BULLETIN # 118

Manitoba Drug Benefits and Manitoba Drug Interchangeability Formulary Amendments

The following amendments will take effect on June 1, 2022

The amended Manitoba Drug Benefits Formulary and Manitoba Drug Interchangeability Formulary will be available on the Manitoba Health website http://www.gov.mb.ca/health/mdbif on the effective date of June 1, 2022

Bulletin 118 is currently available for download:
http://www.gov.mb.ca/health/mdbif/bulletin118.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*
02511282 02511290	**Auro-Ondansetron ODT**	ondansetron	4 mg 8 mg	Orally Disintegrating Tablet	AUP
02447851	**Buspirone**	buspirone	10 mg	Tablet	SAH
02523493	**Depo-Provera** *(new format)*	medroxyprogesterone acetate	150 mg/mL	Injection	PFI
02400650	**Enalapril**	enalapril maleate	2.5 mg	Tablet	SAH
02466864	**Entuzity Kwikpen**	insulin injection human biosynthetic	500 U/mL	Injection	LIL
02497654	**Jamp Abacavir/Lamivudine**	abacavir/lamivudine	600/300 mg	Tablet	JPC
02517701 02517728	**Jamp Midodrine**	midodrine	2.5 mg 5 mg	Tablet	JPC
02507773 02507781 02507803	**Jamp Paroxetine**	paroxetine	10 mg 20 mg 30 mg	Tablet	JPC
80035346	**M-K 8 L.A.**	potassium chloride	600 mg	Tablet	MNP
02513285	**M-Latanoprost**	latanoprost	0.005 %	Ophthalmic Solution	MNP
02514516	**M-Latanoprost-Timolol**	latanoprost/timolol maleate	50 mcg/5 mg/mL	Ophthalmic Solution	MNP
02519054	**Mint-Buspirone**	buspirone	10 mg	Tablet	MPH
02503751 02503778 02503786	**Octreotide**	octreotide acetate	10 mg 20 mg 30 mg	Powder for Injection	TEV
02519720 02519739	**Perindopril/ Indapamide**	perindopril/indapamide	4 mg/1.25 mg 8 mg/2.5 mg	Tablet	SAH
02479834 02479842	**Perindopril Erbumine/Indapamide**	perindopril/indapamide	4 mg/1.25 mg 8 mg/2.5 mg	Tablet	SIP
02520303 02520311	**pmsc-Metformin**	metformin HCl	500 mg 850 mg	Tablet	PMS
02516217 02515784 02515792	**Sandoz Clonidine**	clonidine HCl	0.025 mg 0.1 mg 0.2 mg	Tablet	SDZ
02522306	**Taro-Acyclovir**	acyclovir	5 %	Ointment	TAR
02519194	**Tranexamic Acid**	tranexamic acid	500 mg	Tablet	JPC
02342863	**Vancomycin Hydrochloride**	vancomycin HCl	1 G	Powder for Injection	SMI
02516535 02516543 02516551	**Venlafaxine XR**	venlafaxine	37.5 mg 75 mg 150 mg	Capsule	JPC

Part 2 Additions

02508249 02508257 02508265	**Jamp Amoxi Clav**	amoxicillin/clavulanic acid	250/125 mg 500/125 mg 875/125 mg	Tablet	JPC

a) For treatment of patients not responding to alternative antibiotics (e.g. amoxicillin)
b) For treatment of patients with infections casued by organisms known to be resistant to alternative (e.g. amoxicillin)

02476576	**pms-Progesterone**	progesterone	100 mg	Capsule	PMS
02463113	**Reddy-Progesterone**	progesterone	100 mg	Capsule	DRL

For the treatment of post-menopausal patients unable to tolerate oral medroxyprogesterone or in patients with low High Density Lipoprotein Cholesterol.

02516756	**Rizatriptan**	rizatriptan	10 mg	Tablet	SAH

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

Exception Drug Status Additions

02511061 02511053	**Abrilada** *(biosimilar)*	adalimumab	20 mg/0.4 mL 40 mg/0.8 mL	Injection *prefilled syringe*	PFI
02511045	**Abrilada** *(biosimilar)*	adalimumab	40 mg/0.8mL	Injection *prefilled pen*	PFI

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

For Pediatrics: Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada 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.

Abrilada 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 Abrilada to another adalimumab product or vice versa, if:

• Previously trialed and deemed unresponsive to adalimumab.

02497859	**Ajovy**	fremanezumab	225 mg/1.5 mL	Injection *prefilled syringe*	TEV
02509474	**Ajovy**	fremanezumab	225 mg/1.5 mL	Injection *prefilled autoinjector*	TEV

For the prevention of migraine in patients who have a confirmed diagnosis of either:

1. Episodic migraine: headaches for less than 15 days per month for more than 3 months of which at least 4 days per month are with migraine; OR
2. Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least 8 days per month are with migraine.

Initiation criteria:

• The patient must have experienced an inadequate response[1], intolerance, or contraindication to at least two oral prophylactic migraine medications[2] of different classes; AND
• The patient must be under the care of a physician who has appropriate experience in the management of migraine headaches; AND
• The physician must provide the number of headache and migraine days per month at the time of initial request for reimbursement.

Initial approval duration: 6 months

Initial Renewal criteria:

• Reduction of at least 50% in the average number of migraine days per month compared with baseline.

Renewal duration: 6 months

Subsequent Renewal criteria:

• Maintenance of 50% reduction in the average number of migraine days per month from baseline.

[1] *Inadequate response to oral prophylactic therapies is defined as less than a 30% reduction in frequency of headache days to an adequate dose and duration of at least two prophylactic medications, which must be of a different class.*

[2] *Oral prophylactic medication alternatives include:*

• *beta blockers*
• *tricyclic antidepressants*
• *verapamil or flunarizine*
• *sodium valproate or divalproex sodium*
• *topiramate*
• *gabapentin*

02479206 02479214 02479222	**Alunbrig**	brigatinib	30 mg 90 mg 180 mg	Tablet	TAK
02479230	**Alunbrig Initiation Pack**	brigatinib	90 mg & 180 mg	Kit-Tablet	TAK

For the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC) previously untreated with an ALK inhibitor.

Eligible patients should have a good performance status and treatment should be continued until disease progression or unacceptable toxicity, whichever occurs first.

02492415	**Baqsimi**	glucagon	3 mg	Powder	LIL

For the treatment of severe hypoglycemia (SH) reactions in patients with diabetes mellitus who are receiving insulin therapy and are at high risk for SH, when impaired consciousness precludes oral carbohydrates.

02514931	**Evrysdi**	risdiplam	0.75 mg/mL	Powder for Solution	HLR

For the treatment of Spinal Muscular Atrophy (SMA). Complete criteria may be obtained from the EDS office at Manitoba Health.

02502380	**Hulio** *(biosimilar - new strength)*	adalimumab	20 mg/0.4 mL	Injection *prefilled syringe*	BGP

Please refer to Bulletin 112 for prescribing criteria.
https://www.gov.mb.ca/health/mdbif/docs/bulletins/bulletin112.pdf

02511355	**Kesimpta**	ofatumumab	20 mg/0.4 mL	Injection *prefilled pen*	BGP

For the treatment of adult patients with an established diagnosis of relapsing-remitting multiple sclerosis (RRMS), when prescribed by a neurologist from the Manitoba Multiple Sclerosis (MS) Clinic.

02475200 02475219	**Lynparza** *(new indication)*	olaparib	100 mg 150 mg	Tablet	AZC

Metastatic castration-resistant prostate cancer (mCRPC)
• As monotherapy for the treatment of adult patients with metastatic castration-resistant prostate cancer (mCRPC) and deleterious or suspected deleterious germline and/or somatic mutations in the homologous recombination repair (HRR) genes BRCA or ATM who have progressed following prior treatment with a new hormonal agent/androgen-receptor-axis-targeted therapy (ARAT).

Eligible patients should have a good performance status and treatment should continue until disease progression or unacceptable toxicity.

02477777	**Monoferric**	iron	100 mg/mL	Injection	PFI

For the treatment of iron deficiency anemia (IDA) in patients who meet the following criteria:
• Patient has a documented diagnosis of IDA based on laboratory test results (i.e. hemoglobin, ferritin); AND
• Patient has failed to respond or is intolerant to an adequate trial (at least 4 weeks) of oral iron therapy; OR
• Patient has a contraindication to oral iron therapy.
• Monoferric is administered in a setting where appropriate monitoring and management of hypersensitivity reactions can be provided to the patient.

02443066 02443074	**Ofev** *(new indication)*	nintedanib	100 mg 150 mg	Capsule	BOE

Chronic fibrosing interstitial lung diseases
Initiation criteria:
• The patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype confirmed by a specialist in interstitial lung diseases.
• The patient has a forced vital capacity greater than or equal to 45% of predicted.

Renewal criteria:
• The patient must not experience a more severe progression of disease, defined as an absolute decline in percent predicted forced vital capacity of 10% or greater over the preceding year of treatment with nintedanib.
• The patient's clinical status should be evaluated every 12 months.

Prescribing conditions:
• The patient's condition has been assessed by a specialist with experience in the diagnosis and management of interstitial lung diseases.
• Concurrent treatment of nintedanib with pirfenidone should not be reimbursed.

02498316	**Riximyo** *(biosimilar - new indication)*	rituximab	10 mg/mL	Injection	SDZ

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.

Riximyo will be a preferred rituximab option for all rituximab-naive patients prescribed a rituximab product for rheumatoid arthritis, Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA). Preferred means the first rituximab product to be considered for reimbursement for rituximab-naive patients. Patients will not be permitted to switch from Riximyo to another rituximab product or vice versa, if:
• Previously trialed and deemed unresponsive to therapy.

02523949 02523965	**Simlandi** *(biosimilar)*	adalimumab	40 mg/0.4 mL 80 mg/0.8mL	Injection *prefilled syringe*	JPC
02523957	**Simlandi** *(biosimilar)*	adalimumab	40 mg/0.4 mL	Injection *autoinjector*	JPC

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: Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi 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.

Simlandi 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 Simlandi to another adalimumab product or vice versa, if:
• Previously trialed and deemed unresponsive to adalimumab.

02519283	**Skyrizi** *(new strength)*	risankizumab	150 mg/mL	Injection *prefilled syringe*	ABV
02519291	**Skyrizi** *(new strength)* *(new format)*	risankizumab	150 mg/mL	Injection *prefilled pen*	ABV

Please refer to Bulletin 106 for prescribing criteria.
https://www.gov.mb.ca/health/mdbif/docs/bulletins/bulletin106.pdf

02243716	**Venofer**	iron sucrose	20 mg/mL	Injectable Solution	VFM
02502917	**pms-Iron Sucrose**	iron sucrose	20 mg/mL	Injectable Solution	PMS

For the treatment of iron deficiency anemia (IDA) in patients who meet the following criteria:
• Patient has a documented diagnosis of IDA based on laboratory test results (i.e. hemoglobin, ferritin); AND
• Patient has failed to respond or is intolerant to an adequate trial (at least 4 weeks) of oral iron therapy; OR
• Patient has a contraindication to oral iron therapy.
• Iron sucrose is administered in a setting where appropriate monitoring and management of hypersensitivity reactions can be provided to the patient.

02517841	**Vyndamax** *(new formulation)*	tafamidis	61 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.

02523760	**Yuflyma** *(biosimilar)*	adalimumab	40 mg/0.4 mL	Injection *prefilled syringe*	CHC
02523779	**Yuflyma** *(biosimilar)*	adalimumab	40 mg/0.4 mL	Injection *prefilled pen*	CHC

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: Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma 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.

Yuflyma 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 Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02509695	**Zolgensma**	onasemnogene abeparvovec	2 x 10^13 VG/mL	injection	NVT

For the treatment of Spinal Muscular Atrophy (SMA).
Complete criteria may be obtained from the EDS office at Manitoba Health.

New Interchangeable Categories

Amoxicillin/Clavulanic Acid - 250 mg/125 mg - Tablets			**$**	**$ + 5%**
02243350	Apo-Amoxi Clav	APX	0.4934	0.5181
02508249	Jamp Amoxi Clav	JPC	0.4934	0.5181

Clonidine - 0.025 mg - Tablets			**$**	**$ + 5%**
02516217	Sandoz Clonidine	SDZ	0.1360	0.1428
02304163	Teva-Clonidine	TEV	0.1360	0.1428

Iron Sucrose - 20 mg/mL - Injectable Solution			**$**	**$ + 5%**
02243716	Venofer	VFM	5.5000	5.7750
02502917	pms-Iron Sucrose	PMS	5.5000	5.7750

Octreotide Acetate - 10 mg - Powder for Injection			**$**	**$ + 5%**
02239323	Sandostatin LAR	NVT	660.4650	693.4883
02503751	Octreotide	TEV	495.3488	520.1162

Octreotide Acetate - 20 mg - Powder for Injection			**$**	**$ + 5%**
02239324	Sandostatin LAR	NVT	853.2952	895.9600
02503778	Octreotide	TEV	639.9675	671.9659

Octreotide Acetate - 30 mg - Powder for Injection			**$**	**$ + 5%**
02239325	Sandostatin LAR	NVT	1094.7619	1149.5000
02503786	Octreotide	TEV	821.0700	862.1235

New Interchangeable Products

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

Abacavir/Lamivudine - 600/300 mg - Tablets			**$**	**$ + 5%**
02497654	Jamp Abacavir/Lamivudine	JPC	5.9875	6.2869

Acyclovir - 5 % - Ointment			**$**	**$ + 5%**
02522306	Taro-Acyclovir	TAR	7.2420	** 7.6041

Amoxicillin/Clavulanic Acid - 500 mg/125 mg - Tablets			**$**	**$ + 5%**
02508257	Jamp Amoxi Clav	JPC	0.3778	** 0.3967

Amoxicillin/Clavulanic Acid - 875 mg/125 mg - Tablets			**$**	**$ + 5%**
02508265	Jamp Amoxi Clav	JPC	0.5551	** 0.5829

Buspirone - 10 mg - Tablets			**$**	**$ + 5%**
02447851	Buspirone	SAH	0.2713	0.2849
02519054	Mint-Buspirone	MPH	0.2713	0.2849

Clonidine HCl - 0.1 mg - Tablets			**$**	**$ + 5%**
02515784	Sandoz Clonidine	SDZ	0.0679	** 0.0713

Clonidine HCl - 0.2 mg - Tablets			**$**	**$ + 5%**
02515792	Sandoz Clonidine	SDZ	0.1212	** 0.1273

Enalapril Maleate - 2.5 mg - Tablets			**$**	**$ + 5%**
02400650	Enalapril	SAH	0.2288	0.2402

Enalapril Maleate - 5 mg - Tablets			**$**	**$ + 5%**
02400669	Enalapril	SAH	0.2706	0.2841

Enalapril Maleate - 20 mg - Tablets			**$**	**$ + 5%**
02400685	Enalapril	SAH	0.3924	0.4120

Latanoprost - 0.005 % - Ophthalmic Solution			**$**	**$ + 5%**
02513285	M-Latanoprost	MNP	3.6335	3.8152

Latanoprost/Timolol Maleate - 50 mcg/5 mg/mL - Ophthalmic Solution			**$**	**$ + 5%**
02514516	M-Latanoprost-Timolol	MNP	4.4268	4.6481

Metformin HCl - 500 mg - Tablets			**$**	**$ + 5%**
02520303	pmsc-Metformin	PMS	0.0247	0.0259

Metformin HCl - 850 mg - Tablets			**$**	**$ + 5%**
02520311	pmsc-Metformin	PMS	0.0339	0.0356

Midodrine - 2.5 mg - Tablets			**$**	**$ + 5%**
02517701	Jamp Midodrine	JPC	0.1153	** 0.1211

Midodrine - 5 mg - Tablets			**$**	**$ + 5%**
02517728	Jamp Midodrine	JPC	0.1921	** 0.2017

Ondansetron - 4 mg - Orally Disintegrating Tablets			**$**	**$ + 5%**
02511282	Auro-Ondansetron ODT	AUP	3.2723	3.4359

Ondansetron - 8 mg - Orally Disintegrating Tablets			**$**	**$ + 5%**
02511290	Auro-Ondansetron ODT	AUP	4.9930	5.2427

Pantoprazole - 20 mg - Tablets			**$**	**$ + 5%**
02392615	Jamp Pantoprazole Sodium	JPC	0.1803	0.1893

Paroxetine - 10 mg - Tablets			**$**	**$ + 5%**
02507773	Jamp Paroxetine	JPC	0.3046	0.3198

Paroxetine - 20 mg - Tablets			**$**	**$ + 5%**
02507781	Jamp Paroxetine	JPC	0.3250	0.3413

Paroxtine - 30 mg - Tablets			**$**	**$ + 5%**
02507803	Jamp Paroxetine	JPC	0.3453	0.3626

Perindopril/Indapamide - 4 mg/1.25 mg - Tablets			**$**	**$ + 5%**
02519720	Perindopril/Indapamide	SAH	0.2556	0.2684
02479834	Perindopril Erbumine/Indapamide	SIP	0.2556	0.2684

Perindopril/Indapamide - 8 mg/2.5 mg - Tablets				**$**	**$ + 5%**
02519739	Perindopril/Indapamide	SAH	0.2859	0.3002
02479842	Perindopril Erbumine/Indapamide	SIP	0.2859	0.3002

Progesterone - 100 mg - Capsules				**$**	**$ + 5%**
02476576	pms-Progesterone	PMS	0.3762	** 0.3950
02463113	Reddy-Progesterone	DRL	0.3762	** 0.3950

Rizatriptan - 10 mg - Tablets				**$**	**$ + 5%**
02516756	Rizatriptan	SAH	3.7050	3.8903

Tranexamic Acid - 500 mg - Tablets				**$**	**$ + 5%**
02519194	Tranexamic Acid	JPC	0.2967	0.3115

Vancomycin HCl - 1 G - Powder for Injection				**$**	**$ + 5%**
02342863	Vancomycin Hydrochloride	SMI	18.7810	19.7201

Venlafaxine - 37.5 mg - Capsules				**$**	**$ + 5%**
02516535	Venlafaxine XR	JPC	0.0913	0.0959

Venlafaxine - 75 mg - Capsules				**$**	**$ + 5%**
02516543	Venlafaxine XR	JPC	0.1825	0.1916

Venlafaxine - 150 mg - Capsules				**$**	**$ + 5%**
02516551	Venlafaxine XR	JPC	0.1927	0.2023

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

Interchangeable Product Price Changes

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

02240835	Advair 100 Diskus	fluticasone propionate/salmeterol	100 mcg/50 mcg	Powder for Inhalation	1.5381	1.6150
02240836	Advair 250 Diskus	fluticasone propionate/salmeterol	250 mcg/50 mcg	Powder for Inhalation	1.8412	1.9333
02240837	Advair 500 Diskus	fluticasone propionate/salmeterol	500 mcg/50 mcg	Powder for Inhalation	2.6139	2.7446
02239665	Alertec	modafinil	100 mg	Tablet	1.6870	1.7714
02031116	Lamisil	terbinafine HCl	250 mg	Tablet	4.5600	4.7880
00569771	Zovirax	acyclovir	5 %	Ointment	15.8250	16.6163
02281260	ACT Fluconazole	fluconazole	50 mg	Tablet	1.2904	** 1.3549
02281279	ACT Fluconazole	fluconazole	100 mg	Tablet	2.2891	** 2.4036
02477130	Apo-Acyclovir	acyclovir	5 %	Ointment	7.2420	** 7.6041
02243350	Apo-Amoxi Clav	amoxicillin/clavulanic acid	250 mg/125 mg	Tablet	0.4934	** 0.5181
02243351	Apo-Amoxi Clav	amoxicillin/clavulanic acid	500 mg//125 mg	Tablet	0.3778	** 0.3967
02245623	Apo-Amoxi Clav	amoxicillin/clavulanic acid	875 mg/125 mg	Tablet	0.5551	** 0.5829
02237370	Apo-Fluconazole	fluconazole	50 mg	Tablet	1.2904	** 1.3549
02237371	Apo-Fluconazole	fluconazole	100 mg	Tablet	2.2891	** 2.4036
02375540	Apo-Lamivudine/ Zidovudine	lamivudine/zidovudine	150 mg/300 mg	Tablet	5.2206	** 5.4816
02278677	Apo-Midodrine	midodrine	2.5 mg	Tablet	0.1153	** 0.1211

02278685	Apo-Midodrine	midodrine	5 mg	Tablet	0.1921	** 0.2017
02414414	Auro-Lamivudine/ Zidovudine	lamivudine/zidovudine	150 mg/300 mg	Tablet	5.2206	** 5.4816
02442809	Jamp Trazodone	trazodone HCl	50 mg	Tablet	0.0554	0.0582
02473984	Mar-Midodrine	midodrine	2.5 mg	Tablet	0.1153	** 0.1211
02473992	Mar-Midodrine	midodrine	5 mg	Tablet	0.1921	** 0.2017
02462192	Mint-Clonidine	clonidine	0.1 mg	Tablet	0.0679	** 0.0713
02462206	Mint-Clonidine	clonidine	0.2 mg	Tablet	0.1212	** 0.1273
02464365	Methotrexate	methotrexate	25 mg/mL	Injection	8.9200	** 9.3660
02245292	Mylan-Fluconazole	fluconazole	50 mg	Tablet	1.2904	** 1.3549
02245293	Mylan-Fluconazole	fluconazole	100 mg	Tablet	2.2891	** 2.4036
02245643	pms-Fluconazole	fluconazole	50 mg	Tablet	1.2904	** 1.3549
02245644	pms-Fluconazole	fluconazole	100 mg	Tablet	2.2891	** 2.4036
02482576	Sandoz Amoxi-Clav	amoxicillin/clavulanic acid	500 mg/125 mg	Tablet	0.3778	** 0.3967
02482584	Sandoz Amoxi-Clav	amoxicillin/clavulanic acid	875 mg/125 mg	Tablet	0.5551	** 0.5829
02046121	Teva-Clonidine	clonidine	0.1 mg	Tablet	0.0679	** 0.0713
02046148	Teva-Clonidine	clonidine	0.2 mg	Tablet	0.1212	** 0.1273
02236978	Teva-Fluconazole	fluconazole	50 mg	Tablet	1.2904	** 1.3549
02236979	Teva-Fluconazole	fluconazole	100 mg	Tablet	2.2891	** 2.4036
02439913	Teva-Progesterone	progesterone	100 mg	Capsule	0.3762	** 0.3950

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

pan-Canadian Category Price Changes

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

Generic Name - Strength - Form	($)	($ + 5%)
Alendronate - 70 mg - Tablets	1.7804	1.8694
Atenolol - 25 mg - Tablets	0.0441	0.0463
Atenolol - 50 mg - Tablets	0.0938	0.0985
Atenolol - 100 mg - Tablets	0.1543	0.1620
Bisoprolol Fumarate - 5 mg - Tablets	0.0606	0.0636
Bisoprolol Fumarate - 10 mg - Tablets	0.0885	0.0929
Carvedilol - 3.125 mg - Tablets	0.2060	0.2163
Carvedilol - 6.25 mg - Tablets	0.2060	0.2163
Carvedilol - 12.5 mg - Tablets	0.2060	0.2163
Carvedilol - 25 mg - Tablets	0.2060	0.2163
Dutasteride - 0.5 mg - Capsules	0.2565	0.2693

Finasteride - 5 mg - Tablets	0.3506	0.3681
Risedronate - 35 mg - Tablets	1.6764	1.7602
Risperidone - 0.25 mg - Tablets	0.0878	0.0922
Risperidone - 0.5 mg - Tablets	0.1470	0.1544
Risperidone - 1 mg - Tablets	0.2031	0.2133
Risperidone - 2 mg - Tablets	0.4062	0.4265
Risperidone - 3 mg - Tablets	0.6083	0.6387
Risperidone - 4 mg - Tablets	0.8111	0.8517

Product Deletions

(as identified for deletion in Bulletin # 116)

The following products have been deleted.

00582301	Dalacin T	clindamycin	1 %	Topical Solution
02190915	Losec	omeprazole	20 mg	Tablet
00010383 00010391	Sintrom	acenocoumarol	1 mg 4 mg	Tablet
02248761	Viracept	nelfinavir	625 mg	Tablet
02349205	Alprazolam	alprazolam	0.5 mg	Tablet
02391562 02391570	Bupropion SR	bupropion	100 mg 150 mg	Tablet
02389096 02389118	Mar-Olanzapine ODT	olanzapine	10 mg 15 mg	Orally Disintegrating Tablets
02392992 02393018 02393026	Mint-Irbesartan/HCTZ	irbesartan/HCTZ	150 mg/12.5 mg 300 mg/12.5 mg 300 mg/25 mg	Tablet
02413485 02413493 02413507 02413515 02413523	Mylan-Risperidone ODT	risperidone	0.5mg 1 mg 2 mg 3 mg 4 mg	Orally Disintegrating Tablets
00792659	pms-Chloral Hydrate	chloral hydrate	100 mg/5 mL	Syrup
00839264	pms-Ibuprofen	ibuprofen	600 mg	Tablet
02148773 02015951	pms-Ketoprofen	ketoprofen	50 mg 100 mg	Suppository
00584339	pms-Metronidazole	metronidazole	250 mg	Tablet
02481979	Sandoz Methadone	methadone	10 mg/mL	Solution

Category Deletions

- Bupropion HCl - 100 mg - Sustained Release Tablets
- Bupropion HCl - 150 mg - Sustained Release Tablets

Discontinued Products

The following products will be deleted with the next Formulary amendments and will appear as "Product Deletions" on Bulletin # 119.

02251787	Cipro XL	ciprofloxacin HCl	1000 mg	Tablet
00353027	Loestrin	ethinyl estradiol/norethindrone acetate	1.5/30	Kit-Tablet
01902660	Retrovir	zidovudine	100 mg	Capsule
00514012	Voltaren	diclofenac sodium	50 mg	Tablet
02351684	Diclofenac K	diclofenac potassium	50 mg	Tablet
02349205 02351099	Lorazepam	lorazepam	0.5 mg 2 mg	Tablet
02423588	Mint-Ciproflox	ciprofloxacin HCl	750 mg	Tablet
02404192	Mylan-Tolterodine ER	tolterodine	4 mg	Extended Release Capsule
02231504 02231505	pms-Diclofenac SR	diclofenac sodium	75 mg 100 mg	Tablet
02231506	pms-Diclofenac	diclofenac sodium	50 mg	Suppositories
02353016 02353024	Ranitidine	ranitidine	150 mg 300 mg	Tablet