Health Canada Santé Canada

Winter 2016

Non-Insured Health Benefits

First Nations and Inuit Health Branch

Updates to the Drug Benefit List

The Non-Insured Health Benefits (NIHB) Program provides supplementary health benefits, including prescription and non-prescription drugs, for registered First Nations and recognized Inuit throughout Canada. Visit our Web Site at: www.healthcanada.gc.ca/nihb

BENEFIT DEFINITIONS

Open benefits: Open benefits are the drugs listed in the NIHB Drug Benefit List (DBL) which do not have established criteria or prior approval requirements.

Limited use benefits: Limited use drugs are those that have been found to be effective in specific circumstances, or which have quantity and frequency limitations. For drugs in this category, specific criteria must be met to be eligible for coverage.

Not added to the formulary: Drugs not added to formulary are those which are not listed in the NIHB DBL after review by the national Common Drug Review (CDR) process and/or the NIHB Drugs and Therapeutics Advisory Committee (DTAC). These drugs will not be added to the NIHB drug list because published evidence does not support the clinical value or cost of the drug relative to existing therapies. Coverage may be considered in special circumstances upon receipt of a completed "Exception Drugs Request Form" from the attending licensed practitioner. These requests are reviewed on a case by case basis.

Exclusion: Certain drug therapies for particular conditions fall outside the NIHB Program's mandate and will not be provided as benefits (e.g., cosmetic and anti-obesity drugs). As well, certain drugs will be excluded from the NIHB Program as recommended by the CDR and the DTAC because published evidence does not support the clinical value, safety or cost of the drug relative to existing therapies, or there is insufficient clinical evidence to support coverage. Note: The appeal process and the emergency supply policy does not apply to excluded drugs.

ADDITIONS TO THE DRUG BENEFIT LIST

OPEN BENEFITS

Single-Source Drug Products

DIN	MFR	BRAND NAME	Effective Date
02250616	BAY	CLIMARA PRO 4.4/1.39MG PATCH	09-12-2015
02392453	FKD	HEPARIN 10000U/ML INJECTION	28-01-2016
02446073	SIV	ST ISMN 60MG TABLET	18-12-2015
02293854	TEP	PLAN B 1.5MG TABLET	05-11-2015
00555126	PMS	MAGLUCATE 500MG TABLET	06-01-2016
02318164	BAY	RESTORALAX POWDER	23-12-2015
09991455	BTD	ST BD LUER-LOK TIP 60ML SYRINGE	01-11-2015
09991454	BTD	ST BD SLIP TIP 60ML SYRINGE	01-11-2015

Multi-Source Drug Products

DIN	MFR	BRAND NAME	Effective Date
02416255	APX	APO-ABACAV-LAMIVUD-ZIDOVUDINE	28-01-2016
02394790	PMS	ST ASA DAILY LOW DOSE 81MG TABLET	05-11-2015

DIN (Drug Identification Number)
MFR (Manufacturer)
ST (Short-Term Dispensing Policy Drug)

Canada

DIN	MFR	BRAND NAME	Effective Date
02377683	APX	[ST] ASA DAILY LOW DOSE 81MG TABLET	15-12-2015
02447576	SIV	[ST] ALFUZOSIN 10MG TABLET	08-01-2016
02443201	AUR	[ST] AURO-ALFUZOSIN 10MG TABLET	16-02-2016
02442736	SAN	ANASTROZOLE 1MG TABLET	11-01-2016
02407264	AUR	[ST] AURO-ATORVASTATIN 20MG TABLET	17-11-2015
02407272	AUR	[ST] AURO-ATORVASTATIN 40MG TABLET	17-11-2015
02407280	AUR	[ST] AURO-ATORVASTATIN 80MG TABLET	17-11-2015
02442434	SIV	AZITHROMYCIN 250MG TABLET	05-11-2015
02427133	MAR	[ST] MAR-CETIRIZINE 10MG TABLET	04-02-2016
02427141	MAR	[ST] MAR-CETIRIZINE 20MG TABLET	24-12-2015
02445719	SAN	[ST] CITALOPRAM 10MG TABLET	28-01-2016
02429691	MIN	[ST] MINT-CITALOPRAM 10MG TABLET	17-02-2016
02429705	MIN	[ST] MINT-CITALOPRAM 20MG TABLET	17-02-2016
02429713	MIN	[ST] MINT-CITALOPRAM 40MG TABLET	17-02-2016
02442469	SIV	CLARITHROMYCIN 250MG TABLET	05-11-2015
02445999	SIV	[ST] DILTIAZEM CD 120MG CAPSULE	17-12-2015
02446006	SIV	[ST] DILTIAZEM CD 180MG CAPSULE	17-12-2015
02446014	SIV	[ST] DILTIAZEM CD 240MG CAPSULE	17-12-2015
02446022	SIV	[ST] DILTIAZEM CD 300MG CAPSULE	17-12-2015
02443090	MIN	MINT-DORZOLAMIDE/TIMOLOL 20/5	16-02-2016
02442426	PMS	PMS-DORZOLAMIDE-TIMOLOL 20/5MG	31-12-2015
02441659	RIV	RIVA-DORZOLAMIDE/TIMOLOL 20/5	04-12-2015
02442981	SIV	[ST] ENALAPRIL 16MG TABLET	18-01-2016
02442957	SIV	[ST] ENALAPRIL 2MG TABLET	18-01-2016
02442965	SIV	[ST] ENALAPRIL 4MG TABLET	18-01-2016
02442973	SIV	[ST] ENALAPRIL 8MG TABLET	18-01-2016
02407418	MIN	[ST] MINT-ESCITALOPRAM 10MG TABLET	01-12-2015
02407434	MIN	[ST] MINT-ESCITALOPRAM 20MG TABLET	01-12-2015
02385627	AUR	[ST] AURO-FLUOXETINE 10MG CAPSULE	11-01-2016
02385635	AUR	[ST] AURO-FLUOXETINE 20MG CAPSULE	03-11-2015
02445824	SAN	[ST] INDAPAMIDE 1.25MG TABLET	04-01-2016
02445832	SAN	[ST] INDAPAMIDE 2.5MG TABLET	04-01-2016
02341085	RIV	RIVA-LATANOPROST 50MCG/ML OPHTHALMIC SOLUTION	04-12-2015
02442078	BMI	[ST] BIO-MODAFINIL 100MG TABLET	16-11-2015
02404656	ATP	ACT MOXIFLOXACIN 0.5% OPHTHALMIC SOLUTION	03-12-2015
02406373	APX	APO-MOXIFLOXACIN 0.5% OPHTHALMIC SOLUTION	03-12-2015
02432218	PMS	PMS-MOXIFLOXACIN 0.5% OPHTHALMIC SOLUTION	14-01-2016
02411520	SDZ	SANDOZ MOXIFLOXACIN 0.5% OPHTHALMIC SOLUTION	03-12-2015
02427931	APX	APO-NEVIRAPINE XR 400MG TABLET	28-01-2016
02442930	SIV	[ST] NIFEDIPINE XR 30MG TABLET	26-11-2015
02442949	SIV	[ST] NIFEDIPINE XR 60MG TABLET	26-11-2015
02418630	PMS	[ST] PMS-NIFEDIPINE ER 30MG TABLET	06-11-2015
02416301	PMS	[ST] PMS-NIFEDIPINE ER 60MG TABLET	06-11-2015
02444674	SDZ	[ST] SANDOZ ONDANSETRON ODT 4MG TABLET	28-01-2016
02444682	SDZ	[ST] SANDOZ ONDANSETRON ODT 8MG TABLET	28-01-2016
00804312	SDZ	VITAMIN K1 10MG/ML USP INJECTION	21-01-2016
00781878	SDZ	VITAMIN K1 1MG/0.5ML USP INJECTION	21-01-2016
02438011	MIN	[ST] MINT-QUETIAPINE 100MG TABLET	30-11-2015
02438046	MIN	[ST] MINT-QUETIAPINE 200MG TABLET	30-11-2015
02438054	MIN	[ST] MINT-QUETIAPINE 300MG TABLET	30-11-2015
02440334	JAP	[ST] JAMP-RAMIPRIL 15MG CAPSULE	19-01-2016
02447800	JAP	JAMP-TIMOLOL 5MG/ML OPHTHALMIC SOLUTION	19-01-2016
02441454	JAP	JAMP-VALACYCLOVIR 500MG TABLET	05-11-2015
02441586	MAR	MAR-VALACYCLOVIR 500MG TABLET	05-11-2015
02442000	SIV	PRIVA-VALACYCLOVIR 500MG TABLET	16-11-2015
02441861	PHA	PRIVA-VALACYCLOVIR 500MG TABLET	16-11-2015

DIN	MFR	BRAND NAME	Effective Date
02425629	NOV	LUCENTIS PFS 10MG/ML INJECTION	02-12-2015

Limited use benefit (prior approval required)
Note: Coverage will be limited to a maximum of one vial of ranibizumab per eye treated every 30 days.
- Administered by a qualified ophthalmologist experienced in intravitreal injections;
- Interval between doses not shorter than one month

For the treatment of DME for patients who meet the following:
- Clinically significant diabetic macular edema for whom laser photocoagulation is also indicated; AND
- Have a hemoglobin A1c of less than 11%

For the treatment of RVO for patients who meet one of the following:
- Clinically significant macular edema secondary to branch retinal vein occlusion (BRVO); OR
- Central retinal vein occlusion (CRVO).
- Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on ranibizumab treatment. Thereafter patients should be monitored monthly for visual acuity.
- Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive monthly assessments.
- Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

For the treatment of CNV for patients who meet the following:
- Visual impairment due to choroidal neovascularization secondary to pathologic myopia (mCNV).
- Treatment is initiated with a single intravitreal injection. Monitoring is recommended monthly for the first two months and at least every three months thereafter during the first year. If monitoring reveals signs of disease activity (e.g. reduced visual acuity and/or signs of lesion activity), further treatment is recommended at a frequency of 1 injection per month until no disease activity is seen.

For the treatment of neovascular w-AMD where all of the following apply to the eye to be treated:
- Best Corrected Visual Acuity (BCVA) is between 6/12 and 6/96- The lesion size is less than or equal to 12 disc areas in greatest linear dimension
- There is evidence of recent (< three months) presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, or optical coherence tomography (OCT)
Note: Coverage will not be approved for patients:
- With permanent retinal damage as defined by the Royal College of Ophthalmology guidelines.
- Receiving concurrent treatment with verteporfin

Continued Coverage:
Treatment with ranibizumab for w-AMD should be continued only in people who maintain adequate response to therapy
Treatment with Lucentis should be permanently discontinued if any one of the following occurs:
- Reduction in BCVA in the treated eye to less than 15 letters (absolute) on two consecutive visits in the treated eye, attributed to AMD in the absence of other pathology
- Reductions in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect, adverse events or both.
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three consecutive visits.

02425483	JNO	INVOKANA 100MG TABLET	07-12-2015
02425491	JNO	INVOKANA 300MG TABLET	07-12-2015

Limited use benefit (prior approval required)
For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

99503020	UNK	[ST] CLONAZEPAM 0.1MG/ML	16-11-2015

Limited use benefit (prior approval not required).
To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4,000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

DIN	MFR	BRAND NAME	Effective Date
09853430	ELN	[ST] DIASTAT 2X15MG RECTAL GEL PACK	09-12-2015
02238162	VAE	[ST] DIASTAT 5MG/ML RECTAL GEL PACK	09-12-2015
09853340	ELN	[ST] DIASTAT RECTAL GEL 2X10MG PACK	09-12-2015

Limited use benefit (prior approval not required).
For children 12 years of age or under.
To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4,000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day

02434571	STE	[ST] DICLOFENAC 15MG/G TOPICAL SOLUTION	30-12-2015

Limited use benefit (prior approval required)
For the treatment of osteoarthritis when:
a- Pain is inadequately controlled with acetaminophen AND a non-steroidal anti-inflammatory (NSAID) OR
b- There is contraindication to acetaminophen and NSAID OR
c- There is intolerance to acetaminophen and NSAID.

02447541	SIV	[ST] FINASTERIDE 5MG TABLET	08-01-2016

Limited use benefit (prior approval required)
For treatment of benign prostatic hyperplasia (BPH) in patients who do not tolerate or have not responded to an alpha adrenergic blocker; OR
For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

02443023	SAN	[ST] GALANTAMINE ER 16MG CAPSULE	16-02-2016
02443031	SAN	[ST] GALANTAMINE ER 24MG CAPSULE	16-02-2016
02443015	SAN	[ST] GALANTAMINE ER 8MG CAPSULE	16-02-2016

Limited use benefit (prior approval required).
Initial six month coverage for cholinesterase inhibitors:
a- Diagnosis of mild to moderate Alzheimer's disease; AND
i. Please provide Mini Mental State Exam (MMSE) score established within the last 60 days (Patient must have a score between 10-26); AND
ii. Please provide Global Deterioration Scale (GDS) score established within the last 60 days (Patient must have a score between 4-6).

Criteria for coverage at every six month interval:
a- Diagnosis is still mild to moderate Alzheimer’s disease; AND
b- MMSE score > 10; OR
c- GDS score between 4 to 6; AND
d- Improvement or stabilization in at least one of the following domains (please indicate improved, worsened, or no change):
i. Memory, reasoning and perception (e.g., names, tasks, MMSE)
ii. Instrumental activities of daily living (IADLs: e.g., telephone, shopping, meal preparation)
iii. Basic activities of daily living (e.g., bathing, dressing, hygiene, toileting)
iv. Neuropsychiatric symptoms (e.g., agitation, delusions, hallucination, apathy)

09991458	SMW	INFUSION SET IV3000	02-02-2016

Limited use benefit (prior approval required).
Patient has type 1 diabetes; AND
The insulin pump should have been prescribed /recommended by an endocrinologist or a specialist prescriber with experience in the use of insulin pumps in children, adolescent and/or adults.

99401038	AUC	INSULIN PUMP BATTERY	10-11-2015

Limited use benefit (prior approval required)
Patient has type 1 diabetes; AND
The insulin pump is prescribed by an endocrinologist or a specialist prescriber with experience in the use of insulin pumps in children, adolescent and/or adults.

DIN	MFR	BRAND NAME	Effective Date
02287188	BCM	FOSRENOL 1000MG TABLET	01-02-2016
02287145	BCM	FOSRENOL 250MG TABLET	01-02-2016
02287153	BCM	FOSRENOL 500MG TABLET	01-02-2016
02287161	BCM	FOSRENOL 750MG TABLET	01-02-2016

Limited use benefit (prior approval required)
For patients with elevated phosphate levels or elevated phosphate X calcium product despite dietary restriction of phosphate and use of calcium-based phosphate binders (short term elevations should be managed with aluminum based binders) OR
For patients with elevated calcium levels despite discontinuation of calcium binder, and vitamin D analogue and/or modification of dialysate calcium OR
For patients with adynamic bone disease and low PTH levels (< 100 pg/ml or < 9 pmol/L) with normal or elevated calcium levels.

99503026	UNK	LEVETIRACETAM 50MG/ML	16-11-2015

Limited use benefit (prior approval required).
For the use in combination with other anti-epileptic medication(s) in the treatment of partial seizures in patients who are refractory to adequate trials of two anti-epileptic medications used either as monotherapy or in combination.

02404923	APX	APO-MOXIFLOXACIN 400MG TABLET	21-01-2016
02432242	AUR	AURO-MOXIFLOXACIN 400MG TABLET	09-12-2015
02447061	JAP	JAMP-MOXIFLOXACIN 400MG TABLET	16-02-2016
02443929	JAP	JAMP-MOXIFLOXACIN 400MG TABLET	09-12-2015
02447053	MAR	MAR-MOXIFLOXACIN 400MG TABLET	09-12-2015
02383381	SDZ	SANDOZ MOXIFLOXACIN 400MG TABLET	09-12-2015
02375702	TEP	TEVA-MOXIFLOXACIN 400MG TABLET	09-12-2015

Limited use benefit (prior approval not required)
Coverage will be limited to 14 days.

80015240	ATP	[ST] NICOTINE 2MG GUM	30-11-2015
80044392	ATP	[ST] NICOTINE TRANSDERMAL 14MG	26-11-2015
80044389	ATP	[ST] NICOTINE TRANSDERMAL 21MG	26-11-2015
80044393	ATP	[ST] NICOTINE TRANSDERMAL 7MG PATCH	26-11-2015
80013549	ADD	[ST] NICOTINE TRANSDERMAL SYST 14MG	20-01-2016
80014250	ADD	[ST] NICOTINE TRANSDERMAL SYST 21MG	20-01-2016

Limited use benefit with quantity and frequency limits (prior approval is not required).
For smoking cessation:
a- Coverage is limited to 945 pieces during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled OR
b- Coverage will be provided for up to the allowable number of patches for one of the following products, during a one-year period. The year starts on the date the first prescription is filled. The number of patches covered in the one-year period is: Habitrol 168 patches or Nicoderm 140 patches or Nicotrol 140 patches Once this quantity has been reached, the client is eligible again for coverage for nicotine patches when one year has elapsed from the day the initial prescription was filled.

02441853	ASI	[ST] PANTOPRAZOLE MAGNESIUM 40MG	04-12-2015
02440628	TEP	[ST] TEVA-PANTOPRAZOLE MAGNESIUM 40	18-12-2015

Limited use benefit (prior approval not required).
NIHB has implemented a quantity limit on proton pump inhibitors (PPIs). A total of 400 tablets or capsules are permitted in a 180-day period. This quantity limit is based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy.
Reasons for exceeding 400 tablets/capsules in 180 days:
a- Zollinger Ellison Syndrome (may be granted a one-year approval) b- Barrett's esophagus (may be granted a one-year approval) c- Erosive esophagitis (may be granted a one-year approval) d- Change from one PPI to another (single exemption may be granted) e- Other.

DIN	MFR	BRAND NAME	Effective Date
02415208	AUR	[ST] AURO-PANTOPRAZOLE 40MG TABLET	19-11-2015

Limited use benefit (prior approval not required).
NIHB has implemented a quantity limit on proton pump inhibitors (PPIs). A total of 400 tablets or capsules are permitted in a 180-day period. This quantity limit is based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy.
Reasons for exceeding 400 tablets/capsules in 180 days:
a- Zollinger Ellison Syndrome (may be granted a one-year approval) b- Barrett's esophagus (may be granted a one-year approval) c- Erosive esophagitis (may be granted a one-year approval) d- Change from one PPI to another (single exemption may be granted) e- Other.

02436000	JAP	[ST] JAMP-PREGABLIN 150MG CAPSULE	04-12-2015
02435977	JAP	[ST] JAMP-PREGABLIN 25MG CAPSULE	04-12-2015
02436019	JAP	[ST] JAMP-PREGABLIN 300MG CAPSULE	04-12-2015
02435985	JAP	[ST] JAMP-PREGABLIN 50MG CAPSULE	04-12-2015
02435993	JAP	[ST] JAMP-PREGABLIN 75MG CAPSULE	04-12-2015

Limited use benefit (prior approval required)
For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA)
OR
For the treatment of neuropathic pain in patients who have a contraindication or intolerance with a tricyclic antidepressant (TCA)
The dose of pregabalin is limited to a maximum of 600 mg per day.
Doses over 600 mg per day will be considered by appeal only.

02442914	SAN	RIZATRIPTAN ODT 10MG TABLET	06-11-2015
02446138	SIV	RIZATRIPTAN ODT 10MG TABLET	18-12-2015
02442906	SAN	RIZATRIPTAN ODT 5MG TABLET	06-11-2015
02446111	SIV	RIZATRIPTAN ODT 5MG TABLET	18-12-2015

Limited use benefit (prior approval is not required)
A total of 12 tablets (or injections) are permitted in a 30-day period.

02424347	JAP	[ST] JAMP-SOLIFENACIN 10MG TABLET	16-02-2016
02424339	JAP	[ST] JAMP-SOLIFENACIN 5MG TABLET	16-02-2016
02437996	RBY	[ST] RAN-SOLIFENACIN 10MG TABLET	28-01-2016
02437988	RBY	[ST] RAN-SOLIFENACIN 5MG TABLET	28-01-2016

Limited use benefit (prior approval required)
For the symptomatic relief of overactive bladder in patients:
a- with symptoms of urinary frequency, urgency or urge incontinence; AND
b- who have failed on or are intolerant to therapy with immediate-release oxybutynin

02421933	APX	[ST] APO-TADALAFIL PAH 20MG TABLET	08-12-2015

Limited use benefit (prior approval required)
Maximum dose covered is 40 mg daily. Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization

02441160	ATP	ACT-TEMOZOLOMIDE 5MG CAPSULE	09-11-2015

Limited use benefit (prior approval required)
For the treatment of adult patients with recurrent or progressive glioblastoma multiforme or anaplastic astrocytoma and documented evidence of recurrence or progression after standard therapy (resection, radiotherapy, and chemotherapy), OR
For treatment of adult patients with newly diagnosed glioblastoma multiforme concomitantly with radiotherapy and then as maintenance treatment.

DIN	MFR	BRAND NAME	Effective Date
02423308	MIN	MINT-TOLTERODINE 1MG TABLET	25-02-2016
02423316	MIN	MINT-TOLTERODINE 2MG TABLET	25-02-2016
02404184	MYL	[ST] MYLAN-TOLTERODINE ER 2MG CAPSULE	10-12-2015
02404192	MYL	[ST] MYLAN-TOLTERODINE ER 4MG CAPSULE	10-12-2015
02413159	SDZ	[ST] SANDOZ TOLTERODINE LA 4MG CAPSULE	14-01-2016
02299593	TEV	TEVA-TOLTERODINE 1MG TABLET	25-02-2016
02299607	TEV	TEVA-TOLTERODINE 2MG TABLET	25-02-2016
02412195	TEP	[ST] TEVA-TOLTERODINE LA 2MG CAPSULE	14-01-2016
02412209	TEP	[ST] TEVA-TOLTERODINE LA 4MG CAPSULE	14-01-2016
Limited use benefit (prior approval required) For the symptomatic relief of overactive bladder in patients: a- with symptoms of urinary frequency, urgency or urge incontinence; AND b- who have failed on or are intolerant to therapy with immediate-release oxybutynin			
00122823	JAM	[ST] VITAMIN E 100IU CAPSULE	02-12-2015
Limited use benefit (prior approval required) For use in malabsorption.			
02438453	ANG	AG-ZOLMITRIPTAN ODT 2.5MG TABLET	19-01-2016
Limited use benefit (prior approval is not required) A total of 12 tablets (or injections) are permitted in a 30-day period.			

CRITERIA CHANGES

CHANGE IN QUANTITY LIMIT OF SPACER DEVICES

Effective November 27, 2015, quantity limit of Spacer Device was changed to two (2) devices every 12 months.
Previously quantity limit for Spacer Device was one (1) device every 12 months.

NEW PSEUDO DINS FOR OPEN BENEFIT EXTEMPORANEOUS MIXTURE

Effective November 16, 2015, Non-Insured Health Benefits (NIHB) replaced the extemporaneous mixture open-benefit pseudo-DINs 00999999, 00990019, 00999997 and 00999994 with pseudo-DINs that are specific to the mixture being submitted. Providers are no longer be able to bill these pseudo-DINs and the following message will be sent back: "DIN/PIN/GP# not a benefit". If this happens, providers should refer to the pseudo-DINs below to identify the correct billable pseudo-DIN for their claim. If providers are unable to determine the appropriate pseudo-DIN, then please call Express Scripts Canada at 1-888-511-4666.

99503009	ALDACTAZIDE 5MG/ML
99501006	ALL PURPOSE NIPPLE OINTMENT
99503018	ALLOPURINOL 20MG/ML
99503016	AMIODARONE 5MG/ML
99503003	AMLODIPINE 1MG/ML
99503028	ANTACID AND LIDOCAINE SUSPENSION
99503011	BACLOFEN 5MG/ML
99502000	CLINDAMYCIN IN DILUSOL
99503021	CLONIDINE 0.1MG/ML
99503007	DEXAMETHASONE 1MG/ML
99503005	DOMPERIDONE 1MG/ML
99503013	ENALAPRIL 1MG/ML
99503000	HYDROCHLOROTHIAZIDE 5MG/ML
99500000	HYDROCORT. PD AND CLOTRI. CREAM
99506015	IRON SUCROSE INJECTION
99503031	ISONIAZID 25MG/ML SUSPENSION
99500010	LCD IN CORTICOSTEROID CREAM
99501000	LCD IN CORTICOSTEROID OINTMENT
99500009	LCD IN NON-MEDICATED CREAM
99501005	LCD IN NON-MEDICATED OINTMENT
99503029	MAGIC MOUTHWASH
99500002	MENTHOL &/OR CAMPHOR IN STEROID
99502001	MENTHOL&CAMPHOR IN STEROID LOTION
99503015	METOPROLOL 10MG/ML
99503012	METRONIDAZOLE 50MG/ML
99502002	MISC. COMPOUNDED EXTERNAL LOTION
99504000	MISC. COMPOUNDED EXTERNAL POWDER
99507000	MISC. COMPOUNDED EYE/EAR DROP
99506021	MISC. COMPOUNDED INJ./INFUSION
99503025	MISC. COMPOUNDED INTERNAL LIQUID
99505000	MISC. COMPOUNDED INTERNAL POWDER
99508000	MISC. COMPOUNDED SUPPOSITORY
99500004	MISC. COMPOUNDED TOPICAL CREAM
99501004	MISC. COMPOUNDED TOPICAL OINTMENT
99500008	MOMETASONE 0.05% CREAM
99501003	NIFEDIPINE IN CALMOSEPTINE OINTMENT
99503004	NITROFURANTOIN 10MG/ML
99503002	OMEPRAZOLE 2MG/ML
99503008	PREDNISONE 5MG/ML
99503014	PROPRANOLOL 1MG/ML
99503022	RIFAMPIN 25MG/ML
99500003	SAL ACID IN CORTICOSTEROID CREAM
99501001	SAL ACID IN NON-MEDICATED OINTMENT
99503023	SOTALOL 5MG/ML
99503001	SPIRONOLACTONE 5MG/ML
99500001	STEROID CREAM AND ANTIFUNGAL CREAM
99500006	SULFUR IN NON-MEDICATED CREAM
99501002	SULFUR IN NON-MEDICATED OINTMENT
99503027	TOPIRAMATE 6MG/ML
99503006	TRANEXAMIC DENTAL MOUTHWASH 100MG/ML
99503017	TRIMETHOPRIM 10MG/ML
99503024	UROSODIOL 50MG/ML