under EDS, coverage is valid from the date of application to date of expiration.
- If denied, payment for the medication is the responsibility of the patient.
- For NEW requests - If a client meets Part 3 EDS criteria for one of the products identified in the List of Designated Drugs with Indefinite EDS Approval, benefit coverage will be granted indefinitely. The client will receive an initial approval letter which confirms indefinite EDS approval.
- For RENEWAL requests - If a client has an active EDS approval for a product identified in the List of Designated Drugs with Indefinite EDS Approval – as of October 1, 2017, this coverage will be grandfathered indefinitely; no renewal will be required. The client will not be sent a letter to confirm their continued EDS approval.
- If the request for benefit coverage is not approved, payment for the medication is the responsibility of the patient.

NOTE: Not all medications currently available on the market in Canada are benefits under the Manitoba Drug Benefits Formulary or under the EDS Program.

NOTE: Some private and extended health insurance providers require their clients to have the EDS approval before they agree to cover any part of the prescription cost. It is the clients' responsibility to contact their private drug plan directly for further information.

PRODUCT SELECTION:

In September 2001, F/P/T Health Ministers agreed to establish a single Common Drug Review for new drugs (chemical entities) submitted in Canada for coverage by F/P/T drug plans. Beginning September 2003, all new drugs are reviewed nationally through the CDR process, with expert advice and recommendations being provided by the Canadian Agency for Drugs and Technologies in Canada. The recommendations of CADTH are taken into consideration by each jurisdiction when making a listing decision.

CADTH recommendations are taken into account by the Manitoba Drug Standards and Therapeutics Committee who makes recommendations to the Minister of Health on drug products to be considered for benefit under the Pharmacare Drug Benefit Program.

Committee members provide recommendations on drug interchangeability and on the therapeutic and economic value of drug benefits.

For more information on the Manitoba Drug Formulary Review Process, please visit:

<http://www.gov.mb.ca/health/mdbif/review.html>

For more information on the Manitoba Drug Benefits and Interchangeability Formulary, please visit:

<http://www.gov.mb.ca/health/mdbif/>

PROVINCIAL DRUG PROGRAMS REVIEW PROCESS (SPECIAL CIRCUMSTANCES):

Should a prescriber wish to obtain EDS status for a drug not normally eligible for Part 3 EDS status, the prescriber may apply in writing and include the information listed below.

Please address request to:

Provincial Drug Programs Review Committee
 300 Carlton Street – Room 1015
 Winnipeg MB R3B 3M9
 Fax (204) 942-2030 or 1-877-208-3588

Please include all of the information required for an EDS request (see page 1) as well as:

- Information and background on the original EDS request.
- Previous therapies tried and response to those therapies.
- Additional Information such as supporting literature to support the review.

CRITERIA:

Following are the criteria for coverage of **common** drugs requested under Exception Drug Status. Further information can be provided by professional staff at the Exception Drug Status program.

ANTIHYPERTENSIVE/ANTILIPIDEMIC DRUGS

02411253 02411261 02411288 02411296 02411318 02411326 02411334 02411342	Apo-Amlodipine/ Atorvastatin	amlodipine/atorvastatin	5/10 mg 5/20 mg 5/40 mg 5/80 mg 10/10 mg 10/20 mg 10/40 mg 10/80 mg	Tablet
02273233 02273284 02273241 02273292 02273268 02273306 02273276 02273314	Caduet	amlodipine/atorvastatin	5/10 mg 10/10 mg 5/20 mg 10/20 mg 5/40 mg 10/40 mg 5/80 mg 10/80 mg	Tablet
02362759 02362767 02362775 02362783 02362791 02362805 02362813 02362821	GD-Amlodipine/ Atorvastatin	amlodipine/atorvastatin	5/10 mg 5/20 mg 5/40 mg 5/80 mg 10/10 mg 10/20 mg 10/40 mg 10/80 mg	Tablet

02404222 02404230 02404249 02404257	pms-Amlodipine/ Atorvastatin	amlodipine/atorvastatin	5/10 mg 5/20 mg 10/10 mg 10/20 mg	Tablet
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For patients who have been titrated to a stable combination, for a minimum of at least 3 months, of the separate components, amlodipine besylate and atorvastatin.

AUTONOMIC DRUGS

02336715 02336723 02336731 02336758	Apo-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02232043 02232044	Aricept	donepezil	5 mg 10 mg	Tablet
02362260 02362279	Apo-Donepezil	donepezil	5 mg 10 mg	Tablet
02400561 02400588	Auro-Donepezil	donepezil	5 mg 10 mg	Tablet
02412853 02412861	Bio-Donepezil	donepezil	5 mg 10 mg	Tablet
02397595 02397609	CO Donepezil	donepezil	5 mg 10 mg	Tablet
02420597 02420600	Donepezil	donepezil	5 mg 10 mg	Tablet
02422645 02402653	Donepezil	donepezil	5 mg 10 mg	Tablet
02404419 02404427	Jamp-Donepezil	donepezil	5 mg 10 mg	Tablet
02416948 02416956	Jamp-Donepezil	donepezil	5 mg 10 mg	Tablet
02402092 02402106	Mar-Donepezil	donepezil	5 mg 10 mg	Tablet
02359472 02359480	Mylan-Donepezil	donepezil	5 mg 10 mg	Tablet
02439557 02439565	NAT-Donepezil	donepezil	5 mg 10 mg	Tablet
02428482 02428490	Septa-Donepezil	donepezil	5 mg 10 mg	Tablet
02426943 02426951	VAN-Donepezil	donepezil	5 mg 10 mg	Tablet

02401614 02401622 02401630 02401649	Med-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Tablet
02406985 02406993 02407000 02407019	Mint-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Tablet
02322331 02322358	pms-Donepezil	donepezil	5 mg 10 mg	Tablet
02381508 02381516	Ran-Donepezil	donepezil	5 mg 10 mg	Tablet
02328666 02328682	Sandoz Donepezil	donepezil	5 mg 10 mg	Tablet
02340607 02340615	Teva-Donepezil	donepezil	5 mg 10 mg	Tablet
02242115 02242116 02242117 02242118	Exelon	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02245240	Exelon	rivastigmine	2 mg/mL	Oral Liquid
02425157 02425165 02425173	Auro-Galantamine ER	galantamine	8 mg 16 mg 24 mg	Capsule
02443015 02443023 02443031	Galantamine ER	galantamine	8 mg 16 mg 24 mg	Capsule
02339439 02339447 02339455	Mylan-Galantamine ER	galantamine	8 mg 16 mg 24 mg	Capsule
02420821 02420848 02420856	Mar-Galantamine ER	galantamine	8 mg 16 mg 24 mg	Capsule
02332809 02332817 02332825 02332833	Mylan-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02305984 02305992 02306018 02306026	Novo-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule

02316943 02316951 02316978	PAT-Galantamine ER	galantamine	8 mg 16 mg 24 mg	Capsule
02398370 02398389 02398397	pms-Galantamine ER	galantamine	8 mg 16 mg 24 mg	Capsule
02306034 02306042 02306050 02036069	pms-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02311283 02311291 02311305 02311313	ratio-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02266717 02266725 02266733	Reminyl ER	galantamine	8 mg 16 mg 24 mg	Capsule
02324563 02324571 02324598 02324601	Sandoz Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02377950 02377969 02377977	Teva-Galantamine	galantamine	8 mg 16 mg 24 mg	Tablet

Confirmed diagnosis of Alzheimer's Disease with DSMIV criteria with:

(a) Memory impairment (impaired ability to learn new information or to recall previously learned information); plus

(b) at least one of the following:

- Aphasia; problems with language (receptive and expressive)
- Apraxia; impaired ability to carry out motor activities despite intact motor function
- Agnosia; failure of recognition - especially people
- Disturbance in executive functioning

The above deficits must have:

- Caused significant decline in previous levels; and
- A gradual onset and continued cognitive decline; and
- The absence of other causative conditions; and
- The deficits do not occur exclusively during the course of delirium; and
- Normal test results for all of the following values: CBC, TSH, Electrolytes, Vitamin B12, and Glucose; and
- The initial MMSE score must be between 10 and 26 and measured within 30 days of the application.

02423596	Incruse Ellipta	umeclidinium	62.5 mcg	Inhaler
02394936	Seebri Breezhaler	glycopyrronium	50 mcg	Powder for Inhalation

02246793	Spiriva	tiotropium	18 mcg	Capsule
02435381	Spiriva Respimat	tiotropium	2.5 mcg/dose	Inhaler
02409720	Tudorza Genuair	aclidinium	400 mcg	Inhaler

For patients with moderate to severe COPD who remain symptomatic despite an adequate trial (3 months) of ipratropium.

02418401	Anoro Ellipta	umeclidinium/vilanterol	62.5/25 mcg	Powder for Inhalation
02439530	Duaklir Genuair	aclidinium/formoterol	400 mcg/12 mcg	Inhaler
02441888	Inspiroto Respimat	olodaterol/tiotropium	2.5 mcg/2.5 mcg	Inhaler
02418282	Ultibro Breezhaler	indacaterol/glycopyrronium	110/50 mcg	Inhaler

For patients with moderate to severe COPD who remain symptomatic despite an adequate trial (3 months) of a long acting bronchodilator.

Note: Should not be used in combination with another LAAC or LABA

BLOOD FORMING AND COAGULATION

02132621 02132656 02430789 02132648 02132664 02231171 02352680 02352648 02352672 02352656 02352664	Fragmin	dalteparin	2500 IU/0.2 mL 2500 IU/mL 3500 IU/0.28 mL 5000 IU/0.2 mL 10000 IU/mL 25000 IU/mL 18000 IU/0.72 mL 7500 IU/0.3 mL 15000 IU/0.6 mL 10000 IU/0.4 mL 12500 IU/0.5 mL	Injection
02236913 02240114	Fraxiparine	nadroparin	9500 IU/mL 19000 IU/mL	Injection
02229755 02167840 02231478 02229515 02358182 02358158 02358166 02358174 02429462 02429470 02429489	Innohep	tinzaparin	2500 IU/0.25 mL 10000 IU/mL 10000 IU/0.5 mL 20000 IU/mL 18000 IU/0.9 mL 3500 IU/0.35 mL 4500 IU/0.45 mL 14000 IU/0.7 mL 8,000/0.4 mL 12,000/0.6 mL 16,000/0.8 mL	Injection

02012472 02236883 02242692 02236564 02378426 02378434 02378442 02378469	Lovenox	enoxaparin	30 mg/0.3 mL 40 mg/0.4 mL 120 mg/0.8 mL 300 mg/3 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/mL 150 mg/mL	Injection
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Please contact the EDS Program at Manitoba Health for specific criteria.

02316986	Xarelto	rivaroxaban	10 mg	Tablet
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For the prophylaxis of venous thromboembolism following total knee replacement for up to two (2) weeks, and following total hip replacement surgery for up to five (5) weeks, as an alternative to low molecular weight heparins.

02378604 02378612	Xarelto	rivaroxaban	15 mg 20 mg	Tablet
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For the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) for a duration of up to six months.

Exclusions:

- Patients with clinically significant active bleeding, such as gastrointestinal bleeding, including that associated with hemorrhagic manifestations, bleeding diathesis, spontaneous impairment of hemostasis or patients with spontaneous impairment of hemostasis.
- Patients with severe renal impairment (CrCl < 30 mL/min).

02377233 02397714	Eliquis	apixaban	2.5 mg 5 mg	Tablet
02312441 02358808	Pradaxa	dabigatran	110 mg 150 mg	Capsule
02378604 02378612	Xarelto	rivaroxaban	15 mg 20 mg	Tablet

At-risk patients with non-valvular atrial fibrillation for the prevention of stroke and systemic embolism AND in whom:

- (a) Anticoagulation is inadequate following a reasonable trial on warfarin; **OR**
- (b) Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

02377233	Eliquis	apixaban	2.5 mg	Tablet
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For the prophylaxis of venous thromboembolism (VTE) following elective total hip replacement surgery or elective total knee replacement surgery, where the initial post-operative doses are administered in an acute care (hospital) setting.

02377233 02397714	Eliquis	apixaban	2.5 mg 5 mg	Tablet
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For the treatment of venous thromboembolic events (VTE) (deep vein thrombosis [DVT] and pulmonary embolism [PE]), and the prevention of recurrent DVT and PE for a duration of up to six months.

CENTRAL NERVOUS SYSTEM AGENTS

Anorexigenic Agents and Respiratory and Cerebral Stimulants

02239665	Alertec	modafinil	100 mg	Tablet
02285398	Apo-Modafinil	modafinil	100 mg	Tablet
02430487	Auro-Modafinil	modafinil	100 mg	Tablet
02432560	MAR-Modafinil	modafinil	100 mg	Tablet
02420260	Teva-Modafinil	modafinil	100 mg	Tablet

1. To treat narcolepsy where:
 - (a) Amphetamines are contraindicated; OR
 - (b) Patients over 40 years old who have underlying cardiovascular disease or history of the disease; OR
 - (c) Patients have Parkinson's Disease or are unresponsive to methylphenidate (Ritalin) or dexamphetamine.
2. To treat patients with sleep lab confirmed diagnosis of narcolepsy, or idiopathic CNS hypersomnia.
3. To treat Multiple Sclerosis fatigue not responding to amantadine.

Anticonvulsants

02284294 02284308 02284316	Apo-Oxcarbazepine	oxcarbazepine	150 mg 300 mg 600 mg	Tablet
02242067 02242068 02242069	Trileptal	oxcarbazepine	150 mg 300 mg 600 mg	Tablet
02244673	Trileptal	oxcarbazepine	60 mg/mL	Liquid

For the treatment of patients with refractory partial epilepsy;
 (a) when intolerant to other anticonvulsant therapy;
 (b) adjunct therapy when current anticonvulsant therapies are not providing adequate seizure control.

02247027 02247028 02247029	Keppra	levetiracetam	250 mg 500 mg 750 mg	Tablet
02285924 02285932 02285940	Apo-Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet

02375249 02375257 02375265	Auro-Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02274183 02274191 02274205	CO Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02403005 02403021 02403048	Jamp-Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02399776 02399784 02399792	Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02353342 02353350 02353369	Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02454653 02454661 02454688	Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02442531 02442558 02442566	Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02296101 02296128 02296136	pms-Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02440202 02440210 02440229	NAT-Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02396106 02396114 02396122	Ran-Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet
02461986 02461994 02462001	Sandoz Levetiracetam	levetiracetam	250 mg 500 mg 750 mg	Tablet

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.

02426862 02426870 02426889 02426897	Aptiom	eslicarbazepine	200 mg 400 mg 600 mg 800 mg	Tablet
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02404516 02404524 02404532 02404540 02404559 02404567	Fycompa	perampanel	2 mg 4 mg 6 mg 8 mg 10 mg 12 mg	Tablet
02357615 02357623 02357631 02357658	Vimpat	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet

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

Non-Steroidal Anti-Inflammatory Agents				
02248973 02248974	Apo-Meloxicam	meloxicam	7.5 mg 15 mg	Tablet
02390884 02390892	Auro-Meloxicam	meloxicam	7.5 mg 15 mg	Tablet
02250012 02250020	CO Meloxicam	meloxicam	7.5 mg 15 mg	Tablet
02353148 02353156	Meloxicam	meloxicam	7.5 mg 15 mg	Tablet
02255987 02255995	Mylan-Meloxicam	meloxicam	7.5 mg 15 mg	Tablet
02242785 02242786	Mobicox	meloxicam	7.5 mg 15 mg	Tablet
02258315 02258323	Teva-Meloxicam	meloxicam	7.5 mg 15 mg	Tablet
02248267 02248268	pms-Meloxicam	meloxicam	7.5 mg 15 mg	Tablet
02247889 02248031	ratio-Meloxicam	meloxicam	7.5 mg 15 mg	Tablet

For the **long-term treatment of osteoarthritis or rheumatoid arthritis** in patients who have one or more of the following risk factors:

- Previous peptic ulcer, gastrointestinal bleeding, gastric outlet obstruction (endoscopy or radiographic evidence);
- Elderly (more than 65 years of age);
- Concurrent warfarin therapies;
- Bleeding disorders;
- Concurrent prednisone therapy at doses greater than 5 mg/day for more than 2

weeks; OR

- Where at least 3 NSAID's have been tried and failed or were not tolerated.

Also may approve for ankylosing spondylitis, gout, pseudo-gout, lupus or psoriatic arthritis.

NOTE: *If a patient is receiving a proton pump inhibitor (PPI) for reflux disease, COX II inhibitors are not warranted for additional protection.*

Opiate Agonists				
02230302	Codeine Contin	codeine	50 mg	Sustained Release Tablet
02163748			100 mg	
02163780			150 mg	
02163799			200 mg	

For the treatment of:

(a) **Palliative and chronic pain** in patients where hepatotoxicity is a concern due to high doses of acetaminophen (e.g. taking over 12 tablets of acetaminophen compound with codeine 30 mg per day).

(b) **Codeine addiction** using tapering doses.

02231934	Oxy-IR	oxycodone HCl	5 mg	Tablet
02240131			10 mg	
02240132			20 mg	
02319977	pms-Oxycodone	oxycondone HCl	5 mg	Tablet
02319985			10 mg	
02319993			20 mg	
00789739	Supeudol	oxycodone HCl	5 mg	Tablet
00443948			10 mg	
02262983			20 mg	
00392480	Supeudol	oxycodone HCl	10 mg	Suppositories
00392472			20 mg	

Patients who have tried the combination products (e.g. Percocet) and have maximized the acetaminophen dose or have contraindications to acetaminophen.

02372525	OxyNeo	oxycodone	10 mg	Controlled Released Tablet
02372533			15 mg	
02372797			20 mg	
02372541			30 mg	
02372568			40 mg	
02372576			60 mg	
02372584			80 mg	

For the diagnosis of:

1. Cancer related pain; PLUS

Patients who are unable to tolerate or receive an adequate response to either the regular release dosage forms of oxycodone or the sustained release preparations of morphine or hydromorphone; OR

2. Pain management in a specified chronic pain diagnosis (details regarding patient's condition and previous medication history are required); PLUS

Patients who are unable to tolerate or receive an adequate response to either the regular release dosage forms of oxycodone or the sustained release preparations of morphine or hydromorphone.

Selective Serotonin and Norepinephrine Reuptake Inhibitors				
02420864 02420872	Abilify Maintena	aripiprazole	300 mg/vL 400 mg/vL	Injection
02354217 02354225 02354233 02354241	Invega Sustenna	paliperidone	50 mg/0.5 mL 75 mg/0.75 mL 100 mg/mL 150 mg/1.5 mL	Injection
02455943 02455986 02455994 02456001	Invega Trinza	paliperidone	175 mg/0.875 mL 263 mg/1.315 mL 350 mg/1.75 mL 525 mg/2.625 mL	Injection
02298465 02255707 02255727 02255758	Risperdal Consta	risperidone	12.5 mg 25 mg 37.5 mg 50 mg	Injection

For patients with schizophrenia:

- (a) With a history of non-adherence, as evidenced by outcomes such as repeated hospitalizations, or
- (b) Who have tried one or more antipsychotic agents, and who continue to be inadequately controlled, or are experiencing significant side effects such as EPS.

NOTE: Invega Trinza to be used only after Invega Sustenna has been established as adequate treatment for at least four months.

ELECTROLYTIC, CALORIC AND WATER BALANCE

02242814	Apo-Lactulose	lactulose	667 mg/mL	Oral Liquid
02247383	Euro-LAC	lactulose	667 mg/mL	Oral Liquid
02295881	Jamp-Lactulose	lactulose	667 mg/mL	Oral Solution
02412268	Lactulose	lactulose	667 mg/mL	Oral Solution
00703486	pms-Lactulose	lactulose	667 mg/mL	Oral Liquid
00854409	ratio-Lactulose	lactulose	667 mg/mL	Oral Liquid

Portal systemic encephalopathy.

02410702	Zaxine	rifaximin	550 mg	Tablet
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For reducing the risk of overt hepatic encephalopathy (HE) recurrence (i.e. 2 or more episodes), if the following clinical criteria are met:

- (a) Patients are unable to achieve adequate control of HE recurrence with maximal tolerated dose of lactulose alone;
- (b) Must be used in combination with a maximal tolerated dose of lactulose;
- (c) For patients not maintained on lactulose, information is required regarding the nature of the patient's intolerance to lactulose.

EYE, EAR, NOSE AND THROAT PREPARATIONS

02248151	Alphagan P	brimonidine tartrate	0.15%	Ophthalmic Solution
02301334	Apo-Brimonidine P	brimonidine tartrate	0.15%	Ophthalmic Solution

Intolerance to brimonidine 0.2%.

GASTROINTESTINAL DRUGS

02238525	HP-Pac	amoxicillin/clarithromycin/ lansoprazole	500 mg 500 mg 30 mg	Tablet
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For H. pylori Eradication (approved for a 7-14 day treatment course).

02212005	Apo-Loperamide	loperamide	2 mg	Tablet
02256452	Jamp-Loperamide	loperamide	2 mg	Tablet
02229552	Diarr-eze	loperamide	2 mg	Tablet
02183862	Imodium	loperamide	2 mg	Tablet
02132591	Novo-Loperamide	loperamide	2 mg	Tablet
02228351	pms-Loperamide	loperamide	2 mg	Tablet
02233998	Rhoxal-loperamide	loperamide	2 mg	Tablet
02257564	Sandoz Loperamide	loperamide	2 mg	Tablet

For the treatment of:

- (a) Ileostomy or a colostomy;
- (b) Bowel resection, including short bowel syndrome;
- (c) Inflammatory bowel diseases, e.g. Crohn's Disease, Ulcerative Colitis;
- (d) Cancer including chemotherapy and radiation therapy;
- (e) HIV/AIDS;
- (f) Fecal incontinence.

HORMONES AND SYNTHETIC SUBSTITUTES

02229293	Entocort	budesonide	3 mg	Capsule
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Crohn's Disease of ileum, ascending colon (right-sided disease).

02242572	Actos	pioglitazone	15 mg	Tablet
02242573			30 mg	
02242574			45 mg	

02303442 02303450 02303469	Accel-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02302942 02302950 02302977	Apo-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02384906 02384914 02384922	Auro-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02302861 02302888 02302896	CO Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02397307 02365529 02365537	Jamp-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02298279 02298287 02298295	Mylan-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02274914 02274922 02274930	Novo-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02326477 02326485 02326493	Mint-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02391600 02339587 02339595	Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02303124 02303132 02303140	pms-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02375850 02375869 02375877	Ran-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02301423 02301431 02301458	ratio-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02297906 02297914 02297922	Sandoz Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet

02434121	VAN-Pioglitazone	pioglitazone	15 mg	Tablet
02434148			30 mg	
02434156			45 mg	

For use in patients who are not optimally controlled on maximal doses of metformin and either a sulfonylurea (glyburide, gliclazide) or repaglinide or with contraindications to these agents.

Type 2 diabetics on high doses of insulin (over 2 U/kg) and on maximally tolerated metformin who are not achieving optimal control.

NOTE: Pioglitazone should be used as an add-on to pre-existing therapy not a substitution.

02245272	Amaryl	glimepiride	1 mg	Tablet
02245273			2 mg	
02245274			4 mg	
02295377	Apo-Glimepiride	glimepiride	1 mg	Tablet
02295385			2 mg	
02295393			4 mg	
02274248	CO Glimepiride	glimepiride	1 mg	Tablet
02274272			2 mg	
02274256			4 mg	
02273756	Novo-Glimepiride	glimepiride	1 mg	Tablet
02273764			2 mg	
02273772			4 mg	
02273101	ratio-Glimepiride	glimepiride	1 mg	Tablet
02273128			2 mg	
02273136			4 mg	
02269589	Sandoz Glimepiride	glimepiride	1 mg	Tablet
02269597			2 mg	
02269619			4 mg	

For patients poorly controlled on maximum doses of glyburide or gliclazide and metformin and diet (unless metformin is contraindicated because of renal/hepatic dysfunction or G.I. intolerance.)

02355663	Apo-Repaglinide	repaglinide	0.5 mg	Tablet
02355671			1 mg	
02355698			2 mg	
02424258	Auro-Repaglinide	repaglinide	0.5 mg	Tablet
02424266			1 mg	
02424274			2 mg	
02321475	CO Repaglinide	repaglinide	0.5 mg	Tablet
02321483			1 mg	
02321491			2 mg	
02239924	Gluconorm	repaglinide	0.5 mg	Tablet
02239925			1 mg	
02239926			2 mg	

02354926 02354934 02354942	pms-Repaglinide	repaglinide	0.5 mg 1 mg 2 mg	Tablet
02357453 02357461 02357488	Sandoz Repaglinide	repaglinide	0.5 mg 1 mg 2 mg	Tablet

(a) Inadequate control on maximum doses of glyburide and metformin.

(b) Frequent or severe hypoglycemic events despite dosage adjustments of glyburide or gliclazide.

02444844 02444852	Basaglar	insulin glargine	100 IU/mL	Injection
02245689 02251930 02294338	Lantus	insulin glargine	100 IU/mL	Injection
02271842 02412829	Levemir	insulin deetmir	100 U/mL	Injection

First line alternative, secondary to NPH and/or premix at daily optimal dose, for patients who have been diagnosed with Type 1 or Type 2 diabetes AND who have experienced unexplained nocturnal hypoglycemia at least once a month despite optimal management OR have documented severe or continuing systemic or local allergic reaction to existing insulin.

02425483 02425491	Invokana	canagliflozin	100 mg 300 mg	Tablet
02388839 02388847 02303922	Januvia	sitagliptin	25 mg 50 mg 100 mg	Tablet
02443937 02443945	Jardiance	empagliflozin	10 mg 25 mg	Tablet
02375842 02333554	Onglyza	saxagliptin	2.5 mg 5 mg	Tablet
02370921	Trajenta	linagliptin	5 mg	Tablet

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 are intolerant to metformin and a sulfonylurea, and for whom insulin is not an option.

02333856 02333864 02333872	Janumet	sitagliptin/metformin	50/500 mg 50/850 mg 50/1000 mg	Tablet
02416794	Janumet XR	sitagliptin/metformin	50/1000 mg	Tablet

02403250 02403269 02403277	Jentaducto	linagliptin/metformin	2.5/500 mg 2.5/850 mg 2.5/1000 mg	Tablet
02389169 02389177 02389185	Komboglyze	saxagliptin/metformin	2.5/500 mg 2.5/850 mg 2.5/1000 mg	Tablet

For type 2 diabetic patients who have been titrated to a stable combination, for a minimum of at least 3 months, of the separate components, Metformin and Linagliptin/Saxagliptin/Sitagliptin, and for whom insulin is not an option.

02435462 02435470	Forxiga	dapagliflozin	5 mg 10 mg	Tablet
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For the treatment of patients with type 2 diabetes.

1. Added on to metformin for patients:
 - (a) Who have inadequate glycemic control on metformin;
 - (b) Who have a contraindication or intolerance to a sulfonylurea;
 - (c) For whom insulin is not an option.
2. Added on to a sulfonylurea for patients
 - (a) Who have inadequate glycemic control on a sulfonylurea;
 - (b) Who have a contraindication or intolerance to metformin;
 - (c) For whom insulin is not an option.

02449935 02449943	Xigduo	dapagliflozin/metformin	5/850 mg 5/1000 mg	AZC
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For type 2 diabetic patients who have been titrated to a stable combination, for a minimum of 3 months, of the separate components, metformin and dapagliflozin.

MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

02244148 02244149	Protopic	tacrolimus	0.1% 0.03%	Ointment
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Second-line therapy for short and long-term intermittent-treatment of moderate to severe atopic dermatitis in non-immunocompromised patients, in whom the use of conventional topical corticosteroid therapies are deemed inadvisable because of potential risks, or who are not adequately responsive to or intolerant of conventional therapies.

Note: Both 0.03% and 0.1% for adults and only 0.03% for children aged 2 to 15 years.

02319012	Dovobet Gel	calcipotriol/betamethasone	50 mcg/0.5 mg/g	Gel
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For the treatment of moderate to severe scalp psoriasis vulgaris and mild to moderate plaque psoriasis vulgaris on the body after failure of calcipotriol.

SMOOTH MUSCLE RELAXANTS

02402874 02402882	Myrbetriq	mirabegron	25 mg 50 mg	Tablet
02254735	Oxytrol	oxybutynin	36 mg	Transdermal Patch
02275066	Trosec	tropium	20 mg	Tablet

Urinary incontinence in patients unable to tolerate or failing immediate release oxybutynin e.g. headache, dry mouth, dyspepsia.

MISCELLANEOUS THERAPEUTIC AGENTS

02242518 02246896	Actonel	risedronate	5 mg 35 mg	Tablet
02353687	Apo-Risedronate	risedronate	35 mg	Tablet
02406306	Auro-Risedronate	risedronate	35 mg	Tablet
02368552	Jamp-Risedronate	risedronate	35 mg	Tablet
02357984	Mylan-Risedronate	risedronate	35 mg	Tablet
02298376 02298392	Novo-Risedronate	risedronate	5 mg 35 mg	Tablet
02302209	pms-Risedronate	risedronate	35 mg	Tablet
02370255	Risedronate	risedronate	35 mg	Tablet
02411407	Risedronate	risedronate	35 mg	Tablet
02327295	Sandoz Risedronate	risedronate	35 mg	Tablet
02239028	Evista	raloxifene	60 mg	Tablet
02279215	Apo-Raloxifene	raloxifene	60 mg	Tablet
02358840	CO Raloxifene	raloxifene	60 mg	Tablet
02312298	Novo-Raloxifene	raloxifene	60 mg	Tablet
02358921	pms-Raloxifene	raloxifene	60 mg	Tablet
02352966	Alendronate	alendronate sodium	70 mg	Tablet
02299712	Alendronate	alendronate sodium	70 mg	Tablet
02381486 02381494	Alendronate	alendronate sodium	10 mg 70 mg	Tablet
02248728 02248730	Apo-Alendronate	alendronate sodium	10 mg 70 mg	Tablet
02388545 02388553	Auro-Alendronate	alendronate sodium	10 mg 70 mg	Tablet
02258110	CO Alendronate	alendronate sodium	70 mg	Tablet
02385031	Jamp-Alendronate	alendronate sodium	70 mg	Tablet
02394863 02394871	Mint-Alendronate	alendronate sodium	10 mg 70 mg	Tablet

02270129 02286335	Mylan-Alendronate	alendronate sodium	10 mg 70 mg	Tablet
02247373 02261715	Teva-Alendronate	alendronate sodium	10 mg 70 mg	Tablet
02273179	pms-Alendronate	alendronate sodium	70 mg	Tablet
02284006	pms-Alendronate FC	alendronate sodium	70 mg	Tablet
02384701 02384728	Ran-Alendronate	alendronate sodium	10 mg 70 mg	Tablet
02275279	ratio-Alendronate	alendronate sodium	70 mg	Tablet
02288087 02288109	Sandoz Alendronate	alendronate sodium	10 mg 70 mg	Tablet
02428725 02428733	VAN-Alendronate	alendronate sodium	10 mg 70 mg	Tablet

For the treatment of patients with:

- (a) Osteoporotic fractures;
- (b) Osteoporosis diagnosed with bone mineral density (BMD) measurements by any approved technology, e.g. a T score of < - 2.5; or
- (c) x-ray diagnosis of osteoporosis.

NOTE: *Concurrent calcium and vitamin D supplementation is recommended.*

02239146	Actonel	risedronate	30 mg	Tablet
02298384	Novo-Risedronate	risedronate	30 mg	Tablet
02258102	CO Alendronate	alendronate sodium	40 mg	Tablet
02201038	Fosamax	alendronate sodium	40 mg	Tablet

For the treatment of **Paget's Disease**.

02343541	Prolia	denosumab	60 mg/mL	Injection
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To increase bone mass in men or postmenopausal women with osteoporosis who are at a high risk for fracture or who have failed or are intolerant to other available osteoporosis therapy, where the following clinical criteria are met:

High fracture risk defined as either:

- moderate 10-year fracture risk (10% to 20%) as defined by either the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) tool or the World Health Organization's Fracture Risk Assessment (FRAX) tool with a prior fragility fracture;

OR

- high 10-year fracture risk ($\geq 20\%$) as defined by either the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) tool or the World Health Organization's Fracture Risk Assessment (FRAX) tool.

AND

Contraindication to oral bisphosphonates.

Notes:

- Bisphosphonate failure will be defined as a fragility fracture and/or evidence of a decline in bone mineral density below pre-treatment baseline levels, despite adherence for one year.

• Contraindication to oral bisphosphonates will be considered. Contraindications include renal impairment, hypersensitivity, and abnormalities of the esophagus (e.g. esophageal stricture or achalasia).

02269198	Aclasta	zoledronic acid	5 mg/100 mL	Injection
02415100	Taro-Zoledronic Acid	zoledronic acid	5 mg/100 mL	Injection
02422433	Zoldronic Acid	zoledronic acid	5 mg/100 mL	Injection
02408082	Zoldronic Acid	zoledronic acid	5 mg/100 mL	Injection

1. Paget's disease.
2. a) For female patients with post-menopausal osteoporosis (PMO) at high risk for fracture and satisfy at least two of the following three criteria:
 - (i) Age > 75 years;
 - (ii) A prior fragility fracture;
 - (iii) A bone mineral density (BMD) T-score \leq -2.5; OR
- b) Female patients with PMO with a serious intolerance to oral bisphosphonates or for whom oral bisphosphonates are contraindicated.

02368153	Xgeva	denosumab	120 mg	Injection
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For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer with one or more documented bony metastases and good performance status (ECOG performance status score of 0, 1 or 2).

02244324	Apo-Cyclosporine	cyclosporine	100 mg/mL	Solution
02237671	Neoral	cyclosporine	10 mg	Capsule
02150689			25 mg	
02150662			50 mg	
02150670			100 mg	
02150697	Neoral	cyclosporine	100 mg/mL	Solution
02247073	Rhoxal-cyclosporine	cyclosporine	25 mg	Capsule
02247074			50 mg	
02242821			100 mg	

- (a) Psoriasis resistant to topical treatments (steroids, coal tar), systemic retinoids, MTX, hydroxyurea, PUVA, UVB treatment.
- (b) Rheumatoid arthritis.
- (c) Pediatric nephrotic syndrome.
- (d) Vasculitis failing other therapies such as steroids, Imuran.
- (e) Aplastic anemia.
- (f) Inflammatory bowel disease.
- (g) Where prescribed by a neurologist for the treatment of myasthenia gravis refractory to azathioprine, with or without steroids or where azathioprine is contraindicated.

NOTE: TRANSPLANT patients are covered under the WRHA Hospital Insured Program at HSC Psychiatry Pharmacy, phone number (204) 787-7440.

02436841	Entyvio	vedolizumab	300 mg/vL	Injection
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For the treatment of patients over 18 years of age with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy including 5-aminosalicylate compounds corticosteroids and immunomodulators and for the treatment of moderate to severely active Crohn's Disease and/or Fistulating Crohn's Disease in patients refractory or with contraindications to an adequate course of 5-aminosalicylic acid and corticosteroids and/or other immunosuppressive therapy.

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

02402475 02282097	Orencia	abatacept	125 mg/mL 250 mg/vial	Injection
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For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis and who have failed treatment with at least 3 DMARDs (disease-modifying antirheumatic drugs) 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.

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

02455323 02455331	Brenzys	etanercept	50 mg/mL	Injection
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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 DMARD's 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.

Brenzys or Erelzi will be the preferred etanercept option for all etanercept-naive patients prescribed an etanercept product for Rheumatoid Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naive patients.

Patients will not be permitted to switch from Brenzys to another etanercept product or vice versa, if previously trialed and deemed unresponsive to therapy.

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, have failed to respond to methotrexate or sulfasalazine.

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

Brenzys or Erelzi will be the preferred etanercept option for all etanercept-naive patients prescribed an etanercept product for Ankylosing Spondylitis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naive patients.

Patients will not be permitted to switch from Brenzys to another etanercept product or vice versa, if previously trialed and deemed unresponsive to therapy.

02462869 02462877 02462850	Erelzi	etanercept	50 mg/mL 25mg/0.5mL 50mg/mL	Injection
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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 DMARD's 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.

Erelzi or Brenzys will be the preferred etanercept option for all etanercept-naive patients prescribed an etanercept product for Rheumatoid Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naive patients.

Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa, if previously trialed and deemed unresponsive to therapy.

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, have failed to respond to methotrexate or sulfasalazine.

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

Erelzi or Brenzys will be the preferred etanercept option for all etanercept-naive patients prescribed an etanercept product for Ankylosing Spondylitis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naive patients.

Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa, if previously trialed and deemed unresponsive to therapy.

Polyarticular Juvenile Idiopathic Arthritis:

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 years of age or 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.

New requests for the treatment of Polyarticular Juvenile Idiopathic Arthritis for etanercept-naive patients weighing 63 kg (138 pounds) or more will be assessed for coverage with Erelzi.

Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa, if previously trialed and deemed unresponsive to therapy.

02242903 02274728	Enbrel	etanercept	25 mg 50 mg/mL	Injection
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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 DMARD's 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.

Brenzys or Erelzi will be the preferred etanercept option for all etanercept-naive patients prescribed an etanercept product for Rheumatoid Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naive patients.

Patients will not be permitted to switch from Enbrel to another etanercept product or vice versa, if:

1. Previously trialed and deemed unresponsive to therapy.

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 DMARD's 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.

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, have failed to respond to methotrexate or sulfasalazine.

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

Brenzys or Erelzi will be the preferred etanercept option for all etanercept-naive patients prescribed an etanercept product for Ankylosing Spondylitis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naive patients.

Patients will not be permitted to switch from Enbrel to another etanercept product or vice versa, if:

1. Previously trialed and deemed unresponsive to therapy.

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 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ 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.

02258595	Humira	adalimumab	40 mg/0.8 mL	Injection
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Crohn's Disease:

For treatment of moderate to severely active Crohn's Disease and/or Fistulizing Crohn's Disease in patients refractory or with contraindications to an adequate course of 5-aminosalicylic acid and corticosteroids and other immunosuppressive therapy.

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

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 DMARD's 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.

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 DMARD's 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.

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.

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:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ 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.

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.

Ulcerative Colitis:

For the treatment of adult patients with moderately to severely active colitis who have had an inadequate response to conventional therapy including 5-aminosalicylate compounds, corticosteroids and immunomodulators.

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

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.

02245913	Kineret	anakinra	150 mg/mL	Injection
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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 DMARD's 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.

02419475	Inflectra	infliximab	100 mg/vL	Injection
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Rheumatoid Arthritis

For the 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.

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Rheumatoid Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

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 contraindication to these agents is documented. One combination therapy of DMARD 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.

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Psoriatic Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

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 non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

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

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Ankylosing Spondylitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

Psoriasis

For the treatment of adult patients with severe plaque psoriasis with one or more of the following:

- Psoriasis Area and Severity Index (PASI) \geq 10;
- Body Surface Area (BSA) $>$ 10 percent;
- Dermatology Life Quality Index (DLQI) $>$ 10;
- Significant involvement of the face, hands, feet or genital region; AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

The initial request is approved 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:

\geq 50 percent reduction in the PASI score with \geq point improvement in the DLQI; OR

\geq 75 percent reduction in the PASI score; OR

\geq 50 percent 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.

Inflectra will be the preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriasis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

Crohn's Disease

For the treatment of patients over 18 years of age with moderate to severely active Crohn's Disease and/or Fistulating Crohn's

Disease in patients refractory or with contraindications to an adequate course of 5-aminosalicylic acid and corticosteroids and/or other immunosuppressive therapy.

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

Inflectra will be the preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Crohn's Disease. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy including 5-aminosalicylate compounds, corticosteroids and immunomodulators.

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

Inflectra will be the preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Ulcerative Colitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

02244016	Remicade	infliximab	100 mg/10 mL	Injection
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Crohn's Disease

For the treatment of moderate to severely active Crohn's Disease and/or Fistulating Crohn's Disease in patients refractory or with contraindications to an adequate course of 5-aminosalicylic acid and corticosteroids and/or other immunosuppressive therapy.

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

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Crohn's Disease. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Remicade to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

Rheumatoid Arthritis

For the 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.

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Rheumatoid Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Remicade to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

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 contraindication to these agents is documented. One combination therapy of DMARD 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.

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab products for Psoriatic Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Remicade to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

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 non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

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

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Ankylosing Spondylitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Remicade to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

Psoriasis

For the treatment of adult patients with severe plaque psoriasis with one or more of the following:

- Psoriasis Area and Severity Index (PASI) \geq 10;
- Body Surface Area (BSA) > 10 percent;
- Dermatology Life Quality Index (DLQI) > 10;
- Significant involvement of the face, hands, feet or genital region; AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

The initial request is approved 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:

\geq 50 percent reduction in the PASI score with \geq point improvement in the DLQI; OR

\geq 75 percent reduction in the PASI score; OR

\geq 50 percent 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.

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Psoriasis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Remicade to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

Ulcerative Colitis

For the treatment of patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy including 5-aminosalicylate compounds, corticosteroids and immunomodulators.

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

Inflectra will be the preferred infliximab option for all infliximab-naive patients prescribed an infliximab product for Ulcerative Colitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Remicade to another infliximab product or vice versa, if:

- 1. Previously trialed and deemed unresponsive to therapy.***

02241927	Rituxan	rituximab	10 mg/mL	Injection
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Rheumatoid Arthritis:

For the treatment of severely active rheumatoid arthritis (RA), in combination with methotrexate, for patients who have failed to respond to an adequate trial of one or more anti-tumor necrosis factor (anti-TNF) agents (monoclonal antibody OR fusion protein) OR who are contraindicated to anti-TNF agents.

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

As induction-remission therapy for patients with severely active Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA) in whom the use of cyclophosphamide has failed; or the use of cyclophosphamide is not appropriate.

02424770	Actemra	tocilizumab	162 mg/0.9 mL	Injection
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Rheumatoid Arthritis:

For the treatment of adult patients who have moderate to severe active rheumatoid arthritis and who:

- (i) failed treatment with at least 3 DMARD (disease-modifying antirheumatic drugs) therapies, one of which therapies must be either methotrexate or leflunomide, unless intolerance or contraindication to these therapies is documented; and
- (ii) previously tried at least one combination of DMARD therapies.

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

02350092	Actemra	tocilizumab	80 mg/4 mL	Injection
02350106			200 mg/10 mL	
02350114			400 mg/20 mL	

Rheumatoid Arthritis:

For the treatment of adult patients who have moderate to severe active rheumatoid arthritis and who:

- (i) failed treatment with at least 3 DMARD (disease-modifying antirheumatic drugs) therapies, one of which therapies must be either methotrexate or leflunomide, unless intolerance or contraindication to these therapies is documented; and
- (ii) previously tried at least one combination of DMARD therapies.

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

Systemic Juvenile Idiopathic Arthritis:

For the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older who:

- (i) have responded inadequately to previous therapy with one or more non steroidal anti-inflammatory drugs; and
- (ii) who have responded inadequately to previous therapy with one or more systemic corticosteroids.

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.

02324776 02324784	Simponi	golimumab	50 mcg/0.5 mL 50 mcg/0.5 mL	Injection
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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.

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, have failed to respond to methotrexate or sulfasalazine.

Psoriatic Arthritis:

For the 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 have been 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.

Ulcerative Colitis:

For the treatment of patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy including 5-aminosalicylate compounds, corticosteroids and immunomodulators.

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

02417472	Simponi IV	golimumab	50 mg/4 mL	Injection
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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.

02331675	Cimzia	certolizumab	200 mg/mL	Injection
02465574	Cimzia	certolizumab	200 mg/mL	Autoinjector

Rheumatoid Arthritis

For the 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.

Psoriatic Arthritis:

For the 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 contraindication to these agents is documented. One combination therapy of DMARD 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.

Ankylosing Spondylitis:

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least 3 different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

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

02320673 02320681	Stelara	ustekinumab	45 mg/0.5 mL 90 mg/mL	Injection
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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) \geq 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 3 months. For continued coverage the physician must confirm the patient’s response to treatment and demonstration of treatment clinical benefits:

- \geq 50% reduction in the PASI score with \geq 5 point improvement in the DLQI
- \geq 75 % reduction in the PASI score
- \geq 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.

02438070	Cosentyx	secukinumab	150 mg/mL	Injection
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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) \geq 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 3 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.

Psoriatic Arthritis (PsA):

For the 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 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 reactive protein value.

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

Ankylosing Spondylitis (AS):

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least 3 different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

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

02455102 02455110	Taltz	ixekizumab	80 mg/mL 80 mg/mL	Autoinjector Pre-filled Syringe
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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 3 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.

02416328	Aubagio	teriflunomide	14 mg	Tablet
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02237770	Avonex	interferon beta 1-a	30 mcg	Injection
02269201	Avonex	interferon beta 1-a	30 mcg/0.5 mL	Injection
02418320	Lemtrada	alemtuzumab	12 mg/1.2 mL	Solution for IV Infusion
02237319	Rebif	interferon beta 1-a	22 mcg/0.5 mL	Injection
02237320	Rebif	interferon beta 1-a	44 mcg/0.5 mL	Injection
02169649	Betaseron	interferon beta 1-b	0.3 mg	Injection
02233014	Copaxone	glatiramer acetate	20 mg/2 mL	Injection
02245619	Copaxone	glatiramer acetate	20 mg/mL	Pre-Filled Syringe
02460661	Glatect	glatiramer acetate	20 mg	Pre-Filled Syringe
02365480	Gilenya	fingolimod	0.5 mg	Capsule
02444399	Plegridy	peginterferon beta-1a	125 mcg/0.5 mL	Injection
02444402			63 mcg/0.5 mL	
02404508	Tecfidera	dimethyl fumarate	120 mg	Capsule
02420201			240 mg	
02286386	Tysabri	natalizumab	300 mg/15 mL	Injection

Specialists from the MS Clinic may apply for Part 3 EDS. Please contact the EDS Program at MB Health for specific criteria.

Glatect will be the preferred glatiramer acetate option for all glatiramer acetate-naïve patients prescribed a glatiramer acetate product for relapsing-remitting multiple sclerosis (MS). Patients will not be permitted to switch from Glatect to another glatiramer acetate product or vice versa, if:

1. Previously trialed and deemed unresponsive to therapy.

02059762	Aredia	pamidronate disodium	3 mg/mL	Injection
02059789			9 mg/mL	
02244550	Pamidronate Disodium	pamidronate disodium	3 mg/mL	Injection
02244552			9 mg/mL	
02264951	Rhoxal-pamidronate	pamidronate disodium	3 mg/mL	Injection
02264986			9 mg/mL	
02249669	Pamidronate Disodium Omega	pamidronate disodium	3 mg/mL	Injection
02249685			9 mg/mL	

Patients unable to absorb oral medications due to Crohn's Disease or other absorption problems (use for the treatment of osteoporosis).

02296462 02296470 02331667 02296489	Advagraf	tacrolimus	0.5 mg 1 mg 3 mg 5 mg	Capsule
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For the prophylaxis of organ rejection in patients receiving allogeneic liver or kidney transplants

02243144 02175991 02175983	Prograf	tacrolimus	0.5 mg 1 mg 5 mg	Capsule
02176009	Prograf	tacrolimus	5 mg/mL	Injection
00960632	Prograf	tacrolimus	0.5 mg/ mL	Suspension
02416816 02416824 02416832	Sandoz Tacrolimus	tacrolimus	0.5 mg 1 mg 5 mg	Capsule

(a) For the prophylaxis of organ rejection in patients receiving allogeneic liver or kidney transplants.

(b) For use in atopic dermatitis resistant to potent steroids and oral cyclosporine.

02352559 02352567	Apo-Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule Tablet
02192748 00960601	Cellcept	mycophenolate mofetil	250 mg 50 mg/mL	Capsule
02242145	Cellcept	mycophenolate mofetil	200 mg/mL	Injection
02237484	Cellcept	mycophenolate mofetil	500 mg	Tablet
02379996	CO Mycophenolate	mycophenolate mofetil	500 mg	Tablet
02386399 02380382	Jamp-Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule Tablet
02383780 02378574	Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule
02457369 02457377	Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule
02371154 02370549	Mylan-Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule Tablet
02320630 02313855	Sandoz Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule Tablet
02364883 02348675	Teva-Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule Tablet
02433680 02432625	VAN-Mycophenolate	mycophenolate mofetil	250 mg 500 mg	Capsule Tablet

(a) Transplant patients.

(b) Lupus nephritis refractory to I.V. cyclophosphamide.

(c) Glomerular disease resistant or relapsing steroid treatment and/or alkylating agents.

(d) Severe psoriasis failing PUVA, acitretin and immunosuppressants (e.g. MTX, Neoral).

Bullous pemphigoid or autoimmune hepatitis for patients who are intolerant of steroids and azathioprine.

02264560 02264579	Myfortic	mycophenolate sodium	180 mg 360 mg	Tablet
02372738 02372746	Apo-Mycophenolic Acid	mycophenolate sodium	180 mg 360 mg	Tablet

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

02248540	Apo-Tryptophan	l-tryptophan	500 mg	Capsule
02248538 02458721 02248539	Apo-Tryptophan	l-tryptophan	500 mg 750 mg 1 g	Tablet
02240445 02230202	pms-Tryptophan	l-tryptophan	500 mg 1 g	Tablet
02240334	ratio-Tryptophan	l-tryptophan	500 mg	Capsule
02240333 02237250	ratio-Tryptophan	l-tryptophan	500 mg 1 g	Tablet
00718149	Tryptan	l-tryptophan	500 mg	Capsule
02029456 00654531	Tryptan	l-tryptophan	500 mg 1 g	Tablet

Adjunct therapy for refractory depression. Must have tried at least 2 other antidepressants.

02256495 02256509	Apo-Leflunomide	leflunomide	10 mg 20 mg	Tablet
02351668 02351676	Leflunomide	leflunomide	10 mg 20 mg	Tablet
02319225 02319233	Mylan-Leflunomide	leflunomide	10 mg 20 mg	Tablet
02241888 02241889	Arava	leflunomide	10 mg 20 mg	Tablet
02261251 02261278	Novo-Leflunomide	leflunomide	10 mg 20 mg	Tablet
02288265 02288273	pms-Leflunomide	leflunomide	10 mg 20 mg	Tablet
02283964 02283972	Sandoz Leflunomide	leflunomide	10 mg 20 mg	Tablet

Rheumatoid arthritis failing at least 2 disease modifying antirheumatic drugs (DMARDs), eg. gold, methotrexate (MTX), plaquenil, sulfasalazine, minocycline and doxycycline.

02233542	Diane-35	cyproterone acetate/ ethinyl estradiol	2 mg/0.035 mg	Tablet
02290308	Cyestra-35	cyproterone acetate/ ethinyl estradiol	2 mg/0.035 mg	Tablet
02309556	Novo-Cyproterone/Ethinyl Estradiol	cyproterone acetate/ ethinyl estradiol	2 mg/0.035 mg	Tablet

(a) Treatment of severe acne - refractory to birth control pills, topicals (vitamin A/acid gel, tretinoin), Accutane and antibiotics.

(b) Hirsutism not responding to standard therapy (e.g. birth control pills, spironolactone, metformin).

02408163	Fibrystal	uliprostal	5 mg	Tablet
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For the treatment of moderate to severe signs and symptoms of uterine fibroids in adult women of reproductive age, who are eligible for surgery under the following conditions:

(a) The duration of treatment will not exceed three (3) months, per patient, per lifetime;

(b) The patient is under the care of a physician experienced in the management of gynecological conditions such as uterine fibroids.

01968017	Neupogen	filgrastim	0.3 mg/mL	Injection
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For the use in patients with HIV infection for the prevention and treatment of neutropenia to maintain a normal absolute neutrophil count (ANC).

Grastofil will be the preferred filgrastim option for all filgrastim-naive patients. Preferred means the first infliximab product to be considered for reimbursement for filgrastim-naive patients.

02387174	Dificid	fidaxomicin	200 mg	Tablet
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For the treatment of patients:

(a) in place of vancomycin if there is a documented allergy to vancomycin; or

(b) as an alternative to vancomycin if a patient experiences a "severe adverse reaction" to vancomycin therapy; or

(c) treatment that results in the discontinuation of vancomycin;

(d) as an alternative to vancomycin if a patient experiences a 'severe intolerance' to vancomycin treatment that results in the discontinuation of vancomycin therapy; or

(e) for use in the event of vancomycin treatment failure.

In addition to the above, for use in prior Clostridium Difficile Infection (CDI) situations after other current CDI treatment options fail.

02414716	ACT Ezetimibe	ezetimibe	10 mg	Tablet
02427826	Apo-Ezetimibe	ezetimibe	10 mg	Tablet
02429659	Ezetimibe	ezetimibe	10 mg	Tablet
02431300	Ezetimibe	ezetimibe	10 mg	Tablet
02423235	Jamp-Ezetimibe	ezetimibe	10 mg	Tablet
02378035	Mylan-Ezetimibe	ezetimibe	10 mg	Tablet
02422662	Mar-Ezetimibe	ezetimibe	10 mg	Tablet
02423243	Mint-Ezetimibe	ezetimibe	10 mg	Tablet

02416409	pms-Ezetimibe	ezetimibe	10 mg	Tablet
02419548	Ran-Ezetimibe	ezetimibe	10 mg	Tablet
02416778	Sandoz Ezetimibe	ezetimibe	10 mg	Tablet
02354101	Teva-Ezetimibe	ezetimibe	10 mg	Tablet

For the treatment of hypercholesterolemia in patients that are intolerant or have failed to achieve cholesterol target levels on statin therapy.

02393751	Esbriet	pirfenidone	267 mg	Capsule
02443066 02443074	Ofev	nintedanib	100 mg 150 mg	Capsule

For the treatment of adult patients who have a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF)* confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.

*Mild-moderate IPF is defined as: forced vital capacity (FVC) greater than or equal to 50% of predicted.

02425696	Firazyr	icatibant	30 mg/3 mL	Pre-filled Syringe
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For the treatment of acute attacks of hereditary Angioedema (HAE) in adults with lab confirmed c1-esterase inhibitor deficiency (type I or II) if the following conditions are met:

- (a) Treatment of acute non-laryngeal attacks of at least moderate severity OR
- (b) Treatment of acute laryngeal attacks,
- (c) Limited to a single dose for self-administration AND
- (d) Prescribed by an allergist with experience in the treatment of HAE AND
- (e) Up to 2 doses on hand at any one time.

02418118	Apo-Sildenafil R	sildenafil	20 mg	Tablet
02412179	pms-Sildenafil R	sildenafil	20 mg	Tablet
02319500	ratio-Sildenafil R	sildenafil	20 mg	Tablet

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 20mg three times daily.

On written request by PAH specialist only.